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THEORIES OF COUNSELING AND PSYCHOTHERAPY

A Case Approach

NANCY L. MURDOCK



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A Case Approach

Fourth Edition

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To my parents,
Mary Elizabeth Frojd Murdock
and
Sandlan John Murdock,
also to
Robert W. Lewis

Preface

There is nothing so practical as a good theory.

—Kurt Lewin

I am very excited to present the 4th edition of *Theories of Counseling and Psychotherapy: A Case Approach*. There are many updates in this version; read on to find out.

NEW TO THIS EDITION

The major goals for this revision were to prepare new content for the electronic version of the text, add new theoretical material, and thoroughly update the research and other commentary relevant to the theoretical approaches. Specifically, this edition includes:

- Updated theoretical material in all chapters; reviews of the most recent sources on the theories.
- Substantially revised coverage of psychotherapy outcome research and added discussions of comparative studies using treatment as usual groups, the latest conclusions about the relative efficacy of theoretical approaches, and perspectives on evidence-based practice.
- Major revisions to the Research Support sections of all chapters to include the latest research available on the theoretical approaches.
- Over 300 new sources across all chapters.
- Addition of video resources and exercises for the e-text version of the text.
- Revision and update of the *Evaluation of the Theory* sections, with particular focus on issues of individual and cultural diversity.

WHY I WROTE THIS BOOK

The quote from Kurt Lewin aptly captures my philosophy on the role and use of theory. I have been teaching about counseling theory for longer than I care to say, and I consider myself something of a theory freak. I admit that I think theory is fun. However, over the years I have learned that theory is not very useful if you don't know how to apply it; application is what makes theory practical and good. I have struggled to teach the application of theory to my students, trying different methods and models along the way. Knowing that it is sometimes difficult for me,

how can I expect the application process to be easy for students just learning the basics of counseling theory? That's why I wrote this book; it is an effort to demonstrate the value of theory through its application. Theory comes alive when it is used to understand a client presentation. The pitfalls and strengths of an approach are never more evident than when it is put to use in this way.

The task of understanding a client presentation in a theoretical structure creates a situation in which you need to know the theory in a way that is different from simply knowing its constructs and techniques. At times it is tempting to give up the attempt to apply a theory to a given client presentation, because the theory under consideration just doesn't seem to fit as well as some other one. My experience has been that when this situation occurs, the potential for learning is great. Clients don't offer their problems in theory-laden terms. They tend to speak in their own language, and it is your job to do the best you can to understand that language in ways that are helpful. In essence, you need to interpret the client's presentation in theoretical terms. Another situation in which I have found theory most useful is when my clients have me confused. Instead of operating on automatic pilot, I am forced to ask, "Now what on earth just happened here?" My theory helps me calm down and sort out what initially seems chaotic.

In each chapter of this book I have tried to present the various theories in a straightforward, understandable way. What distinguishes this book from others is that I immediately illustrate the application of a construct or process by showing how it relates to a client case described at the beginning of the chapter. I chose to use different client cases for each chapter for at least two reasons: First, I wanted to show that theory could apply to clients who range across the broad spectrum of individual and cultural diversity and present with many kinds of distress. Second, I did not want my readers to lose interest from reading about the same case chapter after chapter. In essence, I have tried to make this book as engaging as I possibly could without compromising the intellectual quality of the presentations. However, it is an engaging and useful exercise to apply different theories to the same case, so I would urge the users of this book to undertake this task as a way of comparing the approaches in a meaningful way.

THE THEORIES I CHOSE

A question always arises about which theories to include in a text like this one. Some choices are obvious; others less so. I included classical psychoanalysis—even though true analysis may not be common these days—because it is the foundation of the profession and the springboard for many other systems. If you ever write something that generates as much love and hate as Freud's work did, you have really created something important. I chose other theoretical approaches based on several criteria: (a) currency—whether the theory is used by professionals in the real world; (b) potential to contribute to an understanding of the counseling process even if the reader does not adopt the theory wholesale; and (c) comprehensiveness—the extent to which the theory provides a conceptual structure as well as guidelines for counseling and associated techniques.

MY PHILOSOPHY

I am a counseling psychologist and a scientist-practitioner, and these aspects of my professional identity influence the structure and content of the presentations in this book. I am committed to my specialty's values of attending to individuals' strengths and orienting toward health as

much as (or more than) toward dysfunction. I prefer to look at people through a positive lens, seeing personal strength and the potential to change in every life moment. To focus primarily on deficits seems to me to be a disservice to the human spirit. This emphasis leads to the use of terms such as *client* instead of *patient* and *dysfunction* rather than *disorder*. I also include sections in each chapter that describe the theory's version of the healthy personality.

An important element of the identity of a counseling psychologist is a commitment to the scientist-practitioner model. The scientist in me wants some confirmation that a theoretical structure is valid. This is not to say that I endorse the idea of one true reality; rather, I consider myself an intellectual pragmatist. I simply want some evidence that the version of reality presented by a given theoretical structure actually helps me understand the counseling process and help my clients. The sections on research support in each theory chapter grew out of this empirical bent. If I were to be totally honest, I'd have to say that, philosophically, I lean toward the contextual perspective, rooted in Frank and Frank's (1991) work and further supported and elaborated by Bruce Wampold. You'll find this model described in Chapter 17. It would be nice if we could find the one true theory, but for now I think that that possibility is fairly remote, and the data seem to support this position.

Another defining feature of counseling psychology is attention to individual and cultural diversity. We are all aware that our world is changing and that, historically, counseling and psychotherapy have been mired in a White, Western European, male model. The failure to recognize the biases inherent in this model (e.g., an emphasis on individualism, a lack of attention to social and cultural forces in people's lives) is, to be blunt, unethical. I have attempted to address these issues systematically in each chapter. I have also selected clients and counselors of diverse backgrounds for the case presentations.

My concern about the effects of sex bias in language has led me to the solution of alternating the singular pronouns used in this text. In the theory chapters the pronouns used match those of the client and counselor in the case study. If the client is female, references to client issues and processes in the discussion of theory employ feminine pronouns. If the therapist is male, references to therapist activities or processes employ masculine pronouns. The diverse cases include men and women in both client and counselor roles. In Chapters 1 and 16, pronouns are alternated randomly.

ACKNOWLEDGMENTS

All of my teachers—both students and professors—deserve mention; however, the list of names would be so lengthy I must simply acknowledge my graduate program at Virginia Commonwealth University and all of the students over my postgraduate career as significant educators in my journey to becoming a teacher of theory. Numerous students have read and commented on chapters of this book, and I truly appreciate their helpful feedback. I am also deeply indebted to all of the clients with whom I have been fortunate to work over my career.

Numerous reviewers are responsible for significant improvements in all four editions of this book. Specifically, I would like to thank the following reviewers who provided valuable input for this 4th edition: Rachel Dilts, Ph.D., Oregon State University; J. Rico Drake, Central Michigan University; Dr. Bill McHenry, Texas A&M University-Texarkana; and Tamara Coder Mikinski, Ph.D., University of Kansas.

It was important to me to have client cases for study that, while interesting in content, were fairly representative of the clients we see in the real world and covered a diverse spectrum. In all cases, identifying information was changed to protect the identity of the individuals.

Some of these cases were loosely based on my own clients, who have taught me much about being a counselor. Others were contributed by students, so special thanks go to Shawn Roberson, Natalie Wilcox, Laura Shaughnessey, and Meredith Porter. Thanks also to Aaron Rochlen, who allowed me to use the case of Theo for Chapter 3, and to Kate Forristall and David Donovan, who created the case of Helen, used in the video series and in Chapter 6. David also contributed the case of Annika, found in Chapter 16, and provided lots of encouragement and support.

There are always numerous folks to thank for their assistance and support in a project like this one. Bob Lewis, to whom I dedicate this book (along with my parents), was inspirational in my completion of the very first edition of this book and is still the only person other than editors who actually had the patience and perseverance to read all of the chapters in the first and second editions. No one since has attempted that onerous task. Laura Logan, long-time bud, also gets an award for social support and gustatory distraction/stress relief. Heidi Hancock, who contributed to the second edition the photograph for Chapter 1 and the third edition cover image again offered the beautiful photo that became the cover of this edition. I am deeply appreciative of this gift, and of the friendship we have shared over many years. Extra special thanks go to Jeffrey J. Bentley and Amelia vom Drache Feld for their love, encouragement, and continued enthusiasm for my work.

The patience and support of the faculty, staff, and students of the Division of Counseling and Educational Psychology at UMKC were also instrumental in the revision process. Marina Khan, Monica Oh, and Leslie Stapley, doctoral students in Counseling Psychology at UMKC, were heroic in their roles as research assistants, speedily tracking down an amazing range of resources. Members of my research group, past and present, contributed interesting content for boxes you will find in Chapters 3, 6, 9, and 16, and expert advice on the currency of cultural references. Finally, I would be remiss if I didn't once again thank the staff at Pearson, and particularly editor Kevin Davis. Kevin is the editor for this edition, but more significantly was actually responsible for this book ever happening—it was his random visit to my university lair many years ago that inspired the first edition.

The video project represents the combined efforts of a group of hard-working, talented individuals to whom I extend my most sincere gratitude. Peter Morello, Associate Professor of Communication Studies at UMKC, served as producer, working closely with Kevin Mullin, Instructor and Studio Engineer in Communication Studies, our ace camera and editing expert. Kate Forristall, the actress who portrayed Helen, the client, was magnificent—many who viewed the rough cuts of the video had no idea that she was not a "real" client. Huge thanks go to David Donovan, who you will see as the psychoanalyst, for his help in finding Kate and many of the other therapists you will see in the series. It is difficult to find the right words to express my appreciation (and awe) for the hard work and enthusiasm of Kate, David, and the other therapists: Paul Anderson, Jennifer Lundgren, Jim Kreider, Linda Moore, and Shelley Stelmach. Without them, my dreams for this project would have remained unrealized.

Finally, I pay tribute to my parents, Mary Elizabeth Frojd Murdock and Sandlan John Murdock, and to my sisters, Kathy Winn and Cecelia Niemann, for helping me become the person who could write this book. One of my fondest memories involves asking my mother why cats purr. She sent me off to complete my first literature search in the hope of answering this question. Among other things, my sisters taught me to swim, dance, and write in cursive, important skills at which I have had varying rates of success. Most important, my family taught me the value of relationships and attention to others that is so necessary to becoming a professional helper.

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CHAPTER 1

Theory Is a Good Thing



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

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

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

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

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Video Example 1.1 Introducing Scarlett

YouTube Video

https://www.youtube.com/watch?v=GQ5lCXMC4xY

You are Scarlett's counselor. She looks at you, imploring you to help her get Rhett back. What are you going to do? She is crying, fainting, and having panic attacks. Should you address these symptoms first, or help her make a plan to find Rhett and win him back with her love (which is what

she wants most)? How do you help Scarlett with her grief over the loss of her daughter? What is the contribution of Scarlett's family background and more recent history to the current situation?

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

WHAT IS THEORY?

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

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

WHAT IS PSYCHOTHERAPY?

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

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

Wampold and Imel (2015) took a slightly different view:

> Psychotherapy is a primarily interpersonal treatment that is (a) based on psychological principles; (b) involves a trained therapist and a client who has a mental disorder, problem, or complaint; (c) is intended by the therapist to be remedial for the client's disorder, problem, or complaint; and (d) is adapted or individualized for the particular client and his or her disorder, problem, or complaint. (p. 37)

The American Counseling Association (ACA) offers still another definition: "counseling is a professional relationship that empowers individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (ACA, n.d.)

Which definition do you think is best? As you can see, what we assume everyone knows is not necessarily so. What are the implications of using language such as "overcome obstacles to their personal growth" versus "remedial for the client's disorder, problem, or complaint"? Are the effects of counseling limited to "mental health, wellness, education, and career goals"? These kinds of philosophical differences supply the underpinnings for the various theories of psychotherapy that will be presented in this text.

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

MyCounselingLab

Video Example 1.2 Is this counseling or psychotherapy?



https://www.youtube.com/watch?v=24d-FEptYj8

WHY BOTHER WITH THEORY?

Once you've tentatively decided what counseling is, the next step is to consider how to do it. A long-standing tradition, dating from Sigmund Freud, is that the practice of psychotherapy is guided by the use of theory. For Freud, of course, there was only *one* theory. In the 2000s, we can count over 500 different approaches to counseling (Kazdin, 2008). The situation may seem bewildering, and you may be wondering, "Do I have to have a theory?" After all, we've all heard the phrases "That's just theoretical" and "Theoretically. . . ." The general message seems to be that theory is one thing, reality is another. Theory is something that is the concern of ivory-towered fuzzy-headed intellectuals, and it is well known they live their lives far from reality.

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

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

THEORY IS FUN

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

THEORY WORKS

As you will see before this chapter is over, we are pretty certain that the major counseling theories are effective. Each of the theories I present explains why people behave as they do, how to

help them grow, and how to change aspects of their lives if they wish to do so. Careful, critical application of these principles seems to result in decreases in psychological symptoms and increased signs of psychological health. I'd also risk saying that good psychotherapy results in better self-understanding and, ultimately, can produce changes in lives that increase happiness.

THEORY IS ESSENTIAL TO HUMAN LIFE

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

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

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

COUNSELORS WHO DON'T USE THEORY MAY GET LOST

What about those who don't think about theory or, even worse, reject it outright? Consider a metaphor: If I wanted to travel from Lake Lotawana, Missouri, to Key West, Florida, how would I proceed? I consider flying on a plane, but then reject that notion in favor of my trusty old Miata, which I have always wanted to drive across the Seven Mile Bridge. So driving is the thing, but do I just pack my bags and head out the door? Well, some folks might—but we will leave this approach for another paragraph. The first thing I would do is find a map of the United States.

As I scrutinize my map, I discover several things. First, many major roads (interstate highways) seem to be very efficient, well-trodden paths. There are also back roads—scenic, but perhaps less

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

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

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

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

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

YOUR TASK: FIND YOUR MAP

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

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

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

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

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

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

CHARACTERISTICS OF GOOD THEORY

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

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

Questions about whether individuals can truly integrate the elements of the scientist–practitioner model have raged for years (Nathan, 2000). At one extreme, the model is interpreted to mean that professionals should routinely engage in both science and practice in their everyday activities. Proponents of this view have been disappointed to find that very few practitioners engage in scientific research. Interestingly, some research indicates that

individuals who are mainly scientists—college and university professors who teach counseling and psychotherapy—do practice what they preach (Himelein & Putnam, 2001; Hinshaw, Murdock, Ng, & Ross, 2012; Murdock & Brooks, 1993). Studies consistently demonstrate that about 60% of university faculty report that they regularly work with clients in some form (mostly individual counseling). Thus, it is at least possible to realize both components of the scientist–practitioner model, although it appears that, for practical reasons, very few professionals do.

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

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

Precision and Testability

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

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

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

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

Another quality related to testability is refutability (Sollod, Wilson, & Monte, 2009). In essence, you should be able to deduce what kind of information will lead to disconfirmation of the theory. However, because a theory is refutable does not mean it will be abandoned if disconfirming evidence emerges. The history of science shows us that it is indeed difficult to discard a theory, because what constitutes good evidence is often a topic of debate (Kuhn, 1970).

EMPIRICAL SUPPORT

A good theory should have some empirical support (Maddi, 1996). From a scientist–practitioner perspective, this is a given. The question is, what constitutes empirical support? Some wise individuals have opined "one theorist's placebo (e.g., nondirective discussion) is another's favorite treatment" (Haaga & Davison, 1989, p. 502).

Sigmund Freud's idea of empirical support was found in his own case descriptions, which he wrote mostly after the fact. Nowadays, uncontrolled methods such as these are not considered good empirical support because they reflect one person's views and are therefore subject to much bias (Heppner, Wampold, Owner, Thompson, & Wang, 2016). More appropriate are controlled case studies in which specific, standardized measurements are made over the course of counseling and the interventions performed are well defined and verified (i.e., the extent to which the therapist faithfully performed the treatment is ascertained).

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

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

Over the years since Eysenck's article, huge numbers of studies have been conducted to test the effects of psychotherapy, and there is now agreement within the profession that psychotherapy is indeed effective (Lambert, 2013; Wampold & Imel, 2015). In what is generally cited as the authoritative reference on psychotherapy outcome, Lambert (2013) concluded that "Indeed, psychotherapy is more effective than many 'evidence-based' medical practices" (p. 172, quotes in original). The sheer amount of data gathered since the original 1952 challenge is overwhelming but can generally be classified into three sets: meta-analytic studies, what I call "exemplar" outcome studies, and, perhaps most controversial, consumer survey data (Seligman, 1995).

Meta-analysis is a statistical technique that combines the results of a selected set of studies into an overall index of effectiveness, called *effect size*. Effect size tells us whether, across all studies, the treatment being observed is associated with significant differences between treated and untreated groups or with differences between two theoretical or treatment approaches.

For example, the earliest meta-analyses compared counseling to no treatment and found effect sizes in the 0.75 to 0.80 range (Smith & Glass, 1977; Smith, Glass, & Miller, 1980). These results indicate that across the research studies compiled, the average client in psychotherapy improved more than about 80% of clients who were not treated. Meta-analysis has also demonstrated that the effects of psychotherapy are at least equal to antidepressant medication and that the combination of medication and psychotherapy is more effective than medication alone in the treatment of depression (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Imel, Malterer, McKay, & Wampold, 2008; Lambert, 2013). In what is a disappointing finding for some, the various theoretical orientations have been repeatedly shown to be equally effective with a wide variety of client presentations (Lambert, 2013; Wampold & Imel, 2015).

What I call "exemplar" studies are those that are generally recognized as stringent comparisons of psychotherapy groups to no-treatment groups following the best scientific procedures. They are also called efficacy studies or randomly controlled trials (RCTs) and are based on the clinical trials approach adopted from pharmacy research. Efficacy studies involve random assignment of participants (clients) to treatments, rigorous controls, carefully specified treatments, fixed numbers of sessions offered to clients, narrowly defined entrance criteria (e.g., clients having only one identified disorder), and independent raters to assess client dysfunction and improvement. An important feature of these kinds of studies is that they use treatment manuals that detail the expectations for what the therapist will do. Of the exemplar studies I describe here, the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program and the Project MATCH studies are true clinical trials (RCTs); the Temple study is not because it admitted clients presenting a wide range of concerns.

One of the earliest controlled studies of psychotherapy, the Temple study (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975), compared short-term psychoanalytically oriented therapy and behavior therapy with a minimal-contact control group. Over a 4-month period, experienced therapists provided the treatments to 90 clients, who were randomly assigned to one of the three groups. Therapists' adherence to their approaches was assessed, and independent observers rated client outcomes, as did the participating counselors and clients. A 1-year follow-up assessment was included, along with pre- and post-therapy tests of symptoms. Across all measures of outcomes, the treated groups improved significantly more than the control group. Differences between the two therapeutic approaches were negligible.

Critics of the early exemplar research suggest that the problem in finding differential effectiveness of counseling approaches can be attributed to the fact that significant client factors were ignored in these studies. Such client factors are usually operationalized as a diagnosis, as exemplified in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V; American Psychiatric Association, 2013).

A second exemplar study that attempted to assess psychotherapy for depression adopted the philosophy that specific approaches will work best for specific diagnoses. The NIMH Treatment of Depression Collaborative Research Program (TDCRP) focused solely on depression and compared psychotherapeutic treatment to antidepressant medication and placebo groups. The antidepressant and placebo groups also received clinical management, which apparently amounted to "minimally supportive therapy" (Elkin, 1994, p. 135). The two treatment types were interpersonal psychotherapy, a time-limited, problem-focused approach (see Box 1.1 for an overview), and cognitive-behavioral therapy (most similar to Beck's cognitive therapy; see Chapter 10). Thus, clients were randomly assigned to one of four treatment groups: interpersonal psychotherapy,

cognitive-behavioral therapy, antidepressant medication plus clinical management, or placebo plus clinical management. Ten experienced, carefully trained therapists administered the counseling at three research sites across the United States. A total of 239 clients participated, who exhibited a range of nonbipolar, nonpsychotic depression.

Box 1.1

Klerman and Weissman's Interpersonal Psychotherapy

THEORY

The interpersonal psychotherapy (IPT) approach is a present-oriented, short-term therapy that was developed for clients who present with depression. Based on attachment and communications theories and with recognition of the importance of social factors in everyday functioning, IPT includes a medical model of depression used to educate clients, but then focuses on current interpersonal issues as the targets of intervention. IPT has been adapted for presentations other than depression, including anxiety, eating disorders, and substance abuse (Verdeli & Weissman, 2014); however, my description below focuses on depression for the sake of simplicity.

Four Relationship Problems

IPT theory identifies four basic interpersonal problems: grief, interpersonal role disputes, role transitions, and interpersonal deficits (Klerman, Weissman, Rounsaville, & Chevron, 1984; Verdeli & Weissman, 2014). *Grief* refers to the reaction to the death of a significant person or pet. An *interpersonal role dispute* occurs when two or more individuals disagree on the nature of their relationship, and current overt or covert conflict with another is present. Three general phases of interpersonal role dispute are distinguished: renegotiation, impasse, and dissolution. Clients who are in the midst of a major life change are generally struggling with *role transition*, which includes events such as divorce, retirement, job change, and diagnosis of a major physical illness. The *interpersonal deficits* category refers to problems in communicating about, initiating, or maintaining relationships.

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Video Example 1.3 Interpersonal therapy for role transition



https://www.youtube.com/watch?v=aQUx_az6K-s

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

THERAPY

Two kinds of assessment are important in IPT. First, the counselor confers a formal (DSM-V) diagnosis (from the fifth edition of the *Diagnostic and Statistical Manual* of the American

Psychiatric Association, APA, 2013). A complete medical evaluation of the client is recommended (Klerman et al., 1984). Second, the counselor conducts an interpersonal inventory with the client (Verdeli & Weissman, 2014). All of the important interpersonal relationships in the client's life are reviewed with the goal of establishing a link between changes in one or more of these relationships and the onset of the depression.

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

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

IPT has three stages (Verdeli & Weissman, 2014). In the initial stage (the first three sessions or so), assessment, diagnosis, and conceptualization are the focus. The medical model conceptualization of depression is presented to clients, and they are given the "sick role." Clients are told that depression results from the interaction of biological and environmental factors (i.e., life events). Advocates of this approach argue that making psychological dysfunction partly biological in nature relieves clients of the overwhelming responsibility for their problems and allows separation of the problems from the clients' sense of self (Markowitz & Swartz, 1997). Adopting the sick role is significant because it not only relieves clients of significant social responsibilities and stressors, but also creates in clients a commitment to working in therapy (Weissman & Markowitz, 1998). Stage 1 also involves giving clients the conceptualization of their depression in terms of the four areas: grief, role dispute, role transition, and interpersonal deficit. Only one or two of these areas should be identified for each client.

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

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

(continued)

Box 1.1 *(continued)*

TECHNIQUES

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

Exploration: Engaging in nondirective exploration of the problem; giving supportive acknowledgment

Encouragement of affect: Accepting painful emotion; facilitating suppressed affect

Clarification: Rephrasing; attending to contradictions

Communication analysis: Identifying problems in communication, such as assuming that one is understood and communicating ambiguously on nonverbal channels

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

Behavior-change techniques: Providing advice and suggestions; educating; modeling

Adjunctive techniques: Forming a therapeutic contract

Using multiple outcome measures, the study found virtually no differences among the four treatment groups. All groups, even the placebo group, showed improvement following treatment. What remains unclear is whether the unexpected improvement in the placebo–clinical management group was a result of the placebo pill or the clinical management. Thus, this study clearly supports the effectiveness of psychotherapeutic interventions, but also calls into question the specificity of these effects because the therapies did not outperform the reference conditions (the drug and placebo groups).

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

The results of Project MATCH were consistent with those of previous studies. There were no differences in the effectiveness of the three treatments, and virtually no effects of client factors were found. Of the client characteristics, only one significant difference was apparent: Clients who were relatively low in psychological distress did better with the 12-step approach than the others did. These differences were not evident in more-distressed clients. Other more recent, carefully conducted studies have shown similar outcomes, including a very large study of treatment for dysfunction related to alcohol use performed in the United Kingdom (UKATT Research Team, 2007; Knekt et al., 2011).

A final, and controversial, approach to studying counseling outcome involves what has been called the *effectiveness* approach, to emphasize the difference between this and the efficacy or RCT method (Seligman, 1995). The *Consumer Reports* (CR) study is the most famous effectiveness study, and in fact the distinction between efficacy and effectiveness was proposed by Seligman, who consulted with CR on the research and presented it to the psychological community in the journal *American Psychologist*. The intent of the CR study was to assess the outcomes of counseling *as it is actually practiced in the real world* (Seligman, 1995). Fixed numbers of sessions, strict adherence to manuals, and random assignment (i.e., the methods required in RCTs) are serious distortions of what actually happens when real people go to therapy. Further, clients usually have more than one specific problem (which they don't present as DSM diagnoses), and the client and the counselor are concerned with overall client functioning, not just improvement in specific symptoms. This approach is quite controversial because it does away with control groups, random assignment, and all of that other hard-core scientific stuff. Instead, effectiveness studies simply ask clients about their experiences using a large-scale survey method.

Imagine having folks rate therapy the way they do washing machines. Actually, that's what the *Consumer Reports* study did. CR sent out 180,000 surveys instructing individuals to complete the section on mental health if in the past 3 years they had sought help for stress or emotional difficulties. A total of 4,100 respondents reported having obtained professional help of some kind (e.g., attended support groups, visited physicians or mental health professionals); of these, 2,900 reported having received the services of a mental health professional. Twenty-six specific questions explored the participants' experiences with counseling. Without getting too detailed, the results of this study suggested that the efficacy studies are perhaps right—the vast majority of the respondents reported improving as a result of counseling. The amount of improvement was correlated with the length of counseling. Most relevant for our study of theory is that, once again, no theoretical approach was found to be superior to any other. A follow-up study focusing on depression and anxiety showed counseling to be as effective as drug therapy, although slightly more positive outcomes were reported by clients who engaged in both ("Depression and Anxiety," 2010).

The controversy about the applicability of RCTs to practice in the field has also led to efforts to transport treatment approaches tested in controlled trials to natural settings, comparing them to "treatment as usual" (TAU). These kinds of studies generally have some strengths, like random assignment of clients to the target treatment and TAU, supervision of practitioners, and standardized outcome measures. Sometimes, they seem to demonstrate that approaches tested in RCTs are more effective than TAU. However, when one looks more closely it is apparent that in many cases TAU is not bona fide psychotherapy (e.g., visits to primary care physicians) or the amount of treatment (e.g., the "dose") is different for the two conditions. In addition, TAU studies are often conducted by advocates of the specific approach tested, raising the question of allegiance effects or the well-documented tendency for approaches favored by the researchers conducting the study to do better than alternative treatments (Wampold & Imel, 2015).

Even long before the era of meta-analyses, clinical trials, and effectiveness studies, Rosenzweig (1936/2002) captured the state of psychotherapy outcome research by quoting the Dodo bird from Carroll's *Alice in Wonderland*: "*Everybody* has won and *all* must have prizes" (p. 5). However, this verdict is not fully accepted by all scholars involved in psychotherapy research (Ollendick & King, 2006). In fact, in the late 1990s a large group of psychologists initiated a movement to develop a list of treatments that work—known as *empirically supported treatments*, or ESTs.

The idea behind the EST movement is that the solution to the Dodo bird dilemma will be found in identifying specific treatments that are efficacious for specific problems.

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

It is not possible to summarize the results of the entire special issue here. Interestingly, very few approaches were labeled *efficacious and specific*—that is, better than comparison approaches for a given disorder. Efficacious and specific approaches included cognitive therapy for generalized anxiety disorder and panic disorder, exposure plus response prevention for obsessive-compulsive disorder, and exposure therapy for agoraphobia. However, DeRubeis and Crits-Christoph (1998) pointed out that the conclusion that cognitive therapy is specific for depression relative to other psychological treatments is probably premature, particularly in light of results found in such careful and powerful studies as the NIMH TDCRP study.

The EST movement set off a major controversy within professional psychology. Opponents of the movement criticized it on the grounds that it was biased toward cognitive and behavioral approaches (i.e., those approaches that are easily manualized) and that the requirement for clinical trials methodology was too strict. Others reiterated the criticisms elaborated by Seligman (1995) (i.e., clinical trials don't represent reality). Various political, philosophical, and methodological issues are still debated heatedly (Hilsenroth, 2014; Norcross, Beutler, & Levant, 2006; Wampold & Imel, 2015).

Several other approaches to empirically supported interventions emerged as a result of these arguments—most notably those proposed by APA's Division 17, the Society of Counseling Psychology (Wampold, Lichtenberg, & Waehler, 2002), and Division 29, the Society for the Advancement of Psychotherapy (Norcross, 2001). Both of these groups tried to get away from the randomized clinical trial + DSM diagnosis approach used by Division 12. The issues became so important that APA jumped into the fray with a presidential task force on evidence-based practice in psychology (EBPP).

APA's task force (APA, 2006) comprised expert members with diverse perspectives on the issue of EBPP. However, if one examines the definition of EBPP offered by the group, it is clear that this melding of minds produced a broad outlook: "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). According to the task force, EBPP "starts with the patient, and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome" (p. 273). Clinical expertise (the knowledge gained from education and practice) is essential for using this research evidence in practice. Further, consideration of client

variables is critical to EBPP. In essence, out of all of this controversy came what appears to be a flexible approach that recognizes a foundation of science, the skills of the counselor, and the client qualities that affect intervention. For the most part, the field seems to be satisfied with this solution.

A second perspective on the Dodo bird verdict is called the *common factors* approach. Observing the similarities among outcomes has led to the proposal that there are commonalties among therapies that are the *real* curative factors (Lambert, 2013; Wampold & Imel, 2015). Lambert (2013) proposed the taxonomy of common factors shown in Table 1.1 and opined that "when considered as a whole, common factors are probably much more powerful than the contribution of specific techniques" (p. 202). One of the most often cited common factors is the therapeutic relationship or alliance. Although the therapeutic relationship is strongly correlated with client outcomes, it is difficult to tease out the direction of the causality: The alliance could be causing good outcomes or the good outcomes could be responsible for positive ratings of the alliance (sort of a "halo" effect). However, Laska, Gurman, and Wampold (2014) contend that we do see data indicating that the alliance is predictive of client improvement even when early improvement is taken into account. We should note, though, that different aspects of the therapeutic alliance are identified (agreement on goals and tasks of therapy, the affective bond between therapist and client, the "real" relationship) and may have different relationships with client outcome (Wampold & Imel, 2015).

TABLE 1.1
LAMBERT AND OGLE'S COMMON FACTORS

Support Factors	*Learning Factors*	*Action Factors*
Catharsis/release of tension	Advice	Facing fears
Mitigation of isolation	Affective re-experiencing	Cognitive mastery
Structure/organization	Assimilating problematic experiences	Encouragement of experimenting with new behaviors
Positive relationship	Cognitive learning	Taking risks
Reassurance	Corrective emotional experience	Mastery efforts
Safe environment	Feedback	Modeling
Identification with therapist	Insight	Practice
Therapeutic alliance	Rationale	Reality testing
Therapist/client active participation	Exploration of internal frame of reference	Success experiences
Recognition of therapist expertness	Changing expectations of personal effectiveness	Working through
Therapist warmth, respect, empathy, acceptance, genuineness	Reframing of self-perceptions	Behavioral/emotional regulation
Trust/open exploration		

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

Other common factors that have been proposed are (a) empathy, (b) client and counselor sharing similar views of the world, (c) positive client expectations, and (d) rituals or interventions that are acceptable to the client and counselor (Fischer, Jome, & Atkinson, 1998; Wampold & Imel, 2015). Fischer et al. (1998) suggested that our understanding of counseling relationships between diverse individuals (i.e., when the client and counselor differ on significant dimensions such as sex, race, or ethnicity) could be understood using a common factors perspective. For example, the counselor's possession of knowledge about the client's culture aids in building a shared worldview, which may in turn contribute to the therapeutic alliance and allow the counselor and client to formulate culturally appropriate rituals or interventions. Understanding the culture of the client may also boost client expectations (hope and faith) by giving the counselor credibility in the eyes of the client.

In summary, the research on counseling and counseling theory suggests that many approaches can be taken to helping clients grow or alleviate troubles that bring them to therapy. As I describe each theoretical viewpoint in this text, I will also provide a summary of research relevant to the approach. We will return to the issue of empirical validity in Chapter 17.

PARSIMONY

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

STIMULATION

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

PRACTICALITY

Practicality implies applicability. For our purposes, all of the approaches in this text are practical; I chose them because they provide solid conceptual frameworks that are well known for their applicability. Some roadmaps are easier to use than others, and I will note that the approaches presented in this text vary to some degree on this criterion. Also, the degree to which an approach lends itself to particular problems and other modes of counseling varies considerably.

SO HOW DO I CHOOSE A THEORY?

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

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

The question always arises, "Why do I *have* to pick a theory? Can't I borrow from several (or more) of the major ones?" In fact, many therapists do this; it is a theoretical stance called *eclecticism*. Consider Table 1.2, which shows the theoretical orientations found in nine studies conducted between 1982 and 2015. Based on these data, it appears that the most popular orientation is eclectic, with somewhere between 22%–41% of respondents choosing this option. The exception is Jensen, Bergin, and Greaves (1990), who cited 70%. However, their sample size was much smaller than those in the other studies, so the higher percentage may be an anomaly related to the sample.

This kind of research is usually cited as evidence that therapists are mostly eclectics, but let me draw your attention to two issues. First, even if we consider the high end of the range, 41% is less than half of a sample. In most studies, over 60% of these therapists endorsed a single

TABLE 1.2
THEORETICAL ORIENTATIONS OVER THE YEARS

	1982[1]	*1983*[2]	*1986*[3]	*1990*[4]	*2001*[5]	*2001*[6]	*2003*[7]	*2009*[8]	*2012*[9]	*2015*[10]
Eclectic	41	30	40	70	39	36	29	26	25	22
Cognitive	10	8	11	5	21	16	28	36	17	15
Psychodynamic	11	18	10	9	10	21	15	16	27	22
Other	9	8	5	2	7	5	7	1	6	4
Systems	N/A	3	5	3	5	3	3	3	2	4
Interpersonal/ Sullivan	N/A	1	2	1	5	3	4	N/A	3	8
Behavioral	7	6	6	8	4	3	10	1	3	1
Existential	2	4	3	0	3	1	N/A	2	2	3
Person-Centered	9	2	8	1	2	2	1	2	4	3
Humanistic	N/A	4	4	1	2	2	1	1	2	6
Gestalt	2	3	2	0	2	2	N/A	0	4	1
Psychoanalytic	N/A	9	2	N/A	1	8	N/A	5	5	11
Adlerian	3	2	2	0	1	N/A	N/A	N/A	N/A	N/A

Notes. N/A means "not assessed." Dates in the table may differ from references because they reflect when the data were actually collected, if available.
[1]Smith, 1982; *N* = 422, 1/2 Division 12 (Clinical Psychology) members, 1/2 Division 17 (Counseling Psychology) members.
[2]Prochaska & Norcross, 1983; *N* = 410, Division 29 (Psychotherapy) members.
[3]Watkins, Lopez, Campbell, & Himmell, 1986, *N* = 716; Division 17 members.
[4]Jensen, Bergin, & Greaves, 1990; *N* = 122, Division 12 members.
[5]Murdock, 2001; *N* = 691, Division 17 members.
[6]Norcross, Hedges, & Castle, 2001; *N* = 538, Division 29 members.
[7]Norcross, Karpiak, & Santoro, 2005; *N* = 694, Division 12 members.
[8]Thoma & Cecero, 2009; *N* = 200; doctoral-level licensed mental health practitioners from APA membership.
[9]Norcross & Rogan, 2012; *N* = 393; Division 29 members.
[10]Murdock, 2015, *N* = 158, wide range of doctoral- and master's-level therapists.

orientation. Second, studies of those who endorse an eclectic orientation suggest that eclectics do identify with particular orientations from among the major theoretical approaches. In Jensen et al.'s (1990) sample of clinical psychologists, 63% and 62% of the eclectics said they were cognitive or psychodynamic, respectively (they were allowed to choose more than one approach), whereas 56% indicated a behavioral orientation. In a large international sample of psychotherapists (Orlinksy & Society for Psychotherapy Research Collaborative Research Network, 2015) about 41% said that multiple perspectives influenced their work, whereas about 24% were characterized as influenced by psychoanalytic theory alone.

So why hasn't eclecticism taken over the profession? Certainly, the idea of doing what will work best for the client is an attractive one. Several factors probably account for the fact that we have not overwhelmingly jumped on the eclecticism bandwagon. For one thing, it is hard to say exactly what eclecticism is: Which theories do you borrow from? From our data, my hunch is that eclectics borrow from several approaches within the same general theoretical domain—for example, Beck's cognitive therapy and rational emotive behavior therapy. In fact, Norcross, Karpiak, and Lister (2005) studied a sample of self-identified eclectic/integrative therapists and found that the most common combination of orientations was behavioral and cognitive, and a cognitive perspective was overall the most commonly identified orientation in these therapists' reports of what they integrated.

A second question is, Do you borrow ideas about how human beings function, or do you steal techniques? If just techniques, how do you know which technique to use when? These are some tough questions, particularly for a beginning therapist. I'd also note that it is difficult to scientifically test eclecticism because, by definition, the counselor does different things with different clients at different times. I don't know about you, but that would make me a little nervous. One final point can be made here: In an odd way, it seems that we could say that most counselors are person-centered counselors at heart, for in a recent study Cook, Biyanova, Elhai, and Shnurr (2010) found that in a survey of over 2,000 practitioners, the top three techniques used were those that originated with person-centered therapy (such as conveying warmth, caring, and respect; communicating understanding; and accepting and prizing the client). Similarly, Thoma and Cecero (2009) found that person-centered techniques dominated the top five identified by a survey of 200 doctoral-level licensed mental health professionals; the only exception was the technique of "challenging maladaptive or distorted beliefs" (p. 413).

So whether you turn out to be an eclectic or a single-theory proponent, knowing the major approaches to counseling and psychotherapy is essential. Even eclectics need to know the approaches from which they borrow. After you learn about some theories, we will return to the issue of integrated/eclectic approaches in Chapter 17.

Box 1.2

Do Counselors Seek Counseling? With Whom? Some Relevant Data

Beginning with Freud, personal therapy has been thought to be important in the development of counselors. Whether for growth or remediation, mental health professions have long encouraged counselors and therapists to undertake personal therapy (APA, 2002; Geller, Norcross, & Orlinsky, 2005; Norcross, Strausser-Kirtland, & Missar, 1988). Various studies have looked at

the kinds of personal problems experienced by psychologists, but few have examined their perceptions of their psychotherapy (Good, Thoreson, & Shaughnessy, 1995; Mahoney, 1997; Pope & Tabachnick, 1994). An exception was a study by Watkins, Lopez, Campbell, and Himmel (1986), who found that 66% of their sample had engaged in personal counseling; their counselors' orientations most often fell into the category labeled "other," which the researchers defined as a mixture of approaches that were not identified as "eclectic" by respondents. Norcross and Guy (2005) reviewed the surveys on therapists' therapies and found that, on average, 72% of therapists in the United States reported having been in personal therapy. They also found that insight-oriented psychotherapists were more likely to have had personal counseling than were therapists of other orientations.

Seeking more recent data, I conducted a brief survey of U.S. therapists, asking about their experiences with personal counseling (Murdock, 2015). Receiving 158 replies, I found that 79.1% reported having engaged in personal therapy since obtaining their terminal degrees. This percentage is comparable to or higher than those reported in previous surveys. These therapists' theoretical orientations can be found in the last column of Table 1.2. When reporting on their most helpful therapist, these professionals indicated that the most common theoretical orientations of their therapists were psychoanalytic or psychodynamic (33%). About 16% of the helpful therapists were eclectic/integrative, according to my sample. When I compared the theoretical orientations of respondents to those of their counselors, I found that 42% of respondents had counselors of the same or similar theoretical orientations. However, I found no relationship between a match of theoretical orientations and reported satisfaction with counseling.

WHAT ABOUT ME?

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

You need to find an approach that is consistent with your assumptions about people, your values, and your preferred way of relating to others. Studies of therapists' choices of theories are rare; those that are available document that personality style is associated with theoretical orientation (Murdock, Banta, Stromseth, Viene, & Brown; 1998). For example, Walton (1978) found that psychodynamic types "perceive themselves as complex and serious. Rational emotive therapists (now rational emotive behavior therapy) maintain a diametrically opposed position, namely, simple and humorous" (p. 392). Because different studies look at different characteristics, it is difficult to fully integrate the results, and it is probably risky to apply them directly. However, data do seem to indicate that the choice of a cognitive-behavioral orientation is related to conscientiousness (and perhaps negatively to choosing a psychodynamic orientation) and that openness to experience may predict choosing psychodynamic, humanistic, feminist, or family systems orientations (Buckman & Barker, 2010; Ogunfowora & Drapeau, 2008). In Box 1.3 I describe a study of philosophical assumptions and personality characteristics that some of my students and I did to give you an example. However, what is clear is that you need to fit your theory (and it needs to fit you).

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

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

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

Box 1.3

Joining a Theoretical Club

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

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

PHILOSOPHICAL ASSUMPTIONS

Emphasis on Behavioral Content	*Emphasis on Experiential Content*
Cognitive/Cognitive-behavioral	Psychoanalytic
Systems/Interpersonal	Person-centered
	Existential/Gestalt
Elemental Emphasis	*Holistic Emphasis*
Psychoanalytic	Person-centered
Systems/Interpersonal	Existential/Gestalt
Cognitive/Cognitive-behavioral	

Emphasis on Physical Causation	*Emphasis on Psychological Causation*
Systems/Interpersonal	Existential/Gestalt
Cognitive/Cognitive-behavioral	Psychoanalytic
	Person-centered
Interpersonal Behavior: Interpersonal Dominance	
High	*Low*
Psychoanalytic	Existential/Gestalt
	Person-centered
	Systems/Interpersonal
	Cognitive/Cognitive-behavioral

HOW TO USE THEORY

The problem with theory is that, if you don't know how to apply it, it seems sort of worthless. That's probably where the ivory tower thing came from—it is sometimes difficult to see the connection between the theory and what you see as the "real" world, the client who actually comes in the door asking for help. It is my mission in this text to help you learn to actually use theory through applying it to individuals. I limit my presentation to individual counseling and psychotherapy (with the exception of the family systems chapter) and illustrate the application of each theory to a client. This method gives you an example of the application process. To assist you, I've posted a model for applying theory to individual clients on MyCounselingLab™. Go to the Video and Resource Library and search for the following resource: *How to Use Theory Guide.*

ETHICS: THE ROLE OF PROFESSIONAL VALUES AND STANDARDS

Before you launch into your exploration of counseling theories, there are some important values you need to study, which are those codified by your profession. Now, your professional association is not going to tell you which theory to pick, but there are professional guidelines you need to attend to once you do. If you are reading this text, you are likely interested in the ethical codes—that is, the agreed-upon principles of ethics—of the American Counseling Association (ACA, 2005) or the American Psychological Association (APA, 2002). Following are some of the major ethical issues that appear in both sets of ethical codes (although the titles of the sections vary a little between codes). By necessity, this review is overly broad; I urge you to explore professional ethics in a more focused way by reading one of the excellent books that are available on this topic (e.g., Remley & Herlihy, 2014; Welfel, 2016).

CLIENT WELFARE

The ethical principles of beneficence and malfeasance dictate that counseling professionals must be always attentive to client welfare and must not engage in behaviors that could in any way harm the client (ACA, 2005; APA, 2002). This mandate can be seen as covering a large range of issues, from informed consent to decisions about the termination of counseling. Your first

responsibility is to your client! One thing you should be clear about is that counseling is about clients' needs and values, not yours. Part of ensuring the welfare of your clients is respecting the diversity they present, and this diversity comes in many forms.

INFORMED CONSENT

Related to client welfare, the issue of client informed consent appears in both the ACA and APA ethics codes. Simply put, clients have the right to know what's up with therapy. Counselors should tell clients about their approach to therapy (in client-friendly terms); the rights and responsibilities of each party in the relationship; any potential risks involved; the benefits that might be expected; the counselor's qualifications, fees, and billing information; and perhaps most importantly, the limits of confidentiality (which is discussed in more detail in the following section; Remley & Herlihy, 2014). Most experts in this area advocate for a written document containing this information that is signed by the counselor and client, and in fact the Health Insurance Portability and Accountability Act (HIPPA) dictates that clients be given information in writing, particularly about the confidentiality of information they give to therapists (Remley & Herlihy, 2014).

If you are working with clients under the age of 18, you'll need to know that they legally cannot give informed consent to treatment (except in a few circumstances). You will need parent or guardian consent to counsel these clients. However, depending on the age of the child, you might want to obtain *assent* to treatment, which basically means that you explain the things that are in your consent document to the child in a way that he or she can understand and get his or her agreement. Some counselors actually use a written assent form that is similar to their informed consent form. It is particularly important that minor clients understand the kind of information that might be disclosed to their parents or guardians. At the same time, it is important to try to recruit the parents or guardians as collaborators in assisting the therapist—most parents are more than willing to be supportive of a child's counselor (Welfel, 2016).

CONFIDENTIALITY

One of the biggest issues in counseling is confidentiality. Counseling is a very personal process, and clients need to be able to trust that what they discuss in counseling stays in counseling. Therefore, it is very important that you tell clients about the boundaries of confidentiality. Generally, the following are the most clearly defined rules: (a) The client can give consent to the counselor to disclose information as the client wishes; (b) the counselor is bound to disclose information if the client is in danger of harming himself, herself, or someone else; and (c) all states in the United States mandate that the counselor must report evidence of abuse of a child, and many require that the counselor report evidence of abuse of an elder or incompetent person. In addition, there are times when courts may subpoena you or your records.

Confidentiality may also be breached when clients pursue legal action against their therapists or when they claim psychological harm in legal actions not involving their therapists. State and federal laws may contain other exceptions, so you must be familiar with these to be a competent, ethical practitioner. For example, in some states you are legally bound to disclose a client's plans for a future criminal action (Welfel, 2016). Controversies abound about whether counselors should warn individuals who have sexual contact with a client who has tested positive for HIV. There are also exceptions to the rules: To give one example, both the APA and ACA take the

stance that under the right conditions therapists don't have to disclose when a client is nearing the end of life and contemplating suicide.

I am sure that I have convinced you that issues of confidentiality are complicated and, at times, difficult. Study up on them.

Competence

You should practice only what you are competent to practice. That statement may seem simple, but then again, what is competence exactly? Your response is likely "What I am being trained in!" This answer would be correct. However, as with other issues of ethics, the standard of competence is more complex and encompassing than you might expect at first glance.

Competence means that you have knowledge and skills and are diligent in practicing these skills and attending to the welfare of your clients (Welfel, 2016). It also means that you are aware of those areas in which you are not competent. Almost daily you will receive advertisements for workshops to learn some new technique or approach. If you attend one workshop, does that make you competent to practice that intervention? The answer is "maybe," depending on your previous education and training. Also, is the technique evidence based, and are the presenters of the workshop qualified individuals?

The principle of competence also extends to self-care. You are clearly not competent if you are experiencing burnout, psychological distress, or are in some other way impaired (Remley & Herlihy, 2014). It is your ethical responsibility to be alert for signs of impairment and take steps to address them.

Multiple Relationships

Let's start with an example. Suzy is a counselor who lives and works in a small town. Dave, a former client who completed counseling 5 years ago, asks her for a date. What should she do?

The answer is that Suzy needs to think hard (and study her ethics code). Although both the APA and ACA prohibit sex with former clients until after some specified time period (2 years for APA and 5 for ACA), that doesn't mean that it is a good idea to engage in such a relationship. Some things are very clear when it comes to dual (also called multiple) relationships. All ethical principles forbid counselors from having sex with current clients. Things get muddier when a question like Suzy's arises or when the dual relationship involves an interaction other than sex.

The Critical Question: How to Decide?

If you look at the literature (and you should), you will find that there are many models of ethical decision making out there. The basic principles of these models are, at a very general level, similar. You need to clearly define the situation, identify the ethical principles involved (and any legal issues, too), study the literature, consult with colleagues, and then decide. Sounds easy, right? Actually, these decisions can be amazingly difficult at times.

I'd like to mention one final question: What do you do if you observe a peer or colleague acting in an unethical way? Most of the time your first step is to try to informally resolve the issue by talking to the transgressor (Welfel, 2016). If informal resolution fails, you can file a complaint with a professional organization, licensing board, or other authority. However, you must be aware of potential issues of confidentiality in these situations.

HOW THEORY IS PRESENTED IN THIS TEXT

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

A Case Study

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

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

Background

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

Basic Philosophy

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

Human Motivation

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

Central Constructs

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

Theory of the Person and Development of the Individual

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

Health and Dysfunction

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

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

Nature of Therapy

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

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

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

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

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

Process of Therapy

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

THERAPEUTIC TECHNIQUES

After a general introduction, I present various techniques associated with the theory.

EVALUATION OF THE THEORY

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

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

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

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Theories are often, and quite rightly, criticized for bias. This bias can take many forms, and to be ethical counselors we must examine approaches we use to understand how we could go wrong. Clearly, White individuals, mostly male heterosexuals, developed most counseling theories. The level of awareness of the theorists about individuals from other backgrounds varies from theory to theory.

THE CASE STUDY

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

Summary

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

ANOTHER RESOURCE FOR LEARNING TO USE THEORY

As I have probably made clear by now, learning to use theory is important, but the process of doing so can be difficult and trying. To further assist you in this process, I've developed another resource that should help: a series of video clips titled *Theories in Action*. These clips can be found

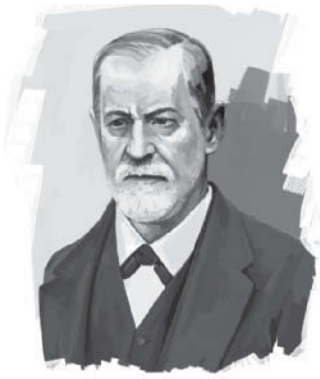
on the MyCounselingLab website in the Video and Resource Library. Here you'll find six counseling sessions with the same client, Helen. The therapists are experts in six of the theoretical orientations presented in this text: psychoanalytic, cognitive, family systems, feminist, narrative, and Gestalt. After each session, the therapists and I discuss what they did in their sessions that was particularly characteristic of their approaches and what they would do with Helen in the next counseling session. It is my hope that watching these experts work with Helen will further help you learn how to apply theory.

CLOSING REMARK

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

CHAPTER 2

Psychoanalysis



Sigmund Freud

Barb is a 47-year-old Caucasian female. She has been divorced twice, the second time 6 years ago. Barb has a high school education and works as a cashier in a grocery store. She speaks rapidly and in great detail. Barb has difficulty sitting for prolonged periods of time, sometimes appearing to be in physical pain during counseling sessions. She has difficulty making eye contact with her counselor.

Barb comes to counseling because she is depressed, experiences mood swings, and has bouts of crying and panic attacks. She has many physical maladies and complaints. These conditions include arthritis in the hands, repeated sinus infections, headaches, numbness in the face, dizziness without known neurological causes, fallen bladder, and injured knees.

Barb is also troubled by her perception that she is too dependent on her current boyfriend and has mixed feelings about the relationship. Barb says that she would like to become a "stronger person." She feels unloved, unwanted, and unneeded. Barb reports that she is "tired of catering to men" but wants to be able to trust men and find someone to "sweep her off her feet."

Barb reports that she has experienced physical and sexual abuse. She remembers being fondled by a male family friend around the age of 5. Barb's mother left the home when Barb was 10; Barb and her younger siblings (two sisters and a brother) remained with their father. From age 10 until about age 16, Barb's father sexually abused her.

At age 17, Barb married her high school sweetheart and had two children in the next 3 years. Shortly after they were married, her husband showed her letters to prove that he had been involved with another woman before their marriage, and he continued to be unfaithful to Barb throughout their 10-year marriage. Barb describes him as "perverted" because he would force her to participate in sexual acts that she perceived as "dirty" and was concerned only with his own sexual satisfaction. She characterized her husband as physically and emotionally abusive. During these 10 years Barb attempted suicide three times. In the first attempt she overdosed on prescription pain medication. Several months later she jumped off a two-story building. In another incident, Barb reports that she jumped out of a moving car.

Barb characterizes her second husband as affectionate, protective, and warm, but uncommunicative. She married him 5 years after her divorce from her first husband. Barb reports that she had great difficulty learning to trust this man, and then after 8 years of marriage he left her.

Please note that pronouns in the theory chapters of this text will match the sex of the client and counselor. Male and female pronouns in Chapters 1 and 17 are alternated randomly, or other gender-neutral forms are used.

Currently Barb is dating a 50-year-old man. Although she describes him as safe, his lack of commitment, alternately withdrawing and clinging behavior, and critical comments are making Barb feel insecure. She is also involved with a married man, even though she thinks that this relationship is not in her best interests.

Barb has not seen her mother since she left the family when Barb was 10. She has some contact with her siblings, but describes her relationships with them as distant. Barb maintains that they do not like her. Her father remarried about 8 years ago and moved to another state. Barb does not visit her father, stating that she does not like his new wife.

BACKGROUND

Psychoanalysis was founded by Sigmund Freud (1856–1939). Freud was a prolific writer; the dates of his work span over 45 years (from 1893 to 1938) and his thinking evolved over his professional lifetime. However controversial this theory is, the influence of psychoanalysis on the profession of counseling and psychotherapy has been enormous. Consider that before Freud, although some philosophers had debated the idea of the unconscious (Gay, 1988), no one had systematically applied the idea to psychological functioning. Also, Freud and his colleague and mentor, Josef Breuer, were the first to explore the "talk" therapy approach as a treatment for psychological dysfunction (Breuer & Freud, 1895/1937). Indeed, psychoanalysis is arguably the first substantial Western system of psychotherapy (Safran, 2012).

Sigmund Freud was an interesting character and has been the subject of many biographies, including his own, published in 1925 when he was 69 years old (S. Freud, 1925/1989a). Depending on whom you read, Freud is characterized as a meticulous scientist or an arrogant controller who could not tolerate dissent in his ranks. Perhaps the safest view is to see him as a combination of both. He presented himself at times as the humble scientist, at times as the wounded victim of a rejecting scientific community, and at times as the absolute authority, taking a dogmatic, stubborn tone. Freud was also known to be a workaholic (18- to 20-hour workdays were common) who seemed to have neurotic symptoms from time to time. During the late 1890s, Freud undertook his self-analysis, the content of which is partially revealed in several of his works, including *The Interpretation of Dreams* (S. Freud, 1900/1913).

Much has been made of Freud's complex family constellation. Freud was the first child of his mother, Amalia, who was Jacob Freud's (Freud's father) second or third wife (there is some controversy surrounding even this simple fact). Jacob's two sons from his first marriage were about the same age as Freud's mother (who was 20 years younger than Jacob), and one of these men had a son, Freud's nephew, who was older than Freud. Thus, Freud's early environment gave him interesting puzzles to investigate, and some speculate that his theories are a reflection of this somewhat unusual family constellation (Gay, 1988).

Sigmund Freud lived most of his life in Vienna, Austria. He was an exemplary student who entered the University of Vienna at age 17. After finally deciding on a career in medicine (with dominant interests in the scientific aspects), Freud obtained his medical degree in 1881. Although he wanted to continue his already recognized work in the medical laboratory, he reluctantly took up the clinical practice of medicine as a way to support his eagerly anticipated marriage to Martha Bernays.

Before his marriage in September 1886, Freud journeyed to Paris to study with the famous neurologist Jean-Martin Charcot, investigator of hysteria and champion of hypnosis in medical practice.

At the time, Charcot was studying hysteria, the appearance of physical symptoms that apparently had no physiological basis. Although the malady was thought to be an exclusively female problem (the name comes from "wandering uterus"), Charcot discovered that hysteria also affected males (Gay, 1988). Peter Gay, an eminent biographer of Freud, maintains that "Freud was amazed and impressed to see Charcot inducing and curing hysterical paralyses by means of direct hypnotic suggestion" (1988, p. 49), a novel approach to this puzzling syndrome. Freud was quite excited by Charcot's work and used it as a basis for his subsequent theoretical efforts.

Freud returned from Paris and began to work in the everyday practice environment, while still pursuing his scientific interests. Freud's first published book, *Studies in Hysteria*, was co-authored with Josef Breuer in 1895 (Breuer & Freud, 1895/1937). According to Gay (1989), Freud first used the word *psychoanalysis* in 1896 (p. xxxvi). One of Freud's most widely acclaimed books, *The Interpretation of Dreams*, was published in 1899; it is an interesting bit of trivia that this book actually had a copyright date of 1900 (Gay, 1988).

Freud's theories about the sexual origins of the neuroses and sexuality in children were quite controversial. If you wish, you can begin your excursion into psychoanalysis by reading a selection from *The Interpretation of Dreams* (S. Freud, 1900/1913) in Box 2.1.

Box 2.1

An Excerpt from *The Interpretation of Dreams*

For years I have been occupied with the resolution of certain psycho-pathological structures—hysterical phobias, obsessional ideas, and the like—with therapeutic intentions. I have been so occupied, in fact, ever since I heard the significant statement of Josef Breuer, to the effect that in these structures, regarded as morbid symptoms, solution and treatment go hand in hand. Where it has been possible to trace a pathological idea back to those elements in the psychic life of the patient to which it owed its origin, this idea has crumbled away, and the patient has been relieved of it. In view of the failure of our other therapeutic efforts, and in the face of the mysterious character of these pathological conditions, it seemed to me tempting, in spite of all the difficulties, to follow the method initiated by Breuer until a complete elucidation of the subject had been achieved. I shall have occasion elsewhere to give a detailed account of the form which the technique of this procedure has finally assumed, and of the results of my efforts. In the course of these psycho-analytic studies, I happened upon the question of dream-interpretation. My patients, after I had pledged them to inform me of all the ideas and thoughts which occurred to them in connection with a given theme, related their dreams, and thus taught me that a dream may be interpolated in the psychic concatenation, which may be followed backwards from a pathological idea into the patient's memory. The next step was to treat the dream itself as a symptom, and to apply to it the method of interpretation which had been worked out for such symptoms.

For this a certain psychic preparation on the part of the patient is necessary. A twofold effort is made, to stimulate his attentiveness in respect of his psychic perceptions, and to eliminate the critical spirit in which he is ordinarily in the habit of viewing such thoughts as come to the surface. For the purpose of self-observation with concentrated attention it is

advantageous that the patient should take up a restful position and close his eyes; he must be explicitly instructed to renounce all criticism of the thought-formations which he may perceive. He must also be told that the success of the psycho-analysis depends upon his noting and communicating everything that passes through his mind, and that he must not allow himself to suppress one idea because it seems to him unimportant or irrelevant to the subject, or another because it seems nonsensical. He must preserve an absolute impartiality in respect to his ideas; for if he is unsuccessful in finding the desired solution of the dream, the obsessional idea, or the like, it will be because he permits himself to be critical of them.

I have noticed in the course of my psycho-analytical work that the psychological state of a man in an attitude of reflection is entirely different from that of a man who is observing his psychic processes. In reflection there is a greater play of psychic activity than in the most attentive self-observation; this is shown even by the tense attitude and the wrinkled brow of the man in a state of reflection, as opposed to the mimic tranquility of the man observing himself. In both cases there must be concentrated attention, but the reflective man makes use of his critical faculties, with the result that he rejects some of the thoughts which rise into consciousness after he has become aware of them, and abruptly interrupts others, so that he does not follow the lines of thought which they would otherwise open up for him; while in respect of yet other thoughts he is able to behave in such a manner that they do not become conscious at all—that is to say, they are suppressed before they are perceived. In self-observation, on the other hand, he has but one task—that of suppressing criticism; if he succeeds in doing this, an unlimited number of thoughts enter his consciousness which would otherwise have eluded his grasp. With the aid of the material thus obtained—material which is new to the self-observer—it is possible to achieve the interpretation of pathological ideas, and also that of dream-formations. As will be seen, the point is to induce a psychic state which is in some degree analogous, as regards the distribution of psychic energy (mobile attention), to the state of the mind before falling asleep—and also, of course, to the hypnotic state. On falling asleep the undesired ideas emerge, owing to the slackening of a certain arbitrary (and, of course, also critical) action, which is allowed to influence the trend of our ideas; we are accustomed to speak of fatigue as the reason of this slackening; the emerging undesired ideas are changed into visual and auditory images. In the condition which it utilized for the analysis of dreams and pathological ideas, this activity is purposely and deliberately renounced, and the psychic energy thus saved (or some part of it) is employed in attentively tracking the undesired thoughts which now come to the surface—thoughts which retain their identity as ideas (in which the condition differs from the state of falling asleep). Undesired ideas are thus changed into desired ones.

From Freud, S. (1913). *The interpretation of dreams*. (3rd ed.). (A. A. Brill, Trans.). Originally published in New York by Macmillan.(Original German work published 1900.)

Despite the rejection of, or indifference to, his work, Freud persevered and gradually gathered a group of adherents. He established the Wednesday Psychological Society in 1902 for the purpose of discussing psychoanalytic ideas (Gay, 1988). Over the years, the membership of this group included Carl Jung and Alfred Adler, among others. Interesting stories are to be found in the "politics of psychoanalysis" (Freud's own term) that space prohibits telling here (see any of the Freud biographies for these).

Freud remained in Vienna until the Nazis invaded in 1938 and then immigrated to London. He was close to death due to cancer of the jaw (probably a result of his favorite vice, cigars). Choosing his own end on September 23, 1939, Freud obtained from his physician a lethal dose of morphine (Gay, 1989). He was survived by his daughter, Anna Freud, whose story is also an interesting one. Anna was Freud's youngest child and was very close to her father. In her 20s, Anna received her training analysis from her father. Without the benefits of any formal training in medicine or psychology, she became an analyst and Freud's intellectual heir. Anna was a staunch advocate of her father's ideas, yet made significant contributions of her own in her psychoanalytic approach to working with children. (You will read more about Anna's ideas in Chapter 3.) It is indeed significant that Freud was willing to analyze Anna, a serious deviation from the standards of abstinent conduct that he developed for analysts. Some authors suggest that this violation of analytic rules was a reflection of the importance he placed on "having a trustworthy and competent intellectual heir" (Sollod, Wilson, & Monte, 2009, p. 181).

Freud's ideas laid the foundation for the profession of psychology and the practice of psychotherapy as we know it today. Most of the prominent theories of counseling and psychotherapy either incorporate Freud's ideas or were formulated in reaction to them. Despite some arguments that psychoanalysis is a dated and discarded theory of human behavior, both ideologically "pure" and variations of psychoanalysis currently thrive. You can watch a classic psychoanalytic session with the client Helen on MyCounselingLab™, conducted by Dr. David Donovan. Because Freud's theory was so groundbreaking for its time and also foundational for contemporary psychoanalysis, I present here a classical rendition of the theory and practice of psychoanalysis. In Chapter 3 you will study other variations of psychoanalytic theory.

MyCounselingLab

Video Example 2.1 Helen's psychoanalysis



The American Psychoanalytic Association has a webpage at www.apsa.org, and the International Psychoanalytical Association can be found at www.ipa.world. Both of these sites offer links to other current information about psychoanalysis. The Division of Psychoanalysis (Division 39) of the American Psychological Association (APA) is one of the larger divisions of the APA and sponsors a journal entitled the *Journal of Psychoanalytic Psychology*.

MyCounselingLab

Video Example 2.2 Documentary about Sigmund Freud



https://www.youtube.com/watch?v=3ySsLRwE3Lk

BASIC PHILOSOPHY

Freud was a pessimist, and thus psychoanalysis presents a rather gloomy view of human nature. Arguing against those who characterized human nature as inherently positive, Freud maintained that "unfortunately what history tells us and what we ourselves have experienced does not speak in this sense but rather justifies a judgment that belief in the 'goodness' of human nature is one of those evil illusions by which mankind expect their lives to be beautified and made easier while in reality they only cause damage" (S. Freud, 1933/1964a, p. 104).

For Freud, human behavior is produced by conflicts among genetically built-in drives, the instincts of self-preservation, sex, and destruction. Although Freud acknowledged the influence of environmental events and genetic predispositions, in his view the most dominant force in human behavior is the sexual instinct, which he thought was innate.

In psychoanalytic theory, a great deal about a person is determined before the age of 6. Children are viewed as enacting a genetically determined developmental sequence, which under normal circumstances progresses until about the sixth year, whereupon the psychological developmental process goes dormant. At puberty, development resumes.

Freud's views of children were much more complex than the views that were current when he was writing. He believed that kids are sexual beings and have murderous fantasies in the search for gratification of primal wishes (i.e., satisfaction of the sexual instinct; S. Freud, 1940/1964b). According to Freud, all psychopathology has its roots in early development and arises out of conflicts among various psychic entities.

Our psychoanalytic therapist, Glenda, begins her work with Barb with the assumption that Barb's current behavior is jointly the result of her genetic inheritance and her childhood experiences. First, she is female, which for Freud is an essential determinant of personality structure. Second, she recalls some sexual experience before age 6 and sexual abuse as a teenager. The trauma of both sequences of sexual abuse would be enough to cause problems on its own, but the nature of her symptoms depends heavily on Barb's early development.

Freud thought that as humans we are not very good at knowing the reasons for our actions. We blissfully endorse the comforting myth that our conscious thought directs our behavior. He said, "The truth is that you have an illusion of a psychic freedom within you which you do not want to give up" (S. Freud, 1920/1952, p. 52). Freud maintained that forces of which we are unaware (the unconscious) are the most powerful sources of behavior. Evidence for the existence of the unconscious is, according to Freud, found in such everyday occurrences as forgetting, mistakes, "slips of the tongue," and dreams. In these events, which we typically dismiss as meaningless, Freud saw the relaxation of the censor that typically keeps unconscious material from surfacing. A good example of such a slip is when a man about to be married is queried by his future in-laws about his religious affiliation. He replies "prostitute" instead of "Protestant." Freud would see this mistake as evidence of the unconscious sexual urges that are close to the surface because of the excitement and stress of impending marriage (and accompanying sexual gratification, of course).

Glenda expects Barb to have little awareness of the real sources of her symptoms. Barb will likely attribute her crying, anxiety attacks, and so on to environmental factors, but the analyst's position is that these are likely the result of the inhibitions in development resulting from the early sexual experience and later sexual abuse.

Glenda sees evidence of Barb's unconscious functioning in several ways. For instance, Barb might "accidentally" use her father's name in place of the family friend who sexually abused her. Such a substitution would be very significant indeed to Glenda. Barb also relates dreams in her analysis, and Glenda looks in these accounts to understand the workings of Barb's unconscious. In one dream, Barb describes a scenario in which she is captured and tormented by a sea monster. She is rescued by an old man in white robes who is riding a mule, but feels confused and tearful when this happens.

Glenda realizes that in this dream Barb is reliving her experiences of sexual abuse. The monster is the abuser, and water is thought to be related to sexual feelings and actions (think about waves). Glenda understands Barb's confusion and tears in response to her rescue as representing conflicting feelings of relief, the loss of possible sexual gratification (which is unconscious), and the resurgence of anxiety and fear connected to her abuser, who was an older man. An interesting facet of the dream is that the scary man is riding a mule (an infertile animal).

HUMAN MOTIVATION

Freud (1940/1964b) was convinced that human behavior is driven by intrapsychic conflict. Specifically, the instinctual urges in the unconscious are considered unacceptable by the conscious mind and society, so the psychic apparatus exerts energy to keep these urges at bay. Behavior is thus a compromise between the warring mental forces.

Glenda knows that Barb's current behavior is a compromise between unacceptable urges and reality. Her mixed feelings about her relationship with her current boyfriend are probably the result of (a) pleasure due to satisfaction of sexual urges and (b) guilt about expressing sexuality. In addition, she is involved in a socially less-acceptable sexual relationship (with a married man), which would also result from conflicting sexual and moralistic impulses.

CENTRAL CONSTRUCTS

INSTINCT THEORY

Freud hypothesized that humans have instinctual urges that are innate, resulting from our evolutionary heritage. These instincts must be expressed or the individual will become dysfunctional (Freud actually used the word *ill*; 1940/1964b, p. 150). In his early writings, he identified the most basic instinct as Eros, or life. Later he described the destructive instinct (more commonly called Thanatos, or the death instinct; S. Freud 1949/1940). In addition to direct expression through satisfaction of the need, instincts can be expressed in four other ways (Rickman, 1957, p. 77): (a) turning into the opposite, (b) turning back on the person, (c) repressing (or banishing to the unconscious), and (d) sublimating (or expressing in socially approved activity).

The life instincts are thought to be composed of those directed toward self-preservation (for example, hunger and reproduction continue the individual and the species). Although it is tempting to see the life and death instincts as opposing one another, Freud indicated that they sometimes can fuse. For example, Eros prompts the person to eat, which allows the destructive instinct to be expressed as destroying the food (S. Freud, 1940/1964b). When a child is learning to control her bowel and bladder functioning, the death and love instincts can fuse into sadism because the child becomes angry at the loved caretaker who forces the child to control elimination.

In Barb's case, Glenda sees the destructive or death instinct as responsible for her suicide attempts. Her depression, crying, and destructive attempts can be seen as the result of a need for punishment for her unacceptable sexual urges. Problems around Eros seem to give rise to her disruptive relationships with men; she simultaneously seeks forbidden sexual gratification and reacts angrily to the rejection she has experienced from men.

Freud had much more to say about Eros than he did about Thanatos because the latter was a late addition to the theory (S. Freud, 1923/1961a). The instincts are unconscious and possess a store of energy, which in the case of Eros is called libido. The term *libido* has become synonymous with sexual drive, even though Freud protested that it was a much more general drive. Libido is considered a very basic drive because it is responsible for the perpetuation of the human species.

Instinctual energy always seeks objects in which to invest (normally, people); such attachment discharges the energy of the instinct and creates pleasure. At birth, libido is directed only to the self, a state known as primary narcissism. Next, and rather quickly, the mothering person becomes the primary object of the libido. As the child develops, she continues to invest life energy in other people or objects until, as an adult, she finds mature love in the investment of libido in a person of the opposite sex. Further journeys of the libido will be described under the discussion of sexual development.

It is important to note that problems in development lead to fixation of the libido at that stage of development. Fixation is rarely total in the neuroses, so the individual continues on a modified developmental path. However, later trauma can lead to regression to the point of fixation, the primary means whereby old, unresolved conflicts become symptoms.

Glenda hypothesizes that Barb's libido is fixed somewhere in her early development, probably around the age of 5 or 6. She is arrested in her development, which explains why she has difficulty with intimate relationships in her adult years. Glenda thinks that Barb, to some extent, reproduces in her current relationships aspects of those she experienced early in life. These immature ways of relating to others tend to get her in trouble.

Topographic Model: The Iceberg Approach

In his early work, Freud differentiated among three types of mental content. Beginning with the most obvious, he recognized the conscious awareness of the individual. To the consternation of many, however, he denied it as the source of most behavior. Instead, he saw most behavior as stemming from the unconscious, so that what we typically think of as driving our behavior (our conscious thought) is only the tip of the iceberg. The real motivations—the instincts in the unconscious—lie beneath the surface of the stormy ocean. Some mental content moves easily from conscious to unconscious, and this material Freud termed the preconscious. Even though he later revised his model (see the structural model that follows), Freud continued to use the terminology of the levels of consciousness to describe mental events.

Structural Model: The Big Three

In later theorizing, Freud (1933/1964a) asserted that there are three basic divisions or entities in the mind, which he termed the It, I, and over-me. The more familiar Latin terms of *id*, *ego*, and *superego* were evidently substituted in translation to English and have since become the terms of choice (Karon & Widener, 1995).

If you want to see an id, look at a newborn baby. The id is the most primitive of psychic entities, the residence of the instinctual urges. It seeks immediate gratification of its instinctual needs. Consider what happens when a baby gets hungry—the message is, Feed me right now!

Freud (1940/1964b) emphasized that the id has no real contact with reality, writing, "No such purpose as that of keeping itself alive or of protecting itself from dangers by means of

anxiety can be attributed to the id" (p. 148). Totally unconscious, the id operates on the *pleasure principle*; it seeks pleasure and avoids pain. Another term for this type of mental processing is *primary process* because it is the most basic, primitive form of psychic activity. The id's version of pleasure is the satisfaction of instinctual impulses through the discharge of energy associated with them. In this process of discharge, the instinctual energy is attached to objects, including people.

The psychic entity with which we are most familiar is the ego. The ego develops out of the id in response to pressure from the child's environment to restrain instinctual drives. Operating according to *secondary process*, or the *reality principle*, the ego strives for satisfaction of the id impulses, while at the same time preserving the person. Because of the nature of the instinctual impulses, outright gratification of them could result in damage to the organism, or even death, and the ego's job is to prevent these outcomes.

The superego is the last psychic entity to develop; it is the internalized version of parental or other authority figures. We know the superego as our conscience, and it is also the vehicle for the ego-ideal, or our vision of the perfect ego. Freud (1940/1964b) maintained that the superego "observes the ego, gives it orders, judges it and threatens it with punishments, exactly like the parents whose place it has taken" (p. 205).

Figure 2.1 was proposed by Nye (1986) as an illustration of the relationships between the structural and functional models of psychoanalytic theory. The drawing emphasizes that all three psychic entities have unconscious elements, with the id entirely and safely in the unconscious. Note that portions of the ego, primarily the defenses and processes most intimately related to dealing with the id, are unconscious.

Barb's ego seems to be struggling with unconscious forces that result in her current dysfunctional behavior. Her basic id impulses are at war with the demanding and rigid superego. She has sexual urges that seek fulfillment, yet the internal voice of her superego tells her that sex and intimacy are forbidden and dangerous. The superego exerts its control in the form of Barb's depression and crying. Glenda guesses that this

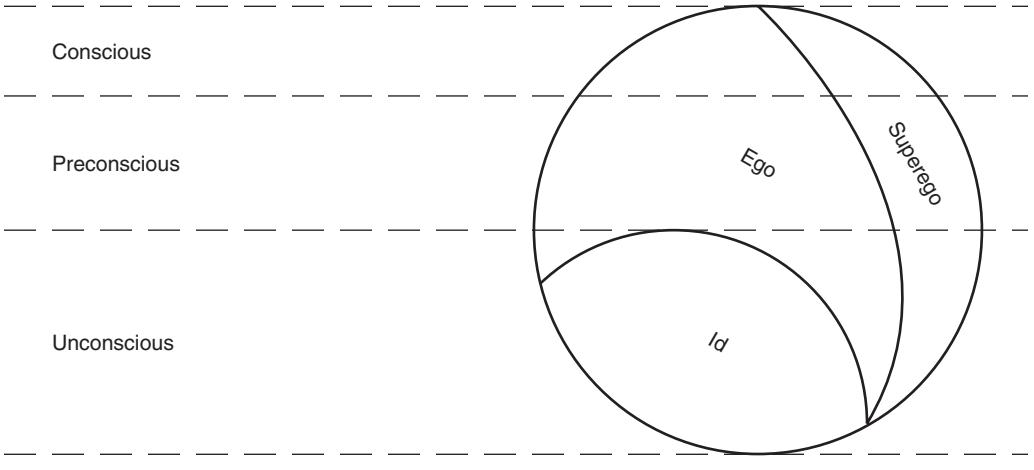


FIGURE 2.1. An Integration of the Structural and Topographical Models of the Personality.
Source: From Nye. *Three Psychologies*; 6E. ©2000 South-Western, a part of Cengage Learning, Inc. Reproduced by permission. www.cengage.com/permissions.

punishment has resulted in a poor self-concept and an exceedingly strict ego-ideal. The impulses of Barb's id are fighting for gratification but are so unacceptable that they are not directly expressed in behavior. Her ego, although taxed, is still intact, and therefore Barb is able to participate in the counseling relationship.

REPRESSION

One of the most important processes in psychoanalytic theory is *repression*, the act of containing unacceptable psychic material in, or pushing it to, the unconscious. The process of repression is unconscious and is always involved in symptom formation, although not all repression results in symptoms. Repression uses psychic energy and can result in the person becoming developmentally "stuck" at the psychological stage of a traumatic event, a mechanism called *fixation*. Although some would characterize repression as one of the most important defense mechanisms (discussed later), Freud also wrote of it as a more general psychic process.

From a psychoanalytic perspective, it is interesting that Barb retains the memories of her childhood sexual abuse. The symptoms that she is experiencing likely result from the repressed emotion related to the abuse. Early sexual experience, in Glenda's view, would overgratify the sexual instinct; this overgratification would explain Barb's pronounced desires to fulfill sexual needs with a safe male. These desires are seen in her many attempts to establish relationships, but their dysfunctional nature is evident in that she does not pick safe men. Barb seems doomed to repeat her early experiences, a sign of fixation.

Barb's psychic processes are repressed, and the memories that trigger them are accessible only through lengthy analysis. Glenda proceeds carefully in conceptualizing these memories because one psychoanalytic understanding would be that these memories are wish fulfillments—they represent childhood fantasies of gratification of the sexual drive. That is, the abuse may have happened only in Barb's fantasies. A second type of interpretation would be that the abuse was real. Either explanation would lead Glenda to expect fairly significant dysfunction in Barb's relations with men.

SYMPTOMS AS SYMBOLS

For Freud (1920/1952), symptoms were symbols of psychic conflict. In his earlier writings he always described them as expressions of unacceptable sexual impulses: "Every time we should be led by analysis to the sexual experiences and desires of the patient, and every time we should have to affirm that the symptom served the same purpose. This purpose shows itself to be the gratification of the sexual wishes; the symptoms serve the purpose of sexual gratification for the patient; they are a substitute for satisfactions which he does not obtain in reality" (p. 308).

The most obvious examples of such symbolization are things like uncontrollable vomiting, which was thought to symbolize morning sickness accompanying a wish for impregnation (Nye, 1996). In one of his most controversial cases, that of Emma E., Freud interpreted repeated bleeding from the nose as a wish to be taken care of (Masson, 1984). Freud also said that symptoms could serve as a defense against unacceptable wishes. In either case, they are attempts to keep the unacceptable thoughts or desires from surfacing in the conscious. Glove anesthesia, in which only a portion of the arm becomes paralyzed, was thought to be a defense against masturbation. In addition, Freud's later theorizing included the destructive drives as the source of symptoms; for instance, a suicide attempt would represent the activity of the death instinct.

Barb's symptoms are, in Glenda's view, symbolic of her conflicts around sexual impulses and fixation at an early developmental stage. Her depression is the result of her superego punishing her for her unacceptable sexual wishes. Her panic attacks probably result when these wishes come close to the conscious and would be dangerous or socially unacceptable to express. Barb's physiological symptoms, particularly the neurological ones, are probably representative of mental drives that are not being expressed. Quite likely, they symbolize unconscious sexual desires. Her face may be numb because she wishes for forbidden kisses. Barb's fainting spells may be reflective of a wish to "swoon" over the man who will "sweep her off her feet," most likely her father.

DEFENSE MECHANISMS

In addition to repression, the ego has several other ways to prevent unacceptable wishes from emerging into awareness. These tactics are called *defense mechanisms* (Hall, 1954). As noted earlier, repression is often listed as one of the defenses. Defense mechanisms are triggered when anxiety signals that unconscious material is threatening to break into the conscious mind. They distort reality so that the unconscious material does not enter consciousness and interfere with the ego's functioning or jeopardize the safety of the individual.

The operation of defenses is recognized through their extreme manifestations; the individual's perceptions or reactions seem extraordinarily strong. Freud cautioned that defense mechanisms, even the relatively healthy ones, are able to discharge only a fraction of the energy attached to the instinctual impulses. For example, transforming aggression into the socially approved racquetball game would not fully satisfy the instinctual drive.

Depending on which source one consults, the list of defenses varies, and Freud himself apparently never enumerated them in one place. Repression, described earlier, is the cornerstone of the psychic defenses. A brief description of others follows.

Identification is operating when the qualities of another person are taken into the individual's personality (Hall, 1954). For males, this process is the key to resolving the Oedipal complex (discussed later), but it is also seen in other situations in which individuals are threatened by another person. For this reason, this defense is sometimes referred to as *identification with the aggressor*, although identification through positive emotions is also possible.

Displacement occurs when an unwelcome impulse is deflected onto another person, presumably someone who is less dangerous than the original target. The classic example of displacement is the man who gets angry with his boss, but instead of aggressing against the boss, he comes home and yells at his wife, his kids, the dog, and the goldfish.

Projection is the externalization of an unacceptable wish. People who are paranoid, for example, externalize their instinctual rage by perceiving others as out to get them. This strategy reduces the anxiety associated with the aggressive drives by placing the aggression in the external world. In some cases, the projection of one's aggression allows the angry individual to act on these urges and thereby achieve some degree of instinctual gratification.

Reaction formation occurs when an unacceptable urge is transformed into its opposite. Rage is transformed to love and sexual desire to hate. For example, a man's rage against his younger sister that stemmed from sibling rivalry could be transformed into an overly solicitous love.

Sublimation, thought to be one of the healthiest of the defense mechanisms, is the funneling of the unacceptable impulse into a socially acceptable activity. For instance, Freud thought artists sublimated their libidos into creative products. Football players are likely sublimating aggressive drives.

According to Maddi (1996), the expression of love toward a socially approved other is a form of sublimation because it represents the disguised expression of incestuous wishes (p. 39).

Regression is seen when a threatened individual retreats to an earlier stage of development, typically to one in which she is fixated. When the demands of a current situation are overwhelming and the person's current defenses and ego operations are unable to handle the stress, she reverts to earlier ways of dealing with life. A school-aged child chastised for lying to a parent may resort to sucking her thumb or curling up in a fetal position to deal with the attack on the ego.

Barb is likely employing several defense mechanisms that revolve around the issues of sexuality in her life. She has repressed her sexual desire for her father and her subsequent feelings of anger and hatred toward men who reject her advances. She may be using reaction formation to deal with some of these feelings that threaten to emerge into awareness because she continues to value and seek intimate relationships. However, she is doomed by her fixation, which causes her to repeat the patterns of the past—seeking men who will ultimately abuse and then reject her. When involved in interpersonal conflict with men, Barb probably regresses to earlier coping mechanisms of being passive and distant. Her belief that her siblings don't like her is probably a projection of her own hostile feelings for them as usurpers of parental attention.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Freud formulated a complex theory of early human development that focused primarily on sexual development. Shocking his Victorian professional community, Freud proposed that humans are inherently sexual creatures and that even infants and young children have sexual urges. He further proposed that humans are inherently bisexual, with gender identification resulting from an inherent tendency toward maleness or femaleness, along with the way in which a key developmental crisis is resolved (see the later discussion of the Oedipal complex).

According to psychoanalytic theory, humans progress through a series of stages of sexual development beginning at birth and ending with mature sexual identity in puberty. The psychosexual stages are identified by the satisfaction of the sexual drive via different zones of the body, termed erotogenic zones (S. Freud, 1933/1964a). Too much or too little satisfaction can lead to too much investment of the libido at a given stage (fixation), resulting in the individual having difficulty negotiating subsequent stages. Fixations vary in intensity. We all have minor ones, but when a large amount of energy is attached at one of the developmental stages, problems can result later in life.

The first erotogenic zone is the mouth, and therefore the first stage of sexual development is termed the *oral* stage. The infant (or little id) first obtains nourishment from sucking at the mother's breast (thereby satisfying the self-preservation instinct). This satisfaction quickly becomes independent from nourishment, which for Freud was evidence that sucking was satisfying sexual needs as well. Think of all the kids you have seen sucking on pacifiers, their thumbs, and other assorted objects. The oral stage lasts roughly from birth through the first year.

Minor fixations at the oral stage are seen in such oral activities as nail biting, smoking, and overeating. More intense fixation can result in the oral character types (Maddi, 1996). Maddi described these characters as focused on the activities of taking (oral aggressive) and receiving (oral incorporative).

The second stage of development is the *anal* stage, in which satisfaction is gained through the functions of elimination. Freud characterized this stage as sadistic, suggesting that the libidinal and destructive urges fused at this stage to create sadism. Initially, the infant values her excretions, particularly the feces, producing them as "presents" for those whom she especially values (S. Freud, 1920/1952). As an example of this early attitude, a certain niece of mine placed hers in a jar in the refrigerator for her parents to find.

Later in this stage the infant comes into conflict with the environment for the first time in her young life when the lessons begin about when and where she can gain gratification of pleasurable urges. Toilet training, in which the child is forced to produce urine and feces only at certain times, can have a great impact on later personality characteristics, according to psychoanalytic theory. Harsh toilet training can result in individuals who are stingy, orderly, and precise (anal retentive characters), whereas excessive praise leads to people who are overgenerous, messy, and vague (anal expulsive characters; Maddi, 1996).

The most important stage of human psychosexual development for psychoanalytic theory occurs between ages 4 and 6 and is known as the *phallic* stage. The focus of sexual gratification becomes the genitals, and little boys and girls begin to notice differences in their bodies. Children are sexually curious prior to this age, particularly about the origin of babies, which they have concluded come from the anus. However, as their knowledge increases, they begin to suspect that something else is going on, and both sexes, according to Freud, turn their attentions to the penis. Up to this point, kids have assumed that both sexes possess a penis. However, with the awakening of satisfaction in the genital areas, it becomes evident that boys have one and girls don't. This realization is often the result of accidental viewing of a girl's or woman's genitals, but can also be set off by the trauma of observing adult or parental sexual intercourse. In any case, the discovery that male and female genitals differ is critical; at this point the course of development for boys and girls takes sharply different courses.

As a boy begins to masturbate, he has fantasies about doing something of the sort with his primary love object (an attachment established in the oral phase, you recall), his mother. At this point, he has entered the *Oedipus* complex, named for the mythical Greek character who unknowingly killed his father and married his mother. However, the little boy becomes aware that girls do not have penises and worries that this might happen to him. Also, the little boy remembers earlier warnings of adults when they caught him masturbating—they threatened to cut off the offending member. *Castration anxiety*, a powerful force in male development, ensues. The little boy fears that his father, the rival for his mother's attention, might find out about his incestuous desires for his mother and exact the ultimate revenge, castration. After all, there are a lot of people in the world who don't have penises. The terrified boy therefore represses the desires for his mother, and Freud (1933/1964a) maintained that in most cases the complex is "destroyed" (p. 92). As a result of this process, the superego makes its first appearance, developed out of the identification with the parents, particularly the father (identification with the aggressor). Identification compensates for the necessary loss of attachment to the mother while defending against the threatening father.

The development of women was much more puzzling to Freud; he devoted a lecture to this topic, although acknowledging therein that "psychology too is unable to solve the riddle of femininity" (S. Freud, 1933/1964a, p. 116). Like little boys, little girls' initial attachment is to the mother; yet to become fully female, they turn from her to attach to the father, but then they must seemingly renounce this second important attachment. Freud maintained that early development

in girls was masculine in nature, culminating in discovering the clitoris as a source of pleasure analogous to the penis. However, the little girl soon afterward discovers that she does not truly have a penis, the realization that initiates the feminine form of the Oedipus complex, which Freud sometimes referred to as the *Electra complex* (Sollod et al., 2009). However, the term *Oedipal complex* is routinely used to refer to both male and female development. The primary problem for girls is *penis envy*, which Freud thought often was never resolved. In fact, Freud (1933/1964a) thought that unresolved penis envy was responsible for homosexuality in women as well as the pursuit of "masculine" professions. Both courses of development are considered abnormal and represent a continued quest for a penis.

The resolution of the Oedipal complex resulting in normal femininity begins when the girl renounces clitoral masturbation and seeks to sexually attach to her father as a way to gain the wished-for penis. She becomes hostile to her mother, blaming the mother for her (the girl's) lack of a penis. However, this wish for the penis of her father is frustrated, and so is the next transformation of the wish, that for a "penis-baby" from her father. Unfortunately, the press to resolve the Oedipal complex among boys, castration anxiety, is not present, so girls are much slower to resolve the complex, if at all. They are thereby limited in their superego development and are prone throughout life to envy and jealousy. They feel inferior because their clitoris can't compare to a real penis. Women continue to search for a penis of their own and really only find one in bearing a male baby. Freud (1933/1964a) said, "A mother is only brought unlimited satisfaction by her relation to a son; this is altogether the most perfect, the most free from ambivalence of all human relationships" (p. 133). The girl's relationship with her mother remains ambivalent or hostile unless she reidentifies with the mother upon the birth of her own children.

After the phallic stage, the individual enters *latency*, which is usually a period of sexual quiescence. The sexual urges are usually repressed; however, Freud (1924/1989b) cautioned that occasionally some manifestations of sexuality may break through or that some individuals may remain sexually active throughout the latency period. In essence, repression is not always total during latency, and behavior during this period is variable.

Mature sexuality, according to Freud, develops during the *genital* stage, which we enter during adolescence. During this phase, the sexual instinct is integrated with the reproductive function. The process toward mature sexuality can be derailed during the genital phase if excessive pleasure has been derived from one of the other erotogenic zones during early development. The individual then becomes too invested in foreplay to the detriment of intercourse, thereby leaving unfulfilled the reproductive function of sex (S. Freud, 1924/1989b).

Glenda is certain that Barb has unresolved Oedipal issues. First, the question of the early sexual abuse is important; it is uncertain whether she was actually abused or whether these memories are wish fulfillments of an Oedipal nature. In Freud's view, the course of development would be similar in either case. If the abuse was actual, the symbolic gratification of the Oedipal complex would strongly fixate Barb in the Oedipal period. This fixation would cause her to search continually for her father as a love object—she has symbolically obtained him through the "family friend's" abuse. After this initial abuse, her father abandoned her (at least until she was an adolescent), but the fixation was not resolved and results in her duplication of the faithless father in her choice of a faithless first husband and in her view of men as untrustworthy. The symbolic attainment of her father would also likely intensify her hatred for her mother, resulting perhaps in stormy relationships with other women.

If the abuse was an Oedipal wish fulfillment, the abuser is transformed into a "family friend" because the actual representation of her father in this context is unacceptable. That Barb recalls this memory indicates that her repressive processes were not at full strength, a sign that her psychic system was overtaxed. In either case, she emerges from this stage with an unresolved Oedipal complex. The sexual abuse that occurred when she was a teenager served to reinforce Barb's Oedipal fixation and the resulting conflicting feelings about men.

Barb demonstrates her ambivalent, Oedipal relations with men in the relationship with her current boyfriend. She is worried about being too dependent on him, yet wants a man to sweep her off her feet. Glenda sees these conflicting urges as evidence of Barb's unresolved conflict and her incomplete identification with the female role.

HEALTH AND DYSFUNCTION

Healthy people are able to love and work. They have a minimal level of repression because they have mostly resolved their Oedipal complexes in ways resulting in less fixation at that stage and therefore less leftover unconscious material. Thus, the goal of psychoanalysis is to bring unconscious material into the conscious—that is, to reduce repression. Individuals who successfully complete psychoanalysis are those who are able to work through unconscious conflicts by allowing them to surface into the conscious and to recognize them as the sources of current behavior and symptoms. It is probably important to note that one can never get rid of the id or superego, so the story of life is the ego's attempts to manage these pressures along with the demands of the external environment (reality). In fact, one interpretation of psychoanalytic theory is that a healthy person is the one who uses the healthiest defenses (Maddi, 1996).

Dysfunctional people are individuals who have unresolved unconscious conflicts, particularly those of an Oedipal nature. Freud (1917/1963) maintained that all dysfunction originates by age 6 and is due to unsuccessful resolution of the stages of psychosexual development: "Among the occurrences which recur again and again in the youthful history of neurotics—which are scarcely ever absent—there are a few of particular importance . . . As specimens of this class I will enumerate these: observation of parental intercourse, seduction by an adult, and threat of castration" (pp. 368–369). In adults, dysfunctional behavior is the result of fixation due to unresolved conflicts plus some kind of activating, traumatic experience. The adult trauma reactivates the childhood fixation, resulting in symptoms (S. Freud, 1920/1952).

Before discussing the psychoanalytic understanding of various psychological dysfunctions, it is critical to note that most of Freud's work was with a very narrow sample of clients. Most of his clients were neurotics and, in the parlance of the day, suffering from either hysteria or obsessive-compulsive neurosis. Today these dysfunctions would be called conversion disorder and obsessive-compulsive disorder or personality. Freud's discussions of other types of dysfunction were far less detailed.

Anxiety forms the basis of dysfunction, and Freud (1933/1964a) identified three kinds: realistic, neurotic, and moral. Realistic anxiety is the appropriate affective reaction to real danger to the organism. Birth anxiety is the original realistic anxiety. Neurotic anxiety is the fear of libido. It is based in realistic anxiety because, if the libidinal drives are expressed, danger to the organism could result. Moral anxiety is the fear of the punitive superego. The nature of the response is identical in all three types of anxiety, but moral and neurotic anxieties are responses to an internal rather than an environmental threat.

By far the most important in Freud's work was neurotic anxiety, which results when an emerging instinctual urge is close to consciousness. The ego, perceiving the state of danger that would arise if the demand were satisfied, allows the anxiety to surface as an aversive experience. In most cases, repression then does away with the unpleasant state, and the unsatisfied urge is relegated back to the unconscious. If the energy of the psychic apparatus is overtaxed, the drive can be converted into a symptom that is symbolic of the conflict that generated the anxiety.

The most common client for Freud, and perhaps the most interesting, presented with what was then termed hysterical neurosis, which was originally thought to occur only in females (the result of dysfunction of the uterus). Charcot and Freud were the earliest advocates of the psychic determinants of hysteria and its existence in individuals of both sexes. Charcot thought that any kind of trauma created hysteria, whereas as early as the 1890s Freud was beginning to assert the sexual origins of hysteria. His insistence on this principle disrupted his relationship with mentor Josef Breuer, with whom he had co-authored his first book, *Studies in Hysteria* (Breuer & Freud, 1895/1937).

Early on in his explorations of neurosis, Freud noticed that his clients almost always related memories of early sexual experience, mostly perpetrated by male relatives. He initially assumed that the stories that his clients were telling were true and located in these traumas the origins of neurotic symptoms. This assumption is called the *seduction hypothesis*. However, later Freud abandoned this notion, seeing these "scenes" as the fantasy creations of his analysands (a person undergoing psychoanalysis) based on Oedipal longings. The renunciation of the seduction hypothesis is first seen in an 1897 letter to his confidant, Wilhelm Fliess, and his first public acknowledgment was in 1905 in *Three Essays on the Theory of Sexuality* (Masson, 1984). The decision to treat these client recollections as fantasy is considered critical among the adherents of psychoanalysis because it opened the way to the understanding and exploration of the Oedipal complex. Box 2.2 presents an interesting but controversial examination of why Freud abandoned the seduction hypothesis.

Box 2.2

A Failure of Courage? Another View of Freud's Abandonment of the Seduction Hypothesis

Freud's early work with hysterical clients initially led him to believe that these afflictions were caused by sexual trauma (mainly sexual abuse by a male relative) early in life. This position came to be known, somewhat misleadingly, as the seduction hypothesis or theory.

In 1905 Freud changed his mind about the reality of his clients' memories of childhood seduction, declaring that he "overrated the importance of seduction in comparison with the factors of sexual constitution and development" (quoted in Masson, 1984, p. 129). He also wrote, "At that time, my material was still scanty, and it happened by chance to include a disproportionately large number of cases in which sexual seduction by an adult or by older children played the chief part in the history of the patient's childhood. I thus overestimated the frequency of such events (though in other respects they were not open to doubt)" (quoted in Masson, 1984, p. 129).

Box 2.2 *(continued)*

Freud gave several reasons for his altered opinion, including (a) the fact that he was not able to cure his clients based on this hypothesis, (b) the fact that the incidence of hysteria would indicate an unbelievably high rate of sexual offenses by fathers, (c) his conviction that the unconscious has no sense of reality, and (d) the fact that in most severe psychoses, unconscious content does not surface (Masson, 1984). Most analytic writers agree that, if Freud had not changed his opinions, he would not have gone on to discover other significant aspects of psychological functioning, such as the Oedipal complex and the role of fantasy in human psychology.

Jeffrey Masson, however, painted another picture of the situation. Masson (1984) maintained that Freud relinquished the seduction theory for reasons other than those stated in his writings. First, Freud was ostracized by the medical community for his assertions that neuroses resulted from childhood sexual experiences. At the time, the Victorian attitudes toward sex precluded discussion of the topic, and some number of medical authorities dismissed the accounts of sexual abuse among both children and adults as "hysterical lies."

Even more interesting is Masson's argument that Freud changed his opinion partly to cover up for a surgical mistake made by his good friend Wilhelm Fliess. One of Freud's early analytic clients, Emma Eckstein, had come to Freud with stomach complaints and menstrual difficulties. Both Freud and his colleague Fliess considered menstrual problems to be the result of masturbation. Fliess, however, believed that sexual problems (such as masturbation) originated in the nose and thus could be cured only by a surgical intervention, removal of the turbinate bone in the nose. In early 1885, Freud and Fliess apparently decided that this operation was the solution to Emma's problems.

After the surgery, great complications arose, including hemorrhaging that threatened Emma's life. Various remedies were tried to no avail. Finally, a surgeon called in to consult examined Emma and found that in performing the operation, Fliess "had 'mistakenly' left half a meter of surgical gauze in Emma's nose" (Masson, 1984, p. 66). Masson argued that the hemorrhaging was a normal result of a botched surgical procedure, but Freud was motivated to save his friend's reputation. Instead of publicly acknowledging the error, Freud conceptualized Emma's hemorrhaging as the result of hysterical "sexual longing" (Masson, 1984, p. 67).

Masson suggested that Freud's rejection of the seduction hypothesis was the result of the reaction of the medical community to his theory and the need to protect his friend and colleague. Further, Masson contended that his own investigation into this issue caused the orthodox psychoanalytic community to shun him, rescinding his access to the Freud archives. Masson argued that his motivation was to force psychoanalysts to believe their clients rather than dismissing their stories as fantasy.

Prominent scholars of the history of psychoanalysis have found fault with Masson's work (Roazen, 2002; Sollod et al., 2009). However, perhaps the most important lesson learned from this debate is that sexual abuse has been and still is underreported. Counselors would be wise to think carefully before they attribute their clients' reports to need-driven fantasies.

Hysteria, which is now called conversion disorder, is a condition in which an individual displays physiological symptoms that seem to have no apparent physical basis. For example, a woman might display "glove anesthesia," numbness from the elbow downward to the hand, a condition that is neurologically impossible. As noted earlier, glove anesthesia is thought to

result from guilt about masturbation and the accompanying fantasies (probably Oedipal in nature). The term *conversion* conveys the basic assumption about such conditions: that they are anxiety converted to symptoms. In Freud's view, hysteria results from the anxiety produced by unacceptable sexual impulses threatening to break into consciousness. In the case of adult neurotics, unresolved childhood conflicts have been triggered in adult life, and the hysterical symptoms, according to psychoanalysis, always symbolize the childhood event.

Phobias are a special class of hysteria in which sexual impulses are first repressed, then converted to anxiety, and finally attached to some external object (S. Freud, 1920/1952). The phobic then creates structure that keeps the dreaded object at a distance, which represents the feared libido. For example, agoraphobia (literally, "the fear of the marketplace") is the fear of sexual impulses surfacing when the individual finds herself in a social setting. Freud gives the example of an individual who feels sexual urges toward those she passes when walking down the street. The individual displaces the danger (anxiety) into the environment and avoids it, thereby protecting herself (S. Freud, 1920/1952).

Obsessive-compulsive neurosis is conceptualized as having its roots in fixation in the anal stage of development. The sadistic urges developed at this time are a significant feature of obsessional neurosis and are the result of harsh toilet training. Reaction formation is a common defense of these individuals. Freud (1920/1952) wrote, "The obsessive thought 'I should like to murder you' means nothing else but 'I should like to enjoy love of you'" (p. 353).

In the case of depression, it is difficult to reconcile Freud's terminology with today's nomenclature. Freud identified two kinds of depressive syndromes: melancholia and mourning. The contemporary counterparts of these classifications are not clear. Melancholia sounds like what we might term major depressive disorder. Mild to moderate depressions (other than mourning) seem to be the result of a hypercritical superego, as in melancholia.

Mourning and melancholia both begin with the loss of an object, often a loved one. Mourning is the gradual withdrawal of libido from attachment to the object, a process that simply takes time. Melancholia is the result of an extremely critical superego (Rickman, 1957). However, in the case of this more severe disorder, the ambivalent feelings toward the lost loved one (object) become part of the ego through identification. Thus, the superego turns the rage felt toward the lost object onto the ego. Freud maintained that the complaints that the melancholic turns against herself (being worthless, for example) are actually really directed at the loved one.

The terminology of Freud's time also creates confusion around the subject of the psychoses. The surrounding medical community referred to these conditions as dementia praecox or used the newer term *schizophrenia*; Freud called them paraphrenia (Rickman, 1957, p. 105). Conceptually, however, Freud (1920/1952) discussed these conditions as forms of narcissism. He thought that psychosis results when the libido abandons all object attachments and instead attaches to the ego. The individual becomes egotistical and sometimes hypochondriacal (when some of the libido attaches to a body organ). In all psychological dysfunction, but particularly the psychoses, "there is a splitting of the ego" (S. Freud, 1940/1964b, p. 202), in which two separate ideations or impulses coexist—those of the ego and those of the id. If the instinctual element becomes strongest, the stage is set for psychosis.

Glenda sees some of Barb's symptoms, such as the dizziness and numbness, as hysterical in nature. Her ego is not strong because of the amount of energy fixated in her early development. Barb does not have a successful work or love life, which supports the position that her symptoms are hysterical and reflects

libidinal energy at work and the repression of memories of sexual abuse or fantasies of sexual relations with her father. Barb's panic attacks and headaches likely happen when some event activates her fixation in the phallic stage during which the Oedipal complex was unsuccessfully resolved. Her anxiety signals the possible emergence of a forbidden sexual urge, and her depression and mood swings result from her superego's punishment for the unacceptable urges. Glenda also understands Barb's troubles with men as a result of her unresolved Oedipal complex and the trauma of the sexual abuse she experienced in adolescence, which probably reinforced her fixation.

NATURE OF THERAPY

ASSESSMENT

Freud considered assessment very important in his approach to his clients but only had what we would call informal approaches to this task. After determining that his client's symptoms were psychological rather than physiological, Freud (1912/1958c) recommended a 2-week trial period to ascertain that the client was suitable for analysis. Primarily, Freud sought to make a differential diagnosis between hysterical or obsessive neurosis and schizophrenia (paraphrenia) because he thought the latter untreatable by psychoanalysis. A continuing assessment in psychoanalysis is seen in the search for clues to the unconscious in the clients' free associations, dreams, and errors.

In more contemporary forms of psychoanalytic therapy, formal assessment is often used to gain some information about the nature of the client's defenses and unconscious conflicts. The classic (and some would say the only) way to access unconscious material is by using ambiguous stimuli, such as the Rorschach inkblot test (Rorschach, 1942). In these methods, clients are asked to associate to the stimuli, and the therapist records and analyzes these productions. The ambiguity of the stimuli creates a situation in which unconscious processes are thought to be projected onto the cards and can then be deduced from the nature of the client's responses.

Dissatisfied with the approach to diagnosis taken by contemporary professionals, a consortium of psychoanalytic organizations developed a diagnostic system for analysts, found in the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006). A brief glance at its table of contents (which can be found at https://sites.google.com/a/icdl.com/pdm/table-of-contents) reveals a very different approach to assessment and diagnosis than the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, (DSM-V; American Psychiatric Association, 2013). The system, according to the PDM website, is intended to complement the DSM, allowing a "fuller understanding of the functioning of the mind and brain and their development" (Alliance of Psychoanalytic Organizations, 2006).

OVERVIEW OF THE THERAPEUTIC ATMOSPHERE

Freud spent many years searching for the most efficient ways to access the unconscious. His early attempts relied heavily on hypnosis because he had observed the famous Charcot re-creating the symptoms of hysteria through this method. Because he found that some individuals were not very hypnotizable, Freud abandoned the practice in favor of placing his hands on clients' foreheads to evoke memories. Interestingly, in his early attempts to grasp the unconscious, he would exhort his clients to remember and was quite interpretive and forceful in his approach. Later on he deplored such behavior, terming it "wild analysis" (S. Freud, 1910/1957b). At one point Breuer and Freud were

treating a client together and came to believe that the source of a cure for hysteria was catharsis, or emotional expression (the client called it "chimney sweeping"; Breuer & Freud, 1895/1937, p. 20).

Gradually, Freud came upon the position with which we familiarly associate analysis—that the therapist is to remain "abstinent," or a neutral stimulus, in the therapeutic relationship. He described the attitude of the therapist as one of "evenly suspended attention" (S. Freud, 1912/1958c, p. 111). Freud banished the personality of the therapist from the interaction, leaving the client free to project her unconscious material into the analytic situation.

One of the most conspicuous features of classical psychoanalysis is the analytic couch. Freud's couch was a gift from one of his clients (Gay, 1988). These and other incidents (such as inviting clients to meals and analyzing his own daughter) suggest that, although Freud preached abstinence and strong client–counselor boundaries, he liberally broke the rules, too.

Freud had at least two reasons for the use of the couch and the tradition of the analyst sitting behind it, out of the client's view. First, preventing the client from seeing the analyst helped to maintain the abstentious atmosphere. The therapist, who is admonished to let the client's unconscious work, might reveal something or otherwise influence the client through her facial expression. Freud (1913/1958b, p. 134) also admitted that he simply did not like to be stared at for 8 hours a day.

Psychoanalysis is a long-term process. Freud believed in seeing his clients daily (i.e., 6 days a week), some of them for years. Mild cases required 3 days of analysis a week. Some analysts even took their clients along on vacations!

Glenda, who typically performs classical analysis, would like Barb to come to therapy 5 days a week. However, arrangements might be made for less frequent sessions if financial concerns interfere. After a few exploratory sessions (in which assessment of suitability for analysis was the focus), Glenda asks Barb to lie on the couch and obey the fundamental rule (discussed next).

Freud finally settled on *free association* as his primary analytic technique. He insisted that his clients obey the "fundamental rule" of psychoanalysis: The client is to reveal "everything that comes into his head, even if it is disagreeable for him to say it, even if it seems to him *unimportant* or actually *nonsensical*" (S. Freud, 1940/1964b, p. 174; emphasis in original). Freud explained to his clients that what happens in analysis is different from everyday conversation. They were not to try to make any sense; they were only to be totally honest with him.

Glenda describes the fundamental rule to Barb, even using Freud's own words. When Barb agrees to this contract, Glenda concludes that she can proceed with the analysis.

ROLES OF CLIENT AND COUNSELOR

Both the theory's nature and its historical roots in medicine combine to create the roles of the client and counselor in psychoanalysis. Freud was a physician first, and his belief that we are unable, for the most part, to access our unconscious led to the doctor role for the therapist and the patient role for the client. The client must comply with the fundamental rule and, in turn, the therapist will correctly interpret the client's productions. In addition, it is the therapist who decides what is real and not real (see the sections on resistance, transference, and countertransference that follow). Freud (1912/1958c) urged his students to take as a model the surgeon "who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible" (p. 115).

Freud believed that to achieve the proper attitude as a psychoanalyst, candidates should undergo analysis themselves. "It may be insisted, rather, that he should have undergone a psychoanalytic purification and have become aware of those complexes of his own which would be apt to interfere with his grasp of what the patient tells him" (S. Freud, 1912/1958c, p. 116). This analysis is termed the training, control, or personal analysis. Interestingly, Roazen (2002) presents evidence that Carl Jung (see Chapter 3), Freud's student and later nemesis, originated the idea of the training analysis, not Freud.

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Video Example 2.3 Training to be a psychoanalyst



https://www.youtube.com/watch?v=yMSYAww8qD0

Glenda takes the orientation that she is the expert, able to listen to and understand Barb's associations in terms of Barb's unconscious process. Glenda remains relatively passive and opaque in her sessions with Barb, becoming active only when she has something to interpret to Barb. She expects Barb to cooperate with the analytic goals by freely expressing everything that comes to mind.

GOALS

The goal of psychoanalysis is to help the client uncover and resolve unconscious conflicts and to strengthen the ego by redirecting energy to conscious processes. The psychoanalyst is not really interested in symptoms; these will go away if the analysis succeeds. In fact, simple removal of a symptom is useless because the conflict will inevitably be expressed through some other symptom, a phenomenon known as symptom substitution (Yates, 1960).

Contemporary psychoanalysts offer a discussion of the purposes of analytic methods. Luborsky, O'Reilly-Landry, and Arlow (2011) identified four of these: (a) uncover inner problems that are disguised as symptoms, (b) promote client integration, (c) uncover sources of pain in the client's history that are likely to creep into the present, and (d) discover what stands in the way of taking appropriate actions for the self (p. 39).

Glenda attempts to help Barb understand how her current behaviors and symptoms are related to unconscious conflicts in her past. As Barb free associates, her repressed memories and emotions slowly begin to surface. Barb examines her early memories, particularly those of her relationship with her parents and siblings. With Glenda's help, Barb will begin to gain awareness of psychic material and events that have long been unavailable to her conscious mind.

PROCESS OF THERAPY

Arlow (2005) identified four phases of psychoanalytic treatment. However, before describing these phases, you should understand some important psychoanalytic constructs relevant to intervention.

INSIGHT

The goal of psychoanalysis is insight. The client will understand the sources of her current behavior and symptoms as stemming from unresolved unconscious conflicts originating in childhood. In essence, the counselor is teaching the client to think in psychoanalytic terms.

However, insight has an emotional component, too, because the client is actually experiencing and coming to understand her conflictual unconscious dynamics in the context of the therapeutic relationship (with the help of the therapist's interpretations, of course; Safran & Kriss, 2014).

RESISTANCE

In any analysis, one will see the workings of the unconscious ego and superego in the form of resistances. Because it is dangerous for unconscious material to surface, the psychic apparatus fights to keep it out of awareness, using any means possible. Early forms of resistance to treatment can be seen in such tactics as having nothing to say, being late to or missing sessions, and being unable to pay the analyst. All of these are "grist for the mill" for the psychoanalyst, and they are eventually interpreted to the client. The most powerful, and in the end the most healing, resistance is the transference neurosis (discussed next).

TRANSFERENCE

Over the years of his work, Freud came gradually to the conviction that transference is the key to successful psychoanalysis. It is still a major construct in psychoanalytic approaches today (Luborsky et al., 2011). Every client inevitably re-creates a pivotal former relationship with the analyst, and the secret is to analyze and resolve this transference neurosis. Freud (1940/1964b) called the transference "ambivalent" (p. 175) because it is composed of both positive and negative emotions toward the therapist. Most often, in classic analytic models, the therapist is placed in the role of the client's mother or father. Thus, the client can fall in love with the analyst (the erotic component), but then become angry when the analyst does not return this love or show her special favor. Much of the transference reaction is rooted in the Oedipal complex.

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Video Example 2.4 Watch Dr. Donovan explore Helen's transference.



After a number of sessions, Barb will begin to develop a therapeutic bond with Glenda. At first, this bond is likely to be positive, but as the relationship develops, ambivalence and resistance start to emerge. Barb may be initially quite loving of her therapist, perhaps wanting to recapture the ruptured relationship with her mother. An alternate possibility is that she will be trying (unconsciously) to re-create her special relationship with her father. She will want to know all about Glenda and ask for special favors (such as changing the time of her appointments or not having to lie on the couch). As the analysis progresses and Glenda refuses to gratify such wishes, Barb may become angry with Glenda, refusing to free associate or discounting Glenda's interpretations. She may also develop new and troubling symptoms. The ambivalent feelings Barb has toward her therapist stem from her Oedipal impulses of seeing her mother as a competitor and responsible for her lack of a penis. If Barb transfers her feelings for her father to Glenda, then Barb's anger will duplicate Barb's rage at her father's rejection of her.

COUNTERTRANSFERENCE

Countertransference is what happens when the therapist has not had a proper training analysis. Conflicts from the counselor's past are projected into the analytic situation, and the therapist loses her objectivity (Safran & Kriss, 2014). The client becomes "special" to the counselor

(a positive countertransference), or the therapist begins to want to argue or gets angry with the client. The counselor may find herself looking forward to or dreading seeing a particular client. The only way to resolve countertransference is for the analyst to seek the aid of her training analyst or a professional consultant.

At the conclusion of her academic training, Glenda underwent her training analysis as a requirement for her certification as a full-fledged analyst. As a result, Glenda is now able to listen neutrally to Barb's associations and avoid responding on the basis of her own conflicts. In the event that Glenda feels she is reacting emotionally to Barb's associations and behaviors, Glenda will seek analysis to work through her own difficulties.

PHASES OF THERAPY

According to Arlow (2005), the four stages of psychoanalytic treatment are (a) the opening phase, (b) development of transference, (c) working through, and (d) resolution of the transference (p. 35).

Opening Phase. The first few sessions with the client are typically conducted face-to-face and are an attempt to see if analysis is appropriate (Arlow, 2005). The client must have a certain level of psychological sophistication to engage in the analytic process, and the problem presented should be suitable from the perspective of psychoanalytic theory. The counselor observes the client's presentation and listens to her story. If the analyst decides that the client is a good candidate for analysis, the fundamental rule is explained, and the client is asked to take her place on the analytic couch. The analysis then begins, with the client relating whatever comes to mind and the therapist observing these productions to get an idea of the client's conflicts and characteristic defenses. This stage lasts 3 to 6 months (Arlow, 2005).

Development of Transference. As the client continues to free associate, she eventually gets closer to relating her current difficulties to unconscious material. At about this time, the therapist begins to become a very important figure in the client's life as the client starts to transfer to the analyst feelings associated with past significant others (Arlow, 2005). According to Arlow, "the professional relationship becomes distorted as the patient tries to introduce personal instead of professional considerations into every interaction" (2005, p. 36). The therapist analyzes these interactions and interprets them to the client, starting with relatively benign, surface observations and progressing to interpretations involving deep unconscious material. This process is called analysis of the transference.

Working Through. As therapy progresses, the transference appears in many forms and is analyzed. Once an incident is analyzed and the client accepts the therapist's interpretation, new memories from the client's past are likely to surface, providing new material for analysis (Arlow, 2005). The repeated and more elaborate analysis of the transference that constitutes this phase results in the client becoming more confident about the relationships between her current thoughts, feelings, and behavior and her past.

Resolution of the Transference. When the analyst and client decide that the client has insight into her conflicts and the transference process, a date is set for termination of the therapy. Commonly, this event is marked by a resurgence of the client's symptoms because the client does not want to give up the therapist. This infantile urge is then analyzed by the client and therapist.

New memories and fantasies can surface during this stage of treatment, which are then interpreted, until the client finally deals with her fantasies about what life will be like with no therapist (Arlow, 2005). At this point, therapy can end.

THERAPEUTIC TECHNIQUES

Very few techniques are available to the therapist in psychoanalysis, but they are considered quite powerful. Generally, the counselor is to be passive, rather than active, so the lack of overt technique is consistent with this attitude.

FREE ASSOCIATION

As I indicated earlier, the most important weapon in the therapist's arsenal is free association. Only in the special environment created by the fundamental rule will the unconscious start to show itself.

INTERPRETATION

The second powerful technique available to the psychoanalyst is interpretation of the client's material as it relates to conflicts from the past or unconscious material. Because Freud found that premature interpretations evoked resistance in his clients, he insisted that none be made until the client was almost ready to discover the connections herself. Further, one must have developed a sufficient level of relationship with the client (the transference) prior to interpretation. In general, interpretation in the early part of therapy is oriented toward more "surface" material, and deep unconscious material is addressed later in the therapy.

Interpretation plays a part in the two other techniques described here, analysis of the resistance and dream analysis. Correct interpretations of the transference are critical so that the client can finally see that her behavior is based not in the actual relationship between therapist and client, but in relationships in the past.

Glenda invites Barb to talk about whatever comes to mind and is interested in the associations Barb produces as she engages in the analytic process. Barb's initial productions will not be very close to her unconscious urges, so Glenda is very general and cautious in interpreting the material. For instance, Barb may talk about her feelings about men, but instead of bringing up Oedipal issues Glenda will likely talk to Barb about feeling unloved and rejected, while at the same time longing for a savior. Later Glenda could tentatively relate Barb's feelings about men to those about her father, her abuser, and finally to Glenda (who by then represents a powerful, important person in Barb's life).

ANALYSIS OF THE RESISTANCE

The psychoanalyst must always be alert for signs of client resistance. Minor, common resistances (such as forgetting appointments or having nothing to say) must be interpreted for the client, lest they get in the way of treatment. Symptoms may begin to disappear, and the client may begin to think she is getting well. However, the wise analyst knows that this is yet another form of resistance, called *flight into health* (Safran, 2012). As analysis continues, resistances connected with more threatening material, such as the transference neurosis, are interpreted and analyzed much more cautiously. In fact, the transference neurosis will have to be reinterpreted many times (called *working through*) before the client can resolve it.

At some point in the analysis, Barb will show signs of serious resistance. She may openly refute Glenda's interpretations, grow silent, or miss sessions. Glenda will remain calm in the face of such resistances, gathering information to make her case convincing. Barb may at some point begin to feel better and want to discontinue analysis. Glenda will interpret this "flight into health" as Barb's aversion to dealing with difficult material. Glenda will then offer repeated interpretations of the feelings of being unloved and worthless until Barb begins to accept these. New information will surface and be interpreted, perhaps at deeper levels. When the time is right, Glenda will begin to offer more intense interpretations involving Oedipal material.

DREAM ANALYSIS

The special place of dreams in psychoanalytic theory is considered one of Freud's most original and important contributions. His 1900 book, *The Interpretation of Dreams*, was probably the work of which Freud was most proud, and many consider it his finest. Freud considered dreams to be symbolic wish fulfillments. He wrote, "A dream is itself a neurotic symptom and, moreover, one which possesses for us the incalculable advantage of occurring in all healthy people" (S. Freud, 1920/1952, p. 87). The content that the dreamer reports is known as the *manifest content.* However, the most important part of a dream is the *latent content*, that which has been disguised by *dream work* for the usual reason (i.e., the content is unacceptable to the conscious). Elements in the dream are only substitutes for the latent material that is of the most interest in psychoanalysis. When a client reports a dream, the analyst then asks her to free associate to the content. The alert analyst then listens and interprets the latent content from the manifest content.

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Video Example 2.5 Watch Dr. Donovan do dream analysis with Helen. Can you identify the manifest and latent content?



As you might have divined, an "overwhelming majority of symbols in dreams are sexual symbols" (S. Freud, 1920/1952, p. 161). Box 2.3 shows a list of dream elements and their hypothesized underlying contents. However, when examining such lists, remember that symbols may have multiple determinants and that dream elements may even represent the opposite of what they appear to be. For example, in one of Freud's most famous cases, the client (the wolf man) had dreamed that he woke up and saw a pack of wolves sitting motionless outside of his window. Freud (1918/1955b) interpreted this dream as symbolic of the wolf man's early observation of vigorous parental sexual intercourse, but the stillness of the wolves represented the opposite.

Box 2.3

The Meaning of Dream Symbols

In *A General Introduction to Psychoanalysis* (S. Freud, 1920/1952), Freud wrote that "the number of things which are represented symbolically in dreams is not great. The human body as a whole, parents, children, brothers and sisters, birth, death, nakedness—and one thing more"

(here Freud meant sex; p. 160). By far, the majority of symbols in dreams, according to Freud, have to do with sex. Following is a list of symbols presented by Freud in this work, along with their possible interpretations.

Symbol	*Interpretation*
House	With smooth walls, a man
	With ledges and balconies, a woman
Exalted personages (queens, emperors, kings, etc.)	Parents
Little animals or vermin	Children, brothers, sisters
Water (falling into, climbing out of)	Birth
Traveling by train	Dying
Clothes, uniforms	Nakedness
The number three	Male genitals
Long and upstanding objects (sticks, umbrellas, trees, etc.)	Penis
Objects that can penetrate (knives, firearms)	Penis
Objects from which water flows (springs, taps)	Penis
Objects capable of elongation (pencils that slide in and out of sheaths)	Penis
Balloons, airplanes, zeppelins	Penis (the property of erection)
Flying	Erection
Reptiles and fishes	Penis
Serpent	Penis
Objects that enclose a space (pits, jars, bottles, boxes, chests, pockets)	Female genitalia
Cupboards, stoves	Uterus
Rooms	Uterus
Doors and gates	Opening of the vagina
Church, chapel	Woman
Snails and mussels	Woman
Fruit	Breast
Woods and thickets	Pubic hair (both sexes)
Landscape	Female genitalia
Machinery	Male genitalia
Jewel case	Female genitalia

(continued)

Box 2.3 *(continued)*

Symbol	*Interpretation*
Blossoms or flowers	Female genitalia
Play	Masturbation
Sliding or gliding	Masturbation
Teeth falling out or extracted	Punishment (castration) for masturbation
Dancing	Sexual intercourse
Riding or climbing	Sexual intercourse
Experiencing some violence	Sexual intercourse
Mounting ladders, steep places, stairs	Sexual intercourse
Windows or doors	Body openings
Key	Penis
Oven	Uterus
Plow	Penis

Barb reports to Glenda that she had the following dream: She is at work (in the grocery store) and is carrying two bags of groceries when she trips and falls, scattering the contents of the bags and breaking glass items. What caused Barb to fall was a broom that was carelessly left in the grocery aisle by Carlos, one of the other workers in the store.

Most likely, Glenda would see Barb's dream as Oedipal in nature. The bags represent her womb, full of goodies. Barb trips over a phallic object (the broom), and everything is broken. Clearly, Barb is expressing her desire for sex or perhaps her fear of it. Glenda has to discover which interpretation is correct based on Barb's associations to the dream. Because Barb reports being afraid and anxious in the dream (manifestly attributed to fear of punishment by her boss), Glenda concludes that Barb's dream represents her fear of forbidden sex; that is, sex with her father. Carlos is merely a safe substitute for Barb's father, inserted into the dream by the dream censor. Barb's superego takes the form of the boss.

Analysis of the Transference

The ultimate key to a successful analysis is the analysis of the transference neurosis. The client will unconsciously transfer onto the counselor qualities of significant individuals in her past, particularly parental figures. Feelings associated with these early interactions are evident in the client–counselor relationship but, in the analyst's view, are unreal because the analyst has been properly abstinent in the therapeutic environment (Safran, 2012).

Cautiously, the counselor interprets the client's behavior and feelings, starting with the least threatening aspects. Early on, the transference is often affectionate and positive, resulting in the client idealizing the therapist as she would her "good" parents. The analyst can enlist this energy, encouraging the client to work hard to understand her unconscious material. Over the course of the therapy, the deeper issues emerge in the transference, which usually becomes

erotic or hostile in nature, resulting in powerful resistance (S. Freud, 1915/1958a). For example, a female client might perceive a male therapist as unloving and uncaring, echoing the earlier rejection by her own father in the Oedipal phase. A male client may transfer to a female analyst feelings about his mother, becoming angry when the therapist refuses to gratify his wish to be special. You will note that these examples involve cross-sex pairings. However, in many cases transference feelings are not dependent on the sex of the analyst. For example, feelings of anger directed at an authority or power figure could be transferred to a therapist of either sex.

The job of the analyst, then, is to interpret the transference, showing the client that the feelings that she is having are not real but are instead rooted in the past. This process is long and sometimes tedious because transference tends to pop up again and again in the relationship. Analysts call this process *working through*.

As her work progresses, Barb will begin to feel that Glenda does not care about her, a transference of her feelings of being unwanted, mistreated, and unloved that result from her unresolved Oedipal complex. Barb is also likely to become angry at Glenda, attributing her anger to Glenda's uncaring treatment of her. Glenda interprets these feelings as transference of feelings resulting from the longing associated with her father's abuse and abandonment. Some of Barb's feelings might also stem from her rage at her mother for stealing her father away. Barb's transference is likely to be quite ambivalent, however, vacillating between desperately seeking Glenda's love (reflecting Barb's longing for her father) and being angry at Glenda (reflecting Barb's anger at her father's abandonment—the result of the Oedipal fantasies or abuse she suffered at that early age—and his abuse of her as a teen). Feelings of distrust of Glenda could also appear as a result of Barb's feelings about her father or her ambivalent feelings about her mother. Glenda will patiently interpret these feelings for Barb, slowly demonstrating that Barb's reactions are based in her psychological conflicts rather than in reality.

Eventually, Barb will come to recognize that the feelings and impulses she has toward Glenda are not real. Together, Glenda and Barb will work through multiple examples of this transference until Barb understands fully the nature of her psychological processes. Barb will probably always have some of the same tendencies to be angry at men and to mistrust others, but she will have insight into them and will be more able to operate based on ego rather than id or superego processes. After a lengthy analysis, Barb is finally ready to begin termination, but shortly after she and Glenda begin to discuss ending the analysis, Barb's symptoms, which have almost disappeared, re-emerge. Glenda helps Barb see that this resurgence is the result of Barb's not wanting to give up the safe analytic relationship. When Barb can fully acknowledge this interpretation, she is truly ready to end the analysis.

EVALUATION OF THE THEORY

There is no doubt that psychoanalytic theory has had a major impact on many professional and scholarly disciplines, including literature, psychology, and the practice of counseling. Reactions to psychoanalytic theory are rarely neutral; it seems to be both the most idolized and the most criticized theory in existence. Numerous prominent theorists of counseling admit that their approaches were developed partly in reaction to psychoanalytic theory (e.g., individual psychology, rational emotive behavior therapy, reality therapy, cognitive therapy, and person-centered therapy). The sheer volume of literature that critiques the psychoanalytic approach is

huge, so it is simply impossible to summarize it succinctly in this section. Thus, I will attempt to hit only the high points of these evaluations, leaving the interested scholar a lot of fascinating reading.

Although still practiced, classical psychoanalysis as it is currently practiced in the United States looks quite different than the version practiced by Sigmund Freud and colleagues. For starters, the 5-day-a-week analysis lasting years is probably nonexistent; two to three sessions per week is probably more common. Safran (2012) contends that American psychoanalysis is more optimistic, pragmatic, and, partly in response to feminist and postmodern critiques, less vested in the notion that the analyst knows the Truth and will convey it to the client. The downside of these modifications, according to Safran, is the risk of downplaying the complexity of human existence and the sometimes tragic nature of human life.

Psychoanalysis has spawned a second generation of analytically oriented theories, generally subsumed under the headings psychoanalytic (small *p*), neoanalytic, or psychodynamic. They are also known as self psychology, ego psychology, and object relations theory (St. Clair, 2004). Theorists associated with these approaches include Fairbairn, Kernberg, Klein, Kohut, Jacobson, Mahler, and Winnicott. Their theories share an interest in mental representations of self and others (i.e., objects) and how these influence relationships. You will read more about these theorists in Chapter 3, on neoanalytic approaches.

Qualities of the Theory

Precision and Testability. One of the most common critiques of Freud's theory is that it is not very testable. Entities such as the id, ego, and superego are not easily observed directly; researchers must be satisfied with only indirect evidence of their existence. A second problem with psychoanalytic theory relates to refutability (Sollod et al., 2009). It is very difficult to disconfirm psychoanalytic theory. Consider, for example, the idea of resistance. If an analyst makes an interpretation that the client rejects, the client can be said to be resisting because she is too threatened to acknowledge the unconscious material revealed; the therapist is still correct. If the client accepts the interpretation, it is right, end of story. Monte (1999) provides the following example:

> Imagine telling the mythical "man on the street" that sometime between ages three and six years, he lusted after his mother, hated his father, and was terrified that his father would remove his penis. If our man on the street protests that this is nonsense or berates us for being offensive, we must point out to him that he is incredulous or offended precisely because he is repressing these experiences! And, indeed, the more he protests, the more we are prone to assume that he is threatened by these ideas because he, like all males, has *repressed* his Oedipal strivings. What possible evidence could the man produce that would *disconfirm* our theoretical assertion that he was Oedipal as a child? (p. 97; italics in original)

It is also difficult to derive precise predictions from psychoanalytic theory that might be easily tested. In psychoanalytic interpretation, things are often their opposite (as with the wolf man or defense mechanisms). Further, reading Freud in the original reveals his heavy reliance on metaphor in his descriptions of psychic functioning. Maddi (1996, p. 492) warned that such language impairs the precision and clarity of the theory. Finally, because of the various revisions of psychoanalytic theory, different interpretations can be made of the same or similar phenomena.

Other views of the testability of psychoanalytic theory are less negative. Bornstein (2005), Westen (1998), and Shedler (2010) argued persuasively that significant support exists for some of the basic assumptions of psychoanalytic theory. Bornstein contends that other branches of psychology have co-opted psychoanalytic constructs and amassed data in support of them. Evidence for this argument can be found in Westen's (1998) review, summarized in the "Theory-Testing Research" section. Seeing this state of affairs as partially a public relations problem, Bornstein suggested that psychoanalysts need to reclaim the scientific heritage that was so important to Freud.

Empirical Support. A good theory should have some empirical support. As you will see in the "Research Support" section, the evidence bearing on psychoanalytic theory is mixed. Notably, however, several studies of psychoanalysis involving the couch and multiple sessions of therapy per week have emerged and are supportive. There is also good empirical support for several more recent, narrowly defined forms of psychodynamic therapy, which have psychoanalytic roots (see Chapter 3). However, Watkins (2012; 2013) demonstrated that research on psychoanalysis and psychoanalytically influenced intervention rarely included individuals of color or simply omitted information about participants' cultural and demographic backgrounds, calling into question the effectiveness of psychoanalysis and its neoanalytic relatives with these cultural groups.

RESEARCH SUPPORT

Outcome Research. As is the case with the other major theoretical approaches, outcome research has generally supported the efficacy of psychoanalytic psychotherapy (Barber, Muran, McCarthy, & Keefe, 2013; Leichsenring, 2009). However, we should note that much of the outcome research is generally not assessing classic (5 days a week on the couch for years) psychoanalysis. For instance, the Temple study described in Chapter 1 (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975) found that psychoanalytic psychotherapy (weekly sessions for 3 months) was as effective as behavior therapy and that both were more effective than no treatment. However, some of the European research projects described in this section do test more intensive forms of psychoanalysis involving multiple sessions per week and the use of the analytic couch.

Leuzinger-Bohleber and Target (2002) reported on the "German studies" of psychoanalytic therapies, which focused on the outcomes of long-term intervention. This study, conducted in the late 1990s, relied heavily on retrospective reports of therapists and clients, although they did administer the Symptom CheckList-90R (SCL-90R; Derogatis, 1994). Their findings, like those in other large studies of therapy, indicated that most clients in analytic therapy of some form reported improvement, as did the therapists. SCL-90R scores revealed that the former clients scored mostly below the mean score defined as "clinical" based on German norms. Roseborough, Luptak, McLeod, and Bradshaw (2013) reported on an archival study of psychodynamic therapy with older adult clients (aged 60–89), tracking symptom change at 3-month intervals. These clients showed improvement, but you will undoubtedly note that this is a descriptive study with no random assignment or comparison groups.

The Helsinki Psychotherapy Study Group has been busily investigating the effects of short- and long-term psychoanalytically oriented psychotherapy using a randomized controlled design

with an impressive schedule of follow-up assessments. Knekt et al. (2011) reported on the effects of these treatments in comparison to solution-focused therapy (SFT) and a sample of clients who were self-selected into psychoanalysis at 1-, 3-, and 5-year follow-ups. Clients presented with anxiety or mood disorders (e.g., depression). SFT was delivered in 8 months or less with a maximum of 12 sessions, short-term psychoanalytic therapy (SPP) consisted of 20 sessions, and long-term psychoanalytic therapy (LPP) was open-ended but averaged two to three sessions a week for about 3 years. Psychoanalysis (PA) lasted about 5 years and involved four sessions a week. Multiple assessments were used in this study, and sophisticated statistical analyses were performed.

The results of this investigation are complex. Data collected during the first-year assessment showed that short-term therapies were more effective than PA. However, no differences emerged at the 3-year assessment. At 5 years, all groups still showed improvement, but PA was found to be more effective than the short-term approaches, although some of the differences were not statistically significant. Although Knekt et al. wanted to conclude that their data support the superiority of PA over the other approaches, it should be noted that the PA group was either still in therapy or relatively recently terminated at the time of assessment (the average length of PA was 56.3 months). That the clients who had completed short-term treatments (some years earlier) maintained their improvement is impressive, and the differences between PA and these groups were not observed across all measurements used. Finally, the clients receiving PA were not randomly assigned to that treatment as were the other clients, leaving the possibility that something about the group that chose PA was related to the observed changes. In an interesting further analysis of these data, Heinonen, Lindfors, Laaksonen, and Knekt (2012) found that active, extroverted therapists produced quicker change in short-term as compared to long-term therapy, and more reserved therapists produced better results using longer-term therapy at the 3-year follow-up.

Berghout, Zevalkink, Katzko, and de Jong (2012) examined patterns of change at 2 years into long-term psychoanalytic psychotherapy (PP) and psychoanalysis (PA), expecting that general symptoms (e.g., depression, anxiety) would decrease sooner than would reported interpersonal problems (e.g., being cold, self-sacrificing, domineering). The PA clients received three to five sessions per week and the couch was used. The PP group received an average of 3.9 years of therapy compared to the PA group, who averaged 6.5 years. Needless to say, this study was conducted where health insurance covers these treatments, in the Netherlands. Berghout and colleagues found that rates of change were much slower than expected; after 2 years of treatment both groups were still demonstrating significant levels of symptoms and interpersonal problems. The PP group showed changes in symptoms and in interpersonal problems, but the PA group only showed significant decreases in symptoms. These results would appear to be both good news and bad news for psychoanalysis. Using the Rorschach as an outcome measure, Berghout, Zevalkink, Pieters, and Meyer (2013) found similar results when they compared changes in symptoms among PP and PA clients—more changes were noted in groups receiving PP. However, in both of these studies a naturalistic approach was used that did not involve random assignment to the two forms of therapy, so it is possible that the groups differed in some significant way before treatment that could influence the results.

Meta-analytic results (see Chapter 1) are often helpful in resolving conflicts raised by reviews of individual studies. However, Shedler's 2010 review of meta-analyses bearing on

psychoanalytically informed therapy ignited a small controversy when he declared that psychodynamic psychotherapy is as effective as other approaches deemed empirically supported, and further, "nonpsychodynamic therapies may be effective in part because the more skilled practitioners utilize techniques that have long been central to psychodynamic theory and practice" (p. 98). Shedler's assertions provoked several responses in the flagship journal of the American Psychological Association, the *American Psychologist* (where the original article was also published; Anestis, Anestis, & Lilienfled, 2011; D. McKay, 2011; Thombs, Jewett, & Bassel, 2011; Tyron & Tyron, 2011). Without plunging into the technicalities of the arguments, they can be summarized as asserting that Shedler overstated the case for the efficacy of psychodynamic approaches by choosing data that supported his argument and reporting it uncritically. Anestis and colleagues concluded that "We wholeheartedly agree with Shedler (2010) that blanket assertions that PT [psychodynamic therapy] is worthless are scientifically unwarranted. Nevertheless, in science, a largely uncritical embrace of claims is just as problematic as is cavalier dismissal" (p. 150).

Shedler (2011) responded to the critiques by suggesting that they were narratives in support of a master narrative embedded in mainstream psychology that asserts that psychodynamic therapies are not supported by research. He writes that "intentionally or not, they offer misinformation, omit crucial information, cherry-pick findings to create a misleading impression of the research literature, or impose a disingenuous double standard with respect to what constitutes evidence. Such tactics seem to emerge predictably when the master narrative is at stake" (p. 153). So you can see that the intellectual battle was engaged, with vigor, and no clear winner emerged.

The results of recent meta-analyses of studies of psychoanalysis and psychoanalytic psychotherapy are mixed, and there seems to be more support for short-term dynamic psychotherapy than classical long-term psychoanalytic therapy. De Maat et al. (2013) conducted a meta-analysis of studies investigating something resembling classical psychoanalysis using the inclusion criteria that adult clients had to be seen two to five times per week using the couch. Clients in the studies presented a large range of problems. The effect of psychoanalysis was found to be large across 10 studies using pre- to post-therapy assessments (average effect size 1.27). Strong effects were also found in a much smaller group of studies in which follow-up assessments were made. Only one of the studies included in this meta-analysis was a randomized controlled trial (see Chapter 1), and de Matt and colleagues acknowledged that the quality of the studies varied.

In contrast, Smit et al. (2012) were less optimistic about the effectiveness of long-term psychoanalytic psychotherapy, asserting that rather than basing meta-analyses on studies of pre- to post-treatment change, we should be analyzing studies that compare psychoanalytic psychotherapy to other forms of treatment. They performed such a meta-analysis, finding that long-term psychoanalytic therapy was about as effective as treatment as usual, concluding that "our findings contradict the previously published large effect sizes for long-term psychoanalytic psychotherapy" (p. 90).

Other meta-analyses have investigated short-term psychoanalytically oriented therapies with specific client groups and presenting problems. Town and Driessen (2013) reported on a meta-analysis of intensive short-term dynamic therapy with clients diagnosed with personality or somatic disorders (physical disorders that are medically unexplainable). They found moderate to large effect sizes across a small group of studies. Abbass, Rabung, Leichsenring, Refseth, and

Midgley (2013) meta-analyzed 11 studies of short-term therapy with children and adolescents, finding positive results, although highly variable across studies.

Theory-Testing Research. Theory-testing research does exist in the psychoanalytic realm, although many of the empirical studies of pure psychoanalytic theory are dated and can be questioned on methodological grounds. For example, R. B. Levin (1966) examined penis envy and found that "career women" showed more penis envy than did married women who did not work outside of the home. However, the measure of penis envy was based on the Rorschach test, another projective device with debatable psychometric properties, at least when considering the measurement of penis envy. In yet another test of the penis envy construct, G. B. Johnson (1966) expected that more females than males would fail to return special pencils after completing a test in a psychology class, indicating that penis envy was operative among the women. Results of the study confirmed Johnson's prediction. A more recent replication of the study failed to support the hypothesis that women would steal more pencils/penis symbols (N. F. Skinner, 1977). Is coveting pencils a good measure of penis envy? You can see the difficulty in operationalizing this psychoanalytic construct.

In a more comprehensive review of psychoanalytic constructs, Westen (1998) summarized the research on five postulates of psychoanalytic theory:

1. The existence and centrality of unconscious processes
2. Conflicting feelings and motivation that result in ambivalence and compromise
3. The role of childhood experiences and their impact on adult relationships
4. The importance of mental representations of the self, others, and relationships in social interaction
5. The idea that development involves learning to regulate sexual and aggressive tendencies and that it progresses from immaturity and dependence to maturity and independence (adapted from pp. 334–335)

Reviewing an impressive amount of literature from cognitive, developmental, and social psychology, Westen (1998) concluded that there is ample support for the five propositions. For example, he reported that the idea that unconscious processes influence overt behavior is "no longer controversial" (p. 336). Studies of subliminal exposure (exposure to stimuli in very brief intervals that are not registered in conscious awareness) confirm the idea that these stimuli can affect emotion, preferences, and attitudes. Westen presented similar evidence in support of the other psychoanalytic assumptions. Scientists who want to dismiss Freud's theoretical work had better read this article.

More recently, research has examined the utility of transference interpretations in psychodynamic therapy, which would seem to have implications for the theory of psychoanalysis. For example, Høglend, Johansson, Marble, Bøgwald, and Amlo (2007) used an RCT to assess the effects of moderate levels of transference versus no transference interpretation. Surprisingly, they found no differences in outcome between clients in either condition, and contrary to predictions the more severely dysfunctional clients responded more positively when they received therapy involving transference interpretation than when they received no interpretation. Similarly, Høglend et al. (2006) and Høglend et al. (2008) found no differences in outcomes between clients who received transference interpretations and those who did not.

Exploring this issue further, Johansson et al. (2010) tested the hypothesis that insight mediates the relationship between interpretation and outcome in terms of interpersonal

functioning (i.e., interpretations create insight, which then leads to good outcomes). Again using an RCT design, they gave clients 1 year of weekly sessions of psychodynamic psychotherapy with transference interpretation or the same treatment with the same therapists but without transference interpretation. All of the clients showed significant improvement over time, but the hypothesized relationship among transference, insight, and outcomes held only for clients who were more significantly dysfunctional. In attempting to understand this difference, Johansson et al. (2010) speculated that the therapists in the study had more difficulty formulating accurate transference interpretation for higher-functioning clients because the cues for such interpretations were more subtle than those in clients who were more dysfunctional. In summary, it seems from this research that transference interpretations are not critical to improvement for all clients, raising questions about the validity of psychoanalytic theory.

Levy and Scala (2012) reviewed the research bearing on transference and transference interpretation in therapy. They observed that studies in social cognition have demonstrated that something like transference happens in everyday life (i.e., we tend to view people in the same ways we see our significant others) but that this research did not capture the unconscious, conflicted, or defensive processes that psychoanalytic theory proposes as driving transference. However, there is some research from a psychoanalytic perspective that supports the dynamic processes thought to underlie transference, leading Levy and Scala to conclude that there is evidence to support the existence of transference phenomena as hypothesized by psychoanalytic theory. In summarizing the research on transference interpretation in psychotherapy, Levy and Scala concluded that transference interpretation is tricky. It can produce positive outcomes, but may also result in poor outcomes or premature termination. The working alliance is critical to the success of these interventions; the therapist must be tactful and nonjudgmental.

Of interest to psychoanalytic theorists and researchers is the construct of working alliance, or the relationship between client and therapist that allows the work of therapy to proceed. The research assessing the relationship between the working alliance and counseling outcome has cut across many theoretical orientations and generally finds that the relationship is modestly related to outcome in the expected direction (i.e., a more positive alliance is related to a better outcome; Hovarth, Del Re, Fluckiger, & Symonds, 2011; Lambert, 2013; Wampold & Imel, 2015). Of note, clients' and independent observers' ratings of the alliance have been found to be more predictive of outcome than therapists' ratings, raising a question about therapists' objectivity when assessing their relationships with clients (Hovarth et al., 2011). None of these findings is supportive of the theoretical structure of psychoanalysis specifically.

A major area of research that bears on psychoanalytic constructs is centered on what is termed the repressed memory controversy (Enns, McNeilly, Corkery, & Gilbert, 1995; Kluft & Loftus, 2007; Loftus, 1993; Loftus & Ketcham, 1994). This debate centers on whether individuals traumatized at an early age, particularly in the case of sexual abuse, can repress and then later accurately recall memories of the incidents. These questions can be seen as relevant to the validity of Freud's construct of repression. Enns et al. (1995), in their review of the historical, political, and scientific issues involved in this debate, discussed Freud's repudiation of the seduction hypothesis as perhaps the first incident of denying the memories of abused women.

The issues discussed in the area of repressed memory have been characterized as political rather than scientific (L. S. Brown, 1995). The interchange of opinions has been connected to the establishment of the False Memory Syndrome Foundation, an organization that was founded to investigate what they termed *false memory syndrome*, seen primarily in cases in which a survivor of sexual abuse recovers previously repressed memories of the abuse. The proponents of false memory syndrome contend that psychotherapists induce such memories via suggestive psychotherapeutic techniques.

At the heart of the repressed memory controversy is the question of whether we do, in fact, repress memories of events in our lives, a question that would certainly be relevant to psychoanalytic theory. Research using retrospective self-report has shown that a certain percentage of victims of sexual abuse report that at some time in their lives they were unable to remember the abuse (Briere, 1995; McNally, Perlman, Ristuccia, & Clancy, 2006). On the other side, research suggests that it is relatively simple to implant created memories, which would question the accuracy of forgotten memories recovered (Desjardins & Scoboria, 2007; Laney, Morris, Bernstein, Wakefield, & Loftus, 2008; Strange, Hayne, & Garry, 2008). Briere (1995) pointed out that, short of observing someone's abuse and then following that person's later reports, establishing the validity of the self-reports used in the recent memory studies is almost impossible.

The implications of this controversy for psychoanalytic theory are mixed: It appears that there is some minimal empirical evidence supporting the existence of repression (based on self-report), but support for the ability to accurately regain and report repressed memories is still a topic of controversy (Kluft & Loftus, 2007). It now appears that most scholars agree that memories can be repressed and recovered, but some recoveries are false. However, the frequency with which true versus false memories appear is still debated, along with the mechanisms of repression (Belli, 2012).

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Psychoanalysis shares with many other theories of counseling the position that the individual, rather than the surrounding environment, needs to change. This assumption is countered by feminist and cultural critiques of the theory that insist that many aspects of society are detrimental to individuals, that oppression of women and minorities is debilitating, and that asking individuals to adapt to an oppressive social system is wrong.

Feminists have been critical of Freud since the early days of the feminist movement (Enns et al., 1995; Kaplan & Yasinski, 1980). To begin with the obvious, the idea that the strongest motivator of female behavior is the envy of the penis is seen as outrageous and demeaning. What women envy is the traditionally conferred power of men in society, not their anatomy! Feminists also criticize Freud's views of women as passive, inferior, and immoral, traveling through life in an endless search for a penis to remedy their inherent inferiority (Kaplan & Yasinski, 1980). Karen Horney, a psychoanalytic theorist in her own right, had a great deal to say about Freud's theories, pointing out that he neglected "womb envy" as a source of men's fear of things feminine (1932, 1930/1967). In an early response to these kinds of criticisms, Freud (1925/1961b) characterized them as "denials of the feminists, who are anxious to force us to regard the two sexes as completely equal in position and worth" (p. 258). In a larger sense,

some of the problems identified by feminists are an unavoidable complication in every theory: A theorist is a product of her environment and culture, and the theory is directly or indirectly infused with the normative expectations of the culture. Clearly, Freud was a participant in and influenced by a culture that was sexist—the role of women was restricted and less valued than that of men.

More recently, some feminists have concluded that psychoanalytic theory, particularly the more recently developed offshoots, can be saved (Zanardi, 1990). Chodorow (1989) identified two general approaches to feminist psychoanalysis: the interpersonal approach and the French postmodern approach. The interpersonal approach attempts to revalue femininity through the use of object relations, self psychology, and Jungian approaches. A more indirect variant of psychoanalysis, the postmodern approach, is more often used in literary criticism than in psychotherapy. In addition, the emergence of the relational approach (see Chapter 3) has probably reduced reliance on the psychosexual theory of development, which, from the feminist perspective, is where most of the problems of psychoanalysis reside.

There have been many calls to better attend to cultural diversity in psychoanalysis (e.g., Foster, 2010; Haaken, 2008). It is clear that psychoanalysis is rooted in Western European values. Intellectualism, individuation, and individual achievement are goals in this theory that do not necessarily translate across cultures. Insight is by no means treasured in other than European-influenced cultures. The analytic emphasis on individual identity and individuation is inconsistent with the values of many cultures, including Asian, Hispanic, and African American, in which membership in the family or group is more defining (Sue & Sue, 2013). The nondirective stance of the analyst can be counter to cultural expectations for authoritative, directive help in Asian cultures, particularly the Chinese (Zhong, 2011, p. 224). Psychoanalysis, in its pure form, is probably accessible only to individuals who have the economic means to pay for intensive treatment. Thus a class bias exists: How many individuals from lower socioeconomic levels have the time and financial resources to devote years to exploring their inner experiences? In addition, Sue and Sue (2013) point out that individuals from lower socioeconomic statuses may hold values counter to the individualistic, insight-oriented, intellectual ones of psychoanalysis. Altman (2013) opined that making psychoanalysis more affordable and culturally relevant is one of the most critical challenges for current psychoanalytic therapists.

Freud called homosexuality a perversion, meaning that it was a deviation from what the theory considered normal sexual development. He did not overtly disparage LGBT orientations, saying "The most important of these perversions, homosexuality, scarcely deserves the name" (S. Freud, 1925/1989a, p. 423). However, the use of the term *perversion* and the assumption of heterosexuality as normal sexual development suggest, according to some authors, a negative moral judgment (Murphy, 1984), and in the not so distant past American analysts considered homosexuality pathological (Gelé et al., 2012). However, current analysts think quite differently; sexuality and mental health have been for some time considered separate issues. For example, one major figure in American psychoanalysis (Sidney Phillips) was quoted as saying "To conceive of lesbian and gay patients as perverse is a product of unanalyzed, internalized homophobia furthering long-standing psychoanalytic stereotypes and prejudice—don't do it!" (cited in Gelé et al., 2012, p. 951).

THE CASE STUDY

The client conceptualized in this chapter, Barb, presented some of the features often associated with typical "good candidates" for psychoanalysis. She appeared to be motivated and interested in investigating her psychological processes. Furthermore, her issues seemed to relate to sexual trauma, neatly fitting in with psychoanalytic thought about the origins of dysfunction in sexual development. Some of Barb's symptoms, such as the fainting and numbness in her face, appeared to fit quite well with a psychoanalytic understanding.

The most difficult aspect of Barb's history from a conceptual standpoint involves the validity of her early sexual experiences. As noted earlier, the final version of Freud's theory would predict that most likely the memories of the early abuse by the family friend were fantasy born out of Oedipal longings. To be fair to Freud, it is important to note that he did not deny that sexual abuse of children occurred. However, he clearly stated that his clients' reports of this abuse were mostly untrue. Current data on sexual abuse indicate that it is very prevalent, which would lead us to conclude that Barb's memories are probably accurate. However, the aftereffects of both real abuse and fantasy abuse would presumably be fixation in the Oedipal stage. The resolution of the validity dilemma is therefore a moot point from a practical perspective.

Summary

Psychoanalytic theory is based on the idea that humans are motivated by conflicts between unconscious and conscious forces. The expression of instinctual drives (libido and Thanatos) is not acceptable to society, so the psychic apparatus evolved to suppress them. Freud proposed that the psyche is composed of three entities: the id, ego, and superego. Dysfunction arises when the instinctual urges (most notably libido or sexual drives) threaten to break into consciousness and are symbolized as symptoms.

Freud proposed an elaborate model of human development, the psychosexual stages. The most important of these stages is the phallic stage, in which children become aware of the anatomy of the other sex. The process of resolution of the Oedipal complex arising in this stage is different for girls and boys. For boys, who have developed a desire to possess their mothers, the complex is resolved through castration anxiety. The boy fears that his father will find out about his incestuous desires and cut off his penis. He resolves this conflict through identification with the father. Girls notice that they have no penis and develop penis envy. The girl turns away from her mother, but because sex with her father is forbidden she represses this urge. She continues her life in search of a penis, most notably through the birth of a male baby.

Psychoanalysis is a long-term process conducted in a doctor–patient model. The client free associates in a process that eventually yields unconscious material. The therapist remains abstinent so that the client can project unconscious conflicts onto the therapist. This projection, which typically involves Oedipal wishes, is called transference and is at the heart of psychoanalysis. The psychoanalytic therapist interprets the client's unconscious material with the goal of helping the client achieve insight into her conflicts.

Psychoanalysis has long had many critics. It is considered by some to be untestable, and direct empirical support for the outcome of traditional psychoanalysis is sparse. The theory also

is based in a male, European model, so it draws criticism from feminists and other scholars of diversity.

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CHAPTER 3

Neoanalytic Approaches



Anna Freud

Theo came to counseling after being told by his girlfriend, Tamia, that if he did not seek help she would end their 3-year relationship. He is a tall, African-American male, 22 years old, currently in his final year of college at a large university with a major in math and computer science. He plans to enter the military after graduation.

Although he presents calmly, Theo says that he feels as if he "is going to explode." He believes that he needs counseling to better understand his problems controlling his anger and how it relates to his behaviors. Most recently, Theo became angry with Tamia after she failed to return his phone call and stayed out "partying" all night. He indicated that Tamia claimed she had told him about her plans and that his anger felt controlling and threatening. Theo also expressed concern about his inability to control his anger when dealing with his family and professional relationships.

Theo is the middle child of three boys. When Theo was 10 years old his parents divorced, and Theo's mother relocated with the boys. Two years later his parents reconciled and remarried. Theo reported that he did not want his parents to remarry and still believes they should not be together because of their regular arguments about financial issues and his father's constant business travel. He noted that his older brother took care of him and his younger brother and tried to maintain peace in the household.

Both of Theo's parents completed college at historically Black colleges. Although supportive of Theo going to college, they wanted him to attend a historically Black college, especially because most of Theo's elementary and secondary school education took place in primarily White schools. Theo said that, even though he chose not to follow his parents' wishes, he still identifies strongly with his African-American heritage. He chose to attend a predominantly White college because he did not want to follow in his parents' footsteps. He reports that going to college was a way of getting away from them and, particularly, "a lot of fighting and yelling."

BACKGROUND

The psychoanalytic crowd is an interesting subset of the psychotherapeutic community. Within the group of therapists who would characterize themselves as psychoanalysts, there are a number of different theoretical camps, ranging from pure classicists (i.e., orthodox Freudians) to those who subscribe to a relatively recently developed constructivist approach, relational psychoanalysis. In between are several other identifiable theoretical variants that contribute to how psychoanalytic therapists currently practice. These are the object relations theorists, the ego

psychologists, and the self psychologists, interpersonal theorists, and intersubjectivists. All of these theorists/therapists consider themselves direct intellectual descendants of Freud, but all extend Freud's theory or deviate slightly or significantly from orthodox psychoanalysis—hence my choice of the label *neoanalytic* to describe them.

Psychoanalysts like to write about their particular perspectives, and a glance at the major journals shows that they also seem to argue a lot about the validity of the various strains of psychoanalytic theory. The orthodox analysts criticize the relationists for being "impure" and "not analytic," and the relationists see the traditionalists as living in the past and clinging to outdated ideas. Psychoanalysts like fancy terms and seem to favor elaborate writing styles, so in the midst of the arguments the variety of names and terms becomes absolutely bewildering at times.

The biggest bone of contention seems to be conceptualizations of motivation. Traditional Freudian theory is often referred to as *drive theory* because of Freud's conviction that the genetically wired-in instinctual drives (sex and aggression) motivated behavior. Contemporary variants of psychoanalysis can be characterized according to the degree to which they accept or reject drive theory (Wolitzky, 2011). In fact, a classic in the modern analytic literature is J. R. Greenberg and S. A. Mitchell's (1983) *Object Relations in Psychoanalytic Theory*. In this book, Greenberg and Mitchell classify theorists by the degree to which they buy (or say they buy) Freud's notion that behavior is motivated by the drives or see motivation as a function of an inherent need to relate to other human beings. Across the four approaches presented in this chapter, ego psychologists tend to be traditionalists, more or less building on Freud's original notions. Relational analysts are the most radical in their rejection of drive theory. There is some argument about the status of self psychology in this regard because its originator, Heinz Kohut, seemed in his early writings to accept drive theory. Later Kohut seemed to abandon this perspective for one more relational in nature (Fosshage, 2003). Otto Kernberg, according to Greenberg and Mitchell, liked to maintain that he was a drive theorist, but their analysis of his theory suggests otherwise. Object relations theorists (with the exception of Melanie Klein, who accepted traditional drive theory) and relational theorists adopt the view that humans are motivated by the need to relate to others.

While they argue about motivation, all of these theorists agree that the most important relationship is that with the primary caretaker. Thus, the mother–child relationship is often the focus of attention (for the most part they were writing prior to our current enlightened views of child care). The mother is most important because she has the breast, the source of biological sustenance for the infant.

Newer versions of analytic thought go beyond Freud's theory in the area of development. For example, these systems are thought to be helpful in understanding more severe forms of dysfunction, such as psychosis, and borderline (meaning to psychosis) and narcissistic states. These types of problems are thought to originate earlier than the neuroses with which Freud was concerned. Thus, the neoanalytic theorists discuss "pre-Oedipal" development. Some of the neoanalytic strains are relatively traditional in their approaches to intervention, relying on free association, interpretation, and an abstinent analyst (traditional ego psychology and object relations); others emphasize the *working alliance* (the psychoanalytic term for the therapeutic relationship) as the primary vehicle of change. All recognize the power of the unconscious. According to Greenberg and Mitchell (1983), it is the content of the unconscious that differentiates the drive and relational theorists: For the drive theorists, the unconscious contains the unacceptable impulses of sex and aggression; for the relational theorists, the unconscious "consists of particular images of the self and others which have been similarly rejected" (p. 382).

The view of human nature among the neoanalytics varies. For instance, Melanie Klein, considered an object relations theorist, wrote a lot about the aggressive instincts, suggesting a rather negative view. Although she did acknowledge libidinal energy (which leads the infant to a state of love), she characterized the early stages of development as scary; the infant is beset by conflicting feelings (particularly aggression) and shifting emotional states (Mitchell & Black, 1995). You can read some of Klein's original thoughts in Box 3.1. The other object relations theorists, the self psychologists, and the relational psychoanalysts seem to offer at least a neutral view of human nature. The ego psychologists, who turned away from the battleground metaphor of Freud's system, emphasize the ego's adaptive capacities, perhaps offering a more positive view of humans.

Box 3.1

Melanie Klein on Early Development

In my view—as I have explained in detail on other occasions—the introjection of the breast is the beginning of superego formation which extends over years. We have grounds for assuming that from the first feeding experience onwards the infant introjects the breast in its various aspects. The core of the superego is thus the mother's breast, both good and bad. Owing to the simultaneous operation of introjection and projection, relations to external and internal objects interact. The father, too, who soon plays a role in the child's life, early on becomes part of the infant's internal world. It is characteristic of the infant's emotional life that there are rapid fluctuations between love and hate; between external and internal situations; between perception of reality and the phantasies relating to it; and, accordingly, an interplay between persecutory anxiety and idealization—both referring to internal and external objects; the idealized object being a corollary of the persecutory, extremely bad one.

The ego's growing capacity for integration and synthesis leads more and more, even during these first few months, to states in which love and hatred, and correspondingly the good and bad aspects of objects, are being synthesized; and this gives rise to the second form of anxiety—depressive anxiety—for the infant's aggressive impulses and desires towards the bad breast (mother) are now felt to be a danger to the good breast (mother) as well. In the second quarter of the first year these emotions are reinforced, because at this stage the infant increasingly perceives and introjects the mother as a person. Depressive anxiety is intensified, for the infant feels he has destroyed or is destroying a whole object by his greed and uncontrollable aggression. Moreover, owing to the growing synthesis of his emotions, he now feels that these destructive impulses are directed against a loved person. Similar processes operate in relation to the father and other members of the family. These anxieties and corresponding defenses constitute the "depressive position," which comes to a head about the middle of the first year and whose essence is the anxiety and guilt relating to the destruction and loss of the loved internal and external objects.

It is at this stage, and bound up with the depressive position, that the Oedipus complex sets in. Anxiety and guilt add a powerful impetus towards the beginning of the Oedipus complex. For anxiety and guilt increase the need to externalize (project) bad figures and to internalize

(introject) good ones; to attach desires, love, feelings of guilt, and reparative tendencies to some objects, and hate and anxiety to others; to find representatives for internal figures in the external world. It is, however, not only the search for new objects which dominates the infant's needs, but also the drive towards new aims: away from the breast towards the penis, i.e. from oral desires towards genital ones. Many factors contribute to these developments: the forward drive of the libido, the growing integration of the ego, physical and mental skills and progressive adaptation to the external world. These trends are bound up with the process of symbol formation, which enables the infant to transfer not only interest, but also emotions and phantasies, anxiety and guilt, from one object to another.

Source: From Klein, M. (1952). The Origins of Transference. *International Journal of Psychoanalysis*, 33, 433–438.

What might be considered a very basic philosophical difference among the neoanalytic writers is whether they are objective positivist thinkers (as was Freud) or relativistic constructivist ones. Freud was very interested in promoting psychoanalysis as a natural science operating on some objectively real material and discovering laws of nature. In this view, the analyst was the scientist charged with accurately interpreting client material and was thus an expert source who knew what was right and wrong for the client. There was a clear and consistent truth, rooted in physical reality (for Freud, neuroanatomy, although he could never demonstrate this).

Some of the descendants of Freud tend to take this approach, but current analysts, particularly the relational and self theorists, for example, are more constructivist in philosophy. Simply put, they view "reality" as inseparable from the observer—one person's truth may not be the same as another's. "Reality" in the therapeutic relationship is constructed by client and counselor, prompting the notion of *two-person psychology*, which emphasizes the roles of the client and counselor in therapeutic events. This demise of the totally objective therapist/observer arose from the revolution of thought in the so-called hard sciences, spurred by Einstein's relativity theory, quantum physics, and Heisenberg's uncertainty principle, which eventually trickled into the social sciences and then into psychoanalytic thought (R. C. Curtis & Hirsch, 2011).

Neoanalytic theorists generally rely on classical psychoanalytic techniques, although they sometimes see them a little differently than Freud did. For this reason, the sections in this chapter are brief and focus on how the traditional techniques of free association, dream analysis, and interpretation are used in the service of the approach described. Most neoanalytic theorists emphasize the relationship between the therapist and client as curative in and of itself (beyond the effect of insight gained via transference interpretation) and empathy is recognized as critical—some writers consider it an important form of intervention (Safran, 2012). Neoanalytic therapists are also known to offer support and advice to their clients, behavior that would be taboo in a classical psychoanalytic model (Safran & Kriss, 2014).

Most analysts practicing today draw on one or more of the various analytic strains, and perhaps all of them (Karon & Widener, 1995). In this chapter I will present four major variants of neoanalytic thought: ego psychology (EP), object relations (OR), self psychology (SP) and relational psychoanalysis (RP). Although this delineation of these general orientations seems logical to me, you should be aware that there is controversy about how to divide up current

psychoanalytic thought into camps. For example, some see Kohut, whom I separate out from the others, as an OR theorist, whereas others would characterize his approach as relational. Only a deeper study than I can provide would allow you to fully understand these arguments. Lest I neglect one other important theoretical offshoot of psychoanalysis, a summary of the views of Carl Jung, one of the earliest of Freud's followers, is presented in Box 3.2.

Box 3.2

Analytical Psychology: Carl Jung's Version of Psychoanalysis

Carl Gustav Jung was born on July 26, 1875, in Kesswil, a village in northeast Switzerland. Like many other famous psychologists (Wilhelm Wundt, Edward Thorndike, and Ivan Pavlov), Jung had a father who was the head of a church. Jung spent most of his life in Switzerland, although he did make one trip to the United States in 1909. Jung made many contributions to the field of psychology—most notably, his work on personality types and his theory of personality.

Originally one of Sigmund Freud's students, Jung eventually broke from Freud over the issue of sexuality as the prime motivator of human behavior. For Jung, sexuality was only one of the things that could influence psychological process; of equal or more importance was the individual's quest for individuality and meaning (Raff, 2007).

Although the most well-known influence on Jung's work was Sigmund Freud (Casement, 2002), like many people in Europe during the late 1800s Jung was fascinated by philosophy, the occult, myths, and symbols (Douglas, 2005). Jung's understanding of the common elements of societal symbols led him to the perspective that there are common elements of human experience, which he called archetypes. Jung was also heavily influenced by Eastern philosophies and perspectives, which can be seen in his focus on the balance of intrapsychic forces, an essential theme throughout Jung's theory.

TYPOLOGY OF THE PERSONALITY

Jung called the psychological makeup of the person the *psyche*. In the center of Jungian personality structure is the *ego*. The ego is the "I," or the "Me," and contains the aspects of the personality people are conscious of. The *persona*, also in the person's consciousness, is the aspect of the personality that is presented to the external world (Douglas, 2005). The persona essentially acts as a socially appropriate ego by presenting to observers the parts of the personality that the person judges socially acceptable.

To balance the conscious ego, Jung hypothesized the existence of the *personal shadow*. The personal shadow lies in the individual unconscious and includes the aspects of the person that the individual views as negative, harmful, or painful. Jung believed that the personal shadow also could contain positive aspects of a person's personality that were underdeveloped or unrecognized and, further, that the individual unconscious as a whole could be a source of creativity and comfort for the individual (Douglas, 2005).

The *collective unconscious* is a set of knowledge, beliefs, and experiences shared by all humans. The most important elements in the collective unconscious are patterns known as *archetypes*. Jung believed that the specific characterization of these archetypes can change over time and

across cultures, but even if the visual and culturally specific details changed, the essential characteristics of the specific archetype did not. As an example, consider the Hero archetype. For some people, this archetype may appear as an image of a knight in shining armor; for others, the Hero might manifest as a samurai. Although these images are visually different, they share the essentials of the Hero archetype. Presaging our current attention to cultural diversity, Jung therefore believed that accurate identification of a client's archetypal images required an understanding of the client's culture and his personal understanding of that culture.

Two other important archetypes are the *animus* and the *anima*. The *animus* represents the masculine aspects of an individual and the *anima* the feminine. These archetypes closely resemble their Chinese counterparts, the yang and the yin. Much like the concepts of the yang and the yin, Jung believed that every person had both the animus and the anima and that individuals should strive to understand and develop both aspects of the personality. Such understandings of the archetypes lead to better self-understanding and more-fulfilling relationships with people of the other gender.

Jung added to the classic Freudian conception of the unconscious the realm of human potential. The unconscious did include negative feelings, but for Jung it was also the seat of human potential, creativity, and existential meaning (Douglas, 2005). This view of the unconscious is one of the key ways in which Jung's theory was different than Freud's psychoanalysis.

JUNGIAN TYPOLOGY

One of the most easily recognizable contributions of Jung has been his theory of personality typology (Douglas, 2005). Jung theorized that there are three basic dimensions of the personality. Each of these dimensions has two opposite concepts that balance each other. A person usually will display qualities of both concepts to some degree, but will typically favor one over the other. As with the rest of his theory, Jung emphasized balance between these aspects of type. Introversion needed to be balanced by extroversion, thinking by feeling, sensing by intuition, and judging by perceiving.

Jung theorized that a healthy psyche had a balance between *introversion* and *extroversion*. Although most people today understand introversion and extroversion as an orientation toward people, Jung found a deeper meaning for these concepts. Introversion is the tendency for a person to explore the inner self. Introverted people need time alone for this exploration, which is primarily directed at understanding their affective reactions. Jung hypothesized that the libido, or driving energy, of an introvert is oriented toward a deeper understanding of himself and a deep understanding of the internal lives of others. Thus, the introvert has a few friends, but those friends are very close. An extroverted person, on the other hand, finds meaning in external objects and relationships. The libido of an extroverted person pushes the person to be near others and find meaning in life through relationships with other people.

The second personality dimension is *thinking* and *feeling*. Thinking individuals favor cognition, logic, and rational thinking. A thinking person likes to understand all of the details of the options available and then make decisions based on logic. A feeling person enjoys experiencing the ebb and flow of emotions and affect. Joy, depression, desire, and satisfaction are the experiential playground of the feeling person.

Sensation and *intuition* make up the third dimension. A person who favors sensing will believe only what he can see, smell, taste, touch, and so forth. He is skeptical of things that he cannot sense. A person that is more oriented toward using intuition, on the other hand, seeks

(continued)

Box 3.2 *(continued)*

to understand the missing or mysterious forces that one cannot actively perceive. An intuitive person is often good at picking up on subconscious cues such as body language, changes in voice tone, and less-than-obvious emotional meaning. An intuitive person may be willing to trust a hunch more than his senses.

The most commonly used assessment of types is the *Myers–Briggs Type Indicator* (MBTI; Myers & McCaulley, 1985), and it includes a fourth dimension, *judging or perceiving*. A person who favors judging will often make a decision based on incomplete information and seek immediate action. A perceiver likes to have as much information as possible before making a decision. A perceiver would be less hasty than a judger in making decisions. Decisions that need to be made quickly might also be a source of a large amount of anxiety for the perceiver. A balanced person might seek as much information as possible, but still be able to make a decision based on incomplete information and adapt later based on new information.

Jungian typology has been used in a wide array of counseling activities and has been found to be useful in counseling centered on helping individuals function in collaboration with others (Douglas, 2005). Helping individuals understand their own and others' typologies is thought to improve a wide range of relationships. Even if people have never heard of Jung, many people have completed the MBTI and are familiar with their own personality type. This widespread knowledge is a testament to the veracity of Jung's theories and the work that Jungian analysts have done since to continue his work.

PSYCHOLOGICAL DYSFUNCTION AND THERAPY

Jung believed that a part of human development was the tendency to develop *complexes*. A complex is a particularly sensitive aspect of the personality. A person can develop a complex centering on life events that he does not understand or that are too painful for him to incorporate into the ego; the complex is formed and relegated to the personal unconscious. Complexes can give rise to symptoms as a person tries to resolve the complicated emotions, sensations, memories, and meaning behind the complex. To alleviate the symptoms, a person needs to bring the complex into consciousness and incorporate it into the ego (Casement, 2002).

To take an example, let's say that Peter had an inconsistent relationship with his older sibling, Dan. Much of the time Dan was very nice to Peter, caring for him and having fun with him, but occasionally Dan would get angry and violent and would hit Peter. Peter looked up to Dan and greatly admired him. Due to Dan's violent outbursts, however, Peter also held strong emotions of fear and anger toward Dan. When Peter was 12, Dan was killed in a car accident. Peter's feelings about Dan's death were too painful to incorporate into his ego, so they were repressed into the personal unconscious, where they became a part of Peter's shadow. By the time Peter reaches adulthood, these emotions have become a complex that may express itself unconsciously in a number of ways throughout his life. For example, Peter may unconsciously sabotage close relationships with mentors. He is unconsciously protecting himself from the anticipated loss of the mentor. Peter may also project anxiety and mistrust onto the mentor, making the mentor uncomfortable with the relationship and tempted to end it. Peter's complex is affecting his relationship, but consciously it appears to Peter that it is the mentor who is abandoning him. To Peter, there is no such thing as a good mentor.

Although Jung's theory of psychotherapy is decidedly psychoanalytic in its focus on the unconscious, early childhood, and transference, it is in many ways similar to humanistic approaches.

Jung believed that the successful therapist understands four critical principles of psychological functioning (Douglas, 2005). The first principle is that the psyche is a self-regulating system; the client knows what is needed to heal and to resolve his complexes. The second is that the unconscious serves a protective function within the personality, shielding the ego from painful feelings and thoughts. The unconscious is also a source for creativity and inspiration and a resource for understanding the self. The third essential principle is that the counseling relationship plays a major role in successful therapy. Jung's final assertion is that personal growth can occur across the lifespan. Complexes can be created and resolved throughout a person's life.

Jung divided therapy into four stages. Similar to parts in a musical score, these stages can occur as solos or they can occur together in harmony. The first part of therapy is called *confession*, in which the counselor explores the client's history, ego, and unconscious. The confession stage emphasizes what Carl Rogers would later come to call unconditional positive regard (see Chapter 5). The counselor explores the client's personality and past in a nonjudgmental way. This acceptance relieves the person of the shame and guilt normally associated with hidden aspects of the self. Jung indicated that during the confession stage transference will be strong and essential. The client will project onto the counselor many aspects of the self that are currently being explored (Douglas, 2005).

Elucidation, or exploration of the transference, is the second stage of therapy, in which the counselor begins to point out to the client the transference and to explore its source. In classical Jungian therapy, the counselor explores events in very early childhood, a period ranging from birth to about 4 years of age. *Education* is the third stage of therapy, in which the client and counselor begin to implement insight achieved in elucidation through action. Most clients do not reach the fourth stage of therapy, *transformation*. In the transformation stage, the client nears self-actualization. According to Jung, self-actualized people value both conscious and unconscious experiences. People who achieve self-actualization have achieved a balance between their conscious and unconscious as well as between the external environment and their internal psyche. Jung believed that self-actualized individuals are rare, but he did think it is possible to reach that stage.

Each of these four stages of therapy is woven in, out, and around the melody of the relationship between the counselor and client. Some clients may engage in only one of these stages of therapy; other clients may encounter two or three stages of therapy. Reaching the fourth stage of therapy is unusual and most often occurs with clients that are in their later years of life.

CONCLUSION

Jung's theory focuses on the internal conflicts of an individual as well as the existential meaning of the individual's life. His theories and life are influential partially because of his intense focus on balancing internal struggles with the importance of maintaining a meaningful existence. Jung died in 1961. He had survived two world wars and had seen the growth and development of psychoanalysis as well as several other schools of psychology. Although some of Jung's ideas have been seriously questioned, Jungian analysts have continued to develop and prosper among psychologists today. Through gaining an understanding of Jung's theory of therapy and personality, we can catch a glimpse of one of the great contributors to today's psychological world.

Source: Contributed by J. Rico Drake, Ph.D. Used with permission.

EGO PSYCHOLOGY: ID LOSES THE LIMELIGHT TEMPORARILY

OVERVIEW

The post-Sigmund history of psychoanalysis begins with Anna Freud. Analyzed by her father in the years 1918–1922, Anna was truly her father's intellectual heir. More information about Anna Freud can be found at the website of the Anna Freud Centre, www.annafreud.org. She is known as one of the founders of child psychoanalysis (along with Melanie Klein) and for her development of theory about defenses. Anna Freud and her intellectual descendants evolved into what is known as the Ego Psychology school, which dominated American psychoanalysis for many years (Wallerstein, 2002). It was considered very close to traditional psychoanalysis but added attention to the adaptive functions of the ego, in addition to the defensive ones, described by Anna in her landmark book *The Ego and the Mechanisms of Defense* (1936/1966).

Another important ego psychologist was Heinz Hartmann. Hartmann, who was analyzed by Freud and studied for a while with sociologist Max Weber, contributed several important ideas to EP. His best known book is *Ego Psychology and the Problem of Adaptation* (1939), in which he freed the ego from subservience to the superego and, more importantly, from the id. Still, his loyalty to classical drive theory prompted Greenberg and Mitchell (1983) to characterize him as a "transitional figure" and as "caught between two models" (pp. 236, 268).

Although some might categorize her as an object relations theorist, I also include in this section Margaret Mahler's view of psychological development because it is a well-known model of ego growth. Other important EP writers are Joseph Sandler, Hans Loewald, and Otto Kernberg. However, I discuss Kernberg's work in the OR section because for the most part he relies on these constructs more than he does drive/structural theory.

Wallerstein (2002) writes eloquently of the history of EP, the oldest chronologically of the neoanalytic approaches, in the United States. It ruled American psychoanalysis in the 1950s and 1960s, and its proponents deemed themselves qualified to determine who was "analytic" and who was "unanalytic" (the latter being a clear excommunication from the community). Its stranglehold on American psychoanalysis was nudged by Sullivan's interpersonal psychiatry and really shaken by Kohut's self psychology. As a result, many EP theorists have integrated OR or RP notions into their work (Kernberg, 2005). Wallerstein also describes several modifications of traditional EP theory (those proposed by Charles Brenner, Loewald, Kernberg, and Sandler), but it is difficult to decide what is truly the state of EP in American psychology today. Therefore, most of what is presented in this section is traditional EP theory, leaving you to pursue this issue further if you wish.

MyCounselingLab

Video Example 3.1 Anna Freud's life



https://www.youtube.com/watch?v=PxaQnXY0bEA

CENTRAL CONSTRUCTS

Structural Model. EP theorists retain Freud's original structural model, composed of id, ego, and superego, along with the sex and aggressive drives. However, whereas traditional Freudian theory emphasizes instincts (drives) and therefore id functioning, EP theory emphasizes ego

functioning. Both Anna Freud and Hartmann were interested in the development of the ego, seeing it as more than a mere product of the need to control id impulses (Quintar, Lane, & Goeltz, 1998). For Hartmann, at least, the ego develops independently from the id—unlike in Freud's version, in which it develops out of the id. The ego is much more alive and energetic in this approach, prompting the use of the term *ego autonomy* in these writings. Contemporary theorists are most interested in the ego's executive and synthesizing functions.

Hartmann contended that the ego had its own store of energy (separate from the id) gained through transforming instinctual energy into ego energy through a process he called *neutralization* (Fine, 1979). The EP theorists examined ego functions such as cognition, reality testing, and judgment as well as the defenses described by Anna Freud (Wolitzky, 2011). Contemporary theorists are also interested in the ego's executive and synthesizing functions, which include organizing incoming information; adapting to the environment, broadly speaking, by, for example, finding socially sanctioned ways to meet id and superego demands; and navigating developmental challenges encountered throughout the lifespan (Schamess & Shilkret, 2008).

Jezebel, Theo's EP therapist, thinks that Theo is struggling with conflicts among the id, ego, and superego. The anger he feels is a transformed version of id impulses, which the ego and superego are fighting. Based on his ability to function in college, it appears that Theo's ego function is intact and, to a large extent, adaptive.

Jezebel thinks that she sees evidence of Theo's conflicts in his relationships with Tamia and his parents. His id, with all of its sexual and aggressive energy, is pushing Theo toward the potential gratification offered by Tamia. When she stays out all night partying, Theo worries that she could be with other men, and aggressive id impulses become prominent in his relationship with her. He lashes out in anger. His anger toward his parents likely has roots in repressed aggressive impulses as well, particularly toward his father. He rebels against them by refusing to go to a historically Black institution for college.

On the other hand, Theo's superego and ego keep him from acting out the id's impulses. His apparent concern over his difficulty with anger is a sign that his superego is operating. That he comes to counseling is probably the result of these superego commands and the rational decision of the ego to attempt to better function in his current situation.

Defenses. As noted earlier in this chapter, some of Anna Freud's most significant work is in the area of ego defenses. Anna Freud elaborated on the reasons for defenses in identifying three kinds of danger to the ego: the wrath of the superego, the threat of the drives, and the dangers of the outside world (Sollod, Wilson, & Monte, 2009). In Box 3.3, you can read about Anna's additional defenses.

Box 3.3

Anna Freud's Defenses

In addition to the defenses formulated by her father, Anna Freud added the following to the list of ways we escape threatening psychological material:

Denial—rejecting external events that are associated with psychically threatening material

Identification with the aggressor—becoming like a feared other (as in the Oedipal resolution for boys)

(continued)

Box 3.3 *(continued)*

Asceticism—renouncing all desires or pleasures; seen mostly in adolescents, who are immensely threatened by their emerging sexual desires

Altruistic surrender—gratifying one's own desires through the fulfillment of another's; sort of a mix of projection and identification

Turning against the self—redirecting threatening impulses against the self rather than into the environment

Reversal—changing into the opposite

Isolation—removing emotion or meaning from events

Undoing—using rituals to cancel threatening thoughts or behaviors; associated with obsessive-compulsive types

Source: Based on Monte, C.F. (1999) *Beneath the Mask: An Introduction to Theories of Personality* (6th ed), Fort Worth, TX: Harcourt Brace, pp. 204–207.

Theo seems to be dealing with his aggressive impulses through repression, identification with the aggressor, and displacement. He is well past the Oedipal stage, but his behavior suggests an incomplete resolution of this conflict, and he is still experiencing unresolved aggression toward his father as a result. Rather than expressing this aggression, which would be dangerous, he represses it, but also damps down the drive by identifying with his father, the aggressor, and displacing the aggression onto safer targets, such as Tamia. Jezebel considers that Theo sees himself as an angry person because he identifies with his father, the Oedipal aggressor. However, he displaces his anger onto Tamia and other safer targets, such as peers and faculty members who frustrate him even in the smallest ways.

Conflict-Free Sphere. Contributed by Hartmann (1939), this construct concerns the EP assumption that not all of psychological life is driven by conflict among the environment, id, ego, and superego. According to this view, there are areas of ego function that are independent of the id and superego, such as thinking, perception, memory, and learning (Fine, 1979; Greenberg & Mitchell, 1983).

Jezebel observes that Theo is able to function in a wide range of circumstances, indicating the function of his ego in the conflict-free zone. His anger has not created enough problems to jeopardize his standing in school. It has, however, put his relationship with Tamia in peril, so the adaptive aspects of his ego have prompted him to enter counseling.

Average Expectable Environment. Hartmann also added the concept of the *average expectable environment* to EP theory (Fine, 1979). If the average expectable environment exists, the infant, who is born with the capacity to adapt to and use this kind of environment, will grow in healthy ways. If the infant is born into a situation that does not meet this level of support, problems ensue. For example, if a mother is depressed, she will fail to attend to and nurture her infant; this neglect will lead to psychological (and possibly physical) deficits in later life.

Although it is not totally clear from Theo's presentation, Jezebel thinks that there may have been some deficits in his early environment, which led to the inadequate resolution of the Oedipal conflict. However, she expects that his very early environment was sufficient for him to grow and develop to a large extent. Departures from the average expectable environment could include lapses in attention from his mother, perhaps because of the disruptive, conflicted relationship with his father.

Theory of the Person

The early EP theorists essentially adopted Freud's developmental and personality theory in toto. So they follow the psychosexual model of development, with all its implications, such as the assumptions that personality is formed by the ways in which the child's instincts are gratified (or not; see Chapter 2) and that the phallic stage is a critical developmental phase. Later EP theorists (such as Mahler, whose work is described next) started paying more attention to earlier stages of development.

Although Anna Freud theorized about child development with her work on developmental lines, Mahler's work has remained more prominent historically. Mahler described the "psychological birth of the infant," contending that "the biological birth of the human infant and the psychological birth of the individual are not coincident in time. The former is a dramatic and readily observable, and well-circumscribed event; the latter a slowly unfolding intrapsychic process" (Mahler, 1972, p. 333). Beginning at about the fourth month of life and completed around age 3, development in this model progresses from symbiosis to separation and individuation.

In the month after birth, the infant is in the state of *normal autism*, in which he can't differentiate between self and mother. In classical terms, the infant is in a state of absolute primary narcissism (St. Clair, 2004). Around the second month, what Mahler called *normal symbiosis* begins, in which the infant becomes increasingly aware of the mother—but as a part of himself, not as a separate identity. The infant is fused with the mother. If the mothering is good enough, the four subphases of separation and individuation begin around the fourth or fifth month. First, the child enters the *differentiation and body image* period, in which he gradually tolerates physical distance from the mother but can be seen to check back to mother to orient himself.

The next subphase is *practicing*, which begins as the child learns to walk. The peak of this phase is when the child can walk by himself upright and thus gains a totally new perspective on the world. The child is, at this point, egotistical and narcissistic, as can be seen in the typical "no" period that is often observed in children of this age. In response to the parent's directive, the infant screams, "NO!"—the ultimate sign of independence.

If parenting is adequate, at about 17 months the child returns to earth and recognizes that he can't really be alone without the parent. He experiences separation anxiety. This event heralds the onset of the *rapprochement* subphase, during which the relationship with the mother is ambivalent. The child's newly found autonomy conflicts with his separation anxiety. In crisis, the child vacillates between closeness and autonomy. This crisis peaks between 18 and 24 months (Mahler, Pine, & Bergman, 1975).

The final subphase of development is called *emotional object constancy and individuality*. In this subphase, the child internalizes a positive mother image so that he can truly be separate from her. This subphase has no defined endpoint and involves ego and superego elaboration.

Jezebel thinks that Theo has negotiated the phases of separation and individuation fairly successfully. He appears to have an elaborated ego and superego and to be struggling with conflicts more from the Oedipal situation than from earlier ones. However, another way of seeing Theo's presentation might be that he is indeed experiencing difficulties resulting from early development that led to the inadequate resolution of the Oedipal conflict. The angry, ambivalent relationship with Tamia is, in essence, the re-creation of the relationship he has with his mother. He gets angry at Tamia when she "disappears" on him, suggesting that he is stuck in the rapprochement subphase; he has some strong but mixed feelings about his mother and father. Perhaps both explanations are useful, thinks Jezebel, in helping Theo.

HEALTH AND DYSFUNCTION

EP theorists, for the most part, accept the version of psychological health proposed by Freud: healthy repression of instinctual drives, the ability to love and work, and so on. They would add that health is observed in the quality of the ego's adaptation to the environment (Wolitzky, 2005). Also like Freud, the EP theorists consider the Oedipal complex to be the source of much dysfunction. However, the views of many EP theorists seem to foreshadow those of the OR theorists in that they emphasize the quality of the very early stages of life and the adequacy of the environment around the infant. Problems in the early environment can cause dysfunction later in life. For example, Mahler contended that, if the mother does not provide a secure enough base for the developing child, the child will show problems in establishing independence, or, in EP terms, in developing an autonomous ego. For Hartmann, if the average expectable environment is not present, the child's development will be compromised.

Brenner (1982) proposed that behavior is a function of *compromise formations*. Conflict is found in the interplay of four psychic motivations: the pressure of the drives, the push of the superego, the ego's motivation to adapt to reality (i.e., the external world), and the ego's need to avoid or minimize anxiety and depression. To integrate the OR perspective, Brenner indicated that all object relations are a product of the negotiation of these forces; in essence, relationships and their internalized representations are compromise formations (Wallerstein, 2002).

Jezebel judges that Theo shows adequate ego and superego development, although he is displaying some Oedipal issues that result in compromise formations through the use of less-than-optimal defenses such as displacement, displacement of aggression, and identification with the aggressor. To some extent, the defensive functions allow gratification of sexual and aggressive instincts in modified forms directed at less-than-threatening entities (e.g., colleagues and Tamia). However, that Theo is feeling bad enough to seek counseling suggests that the sheer amount of energy (perhaps evoked by the stresses of the college environment) is threatening to overwhelm him and damage the delicate balance of the compromise. If this happens, Theo's superego threatens, he would be annihilated.

NATURE OF THERAPY

Assessment. Very little formal assessment is used in an EP approach (Wolitzky, 2011). Instead, the clinical interview serves as the primary mode of assessment, with the intent to observe current and past functioning and to gain information regarding defensive operations and core unconscious conflicts contributing to the client's current presentation. However, as in traditional analysis, the counselor is simultaneously determining the suitability of the client for psychoanalytic therapy. Formal diagnosis (i.e., diagnosis based on the DSM-V, APA, 2013) may be used, but as

noted in Chapter 2 a diagnostic system has been developed for analysts, found in the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006). In general, the neoanalytic therapist is really more interested in underlying dynamics than client symptoms (Wolitzky, 2011).

Jezebel concludes that Theo is a good candidate for psychoanalytic therapy. She is not concerned about formulating a DSM-V diagnosis for Theo. She is more interested in observing how he interacts with her and in hearing his descriptions of his everyday life. She is looking for clues to his psychological dynamics, observing that, although he is docile in the early interviews, his descriptions of anger in other aspects of his life suggest conflicted dynamics.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. It seems difficult to summarize the EP orientation to therapy. In some sources, EP therapists appear to adopt the neutral, objective stance of the classic analysts in their work. This stance would be taken by a traditional EP counselor and implies a doctor–patient model, in which the expert therapist interprets the material provided by the client (Wolitzky, 2011). However, other interpretations see the EP therapists moving away from the authoritarian model. For example, Mitchell and Black (1995) indicated that the EP understanding of the resilience of the ego leads these therapists to be interested in enlisting the client as an ally in therapy who contributes significantly to the work of understanding unconscious material. The latter orientation might suggest a more egalitarian approach to client–counselor roles.

Buckley (2003) maintained that, although Hartmann's influence led to an austere, abstinent therapist as in the classic analytic model, later theorists in the EP group proposed a more interactive model of therapy. For example, Buckley interpreted Loewald (1989) as promoting the idea that psychoanalysis produces ego development through internalization of the relationship between therapist and client, implying a more constructivist view of the process.

A contemporary EP therapist, Jezebel approaches Theo with a warm and friendly manner. She recognizes the importance of his collaboration in the therapeutic endeavor. Theo responds in kind, discussing his anger somewhat uncomfortably.

Goals. EP therapists still accept Freud's original goal of psychoanalysis: to make the unconscious (most importantly, the repressed) conscious (Greenberg & Mitchell, 1983). However, they would add that a second important goal of EP therapy is to improve the client's adaptation to his world (Wolitzky, 2011).

Jezebel hopes that when he is finished with therapy, Theo can understand the unconscious roots of his behaviors and the defenses he uses to cope with the unconscious conflicts. He will gain insight into the anger he feels toward both of his parents and into how he repressed the real roots of this anger in the attempt to protect his fledgling psychological structure. She also intends to try to help him adapt better to his environment and hopes that his insight into his dynamics will carry into future situations.

Process of Therapy

Therapy in an EP model changes depending on which variant of EP one is reading. Anna Freud (1936/1966) seemed to be most interested in classical techniques: analysis of defenses and transference. Other ego psychologists see the transference as re-creating early

relationships and emphasize the emotional support or empathy provided therein (Mitchell & Black, 1995).

In classical EP tradition, the client free associates and the analyst interprets. *Transference* is considered very important, whereas *countertransference* is considered a very bad thing (see Chapter 2).

Jezebel attends to the interpersonal process that she and Theo create, but is also aware that she needs to observe and interpret drive-related processes. She is aware, as a result of her own training analysis, of her tendencies to countertransference and guards against these.

THERAPEUTIC TECHNIQUES

Techniques in a traditional EP approach are the same as in classic psychoanalysis: Free association, interpretation (particularly of the transference), and dream analysis are the mainstays. However, it is interesting that free association has come to be recognized as a goal of analysis, not a technique, for the EP theorists emphasized the pervasiveness of ego defense processes, both outside and within the therapeutic relationship (Mitchell & Black, 1995). In this respect, Anna Freud (1936/1966) commented:

> Even today many beginners in analysis have an idea that it is essential to succeed in inducing their patients really and invariably to give all other associations without modification or inhibition, i.e., to obey implicitly the fundamental rule of analysis . . . such docility in the patient is in practice impossible. The fundamental rule can never be followed beyond a certain point. The ego keeps silence for a time and the id derivatives make use of this pause to force their way into consciousness. The analyst hastens to catch their utterances. Then the ego bestirs itself again, repudiates the attitude of passive tolerance which it has been compelled to assume, and by means of one or other of its customary defense mechanisms intervenes in the flow of associations. (pp. 13–14)

Jezebel asks Theo to talk about whatever occurs to him. As he does, she looks for evidence of defenses operating and then for indications of the accompanying underlying conflicts. As she becomes fairly confident about her hypotheses, she offers them to Theo in the form of interpretations, first of the defenses and later of the underlying conflictual themes. Theo initially talks quite a bit about his anger with Tamia but shifts gradually to speaking about his parents and early experiences with them. It takes a while for this shift to happen because Theo's defenses are operating. As he begins to address his early experiences, his emotions become more vivid, and eventually Theo's anger becomes directed at Jezebel. She carefully begins to interpret these processes so that Theo can gain insight into them.

OBJECT RELATIONS: THE LEGO APPROACH

OVERVIEW

Within the object relations group, there are several important theorists. Most spectacular was Melanie Klein, who was considered a heretic by the psychoanalytic establishment as represented by Anna Freud and her followers. She accepted drive theory but still emphasized the importance of psychic representations of relationships and primitive fantasy, particularly aggressive urges. Her ideas were considered so deviant that in the late 1920s the European psychoanalytic world split into the London school (Klein and her followers) and the Viennese school (Anna Freud and

her colleagues). Still, Klein is seen as having a major impact on psychoanalysis, even as it is practiced today (Mitchell & Black, 1995). You can read more about the controversy surrounding Klein and Anna Freud in Box 3.4.

Box 3.4

Melanie Klein and Anna Freud: Feuding Leaders of the Development of Child Analysis

In 1927, Sigmund Freud wrote a stern letter to his colleague and eventual biographer, Ernest Jones. In this letter, Freud accused Jones, then president of the British Psycho-Analytical Society, of masterminding a campaign against his daughter, Anna Freud (Paskauskas, 1988). Freud reprimanded Jones for publishing the proceedings of the Symposium on Child Analysis in the *International Journal of Psychoanalysis* (of which Jones was the editor). Freud maintained that the publication of the proceedings demonstrated that Jones and the British Psycho-Analytical Society favored Melanie Klein's version of psychoanalysis over Anna Freud's (Klein et al., 1927), and he labeled Jones's criticisms of Anna's child analysis "impermissible" (Paskauskas, 1988, p. 624).

Ernest Jones's criticism of Anna Freud's child analysis techniques and praise for Klein's led Freud to wonder whether Jones's condemnation of Anna Freud was really directed at him (Paskauskas, 1988). However, Jones was not the only psychoanalyst siding with Klein. A decade before the symposium was published, those who championed child analysis began gradually dividing into two separate camps, one commanded by Melanie Klein and the other by Anna Freud. Whereas British psychoanalysts in London accepted Klein's theories of child analysis, Viennese analysts supported Anna Freud's techniques (Donaldson, 1996).

Freud's scolding led Ernest Jones to defend his decision to publish the symposium. Jones stated that he was simply attempting to ensure a fair hearing of both Melanie Klein's and Anna Freud's sides of the argument (Paskauskas, 1988). He contended that the imbalance resulted from the refusal of the other major psychoanalytic journal, *International Zeitschrift für Psychoanalyse*, to publish Klein's work. Jones stated that by publishing the symposium in his *International Journal of Psychoanalysis*, he was trying to allow Melanie Klein the chance to more broadly defend her theories against the assault of Anna Freud.

Born in Vienna in 1882, Melanie Klein, along with Anna Freud, is among the most influential women psychoanalysts in the history of the discipline. Her contributions were primarily to developmental theory, specifically regarding the analysis of children. In response to Ernest Jones's urging, Klein began to work on her developing theories in London (Grosskurth, 1986), when in early 1927 Anna Freud published *Introduction to the Technique of Child Analysis* (A. Freud, 1974). In her book, Anna Freud attacked Klein's methods of child analysis, giving them the dreaded label of "un-Freudian" (Donaldson, 1996, p.160). As a result, the Symposium on Child Analysis was organized for Melanie Klein to respond to Anna Freud's criticisms.

In creating their theories of child analysis, Melanie Klein and Anna Freud drew from different components of Sigmund Freud's work: developmental theory versus therapeutic techniques. Anna Freud focused on Freud's theory of child development, concluding that the

(continued)

Box 3.4 *(continued)*

traditional analytic techniques applied to adults could not be applied to children because adult psychoanalysis is based on the interpretation of the patient's free associations, and free association requires a level of linguistic capabilities that children have not yet acquired. Therefore, she developed a new therapeutic technique, a pedagogical form of child analysis that had the goal of developing and strengthening a child's ego in hopes of repressing the impulses of the id (A. Freud, 1974). Anna Freud's theory presented no challenge to Sigmund Freud's theory of the psychic development of the child.

In contrast, Melanie Klein chose to incorporate adult analytic techniques into child analysis, focusing on Freud's clinical practices and modifying his theories of development. In fact, part of what was so controversial was that Klein posited that consideration of the death instinct should be incorporated into theorizing about the development of the superego, which she saw as emerging prior to the resolution of the Oedipus complex. Through the analysis of her own children and the children of colleagues, Melanie Klein observed a harsh and punitive superego that emerged very early on, and she theorized that a child's relationship with the mother is the foundation of this entity—not the Oedipus complex, as Sigmund Freud had contended (St. Clair, 2004). Klein thought that the aggressive tendencies that the child experiences during the oral and anal stages are evidence of the child's sadistic fantasies (related to the aggressive instincts) that are projected onto the mother and then introjected as hostile objects (Klein, 1927). Through projective identification, these punitive introjects become the superego.

Klein also believed that in an analytic session a full transference relationship is created between the child and the analyst. Specifically, Klein contended that the negative transferences are particularly important because the child's hostile and aggressive impulses are what has brought the child to analysis to begin with. Klein believed that to make therapeutic progress, the analyst must interpret (sometimes forcefully) the negative transference and bring it to the forefront (Donaldson, 1996). In response, Anna Freud criticized Melanie Klein's ideas, saying that Klein's method of analyzing a child's aggressive fantasies is dangerous because the child's developing ego is not strong enough to deal with the aggressive impulses that are brought out of the unconscious (A. Freud, 1974).

Melanie Klein (1927) gave the opening paper in the fateful symposium, in which she described her views of Anna Freud's child analysis, attacking some of the central aspects of Anna's theory. Klein maintained that focusing on the child ego and relying on an educative approach are inadvisable because it leads children to repress hostile impulses, negating the goal of therapy. Klein also posited that ignoring the Oedipus complex prevents the analyst from uncovering the child's source of anxiety. The paper ended with Melanie Klein claiming that her own approach was superior to Anna Freud's because her technique achieved a stronger and more lasting analysis of the child compared to Anna Freud's techniques. After Klein presented, other speakers gave shorter presentations commending her approach. Ernest Jones's closing speech made it clear which child psychoanalyst he personally supported, giving the British Psycho-Analytic Society's final vote of approval to Kleinian child analysis (E. Jones, 1927). The publication of the proceedings then cemented the split between Kleinism and Freudianism that endured for years (Donaldson, 1996).

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Other important OR theorists are R. D. Fairbairn and Donald Winnicott. In terms of allegiance to drive theory, Fairbairn is probably the most radical of the OR group, for he theorized that drives are directed at objects, not simply at the pleasure of expressing the drive or some combination of object seeking and drive release. Fairbairn, Klein, and their associates are identified with the British school of object relations, but Klein and her followers are generally considered distinct enough to be referred to as Kleinians. Eventually an American school developed, and the most prominent of writers in this realm is Otto Kernberg.

At first, the term *object* may seem a little odd in a theory that deals with people, but it stems directly from Freud's use of it to describe the targets of the instincts. In traditional theory, the most important objects are people, who can satisfy libidinal or aggressive urges. The OR theorists generally rejected classic drive theory and instead argued that we seek objects (mostly other people) in and of themselves, not as means of satisfying instinctual drives, as Freud thought (Wolitzky & Eagle, 1997). Because the object-seeking process begins very early in life, the OR writers focus on the early developmental (pre-Oedipal) stages and the mother–child relationship.

Central Constructs

Objects. The term *object* is used in several ways in OR theory, and this is part of the difficulty in reading these theorists. The first use refers to *external* objects: things and people in the environment (N. G. Hamilton, 1988). Ultimately, the most important type of object is the *internal* object, a psychological structure formed early in life through the internalization of interactions with important others (Sollod et al., 2009). The first object of interest is the breast. Internalized objects become part of the developing child's self, and the quality of the child's relationships with them—and particularly the attachment to them—determine the functioning of the individual.

Kernberg called internal representations of relationships *bipolar intrapsychic representations* (Cashdan, 1988). These are composed of three elements: an image of the self, an image of the other person, and associated emotions (Cashdan, 1988, p. 17). The emotion associated with the internalized object contributes to the development of the instinctual drives, according to Kernberg.

Paul is Theo's OR therapist. He speculates on the nature of Theo's internal world, trying to sense the nature of the objects that populate it. He thinks that Theo's parents are certainly represented, as are his siblings. He has a self representation as well. Anger is clearly attached to these representations, which is evidence of the aggressive drive. Sexual urges are likely associated with Theo's internal representations of his mother and Tamia.

Projection. Projection, along with introjection and splitting, is, according to OR theorists, initially a way of relating to the breast and the primitive emotions associated with it (St. Clair, 2004). The aim of these defenses is to protect self-integrity and at the same time the attachment object (N. G. Hamilton, 1989, p. 1553). Initially concerned with the relations with breast and mother, these processes then generalize to other objects (people) that are important to the infant.

Projection is seen when the feelings associated with the object are fused with the object and projected into the external world so that they are safer. The happy infant who has just had a meal projects these feelings onto the breast, and it becomes the good breast. Likewise, the hungry, angry infant associates these feelings with another breast, the bad one. Mothers and other important individuals in the infant's experience become good and bad in the same way.

Paul believes that Theo may project his anger with his mother's unsatisfying breast onto her and his father. He sees them as angry with him for a number of reasons (e.g., his choice of college), but this anger is really Theo's primitive anger with the unsatisfying breast projected onto them so that it is less threatening.

Introjection. A second way to make a scary world safe is to take the bad aspects of it and internalize them so that they can be controlled. *Introjection* is the term used by Klein to describe this process, and although it makes the external world safer, it is problematic because it creates a scary internal world for the infant. Some theorists would say that good objects are introjected as well.

Paul wonders if Theo has introjected the bad breast. The anger he shows may be the anger at the bad breast, but the projection has resulted in these feelings becoming unconscious and thus liable to pop out in his current life. For example, his anger at Tamia could be a result of this process.

Splitting. Splitting is another process by which the infant manages good and bad affect (Cashdan, 1988). It is a normal process by which dangerous feelings, objects, and impulses are separated from pleasant ones, and this makes them easier for the infant to manage. The infant's good and bad emotion is at first not associated with any specific object; however, the breast (or bottle) quickly becomes the first object. When the breast satisfies the infant's hunger, it is good; when it doesn't, it is bad. This process broadens so that people can be good or bad—most notably early on, the mother. Moms aren't perfect, so it is inevitable that they will fail to gratify the infant and become partly bad. To deal with the anxiety associated with experiencing both the good and the frustrating breast/mother, the infant psychologically introjects and then splits the two and so has an inner world populated by good and bad objects. Infants tend to repress the bad mom, making the conscious version of her an idealized one (Cashdan, 1988). Parts of the ego associated with these painful objects are repressed as well. Fairbairn contended that the repressed bad object is further split into the *rejecting* and *exciting* objects (Scharff & Scharff, 2005). Rejecting objects are associated with aggressive urges and exciting objects with sexual, or libidinal, drives.

Paul thinks that Theo's splitting mechanisms have broken down, possibly as a result of the stress of being in college and his unsuccessful attempts to attach to Tamia. The anger associated with the repressed portions of the objects (of the breast, mother, and father) is surfacing and is directed toward other objects. That is, some repression is still functioning, keeping the real objects of the angry feelings (i.e., the breast and parents) in the unconscious.

Projective Identification. Another protective function described by the OR theorists is projective identification, and it is surely one that is difficult to grasp. Originally described by Klein, this process begins when the infant projects some scary feelings outward onto another object (such as the breast or the mother). However, these dangerous impulses are now outside and uncontrollable. The only solution is to continue to relate to the scary object by taking it back inside the self through internalization. Some authors suggest that the impulse to reinternalize the object is also motivated by the wish not to wholly get rid of the object (Flanagan, 2008a). The bad object thus becomes a part of the infant. Although most often discussed in terms of scary/dangerous impulses, projective identification can also involve positive feelings,

such as when drives are satisfied (St. Clair, 2004). Cashdan (1988) goes on to indicate that this dynamic induces the target of the process to feel and behave in ways consistent with the projective identification.

Through projective identification, Theo has taken the bad breast into his self. The excitement and frustration he feels related to his mother's inconsistent support have resulted in both sexual and angry feelings attached to these objects, but these feelings are too threatening to leave outside of him. Similarly, Theo has identified with his father, who abandoned the family early on. The anger Theo feels related to the abandonment is thus directed back at himself and is also bleeding out into his other relationships.

Theory of the Person and Development of the Individual

The process of development, according to the OR theorists, is from a primitive, pristine self through fragmentation to whole-experiencing—the infant, if given the correct environment, gradually develops the capacity to resolve splitting and to integrate the various internal objects into wholes. The self is inherent in the human condition and present at birth (Scharff & Scharff, 2005). It develops through interaction with others, building psychic structure by internalizing objects.

Klein's view of infant development is one beset with turmoil. You can read a bit of her writing on this topic in Box 3.1. The infant first experiences anxiety because the death instinct threatens annihilation of the infant self; this situation is accompanied by feelings of persecution (Klein, 1952). Simultaneously, the feeding and care provided by the mother result in the internalization and idealization of the good object, the breast. The feelings of persecution and wishes to destroy are projected to the bad breast, which withholds from the infant. To deal with these intense emotions, the infant splits them into two internal objects. The infant vacillates between these states, shifting from love to hate and aggression, the latter feelings producing anxiety and guilt. Simultaneously, these are both external objects, as are the mother (to which the breast eventually generalizes) and, eventually, the father. This phase occurs in the first 6 months of the infant's life and is referred to as the *paranoid-schizoid* position.

Around 6 months, according to Klein, the infant begins to perceive the mother as a whole person and, as the good and bad objects begin to synthesize, realizes that the aggressive, hateful emotions associated with the bad breast are directed at her. This development brings on the *depressive* position because the child recognizes his terrible hate and aggression toward the mother object and wishes to repair the relationship (Scharff & Scharff, 2005). Associated with the depressive position, in Klein's (1952) view, is the beginning of the Oedipus complex with its associated feelings of love, aggression, guilt, and anxiety.

Klein thought that we never really outgrow these two positions—we struggle to resolve these issues throughout life. However, healthy people tend to function more out of the depressive than the paranoid-schizoid position (Scharff & Scharff, 2005).

Paul sees Theo's present functioning as resulting from his early experience with his parents, particularly his mother. He is probably standing in the depressive position because he seems to function fairly well in his life. However, the uncontrollable anger he reports could be associated with the paranoid-schizoid position; possibly he never fully made the transition out of this stage and cycles back to it periodically. He may be experiencing Oedipal feelings about his father, and his anger at his mother could be the

result of his conflicting feelings of anger and love for her that were never resolved. Later, when she agreed to reunite with his father, she symbolically deprived Theo of Oedipal satisfaction.

Winnicott, who styled himself as a follower of Klein, had quite a bit to say about child development. He coined the engaging term *good enough mother* to describe a mom that mostly meets the infant's needs, one who creates (or is) a safe *holding environment* (Mitchell & Black, 1995). The mother's role involves two processes. First, she ensures that the infant's needs are met and, in doing so, allows the infant to believe that she has created needed objects, which helps the infant develop an associated degree of omnipotence necessary for ego development. Second, the mother allows the infant periods of quiet time. Failure to provide either of these results in fragmentation of the self, for the self develops out of the gradual reconciliation of internal and external realities.

An interesting and unique contribution of Winnicott is the idea of the *transitional object*. A transitional object is something inanimate, like a teddy bear or blanket, and in the words of Greenberg and Mitchell (1983), these entities provide "a developmental way station between hallucinatory omnipotence and the recognition of objective reality" (p.195). In his omnipotence, the child believes that he has created the bear because he desires it. The parent goes along with this notion, but at the same time the object is a real one that exists in the external world. This ambiguity helps the child make the transition from fantasy to interaction with a real world.

Paul considers Theo from Winnicott's perspective and guesses that his mother did not provide an adequate holding environment, for his anger is evidence that he has not consolidated his objects into a sense of self. Because Theo's mother and father were embroiled in their fights (likely resulting from their own faulty object relations), quiet times were few, and the constant fighting distracted his parents so much that they neglected his needs to some extent. It is too threatening to deal with the anger attached to his mother, so the internalized object associated with her is likely split and the bad part repressed.

Theo still has his battered old panda bear who was his chum as a small child. He still has warm feelings when he glances at Rudy, who is on a shelf in his bedroom.

Fairbairn and other later OR theorists saw development as the process of resolving the twin pulls of individuation and attachment to others (N. G. Hamilton, 1989). In Fairbairn's view, the infant's strong emotions are threatening (they might overwhelm the nascent sense of self), so he externalizes these emotions onto the parent. If the parent can accept the emotion (in Fairbairn's terms, contain it) and still maintain a bond with the infant (creating a *holding environment*), the infant will eventually learn how to do this himself (N. G. Hamilton, 1989).

Paul thinks from Fairbairn's perspective: Theo has likely externalized his anger at his mother's compromised ability to form a bond with him onto both of his parents. That's why he is so angry with their fighting.

HEALTH AND DYSFUNCTION

Simply put from an OR perspective, healthy individuals have good object relations. They have a coherent sense of self, and their inner drives do not significantly distort current relationships (St. Clair, 2004). Their internal representations are not split into good and bad objects; rather,

these representations are of whole objects, which can have many different qualities. The ego develops as a distinct object and can recognize the primary good object (e.g., the mother) as separate and outside of the self. As I noted earlier, these qualities begin to develop when the child enters the depressive position, at about 6 months of age (St. Clair, 2004).

Broadly speaking, OR theorists see psychological dysfunction as the result of faulty early development, with an emphasis on the object relations that result from less-than-optimal parenting (i.e., bad mothering). For instance, Fairbairn thought that infants repressed threatening objects, but these have effects on the individual nonetheless. The individual is essentially doing away with aspects of the self, yet this repression leaves feelings of frustration and negative feelings about the self. The person then becomes terrified of abandonment and, when threatened with it, reacts with rage or extreme neediness (Cashdan, 1988).

From Winnicott's perspective, failures of the mother to provide a holding environment cause the child to experience *impingement*. The mother fails the child either by not allowing omnipotence to develop or by not providing quiet time to consolidate. Development stops, and the child doesn't develop a healthy core sense of self. Instead, the child develops a false self to deal with the external world and also to protect what little self has developed (J. R. Greenberg & Mitchell, 1983).

Kernberg saw dysfunction as stemming from a lack of integration of object representations, or, in his rather ungainly term, *unmetabolized bipolar intrapsychic representations* (Cashdan, 1988). Difficulty in the integration process is typically caused by excessive defensive splitting. For example, Kernberg writes a lot about individuals who display borderline personality organization, or borderline personality disorder in DSM-V terminology. He sees these individuals as harboring a lot of negative affect, mostly aggression, which is intolerable and has to be split off (Levy et al., 2006).

One controversial aspect of Kernberg's theory is that this aggression can be the result of either constitutional (i.e., inherited) or environmental forces (e.g., experiences of abuse). Whatever their origin, these feelings result in a negative emotional tenor that dominates interpersonal relationships, and thus negative objects (actually part-objects) are internalized. The object representations can't be integrated into the self, resulting in *identity diffusion*, Kernberg's diagnostic label. In Kernberg's words, "Identity diffusion is represented by a poorly integrated concept of the self and of significant others. It is reflected in the subjective experience of chronic emptiness, contradictory self-perceptions, contradictory behavior that cannot be integrated in an emotionally meaningful way, and shallow, flat, impoverished perceptions of others" (1984, p. 12). The self is fragile and constantly shifting between good and bad states. These shifts also appear in how these individuals deal with other people in their lives; they alternate between seeing people as very bad and seeing them as very good and behave in ways that convey these perceptions.

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Video Example 3.2 Otto Kernberg on personality and personality disorders



https://www.youtube.com/watch?v=g9YAQay1ljc

Paul sees Theo as having internalized the bad objects created by his parents' treatment of him and the environment that their conflicted relationship created. These feelings have mostly been repressed, but the stress that Theo experiences in having to grow up and negotiate the complex interpersonal environment

of college is taking its toll. He hasn't developed a healthy self or set of integrated internal objects. He has used the defenses of projection, introjection, and splitting to manage the inadequacies of his early environment, but these defenses are breaking down, and his anger is beginning to surface. The surfacing of the anger is scary for Theo—it is powerful, and unconsciously Theo fears that, if it comes out, it will result in the destruction of important objects—most significantly his parents or his shaky self.

NATURE OF THERAPY

Assessment. OR therapists are not likely to use any formal assessment. As with most analysts, they are more interested in observing the client's behaviors and verbal content as clues to underlying dynamic processes. Of particular interest is the therapist's reaction to the client, which yields hypotheses about the client's self in relationships (Frankland, 2010).

Paul simply listens to Theo and tries to get a sense of his internal world. He closely observes Theo's reactions to him and listens carefully to Theo's stories of his stormy relationship with Tamia and others. Paul is looking for clues to Theo's object relations.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. Like ER therapists, OR therapists look very much like orthodox psychoanalysts when they do therapy. However, they are more likely to attend to the environment of therapy than are classic analysts—they see the therapy relationship as replicating the early relationship with the caregiver.

Again, however, Klein stands out. According to Walker (1957), Klein's approach to therapy was influenced by her work with children and differed from classic analysis in a few ways. First, she emphasized the early phases of experience because she was convinced that neuroses are seated much earlier than Freud believed, probably in the oral phases of development. As noted earlier, Klein was much more interested in the aggressive impulses of the client. She advocated the early use of very deep interpretation (Walker, 1957); instead of proceeding from surface to depth, she offered interpretations based on early developmental dynamics much sooner than a traditional analyst would. Mitchell and Black (1995) characterized the relationship between analyst and client in Kleinian therapy as

> much more fundamentally enmeshed than in Freud's view. It is not as if the patient is simply revealing the contents of her own mind to a generally neutral (except when distracted by countertransference) observer; the patient experiences the analytic situation in terms of her primitive object relations. At times, the analyst is a good breast, magically transformative; interpretations are good milk, protective, nurturing, restorative. At times, the analyst is a bad breast, deadly and destructive; interpretations are poisonous, destroying from within if ingested. (p. 107)

Winnicott saw the analytic situation as providing the holding environment that the client did not experience as an infant (or he otherwise wouldn't be a client). The therapist should avoid impinging on the client so that the true self can safely emerge and replace the false self (Kernberg, 1984; Mitchell & Black, 1995). Likewise, Fairbairn thought that analytic change emerged from the new relationship established with the analyst (Mitchell & Black, 1995).

Of recent interest among contemporary analysts is the notion of the therapist's authority in the analytic situation and associated discussions of therapeutic neutrality. Kernberg (1996) addresses this issue and contends that therapists must retain their authority based on education,

training, and skills, but they must also recognize their own input into the therapeutic relationship. He wrote, "Technical neutrality, in short, does not imply anonymity, and natural behavior does not imply that the analyst is not in a consistent, stable, professional role relationship with the patient. Nor does technical neutrality imply that the psychoanalyst's personality will not influence the patient, in the same way as the patient necessarily will influence the analyst through countertransference reactions" (1996, p. 146).

Paul takes a moderate approach to Theo, trying to establish a stable, safe therapeutic environment with him. He realizes that who he is will affect Theo, but also is alert for evidence that suggests that Theo's object relations are surfacing in the therapeutic relationship.

Goals. For OR theorists, good therapy will restore healthy object relations and thus a solid sense of self. Winnicott saw the goal of therapy as development of the self. Fairbairn's goal was for the client to develop new ways of relating to others, ways that are not tied to the faulty patterns the client brought to therapy. Kernberg would see the goal of therapy as the integration of the part-objects within the self and the resulting abilities to maintain a continuous sense of self and others, empathize with them, and reflect on one's own experience (Levy et al., 2006).

Paul hopes that Theo will be able to withstand the necessary surfacing of his internal object world so that he can build a more integrated sense of self through the therapeutic work they will do. He anticipates that it will take a while for Theo to be able to deal directly with the emotions associated with his parents because they are so scary, so he begins with Theo's current relationships, which are the topics of his early free association.

Process of Therapy

OR therapists are very interested in *insight*. However, with clients who display severe dysfunction, the kind of insight expected is a little different than that expected with typical neurotic clients. Transference interpretations with severely dysfunctional clients are restricted initially to here-and-now events, implying that insight is first about the dynamics of the therapy relationship; later the focus becomes historical events.

OR theorists are also very interested in *transference* phenomena. They accept that clients will bring to therapy their old ways of relating and will unconsciously re-create early relationships in the relationship with the analyst. For instance, Fairbairn thought that as hard as the client tried to do otherwise, he eventually comes to experience the therapist as "the old, bad object" (Mitchell & Black, 1995, p. 122) from earlier relationships.

In classical analysis, the therapist deals with the transference objectively, interpreting the transference to the client from an unemotional, neutral standpoint (unless the therapist is a bad analyst, caught up in countertransference). Some of the OR theorists, like Klein, accepted this idea of the therapist's role. For example, Kernberg characterized analysis as having three key components: (a) the analyst's technical neutrality; (b) the use of interpretation; and (c) a goal of developing a full-fledged transference neurosis, which is resolved through interpretation. Even in maintaining technical neutrality, however, Kernberg (1984) advocated that the therapist be able to provide warmth and empathy and, further, to empathize with what the client can't deal with in himself.

Kernberg acknowledged that working with relatively disturbed individuals makes technical neutrality difficult to maintain because of the strong negative transference displayed by these clients. As a result, he recommended that early in therapy, transference interpretations be confined to the immediate therapeutic situation; genetic interpretations (those based on the client's developmental history) are saved for the later stages of therapy. Any acting out of the transference, both within and outside of therapy, is to be blocked, sometimes requiring the therapist to sacrifice neutrality to make directive interventions. Positive transference is not to be interpreted; instead, it is used to build the working alliance (Kernberg, 1984).

For OR theorists, what happens in transference with the more severely disturbed clients is best explained by the nature of the primitive defenses they need to employ to protect their fragile selves. Noting that these primarily negative transferences seem to develop very quickly, Kernberg thought that projective identification is behind them (St. Clair, 2004). The client, because of his unintegrated internalized objects, brings to therapy the aggressive, scary object representations of the parents left over from early experiences and projects these onto the therapist. As a result, the client does not trust the therapist and fears him. The client may then attempt to protect the self in one of two ways: by being hostile and sadistic or by reacting like a frightened child.

Countertransference is seen as an aid to understanding the client (Scharff & Scharff, 2005). Because the client projects his disordered object relationships into the analytic situation, the therapist's reaction to the client becomes diagnostic information about the client's internal dynamics and ways of operating. However, in relation to the more severely disturbed clients, the shifting and mostly negative aspects of the transference can elicit corresponding aggressive and hostile responses on the part of the therapist (Kernberg, 1996; St. Clair, 2004). Kernberg (1996) recommended ongoing peer consultation as a way for the therapist to examine his input into the transference.

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Video Example 3.3 Dr. Jill Savege Schraff, an object relations therapist, talks about OR theory and therapy



https://www.youtube.com/watch?v=N0b7l2SMRiw

Paul hopes that he can help Theo understand the relation between his early experiences and his current relationship problems. He will be alert for Theo's responses to the therapeutic relationship as well as possible historical roots of his current behaviors and feelings. Paul thinks that Theo will eventually become angry with him in the way that he expresses anger toward others in his life. Paul will accept this anger, discussing it first as it applies to the relationship between the two of them and then eventually as it relates to Theo's earliest experiences with his bad objects, his parents—particularly his mother. If Theo's anger threatens to get out of control, Paul will set boundaries on its expression and will work with Theo to structure his life outside of therapy to minimize its effects. In this process, Paul remains attentive to his feelings when he is with Theo and his possible input into their relationship dynamics. He will seek consultation if he believes that his responses are interfering with his work with Theo.

Therapeutic Techniques

As in traditional psychoanalysis, the most potent technique in OR is *interpretation*, particularly of transference. Kernberg (2001) spoke of the "three-person" model of therapy, in which "the analyst is immersed, on the one hand, in a transference–countertransference relationship, and on the other, as maintaining an objective distance, from which observations and interpretations of the patient's enactments of internal object relationships can be carried out" (p. 536).

Some OR theorists believe that the relationship in therapy is the curative factor, not the actual content. For example, Winnicott believed that the holding environment created in therapy provides the proper relationship that was missing in the client's early life. In this environment the client, who is developmentally stuck at the stage where parenting failed, can get unstuck and move forward (J. R. Greenberg & Mitchell, 1983).

A recent approach based on Kernberg's work is known as transference-focused psychotherapy (Kernberg, Yeomans, Clarkin, & Levy, 2008; Levy et al., 2006). In TFP, a structured approach begins with the development of a treatment contract specifying the expectations of therapist and client. The major techniques of TFP are clarification, confrontation, and transference analysis of the here-and-now events of the therapeutic relationship. Clarification refers to the attempts of the therapist to understand the client's experience, helping the client improve his ability to self-reflect (difficulties in self-reflection are thought to result from the poorly integrated self). The TFP therapist also confronts discrepancies in the client's communications, which can then be linked to psychic splits hypothesized to underlie the problems in self-integration. Transference interpretations link the therapist–client interaction to early object relations.

Paul patiently listens to Theo and tries to maintain a relatively neutral but supportive therapeutic environment. He will interpret expressions of Theo's anger in the relationship and lead him to see how it is connected to his feelings about his parents, particularly his mother. Throughout the therapy relationship, Paul will try to provide the correct, supportive holding environment that is essential if Theo is to express his anger and fear on the way to gaining insight.

SELF PSYCHOLOGY—IT'S ALL ABOUT ME

Overview

As the label suggests, self psychology focuses on the development of the self. Heinz Kohut (1913–1981), the founder of this approach, was born in Vienna but eventually relocated to Chicago in 1939, fleeing the invasion of Austria by the Nazis. He began his professional work as a traditional analyst, but over the years developed his own perspective, which was first readily apparent in his 1971 book, *The Analysis of the Self: A Systematic Analysis of the Treatment of the Narcissistic Personality Disorders*. When Kohut died in 1981, he was in the process of writing his final book, *How Does Analysis Cure?*—published posthumously in 1984 (Strozier, 2006). More information on Kohut and SP can be found at the website of the International Association for Psychoanalytic Self Psychology, www.iapsp.org.

SP's subtitle might be "It's All About Me," for Kohut developed his ideas primarily through his work with clients who were labeled as narcissistic personalities, and this perspective is very focused on one's conception of the self, as you will see. Originally, he seemed to see his work as a complement

to traditional theory that applied to the narcissistic syndromes (St. Clair, 2004). However, toward the end of his life Kohut characterized his work as more broadly applicable and as a contribution separate from and parallel to that of Freud (Mitchell & Black, 1995). Nonetheless, Kohut is often seen as trying to have the best of both worlds: He did not reject classical drive theory completely, but reserved it for cases in which clients present with relatively intact self systems (i.e., what Freud called the neuroses). In doing so, he softened the nature of the drives: For instance, the normal Oedipal stage impulses are joyful and assertive rather than libidinous and aggressive. However, drive theory is not to be used to understand the character or personality disorders, such as narcissism. SP is the better alternative here because it emphasizes problems in development that predate the Oedipal conflicts that are the focus of drive theory (St. Clair, 2004). This adaptation prompted J. R. Greenberg and Mitchell (1983) to label Kohut's theory a mixed model. However, Kohut's ideas were considered radical enough by the "mainstream" psychoanalytic crowd to deserve the dreaded label "unanalytic," bestowed by Anna Freud herself (Mishne, 1993).

CENTRAL CONSTRUCTS

Selfobject. Kohut coined a special term, *selfobject*, to emphasize his position that infants can't differentiate between the self and others. Although the term tends to be a bit fuzzy and difficult to pin down, selfobjects are referred to as parts of the self and also as individuals in the environment that are relevant to the self. Kohut used the term *self-selfobject relationships* to describe the role of the selfobjects, but most other writers simply refer to *selfobject relations*, as I will in the following sections.

Selfobjects exist to soothe and support the infant as he grows from the primitive, selfless state to an individual with a self, but the need for selfobjects never disappears. The most important selfobjects are the parents, who need to be good selfobjects but also to occasionally frustrate the infant to spur growth (Kohut, 1984). If these relationships are satisfactory, the infant's self will develop in healthy ways (Quintar et al., 1998).

Sharlene is Theo's SP therapist. In thinking about Theo's presentation, she speculates that he has some problems with his selfobjects—he probably has not established a totally integrated self. Sharlene wonders if Theo's parents provided the optimal levels of gratification and frustration as he was developing—their stormy history suggests that it is possible that their preoccupation with their own issues resulted in higher levels of frustration than would be desired, causing Theo to develop negative selfobjects.

Disintegration Anxiety. Kohut added the conception of *disintegration anxiety* to analytic theory, maintaining that it is the most basic form of anxiety experienced by human beings. Although Kohut (1984) acknowledged that "the attempt to describe disintegration anxiety is the attempt to describe the indescribable" (p. 16), he characterized it as the fear of psychological death. Mollon (2007) noted that the threat of fragmentation is present even in individuals with relatively healthy (cohesive) selves and that all psychic defenses operate to ward off this horrendous, primal anxiety.

Theo is probably suffering the effects of disintegration anxiety, although largely unconsciously. This anxiety, which stems from faulty object relations that do not support a coherent sense of self, is terrifying. Theo represses it and instead expresses it as anger toward important selfobjects who failed to provide him security and protect him from nothingness. He also transfers it to important others in his current situation—most notably, Tamia.

Theory of the Person and Development of the Individual

As you might expect, Kohut's view of development emphasizes the self (St. Clair, 2004). The self develops through relationships with the selfobjects. Two critical processes or functions—mirroring and idealizing—are important in the healthy establishment of the self, and two selfobjects—the *grandiose-exhibitionistic self* and the *idealized parental imago*—must be developed. Little kids need to say, "Look at me! Aren't I great?" This is the operation of the grandiose-exhibitionistic self, and it needs *mirroring* from the parents, which consists of parental approval and admiration. The development of the parental imago requires *idealizing*, which consists of the parent allowing the child to see him or her as perfect and communicating to the child that the parent is enjoying it. In his final book, Kohut (1984) identified a third selfobject function, *twinship*, that was originally subsumed under mirroring but was subsequently differentiated from it (Togashi & Kottler, 2012). Twinship involves the sense that one is like another person and also that that other person recognizes the similarity. More broadly, twinship is a sense of belonging to the human race (Kohut, 1984). Again, these processes are essential to building self-structure, so parents need to give the child a sense that they can see themselves in the child, while the child perceives "wow, I'm like mommy." It is important to remember that even if these needs are satisfactorily met in childhood, Kohut (1984) thought that we still, to some extent, seek mirroring, idealization, and twinship throughout our lives.

Idealizing, mirroring, and twinship make up what Kohut called the empathic relationship between parent and child (St. Clair, 2004). Generally, healthy parents do this well, but inevitably there is some disruption in the process and the child's needs are not met. These disruptions, if mild, push the child toward the development of a cohesive self because the child's response is to take these functions, in small steps, into the self. These disruptions in empathy are called *optimal frustrations* (Kohut, 1984), and with these the self develops gradually through the internalization of the grandiose-exhibitionistic self and the parental image in a process Kohut called *transmuting internalization* (St. Clair, 2004). If all goes well, these representations broaden into good feelings about the self and the idealized superego (Kohut, 1984). Most importantly, the child develops a coherent sense of self.

Normal development (or a good analysis) results in a self that is supported by all three selfobject functions, but the balance of the selfobject internalizations may differ within the individual, creating personality leanings. Personality type, for Kohut, is determined by which of the poles is dominant (J. R. Greenberg & Mitchell, 1983). If the grandiose-exhibitionistic aspects are strongest, the individual will be assertive and ambitious. If the idealized selfobject is dominant, the person will hold strong ideals and values. The third type corresponds to the twinship functions; this person will feel strong and sustained when surrounded by like-minded people, or alter egos (Kohut, 1984).

Kohut seemed ambivalent about traditional drive theory and psychosexual stages. He really thought that the kinds of clients we are dealing with now differed from those that Freud saw. He acknowledged, for example, the Oedipal stage of development, but in his later writings saw it as a phase of joy and affection for the parents (Kohut, 1984). For Kohut, the intense sexual and aggressive impulses sometimes seen at this stage are a product of faulty development (see the following section on dysfunction).

Theo's mother and father attempted to be good parental objects for him, at times playing with him and admiring the products of his play. For instance, Theo's panda bear, Rudy, learned to talk (through

Theo, of course), and his mother would engage in animated conversations with him. Theo also idealized his parents, particularly his father, whom he saw as important and powerful. Sharlene wonders about Theo's twinship and idealization processes: Did his father's frequent absence interfere with the internalization of the idealized parent imago? Did Theo experience twinship with either of his parents, or perhaps a sibling or close friend?

HEALTH AND DYSFUNCTION

In an SP model, healthy people have healthy selves, generally defined as *structurally complete* and cohesive (Kohut, 1984). Kohut rejected the traditional Freudian notion that the pinnacle of health is a heterosexual individual who has successfully negotiated the Oedipal stage of development. He wrote that "there are many other good lives, including some of the greatest and most fulfilling lives recorded in history, that were not lived by individuals whose psychosexual organization was heterosexual-genital or whose major commitment was to unambivalent object love" (Kohut, 1984, p. 7).

Kohut believed that the need for selfobjects is lifelong. It is the way in which one seeks and uses selfobjects that differentiates between healthy and dysfunctional people. He opined: "We must be in possession of available nuclear self-esteem and ambitions, on the one hand, and of core ideals and goals, on the other, in order to seek out mirroring selfobjects and be nourished by their response to us and in order to seek out idealizable selfobjects and be enlivened by the enthusiasm we feel for them" (Kohut, 1984, p. 77). We must also have a sense of belonging to the human race and, ideally, some alter egos to provide us with twinship support.

According to SP, the basic problem leading to dysfunction is self-related and can be traced to deficits in early experiences with caregivers. J. R. Greenberg and Mitchell (1983) put it thus: "The cause of pathology, as Kohut sees it, is *chronic* failure in empathy, attributable to parental character pathology" (p. 355; emphasis in original). These chronic failures result in a kind of "black hole" where the self should be, typically observable only through the extreme emotional reactions associated with threat (Mollon, 2007).

Kohut (1984) recognized three different types of dysfunction: the psychoses, narcissistic personality disorders, and structural–conflict neuroses. In the psychoses, a rudimentary self has not been developed. He believed that, although one could work with these individuals in therapy, it would be nearly impossible to help them create a true self because doing so would require demolishing the defenses that have been erected to compensate for the missing self. Instead, the analyst can help the client shore up the already existing defenses (Kohut, 1984).

SP theory is perhaps best illustrated by Kohut's analysis of narcissistic personality disturbances (Kohut, 1984). In these clients, a basic sense of self has been formed, but there are significant deficiencies in it. In fact, what is really wrong is that the individual has developed neither the idealizing nor the grandiose aspects of the self. In his later writings, Kohut also discussed failures to internalize the twinship selfobject. The chronic failures of his caregiver to satisfy the needs for mirroring, idealization, and twinship (as compared to optimal ones) result in an "enfeebled" self susceptible to *narcissistic injury* (Kohut, 1984). Disintegration anxiety is operative because the person's sense of self is fragmented. In extreme cases, the "black hole" effect described earlier is apparent (Mollon, 2007). Transmuting internalization cannot occur

because either the child has been deprived of mirroring, idealization, or twinship, or has been traumatized in some way related to these needs (e.g., rejection by the idealized parent). The child then never internalizes the selfobjects and does not develop a coherent self—it is shaky, racked by disintegration anxiety and the search for the selfobject provisions that are missing. The individual retains a chronic hunger for the unsatisfied need and carries it forward through life. The individual may engage in a desperate search for satisfaction of the need, for example, constantly looking for praise and admiration, or may turn away from contact altogether if he has been traumatized, a personality labeled the "contact-shunning personality" (Kohut & Wolf, 1978, p. 422).

In referring to the structural–conflict neuroses, Kohut meant the types of dysfunction that are the focus of traditional analysis: those emanating from the phallic stage of development. As noted earlier, in SP theory the Oedipal stage is not considered pivotal in the development of dysfunction—instead, "the child of healthy parents enters the oedipal phase joyfully" (Kohut, 1984, p. 14). If the parents cherish the child's emerging displays of assertiveness and affection all will be well. If they do not serve as good selfobjects in this phase, what Kohut termed the *Oedipal complex* will emerge (he used the term *complex* to distinguish these processes from normal Oedipal phase events). The child will experience two kinds of anxiety: primary and secondary. Primary anxiety, or *disintegration anxiety*—the fear of the loss of the self (i.e., the loss of one or more selfobjects without which the self cannot exist)—is the most primal horror that humans can experience (Kohut, 1984). Secondary anxiety is what occurs when the healthy Oedipal self is lost and the Oedipal sexual and aggressive urges become prominent, leading to castration anxiety among boys and the wish for a penis among girls.

In essence, Kohut argued that the motor of psychological disturbance is disintegration anxiety, which is present in all stages of life. It is the result of faulty parenting—a significant failure by parents in either their mirroring, idealizing, or twinship functions—resulting in flawed selfobject relations and an incoherent sense of self.

Sharlene thinks that Theo's issues arise from faulty early parenting. His parents were likely too distracted by their own conflicts to provide enough mirroring, idealizing, and twinship experiences when he was a very young child. As a result, transmuting internalization failed, his selfobjects are not soothing, and he experiences disintegration anxiety. His sense of self is shaky and easily threatened, as when Tamia went out all night with friends. When she stood up for herself, Theo erupted because, in doing so, she challenged his sense of himself.

It seems to Sharlene that, although Theo's problems are the result of much earlier dynamics, they are somewhat attached to the Oedipal complex. Theo experiences prominent aggressive urges, and Sharlene wonders about his sexual urges as well. However, she thinks that the primary problem area is likely in the need for mirroring: Theo's parents were too distracted to do enough of this, and he is easily injured when someone or something implies that he is not omnipotent and perfect, as Tamia does when they fight.

Nature of Therapy

Assessment. The SP therapist would not be a fan of formal assessment. Instead, the counselor relies on her observation of the client—and particularly of the client's behavior in sessions—to determine the nature of the self-deficits brought to therapy.

Sharlene carefully observes Theo's behavior in sessions, watching for his emotional reactions to her, and tries to gauge the level of coherence of his self-structure. He relates fairly easily to her at first, when discussions are fairly mundane.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. Kohut (1984) claimed that the relationship in SP therapy differs from that in traditional psychoanalysis in that it is warmer and more informal. The SP therapist is more willing than a traditional analyst to be emotionally available to the client. Kohut explained this difference in orientation to the client as resulting from the expanded concept of empathy in SP theory: The SP therapist (seeing the client's problem as stemming from early deprivation) construes the client's neediness and narcissistic demands as the welcome appearance of needs that have been repressed. However, the SP counselor does not gratify these needs (that would be a huge mistake), but does empathize with them. In contrast, a traditional analyst might conceptualize this neediness as avoidance of aggressive and libidinal urges associated with Oedipal conflicts.

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Video Example 3.4 Heinz Kohut on empathy



https://www.youtube.com/watch?v=ZQ6Y3hoKI8U

Despite the assertion that SP analysis is informal and relaxed, the client is still a patient in this approach. The therapist must empathize with the client, but must also provide the correct interpretation of the client's transference manifestations.

While attempting to provide an empathic environment for Theo, Sharlene is aware that she must maintain some sense of authority in the therapy relationship. She maintains the most objective stance she can and does not respond to Theo's bids for admiration or sympathy.

Goals. The goal of SP intervention is to correct deficits in self-structure, or as Kohut put it in the title of his 1977 book, it is "the restoration of the self."

Sharlene hopes that providing the correct environment and interpretations for Theo will enable him to integrate the fragmented aspects of his personality into a coherent self. He will re-experience his rage at his parents (and the associated internal selfobjects), but as Sharlene provides the proper idealizing and mirroring responses, he will eventually reintegrate these objects and establish a more stable sense of who he is. He will initially perceive events as totally related to himself and threatening; later he will use his more stable cognitive processes to objectively evaluate events in his life.

PROCESS OF THERAPY

Therapy in an SP model is very similar to traditional psychoanalytic therapy in many ways. The key technique used in this approach is interpretation, particularly of transference phenomena. Dream analysis is also used in SP therapy. However, the end goal of SP therapy is different than other forms of psychoanalytic treatment: It is rebuilding the self rather than achieving insight or expanding the ego's capacities.

The core of therapy in the SP model is empathy; "the most important rule governing the self psychological approach . . . is that *understanding always precedes explanation*" (Kindler, 2007, p. 65; emphasis in original). Therapy reactivates the client's early needs for selfobjects that were frustrated. Essentially, the therapist must function as a selfobject to the client, providing mirroring, idealization, or twinship functions that were absent in the client's early environment (Kohut, 1984). In this process the therapist will inevitably fail; if these failures are optimal, transmuting internalization will occur and the client will build self-structure. *Resistance* in the SP model is seen as the client's attempts to avoid a repetition of early assaults on the core of the self.

The signature aspect of SP therapy is that the person of the therapist is considered essential to the transference process—the client must establish either a mirroring or idealizing transference (J. R. Greenberg & Mitchell, 1983). Kohut (1984) also acknowledged the twinship transference in his later work, in which the client needs to see himself as akin to the therapist. The therapist basically serves as a selfobject for the client; the process of cure thus recapitulates what went awry in the client's development (Kindler, 2007; Kohut, 1984). This process happens in three stages: defense analysis, development of the transference, and creation of an empathic relationship between the self and selfobject that has been split off and repressed (Kohut, 1984).

In the course of therapy, the very human therapist will inevitably fail the client, and these failures, if optimally frustrating, lead to transmuting internalization and the accompanying new self-structure. For instance, the client, Suzay, idealizes therapist Raphael. However, Raphael misunderstands something Suzay says or ignores her hurt feelings. Raphael, the perfect therapist, has failed. The therapist and client must then discuss the therapist's failure and the client's reaction to it, examining the sequence in what is called the *disruption and repair* process (Kindler, 2007). It is critical that the therapist understand the disruption from the client's perspective, for it tells her about the client's selfobject failures. When the therapist can convey this understanding, the empathic bond is restored and the client's self is bolstered. What failed to happen with the client's parents happens with the therapist and helps the client develop self.

Sharlene struggles to empathize with Theo, providing mirroring and idealizing as he needs it. When she fails, she is aware that the disruption will prove helpful if she can repair the relationship. Theo transfers his early frustrations into the relationship, getting angry with her when she ends a session on time but somewhat abruptly. In the next session, Sharlene brings this anger up with Theo and tries to link it to his early experiences with his parents. In another session, Theo becomes angry because he feels misunderstood when Sharlene interprets his anger with Tamia as resulting from her failure to admire (mirror) him. Sharlene has failed to be the perfect therapist and, further, may have also reproduced Tamia's disrespect. The working through of such incidents becomes the vehicle by which Theo can integrate the selfobjects that he has split off and repressed.

Therapeutic Techniques

According to Kohut (1984), the most important technique in SP analysis is *interpretation*. As noted by Kindler (2007), two elements—understanding and explanation—must be in place for the interpretation to be effective. Understanding provides the optimal frustration that leads to

new self-structure because, although the empathic response of the therapist legitimizes the feelings and needs of the client, the therapist still does not gratify the needs. The empathic bond established (or re-established) in this process substitutes for the direct satisfaction of the client's need, and in the context of this relationship transmuting internalization brings about new self-structure.

Sharlene's interpretations revolve around the source of Theo's anger in his early relationships with his parents—their failure to provide idealizing and mirroring. She empathizes with Theo, knowing that she, too, will fail in the idealizing and mirroring transferences. Sharlene is alert for instances where she fails so that she can offer Theo interpretations of their interaction that will link their relationship to the past. She talks about her failures with him, and through this process Theo's defenses and repression recede and he is able to reintegrate the problematic selfobjects he carries in his self-structure. Transmuting internalization follows the disruptions of the alliance, and slowly Theo builds new self-structure. He is less apt to feel slighted by others and to react with anger to these events.

RELATIONAL PSYCHOANALYSIS

OVERVIEW

The fourth wave of psychoanalytic thought is loosely called the relational school. It is probably the most commonly practiced form of psychoanalytic psychotherapy in the United States at present (J. Mills, 2012). The most distant roots of this approach can be found in the work of Sandor Franzecki, contemporary of Freud and, for a brief time, his analysand. Also considered key is Harry Stack Sullivan who, in establishing what he called interpersonal psychiatry in the late 1940s, argued that the analyst is a participant observer rather than an abstentious blank screen. The term *relational psychoanalysis* is confusing because it is sometimes used to describe a point of view within contemporary psychoanalysis rather than a specific theory (Ghent, 2001). At other times, the term is used to identify a specific theoretical approach, attributed mostly to Stephen Mitchell, who founded the International Association for Relational Psychoanalysis and Psychotherapy shortly before his death in 2000. The website of this organization can be found at www.iarpp.net. In the inaugural issue of the organization's newsletter, Ghent (2001) wrote that

> the term relational was first applied to psychoanalysis by Greenberg and Mitchell back in 1983 when they abstracted the term from Sullivan's theory of interpersonal relations and Fairbairn's object relations theory. Common to these models of psychic development was the notion that psychic structure—at the very least, those aspects of psychic structure that are accessible to psychotherapeutic intervention— derive from the individual's relations with other people. (p. 7)

Oddly enough, the "bible" of the relational approach is titled *Object Relations in Psychoanalytic Theory* (J. R. Greenberg & Mitchell, 1983). What I present in this chapter focuses most closely on Mitchell's model, which he called the *relational-conflict* model (Mitchell, 1988).

CENTRAL CONSTRUCTS

Self. RP theorists discuss the self as the repetitive pattern of experiences and behaviors across time, along with the meanings associated with them (Mitchell, 1992). Mitchell, in writing about the self, maintained that, because of its temporal nature, we each have many different

selves, some that we experience as more authentic than others. However, the need for security (see the following section on anxiety) causes us to modulate our expression of self because we fear that authentic expression might cause anxiety, anger, or withdrawal in significant others on whom we depend (Mitchell, 1992). These later expressions are called the *inauthentic* or *false self*.

Min-Wei, the relational analyst, considers Theo's presentation. He guesses that Theo brings to therapy a set of meanings and behaviors based on his lifelong relationship experiences. Min-Wei assumes that Theo experienced anxiety early in his life, perhaps as a result of observing his parents' stormy relationship. Theo would have also learned a great deal about relationships in observing his parents and others in his early years. He likely learned that relationships are fragile and conflicted, with each partner often threatening to abandon the other. These meanings and patterns are Theo's current version of self, which is to some degree inauthentic.

Relational Matrix. The focus of the RP therapist is relationships; the client's presentation is interpreted through the construct of the relational matrix (St. Clair, 2004). The relational matrix is a hypothetical construct consisting of the self, the object to which the self is relating, and the patterns of interaction between the two (Mitchell, 1988).

Several relational matrices are relevant to Theo's current presentation. Most prominent is the one with Tamia, which is intermittently stormy and angry. Min-Wei thinks that this pattern is one that is lifelong; probably it was learned in the relational matrix with his parents.

Drive Theory. RP theory rejects the notion of instinctual drives. However, it does not abandon the notion that conflict, aggression, and sexuality are important in human relationships. Sexuality is seen as the most intense form of relatedness (in terms of intimacy) and as a vital sphere in which relational events emerge (R. C. Curtis & Hirsch, 2011). Aggression is viewed as the result of frustration or identification with an aggressor. Conflict is routinely found in relationships (compare this perspective to the traditional analytic view that conflict is intrapsychic—among the id, ego, and superego).

Min-Wei assumes that Theo's anger is rooted in relationship conflicts and perhaps is even one of the interaction patterns that he learned through observing his parents. These early lessons are evident in his current relationships. Min-Wei guesses that feelings of desire and anger are scary to Theo because in his parents' relationship they seemed to result in strife and abandonment. Also, Theo learned that his parents' anger disrupted his relationships with them as individuals—sometimes the anger was turned on him, and at other times anger resulted in one of his parents leaving.

Anxiety. Sullivan saw anxiety as key in the early life of the infant; indeed, it drives the need to attach (Mitchell, 1988). Infants innately seek secure environments, and anxiety on the part of the infant or caretaker creates a *not* secure situation.

Beneath Theo's cool exterior also lies anxiety, Min-Wei thinks. This anxiety stems from his discomfort with relationships and his inauthentic self, which in turn are related to his lifelong relationship experiences. He fears intimacy because it brings conflict.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

RP theorists tend to rely on developmental theory, which emphasizes the significance of early events that are thought to lead to the development of the self. RP models accept the notion of learned ways of relating to others as critical in human motivation (J. R. Greenberg, 1999). Mitchell (1988) contended: "There is a powerful need to preserve an abiding sense of oneself as associated with, positioned in terms of, related to, a matrix of other people, in terms of actual transactions as well as internal presences," and further "there is not 'self,' in a psychologically meaningful sense, in isolation, outside a matrix of relations with others" (p. 33). There is, in the RP system, some recognition of the genetic or biological influences, such as temperaments, but the most important part of personality in this view is learned relationship patterns (R. C. Curtis & Hirsch, 2011).

Min-Wei assumes that Theo's current ways of being in relationships (his self, or personality) are related to his experiences growing up. He has learned how to respond to others through observing relationships around him and also the consequences of his attempts to relate to others. He has been unsuccessful in his relationships because he fears intimacy, angers easily, and therefore guards himself carefully, afraid to reveal his real self and emotions in relationships, particularly with Tamia.

HEALTH AND DYSFUNCTION

In RP theory, dysfunction is seen as resulting from developmental problems that have prevented the individual from forming a coherent, consistent experience of self and others (J. R. Greenberg & Mitchell, 1983). Healthy individuals live rich lives in which the experience and expression of the authentic self are more common than the expression of inauthentic selves (Mitchell, 1992).

Problems develop when the individual, having experienced dysfunctional relationships throughout his development, forms a "narrowed relational matrix" (Mitchell, 1988). As a result, the person seeks relatedness to others, but does so using old patterns of relationships that are narrow and restricted. In other words, the sign of health is flexibility in relationships (R. C. Curtis & Hirsch, 2011).

Theo's current struggles are probably linked to his narrow relationship matrix. His limited ways of relating to others are linked to the environment in which he developed and the consequences of these relationships. Theo learned very early on that intimate relationships are dangerous. Intimacy leads to anger, which destroys relationships. Still, he has difficulty controlling his anger because his sense of self is shaky and he unconsciously fears injuries to it. The way to defend against hurt and abandonment is, paradoxically, to get angry.

NATURE OF THERAPY

Assessment. As in the other neoanalytic approaches, the RP therapist is not interested in formal assessment or diagnosis. He simply wants to understand as best he can the client and the characteristic way that the client relates.

Min-Wei begins his work with Theo simply by asking what brings him in to counseling. Theo responds openly, and Min-Wei observes Theo's presentation carefully. He notes how Theo interacts with him, feeling simultaneously seduced and pushed away.

Roles of Client and Counselor. According to R. C. Curtis and Hirsch (2011), RP practitioners prefer to see clients more than once a week to encourage development of an intense therapeutic relationship, which facilitates the emergence of transference. Modern analysts who adopt a relational perspective tend to see the therapeutic relationship differently than more traditional theorists. In traditional analytic theory, the therapist is objective and neutral, striving to stay out of the client's process in treatment. RP theorists have abandoned this notion, preferring instead the notion of the *two-person field*. These therapists recognize therapy as an interpersonal encounter that engages both the client and the counselor. J. R. Greenberg and Mitchell (1983) comment: "Events within the analysis are not understood as preset and unfolding from the dynamic structures of the patient's neurosis. Rather, they are created in the interaction between the patient and the analyst" (p. 389). Transference and countertransference, rather than being products of the client's conflicts, are seen as mutually influenced by both therapist and client. These recognitions seem to imply a less authoritative model of therapy than in traditional analysis. R. C. Curtis and Hirsch (2011, p. 88) suggested that the relationship is mutual but asymmetrical. Both parties contribute to the relationship, but the therapist discloses far less often than the client does.

Min-Wei is aware of his input in the relationship with Theo. He wonders what effect his person will have on the interaction with Theo and how transference might develop. Approaching Theo with a warm, congenial manner, Min-Wei attends closely to his own reactions to Theo as well.

Goals. Broadly speaking, the RP therapist generally shares the goals of the traditional psychoanalyst—to help the client work, play, and love more freely (R. C. Curtis & Hirsch, 2011). More narrowly, the goal of the RP approach is to help clients change relationship patterns that have proven problematic enough to get them to therapy. The client must give up the old, constricted relationship patterns developed earlier in life. Ultimately, these changes should bring about more authentic and fulfilling experiencing of the self.

Min-Wei hopes that Theo can, through the therapy process, develop new and freer ways of relating to others. If he can do so, Theo will find that his life is more meaningful and his relationships more fulfilling. Min-Wei will focus on helping Theo understand the roles of intimacy and anger in relationships, connecting these to what he observed and experienced in relation to his parents. It will also be important to see how these dynamics play out in relation to Min-Wei and Tamia.

Process of Therapy

One of the most distinct features of RP is that an important goal of the therapy is to offer the client new ways of interacting with others. As J. R. Greenberg and Mitchell (1983) put it: "The patient is viewed as having lived in a closed world of archaic object relationships which lead to neurotic self-fulfilling prophecies. Through his new interaction with the patient, the therapist is able to enter that previously closed world and to open the patient to new relational possibilities" (p. 391). The analyst attempts to create a safe environment in which the client can experience the therapist as a new object of relationship first, so that when transference issues do emerge, the client and therapist can readily identify interactions based on them (J. R. Greenberg, 1999).

Although the term *transference* is used by RP theorists, it is always emphasized that "the analyst can never function entirely 'outside' the transference" (J. R. Greenberg & Mitchell, 1983, p. 389; quotes in original). It is acknowledged that the client brings his relationship history/patterns to therapy, but the therapist influences how these play out by how he responds (or doesn't) to them. For instance, in J. R. Greenberg's (1999) reformulation of analytic neutrality, he points out that sometimes the aloof, abstentious analytic stance may too closely replicate how the client's parents treated him. Taking this stance will cause the client to immediately make the therapist the old object, which disrupts the therapeutic process. The analyst in this situation might consider disclosing some of himself to the client to prevent this premature transference and thereby better understand the client's relational patterns (J. R. Greenberg & Mitchell, 1983).

Ultimately, Mitchell (1992) maintained that the process of RP involves both the therapist and the client in a unique encounter, such that "doing analysis, either as a patient or as an analyst, involves a struggle to reach a fully authentic experience of a particular kind that, when fully engaged, makes possible a kind of freedom and authenticity that is both rare and precious" (p. 19). Countertransference comes into play when the therapist unconsciously *actualizes the transference*, which means that the therapist takes on the role of someone important in the client's life (R. C. Curtis & Hirsch, 2011).

Min-Wei asks Theo to talk about whatever he wants, alert for signs of relationship patterns from the past. Well aware that he is in a relational matrix with Theo, Min-Wei tries to be as authentic as he can in the relationship and readily admits to his own feelings and thoughts when appropriate. Theo tends, at first, to be superficial in his conversations with Min-Wei, avoiding emotional expression. Min-Wei feels distant from Theo and comments on this. Theo erupts, contending that Min-Wei does not understand him. As calmly as possible, Min-Wei tries to get Theo to talk about these feelings.

THERAPEUTIC TECHNIQUES

Techniques in the RP model are essentially the same as those in all of the other neoanalytic models. The therapist and client engage in a discussion (whether or not it is called free association), and the therapist interprets the client's productions. Dreams are considered important, and the RP counselor is always interested in how they relate to the client's life (R. C. Curtis & Hirsh, 2011). Discussion of the relationship between therapist and client is common, and the ultimate goal is to relate these interchanges to the client's early and current interactions with significant others. This review is particularly important when the therapist realizes that he is actualizing the transference, a process that some RP theorists call *mutual enactment* (R. C. Curtis & Hirsch, 2011).

Theo and Min-Wei work together to sort out what in their interaction is unique to their relationship and what might be coming in from Theo's previous relationships. Min-Wei works to help Theo see the parallels between his relationship with Min-Wei and those with Tamia and his parents. In this process, Min-Wei tries to help Theo develop new ways of relating to others that will help him feel less like he is about to explode. Hopefully, Theo can learn how to relate to others without the anger that bothered him before he came to counseling.

EVALUATION OF NEOANALYTIC APPROACHES

My first and most vehement comment about these approaches is that they are very difficult to read! Writers in this area seem to like convoluted, complicated styles of writing and create nifty-sounding terms that are hard to understand (self-selfobject relations, for example). Even when the terms and concepts are relatively simple, writers often work at very abstract levels or discuss very specific client presentations or problems (e.g., narcissism, envy). Further, the newer writings seem to be spread about in different sources (chapters, journal articles), making the area seem disjointed. Terminology varies from writer to writer, creating a perception that there are many variants of neoanalytic thought when, in fact, many of the ideas and concepts are quite similar to one another. Mitchell (1998) wrote: "There are cultist features of traditional psychoanalytic institutions and literature. Analysts have often claimed for themselves an esoteric knowledge of mysterious realms expressed in a thick jargon that is inaccessible to the uninitiated. Because they felt they had singular, proprietary rights over access to the unconscious, some traditional psychoanalytic authors claimed a unique knowledge of the underpinnings of all human experience" (pp. 5–6). Although Mitchell was referring specifically to traditional analyses, many of these qualities are seen in neoanalytic writing as well.

The neoanalytic approaches seem less comprehensive than many of the other theories presented in this book. Several of them focus on particular client presentations (such as Kohut's focus on narcissism) and, at times, are less easily applied to other client problems. Unless they specifically adopt the bulk of classical analysis, which some do, these theorists seem to be presenting valuable theory that is somewhat limited in scope.

However, there is general agreement that these approaches are very useful in dealing with clients who present with fairly severe dysfunction in their lives. Until fairly recently, the neoanalytics were about the only theorists to write extensively about the personality disorders. This tendency makes sense because the notion of formal (traditional DSM) diagnosis springs from a medical model, and many of the neoanalytic writers are physicians (i.e., psychiatrists).

Qualities of the Theory

The four groups of theories presented in this chapter are essentially equivalent to classic analytic theory in terms of *precision* and *testability*. Although it was a major goal of the post-Freudians to clarify and build on Freud's work, the constructs they developed and invoked tend to be difficult or impossible to directly observe. Proponents of these theories still seem to rely on single-case analysis—and uncontrolled clinical cases at that. It would be difficult to disconfirm these theories as well.

Although variants of neoanalytic theory have been tested in outcome research (see next page) and found to be effective in helping clients, most of the outcome research conducted tests some form of unspecified "psychoanalytic therapy," further variants of psychoanalytic theory or integrative approaches that do not directly correspond to the theories presented here. Direct tests of their underlying theoretical propositions are relatively rare, although, as you will see in the following sections, some do exist. Thus, we might say we have some, but qualified evidence that these theories are *empirically supported*.

RESEARCH SUPPORT

Outcome Research. In addressing the effectiveness of the various neoanalytic approaches, most writers tend to rely on a number of large studies of psychoanalysis, which by now are relatively dated (see Galatzer-Levy, Bachrach, Skolnikoff, & Waldron, 2000 for an extensive description of these studies). However, more recently investigators have begun to conduct randomized controlled trials (RCTs) of psychodynamic psychotherapy, finding positive results. For example, the studies and meta-analyses reported in Chapter 2 that test psychoanalytic psychotherapy can be construed as support for the neoanalytic approaches. Town and Driessen's (2013) meta-analysis of intensive short-term dynamic psychotherapy (ISTDP; Davanloo, 2000) with clients diagnosed with personality or somatic disorders (physical disorders that are medically unexplainable) revealed medium to large improvements across a number of outcome measures for clients with these diagnoses. ISTDP is a variant of psychoanalytic therapy based in some of the constructs described in this chapter, so this meta-analysis provides only indirect evidence for the neoanalytic approaches described herein. Town and Driessen reported only on comparisons of pre-, post-, and follow-up measurements; no comparisons were made with other approaches.

In contrast, Driessen, et al.'s (2010) meta-analysis included studies in which the outcomes of short-term psychodynamic psychotherapy (STPP) for depression could be compared to those of other approaches. STPP was found to be more effective than control treatments, somewhat less effective than other treatments at termination of treatment, but in follow-up analyses the effects of STPP were equivalent to those of other approaches. In this study, STPP meant not a specific approach to treatment but any treatment that was time limited and based on psychoanalytic theory and technique. You should note that the theoretical approaches described in this chapter are not necessarily short term; in fact, all four are likely to be much longer in duration than the treatments tested in the studies included in the meta-analyses discussed throughout this text.

Transference-focused psychotherapy (TFP), a variant of psychodynamic therapy based in object relations theory, is designed for use with those difficult to treat clients diagnosed with borderline personality disorder (BPD). Since its inception, research on TFP has increased in sophistication, from simple pre–post comparisons of clients in therapy (Clarkin et al., 2001) to well-designed RCTs. The results of these studies are mostly positive, indicating that clients in TFP do as well as those in other treatments designed for clients diagnosed with BPD, such as dialectical behavior therapy (Clarkin, Levy, Lenzenweger, & Kernberg, 2007). For example, Doering et al. (2010) reported an RCT that compared TFP to treatment by experienced community therapists with clients diagnosed with BPD. They found that TFP produced better outcomes in some areas (e.g., borderline symptoms), but that the community therapists (using a range of theoretical approaches) produced outcomes that were similar to those found with TFP on other dimensions (e.g., reduction in levels of depression, anxiety). Levy, Meehan, and Yeomans (2012) and Levy and Scala (2012) reviewed the existing research on TFP finding that, overall, results are supportive. However, it should be noted that TFP does not outperform other approaches. These results and others summarized in Chapter 2 indicate that transference interpretation can be helpful but is not absolutely required for positive outcomes, as would be predicted by psychoanalytic theory.

An older but interesting study by Fonagy and Target (1996) centered on children seen at the Anna Freud Centre. Ratings on a scale of general adjustment showed significant improvement in 62% of children who received intensive psychoanalysis and 44% who received less-intensive psychotherapy. Improvement was related to severity of diagnosis (with less severely disturbed children improving more), longer treatment, and, interestingly, whether their mothers received analysis (those whose mothers received analysis improved more than those whose mothers did not).

Theory-Testing Research. Some research does exist on the themes or constructs that appear in neoanalytic theory. For example, research originating in social psychology has examined the concept of narcissism (Otway & Vignoles, 2006). Kohut attributed unhealthy narcissism to failures in parental empathy and warmth, as you recall. Otway and Vignoles (2006) examined this hypothesis, as well as the possibility that overindulgent parenting resulted in narcissism, and found support for both relationships in their analyses, which examined participants' recollections of parental behavior and their self-reports of narcissism. The predictions of self psychology thereby received partial confirmation in this research, although the hypothesis about overindulgent parenting is less consistent with SP formulations. Another example would be Black, Whittingham, Reardon, and Tumolo's (2007) study of college students' recollections of parental qualities (e.g., loving versus rejecting). They found that students who recalled more-loving mothers were able to relate more intimately to their friends than were those who remembered neglectful mothers. These results could be taken as supportive of object relations theory.

In a direct test of SP theory, Banai, Shaver, and Mikulincer (2005) presented a series of seven studies designed to specifically investigate selfobject processes. First, they developed a new instrument called the Selfobject Needs Inventory (SONI) to assess individuals' levels of yearning for mirroring, idealization, and twinship. They also included subscales that assessed avoidance of the selfobjects and avoidance of mirroring, idealization, and twinship to capture the contact-shunning tendencies that are another possible response to problematic parenting. Interestingly, the data from the scale development part of the research demonstrated that the avoidance of idealization and twinship could not be separated, so one subscale measured these simultaneously. Banai et al.'s results are complex; here I can only briefly summarize the results of the seven studies. With a few exceptions, this research was supportive of SP theory. For example, needs for mirroring and twinship were related to attachment anxiety, whereas avoidance of these was not. Avoidance of mirroring and idealization/twinship were related to attachment avoidance and fear of intimacy, whereas needs for the other selfobjects were not. Banai et al. said "these findings imply that hunger for mirroring and hunger for twinship are two forms of psychological insecurity that are associated with a sense of worthlessness, helplessness, and vulnerability" (p. 251). Avoidance of selfobjects, interestingly, was related to different dimensions than the needs for selfobjects: Whereas needs for mirroring and twinship were related to self-esteem, avoidance of these selfobjects was not. The differences in associations led Banai to hypothesize that somehow the avoidance dynamic was somewhat successful because some of the negative outcomes assessed were not associated with it. This finding would be somewhat inconsistent with Kohut and Wolf's (1978) ideas about the contact-shunning personality. In addition, one SONI subscale, the hunger for idealization, did not relate to the variables measured in the study, and it should predict problems of the self according to SP theory. Banai et al. offer two possible explanations for this finding: Either the wish to identify with powerful others as an adult is not

dysfunctional or the type of dysfunction related to deprivation of idealization was simply not assessed in their study (p. 254). Finally, you should note that this study relied exclusively on self-report, which is problematic from the standpoint of SP theory since selfobject processes are really thought to be unconscious.

Lopez et al. (2013) followed up on Banai et al.'s efforts but took a different direction: They looked at the selfobject dynamics as predictors of attachment anxiety and avoidance and also indicators of the stability of self-esteem as an indicator of coherent self. Their results were mixed. Contrary to the hypothesis that all three selfobject need scales (idealization, mirroring, and twinship) would predict attachment anxiety, Lopez et al. found that only need for mirroring was a significant predictor. In addition, avoidance of idealization/twinship was a significant predictor of attachment anxiety. Only avoidance of idealization/twinship predicted attachment avoidance, providing only partial support for the theoretical prediction that both avoidance scales should be significant predictors of attachment avoidance. Of the four self variables measured (instability of self-esteem, psychological entitlement, self-kindness, and self-judgment), only psychological entitlement was a significant predictor, somewhat surprisingly predicting both attachment scores. In conclusion, Lopez et al.'s results did not provide strong support for their hypotheses, but it is worthwhile to point out that SP theory does not focus specifically on attachment styles, which was what Lopez et al. were trying to predict, so the implications for SP theory are not clear.

As I reported in Chapter 2, transference and transference interpretation have been the subject of research (Levy & Scala, 2012). Generally, some evidence exists that transference does happen in therapy and that transference interpretations also happen. However, transference interpretation seems to be a risky intervention, requiring a sound therapeutic alliance and a sensitive therapist (Levy & Scala, 2012).

Issues of Individual and Cultural Diversity

Although psychoanalysis proper has been heavily criticized for gender and cultural bias, some have argued that neoanalytic approaches are much more hospitable to diversity issues or can be modified to be so by an alert counselor (Hansen, 2010). However, there are still calls to increase attention to cultural diversity among neoanalytic practitioners (Eng & Han, 2007; Haaken, 2008; Moncayo, 1998; Schlosser, 2009). Certainly, the early theorists' emphasis on the relationship with the mother can be seen as problematic from a feminist standpoint. Taken to the extreme, the mother can be seen as the font from which all dysfunction flows. To be fair, Flanagan (2008b) reminded us that the SP theorists emphasize the relationships with both parents, not just the mother.

The ego and self perspectives could be charged with overemphasizing individualism, a problem that plagues many theories of psychotherapy. This shortcoming may make these theories less than optimal for use with clients from cultural backgrounds that emphasize collectivism, respect for family over individual needs, and so forth. Even from the relational perspective, the notion of authentic self may be culturally encapsulated, for the submission of the authentic self to less authentic versions (say, in response to familial requirements) would be seen as dysfunctional when it is really culturally consistent and adaptive.

Wolitzky (2011) noted that the emphasis on expression of emotion in neoanalytic approaches might be at variance with some cultural norms that mandate restraint of feeling expression.

In addition, the neoanalytic therapist is not likely to provide a lot of structure in counseling, which could be counter to the expectations of individuals from cultures that are used to the therapist taking an active, initiating stance.

Analysis as it is practiced today (other than orthodox analysis) is also much more flexible in its views of clients of other-than-heterosexual orientations. Although Freud seemed somewhat ambivalent about homosexuality, traditional psychoanalytic thought has historically labeled this orientation as deviant. In contrast, Chodorow (2002) pointed out that as early as the late 1970s Mitchell (1978) provided a substantial critique of the pathological view of homosexuality. Most analysts today would tend to take this position. Kassoff (2004) found relational psychotherapy, in particular, useful with LGBT clients because the constructivist emphasis within the theory welcomes multiple views of reality and is consistent with recognizing diverse sexual orientations. Kohut's assertion, cited earlier in the chapter, about the nature of healthy maturity would certainly support this perspective.

THE CASE STUDY

The case of Theo seemed to lend itself well to each of the approaches presented in this chapter, although these tend to be complex systems and to some extent a little fragmented. His primary problem is relationship, which is a focus of the current neoanalytic approaches. Anger is also easy to understand through these lenses. The four systems presented in this chapter, however, emphasized different processes, if not different aspects of Theo's presentation. Conceptualization of Theo from the EP perspective was very similar to taking a classical psychoanalytic perspective; the Oedipal complex is easy to relate to Theo's presentation. Working from the OR perspective involves looking at very early relations between Theo and his mother and how these translated into internalized objects, both good and bad, and how these affect Theo's current relationships. Self psychology directs us again to early relationships, but to the effects of parental mirroring and idealizing and the avoidance/repression of disintegration anxiety. The cohesion of the self and the nature of the selfobjects that compose it are dependent on these early relationships from the SP perspective. Finally, the relational perspective broadens the field, including the person of the analyst in the treatment. However, Theo is African-American, so caution must be taken in applying these relatively individualistic approaches with him.

Summary

Neoanalytic approaches to counseling and psychotherapy originated in Freud's model, but to some varying extent they extend or modify it. Ego analysts seem the closest to tradition, whereas the relational models deviate most noticeably from it. Almost all of the neoanalytic approaches emphasize earlier forms of experience than did Freud. The neoanalytic approaches presented here also use essentially the same techniques: free association, interpretation (particularly of transference), dream analysis, and so forth. The goals of these theoretical systems differ significantly: Ego psychology's goals resemble those of traditional psychoanalysis (insight, love, and work), object relations and relational perspectives emphasize changing relationships (and in the case of OR theory, change in internal objects as well), and self psychology focuses on the integration of a fragmented self.

Most analysts today are probably influenced by more than one of these orientations. The theories in the neoanalytic area seem less comprehensive than traditional analytic theory; hence, using different parts of each at times would seem relatively natural. Research support for these theories is about as good as what is found for classic analytic theory. Issues of cultural and individual diversity seem less problematic in the more current approaches, although individualism and gender bias may rear their unpleasant heads in some applications.

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CHAPTER 4

Individual Psychology



Alfred Adler

James is a 17-year-old African-American male who is small and slender and wears glasses. The Division of Family Services referred James for counseling to address problems that may affect his adjustment to a new adoptive home. His presenting problems include defiance of authority, lying, stealing, and a history of inappropriate sexual behavior. Various individuals around him (foster parents, caseworkers) have commented unfavorably on his "attitude." He is currently in high school but comes to counseling during summer vacation.

James is the second child of his birth mother, Denise, who was 18 years old when he was born. Denise also had three other children, James's older sister, Karen, and two younger brothers, Carl and Jeff. James's birth mother and father were not married, and James's father was not the father of any of the other children. Little is known about him except that he is deceased.

When James was 8, he and his siblings, ages 9, 6, and 3, were placed in foster care as a result of severe neglect. His mother had problems with alcohol and had a "nervous breakdown." His stepfather left the home that same month. Conditions at the home prior to the time of placement were very poor. Fourteen people were living in a two-bedroom house strewn with dirty clothes and dishes. No meals were prepared, and no one assumed responsibility for the children. The police had frequently been called to the house in response to loud fights that often involved dangerous weapons. Reportedly, Denise's method of handling behavior problems was to lock the children in their rooms for extended periods of time. James was physically abused by his stepfather on at least one occasion.

Following their initial placement in foster care, James and his siblings had a long history of placements. Between foster homes, James lived in residential treatment centers. His mother and stepfather were sporadically involved with the children, but eventually parental rights were terminated. James was often in trouble at school for stealing or fighting. His grades were poor.

When he was 15, James was removed from the most recent foster home for violent behavior and placed in emergency foster care. He was told that this was the end of the line for him. He seemed to make an effort to settle down and was again placed in a foster home. James apparently got along well with his new family. Conditions seemed ideal. Then the family started taking in other foster children in addition to their own two children. Now there are five children in the home in addition to the foster parents' children and James. The foster parents are talking about getting a divorce, and there is much turmoil in this household.

James is looking forward to getting back to school, mostly for his social life and also to get out of his "crazy" house. He has many friends and seems to be popular with girls. James recently got a job and was

very proud of himself. However, he was fired when he got drunk and his employer saw his friends carrying him out of the building. In counseling, James is struggling to verbalize his feelings, take responsibility for his own actions, and not blame others for his problems. He seems motivated to work, but admits it would be a lot easier if everyone else would change. His goals are to finish school, get a job, and live on his own. James also wants to continue to work on his temper and getting along with others.

BACKGROUND

Alfred Adler (1870–1937), the founder of individual psychology (IP), was born in Vienna, Austria, the second son of a grain merchant. There were six children in his middle-class Jewish family. As a child, Alfred was characterized as frail and fearful, suffering from rickets and problems with his vocal chords that resulted in stuttering (Manaster, 1977). At age 5, Adler contracted pneumonia and almost died, an experience to which he attributed his choice to become a physician—he was motivated to overcome death (Ansbacher & Ansbacher, 1956; Sollod, Wilson, & Monte, 2009). Once again, we can see the connections between a theorist's life and his creation: Adler's triumph over his early inferiorities seems to have set the stage for both his medical career and his theoretical ideas.

At age 25, Adler received his medical degree and began work as a practicing physician. Two years later he married Raissa Timofejewna. It is interesting that Raissa is characterized as an "irreligious political revolutionary" and "an ardent feminist who disliked domesticity" (E. Hoffman, 1994, p. 48), given Adler's progressive ideas about the critical need for equality of men and women. Adler and Raissa had four children, two of whom, Kurt and Alexandra, later became psychiatrists and furthered Adler's work. Valentine, the Adlers' oldest daughter, seemed to follow Alfred and Raissa's socialist political ideology when she immigrated to Russia and lived in dangerous opposition to the Stalin regime. "Vali" disappeared in 1937, causing her parents, and particularly her father, great worry and anguish. Evidently imprisoned for espionage, Vali died after 2 years in prison, at age 44. Alfred Adler died not knowing what had become of his daughter.

In 1895, 3 years after his graduation from medical school, Adler published his first work, which discussed the damage caused by the horrendous working conditions among tailors at the time. In this study, he first demonstrated his special interest in bettering social conditions. Adler was a member of the Social-Democratic movement, a social reformist group, and these values are clearly evident in his theory (K. Adler, 1994). When Adler first began his medical practice, it was in a lower-middle-class neighborhood of Vienna (Ansbacher & Ansbacher, 1956).

In 1902, Adler became a member of Freud's Vienna Circle. The nature of the relationship between these two giants of psychological theory has been the subject of much argument (Ansbacher, 1962; Fiebert, 1997; Gay, 1988). Although Adler is typically viewed as Freud's student, Adler and his followers protested that categorization, pointing out that Adler had published a preliminary version of his theory prior to his relationship with Freud (Sweeney, 2009). There was apparently no contact between Freud and Adler prior to Freud's invitation to Adler to join his Wednesday night discussion group (E. Hoffman, 1994). Abraham Maslow, the well-known humanistic psychologist, reported that Adler vehemently denied being a follower of Freud, having established from the beginning of their relationship that his views differed from Freud's (Maslow, 1962). According to Maslow, Adler maintained that Freud spread the story that Adler was a disciple who had gone astray, and he was very angry with Freud for doing so, calling Freud a "swindler" and "sly" (Maslow, 1962, p. 125). An interesting note is that Adler was the only member of the society who had not been analyzed by Freud (Maniacci, Sackett-Maniacci, & Mosak, 2014).

Despite the controversy, it is clear that Adler was an active member of Freud's group from 1902 until 1911, and Freud designated Adler as his successor as president of the Vienna Psychoanalytical Society. By this time, significant theoretical differences had begun to develop between the two men that eventually resulted in Adler's resignation from the society in 1911. The central issue under debate was the primary motivation for human behavior: Freud, of course, saw this as pleasure or sex; Adler wanted to make it interpersonal/social (Sollod et al., 2009). Apparently, this divorce was not amicable (Gay, 1988). Adler then established the Society for Free Psychoanalytic Research (Ansbacher, 1929/1969), later renamed the Society for Individual Psychology, and in 1914 established the first journal devoted to individual psychology, *Zeitschrift für Individualpsychologie* (Mozdzierz & Mozdzierz, 1997). *The Neurotic Constitution*, Adler's first major book, was published in 1912.

After World War I, Adler's commitment to furthering social change led him to help establish child guidance clinics in Vienna schools. In these clinics, he taught teachers and other laypeople how to use his ideas to understand the behavior of the children with whom they worked.

With the rise of the Nazis, Adler immigrated to the United States in 1929 and encouraged his associates to do the same (E. Hoffman, 1994). Raissa, his wife, remained in Vienna and, according to Adler biographer Edward Hoffman, continued to work as a central figure of the Communist Party in Austria. By the time Adler moved to the United States, many American psychologists had become interested in IP, including G. Stanley Hall, the founder of the American Psychological Association (Ansbacher, 1970). Adler accepted a professorship at Columbia University and continued an active teaching schedule. He was on a lecture tour in Aberdeen, Scotland, when he collapsed and died of a heart attack in 1937 at age 67.

Although a bibliography of his work is lengthy, most of what bears his name was not truly written by Adler himself. Instead, much of the material was gathered from his public lectures and edited and presented by others (Ansbacher, 1929/1969). You can read a bit of Adler's work in Box 4.1. Adler's ideas have been developed and promulgated by a number of talented followers. As noted earlier, Kurt and Alexandra Adler followed in their father's footsteps (E. Hoffman, 1994). Rudolf Dreikurs, the founder of the Alfred Adler Institute of Chicago, was Adler's student and was instrumental in popularizing and extending Adler's ideas about working with children. Other prolific writers in IP theory are Harold Mosak, Donald Dinkmeyer, Heinz Ansbacher, and Rowena Ansbacher. The influence of Adler's theory can be seen in many theoretical approaches devised since his—for example, in rational emotive behavior therapy, family systems theory, and reality therapy.

Box 4.1

Alfred Adler on Individual Psychology

Sometimes the correctness of this title has been doubted. But the opponents are entirely wrong. Particular knowledge already of this science and art can prove that our aim is to understand the individual style of life as a part of the whole. Therefore our subject involves at the same time the understanding of the whole, the life of mankind, connected with this poor earthcrust, and the social relation with the other sex. These three ties are inseparable and every

(continued)

Box 4.1 *(continued)*

human being answers in his individual attitude the questions growing out of these relations. These questions are inevitable. They must be established; i.e., in friendship, comradeship and social connection towards others and develop all those characteristics necessary to become a fellow man such as truth, responsibility, interest for the welfare of others and for the present and future of mankind. The second question demanded by the cosmic influence gives postulations for being useful, working, creating. As is easy to see, this question is deeply conditioned also by the social life and proves that "useful" means useful for society. Out of the relation between the two sexes originates the third call asking for the solution of the question of love and marriage. This question is also related to the first one, connected with the facts of a social life and with a view to the future—*children!*

Every individual is always answering the big and little questions in life. We can notice the answers and their varieties among different persons. And we can understand: the absolute truth lying in those questions, as in a mathematical problem, is never to be found out. We are not blessed with the knowledge of the last truth; we are only striving. So we are entangled in many mistakes and the answers given by every individual are involved and influenced by our lack of understanding. Mankind answered by creating our culture to solve the problems of life for the use of society. We feel and perceive the differences towards a right solution, and the efforts of everybody, the attitudes towards our social life are always gratifications, contradictions, accusations, pushing and dragging along the stream of our culture. Everybody is also perceiving and judging his own way and answer and strives to complete and to accomplish his own totality, always confronted, always asked and driven by the lasting gaping blanks between his individual solutions and the full completion of his life. We can understand that in this way there is always living and stimulating a *feeling of inferiority*.

Source: Adler, A. (1927). Individual psychology. *The Journal of Abnormal and Social Psychology, 22*(2), 116–122. Published by the American Psychological Association.

Currently, Adlerians are a relatively small but very active group. The *Journal of Individual Psychology* is filled with articles on research and practice. The Adler School of Professional Psychology can be found on the web at www.adler.edu, with branches in Chicago and Vancouver, British Columbia. There are Adler institutes all over the place, including New York, Washington state, and San Francisco, and national and international associations include the North American Society of Adlerian Psychology (www.alfredadler.org) and the International Association of Individual Psychology (www.iaipwebsite.org).

BASIC PHILOSOPHY

Adler can be considered a growth theorist with an optimistic view of the human condition. He believed that humans have an innate tendency to strive for perfection and that this striving is the most important motivator of behavior (A. Adler, 1929/1969). This optimism, however, is not equivalent to a positive view of human nature—on this topic, Adler was neutral, believing humans could be bad or good (Maniacci, Sackett-Maniacci, & Mosak, 2014). Equally as important in psychological functioning is the interest in society, for without the support of others

humans will not survive (Dreikurs, 1953). This "social interest" is inherent in the human constitution, but so is the tendency to feel inferior. The ways these two influences are balanced determine the psychological world of the individual. One watchword of IP theory is *holistic*. Thinking, feeling, behaving, and even physiological functioning are an integrated system directed toward pursuit of the individual's goals.

Adler is described as a *soft determinist* (Ansbacher & Ansbacher, 1956), which means that, although he did think that human behavior can be understood according to general principles and laws, these understandings are only probabilistic. For Adler, the individual creates his life path, but that very creativity enables him to change that path and his ultimate goal at any given time. A very popular quote from Adler is this: "The important thing is not what one is born with, but what use one makes of that equipment" (Ansbacher & Ansbacher, 1956, p. 176). Here Adler is saying that it is what one does that matters, not one's genetic or biological inheritance. Adler believed that individuals could very well triumph over physical challenge and that these struggles often lead to significant contributions to society.

One of the earliest social constructivists, Adler believed that individuals' perceptions, rather than some objective external criterion, determine their views of reality. Of the influences of heredity and environment, he said,

> It is neither heredity nor environment which determines his relationship to the outside. Heredity only endows him with certain abilities. Environment only gives him certain impressions. These abilities and impressions and the manner in which he "experiences" them—that is, the interpretation he makes of these experiences—are the bricks which he uses in his own "creative" way in building up his attitude toward life. It is his individual way of using these bricks, or in other words his attitude toward life, which determines this relationship to the outside world. (Ansbacher & Ansbacher, 1956, p. 206)

Known as a social activist, Adler believed that societal change was needed to improve the health of humankind. For example, he characterized the development of striving for power and superiority as the "most prominent evil of our civilization" (1927/1998a, p. 62). He also had a lot to say about the cultural phenomena of overvaluing masculinity and believing in the "alleged inferiority of women" (1927/1998a, p. 106).

Sandy is the IP counselor assigned to work with James. She begins her work by reflecting on the basically positive nature of humans and knows that, even though James appears very troubled, within him is the strength and potential to work toward a better existence. Although James inherited some things and experienced many others, Sandy sees that he has created his view of the world around him and also that this picture can be changed.

HUMAN MOTIVATION

Humans are motivated to strive for superiority. "We all strive to reach a goal by the attainment of which we shall feel strong, superior, and complete" (Adler, quoted in Ansbacher & Ansbacher, 1956, p. 104). IP uses a variety of terms interchangeably for this motive, such as *will to power*, *striving for significance*, and *wish to overcome*. What is most critical to recognize in the IP view of humans is that people are seen as being "pulled" by their goals (of superiority) rather than being driven by their instincts (as in the psychoanalytic view; Ansbacher, 1970).

Paradoxically, humans are also beset by feelings of inferiority. Early on, Adler thought that inferiority feelings were related to the fact that we are born in a relatively undeveloped, defenseless form; are smaller and less powerful than those around us; and depend on our caretakers for existence. The resulting feelings produced the drive for superiority. Later, Adler revised his theory, putting the strivings first: Inferiority feelings came only when the striving for goals was frustrated (Maniacci, Sackett-Maniacci, & Mosak, 2014). Another innate but initially less-developed human inheritance is the need to belong. Adler thought that the need to belong ensures survival because when we are infants, the people around us give us food and water, keep us safe, and so forth.

Ultimately, the motivation for human behavior is how the individual reconciles the search for significance and feelings for others. For Adler, this resolution is an individual, creative process. A person can be known only through his or her personal plan to achieve superiority, which carries the scheme for dealing with feelings of inferiority and a certain level of belongingness.

Sandy thinks that James hides his feelings of inferiority well. He undoubtedly has these feelings, but he comes off as powerful and arrogant (the "attitude"). He doesn't seem to have a sense of belonging to society as a whole, but may have a feeling that he is connected to the friends he "hangs" with.

CENTRAL CONSTRUCTS

LIFESTYLE

According to Adler, everyone develops a plan for his life by the age of 5 or 6. This plan, which Adler called the *lifestyle*,[1] guides individuals' entire lives, including their perceptions of and actions in the world (Carlson, Watts, & Maniacci, 2006). Ansbacher and Ansbacher (1956) listed several of Adler's definitions for this complex construct, including "self or ego, a man's own personality, the unity of the personality, individuality, individual form of creative opinion about oneself and the problems of life, the whole attitude to life" (p. 174).

The lifestyle is the child's way of adapting to the circumstances around him (Dreikurs, 1953). Every lifestyle has a goal, and the goal has two important qualities: (a) The individual is largely unaware of it, and (b) it is a fiction, by which Adler meant that it is not based in external reality but created by the individual (Ansbacher & Ansbacher, 1956). Thus, sometimes the goal is referred to as the fictional goal (Dinkmeyer & Sperry, 2000). A person's goal arises out of the interaction of two influences: the need for significance and feelings of community, or social interest. According to Adler, the only way to truly understand another human being is to understand the goal of the lifestyle: *All behavior is purposeful, oriented toward achieving the lifestyle goal*.

The creative power of the individual explains how he interprets and combines his environment, genetic inheritance, and experiences into the lifestyle and associated goal (Ansbacher & Ansbacher, 1956, p. 177). The way a person strives for significance (i.e., his goal) is unique. Take, for example, the case of identical twins. Identical twins raised in the same family could still have different lifestyles and goals because, from the perspective of IP, they have different perceptions of the world or use their creative powers differently, given the same basic material. Their perceptions of their own abilities and the surrounding environment may be very

[1]This term is, in various sources, spelled life style, life-style, and lifestyle with equivalent meaning. The last will be used in this chapter.

different, creating different beliefs and goals. It is entirely possible that, even if they look exactly alike, behaviorally they will be quite different. Alternatively, because they have genetically identical constitutions and physically appear the same to those around them, they might be treated identically, which may in turn lead them to very similar perception schemes.

Parental and other family influences are very important in the development of lifestyle: "The family is the individual's first society" (M. F. Schneider, 2007, p. 43). Parents are models for beliefs and values. However, Adler warned us not to automatically assume that parental influences singularly "cause" the lifestyle because, above all, the development of the style is a personal, creative, interpretive process. Nonetheless, Adler wrote about the results of abuse, neglect, and pampering at a time when little attention was being devoted to raising children. For instance, Adler thought that pampered children grow up with the notion that the world should always provide everything they want—immediately. The neglected or abused child sees the world as a scary or hostile place. Children who are suppressed through overly strict or punitive environments might develop a drive to gain freedom (Adler, 1929/1969).

MyCounselingLab

Video Example 4.1 Watch Adlerian therapist Jon Carlson do a lifestyle analysis with a client.



Sandy observes that James was neglected as a child, and she guesses that this early experience resulted in a view of the world as a confusing, hostile place. His natural feelings of inferiority may have been magnified by his chaotic early environment. In what Sandy knows is the critical period for the development of lifestyle, it is questionable whether James actually had a family. His situation appears to have been one of neglect, at best. James appears to have established a lifestyle and goal oriented more toward personal superiority than social contribution. His goal probably goes something like this: "Others are evil and dangerous, so I must defeat them before they hurt me." He probably learned these methods through experiences in his life before he was placed in foster care. In other words, James's current behavior is partly a reflection of what he needed to do to survive in a terrible situation.

Sandy doesn't know much about James's inherited strengths and weaknesses, but it does appear that he had virtually no stability in his family, which has resulted in the absence of significant role models to influence his developing lifestyle. If James was indeed physically abused, both the physical abuse and the emotional oppression may have resulted in a feeling of being suppressed. Sandy knows that Adler thought that suppressed children may naturally develop a drive to gain release, and she hypothesizes that this dynamic may contribute to James's rebellious life pattern.

SOCIAL INTEREST

A very important contribution of IP is its emphasis on the social embeddedness of the human condition (Carlson et al., 2006). For Adler, the measure of the individual is the degree to which he cares about his society. Another way of conceptualizing social interest is that it is a sense of belonging and working with others toward the common good (Carlson & Englar-Carlson, 2013). The individual who chants, "Nobody loves me; everybody hates me; I'm going to go out and eat worms" would definitely be viewed as dysfunctional by the individual psychologist. Not to be

confused with extroversion, true social interest is seen in the contributions the individual makes to his community (Ansbacher & Ansbacher, 1956, p. 141).

Only the *potential* for social interest is innate; these feelings must be nurtured and supported in children. During development, problems encountered by children usually result in diminished levels of social interest. Adler identified two general classes of problems: those that arise from physical disability and those stemming from environmental influences such as faulty parenting or social factors such as sexism, racism, and classism (Adler, 1927/1998a). When a child has physical problems (such as slow development or physical disability), society does not typically react in nurturing ways, and thus his development is stunted. Children who experience negative reactions from others based on sex, race, or class may learn that the way to survive is to look out for number one. Parents can pamper, neglect, or suppress children, resulting in distorted attitudes about social relationships. Healthy children are those who are encouraged to empathize with others and contribute to society as a whole. Adler thought that to fully understand a person, one needed to attend to how that person treated others (Ansbacher & Ansbacher, 1956).

Sandy thinks that James grew up in an environment that did not support and encourage social interest. In fact, his early environment was at best neutral on this dimension, but the fighting and possible abuse point toward a situation that was antithetical to the development of social feeling. Because James is African-American, Sandy wonders if he has experienced some of the racism or oppression still present in our society, particularly with regard to young African-American men.

Sandy is encouraged by the glimmers of social feelings evident in James's recent behavior. Judging from his history, James was uncooperative and at times openly rebellious. He engaged in socially useless behaviors such as stealing, aggression, and lying. However, lately he shows interest in interacting with his peers, which is a very positive sign, given his background. Sandy will attempt to nurture these feelings and to help James channel them into socially useful acts.

Inferiority Feelings

The familiar term *inferiority complex* was in all likelihood not Adler's (Ansbacher & Ansbacher, 1956). Adler used the word *feelings* rather than *complex*, probably to avoid the Freudian aura conveyed by the latter term (Brachfeld, 1951, cited in Ansbacher & Ansbacher, 1956). Adler apparently discovered the power of the term *inferiority complex* when he found out (while touring the United States) that he had been called the "father of the inferiority and superiority complex" (Brachfeld, 1951, quoted in Ansbacher & Ansbacher, 1956, p. 256). After Adler finally adopted the inferiority complex, it was typically reserved for dysfunctional or unusual inferiority feelings.

Inferiority feelings are a normal part of life. As Adlerians put it, we are always moving up from down, or from minus to plus in our self-estimates (Maniacci, Sackett-Maniacci, & Mosak, 2014). The good thing about these feelings is that they motivate us to be better; in fact, Adler thought that inferiority feelings were the foundation of human culture because they prompted efforts to improve human life (Ansbacher & Ansbacher, 1956).

Feelings of inferiority begin at a very early age, when the child realizes that he is much smaller and weaker than those around him. How the child is treated by others and how he interprets and reacts to the situation are critical (Ansbacher & Ansbacher, 1956). If others demand too much of the child, he is repeatedly confronted with his inferiority. If he is treated like a piece of precious china, he surely has a different interpretation. How adults relate to children is very

important, and some cultural traditions are harmful, such as the idea that children are not to be taken seriously. "Ridicule of children is practically criminal," cautioned Adler (1927/1998a, p. 61), because it causes the child to feel insignificant and inferior.

But what about people who seem to be entirely lacking in inferiority feelings? The answer lies in the *superiority complex*, in which the individual builds a false sense of significance that is devoid of social interest. This term is used less often, and Adler maintained that people who display this complex are merely signaling that they feel inferior and are using these behaviors to escape their problems (Ansbacher & Ansbacher, 1956, p. 260). In a sense, all those who have inferiority feelings also have superiority complexes in one form or another. The usual manifestation of the superiority complex is the show-off or braggart. Consider, for example, the arrogance of some adolescent males. When you see this kind of presentation, Adler said, "We will always discover . . . an inferiority complex and a desire to overcome it. It is as if they were trying to lift themselves on their toes in order to appear greater and to gain by this easy method success, pride and superiority" (1929/1969, p. 29).

Individuals who present themselves as helpless or weak are also signaling superiority in that everyone else around them must take care of them. Similarly, the display of depression, neglect of one's appearance, and extreme grief can create power for the individual because these behaviors demand that others pay attention.

Sandy thinks that James is surely revealing his feelings of inferiority through his superiority complex. Presenting as cool and unflappable, he uses socially useless ways to gain power, such as stealing and aggression, thereby building a feeling of significance that is based on defeating others. A second aspect of his social presentation is his ability to be charming with the ladies. Both of these faces, Sandy knows, are defenses against the very real sense of discouragement James hides. It is a good sign that now and then James reveals these feelings in counseling. In the past, James has apparently fought off these feelings by seeking power over others in his environment through angry, violent behavior. He finds superiority in deceiving others through lies and theft and builds a sense of power through sexual behavior deemed "inappropriate." However, James seems to be in the midst of a reconsideration of these means. He shows signs of social feelings and verbalizes the intent to begin to seek significance through friendships and continued education.

BASIC TASKS

Adler thought that there were three basic tasks or problems of life: love, work, and community (Ansbacher & Ansbacher, 1956). These problems can be solved in socially useful or useless ways because, in reality, all three tasks involve social interest. One can't love without a wish to contribute to the betterment of another, and work usually contributes to society to some degree (if it is not criminal activity).

Adler believed that solving the task of communal life, or society, is achieved through cooperation (Ansbacher & Ansbacher, 1956). Society cannot exist without this attitude, and the task of society flows naturally into that of occupation because society can't exist without division of labor among its members.

Most people succeed to some extent at the occupational task (Dreikurs, 1953). People are typically able to find an occupation, although they vary along the dimension of social usefulness. For example, teaching children is an occupation with high social interest, whereas trading on the stock market would seem less so. Adler was one of the earliest vocational counselors, saying, "It is an advantage to ask children early what their occupation is going to be, and I often put this question in schools so that the children are led to consider the point"

(Ansbacher & Ansbacher, 1956, p. 431). The choice of one's life work is a good indication of the lifestyle. Think, for instance, of the different views of the world expressed when a little girl says that she wants to be (a) an aerospace engineer or (b) a fashion model.

Adler described love as "the most intimate devotion towards a partner of the other sex, expressed in physical attraction, comradeship, and the decision to have children" (Ansbacher & Ansbacher, 1956, p. 432). Two features of this important task are notable. First, Adler refers to the "other" rather than the "opposite" sex. In using this terminology, Adler sought to downplay the so-called competition between the sexes. Second, for Adler, only heterosexual relationships were worthy; homosexuality was a reflection of fear of accepting the challenge of a male–female relationship (Ansbacher & Ansbacher, 1956). He was even more specific about lesbian orientations, saying that they could result from the masculine protest (discussed later) or the wish to gain power by taking on the masculine role (Ansbacher & Ansbacher, 1956). Contemporary Adlerians do not take this perspective.

Mosak and Dreikurs (1977a, 1977b) maintained that Adler alluded to two other life tasks: (a) coping with the self and (b) the existential task. Sometimes called the "being" task (Yang, Milliren, & Blagen, 2010, p. 29), the first task is about being able to get along with one's self. This struggle arises from the deeply embedded notion of dualism, encouraging a belief that within each of us is good and evil, bad and good, moral and immoral, strong and lazy. These dualities are false, leading only to an internal battle that can't be won. Further complicating the problem, the culture in which we live gives very little information about our individual value, and hence we are constantly uncertain of our own worth. Our task is therefore to find ourselves worthy despite occasional human imperfection.

The existential task is concerned with finding one's place in the cosmos. Coming to terms with religion is part of this task. Mosak and Dreikurs (1977b) discussed negotiating this task through traditional religious paths, but also acknowledged the existence of atheism and agnosticism. The existential task includes developing a general picture of the nature of human beings, coming to terms with the existence or nonexistence of an afterlife, and considering the meaning of life (Mosak & Dreikurs, 1977b).

James is having some difficulty in each of the life tasks. Sandy has already noted that James has had difficulty cooperating with others, but she also observes that he is showing signs of wanting to contribute to society in that he enjoys his friends. James seeks and obtains employment, a good sign, but then finds a way to lose it by failing to cooperate on the job (getting drunk). Reportedly popular with the ladies, James seems to be experimenting with the task of love, but is only in the early stages of work on this problem. Sandy can't see it easily, but she also guesses that James is struggling to come to terms with himself. He has received some consistently negative feedback from the world, and this is bound to affect his self-view. Because of the immediate turmoil in his life, Sandy suspects that he has not had the leisure to consider existential questions.

BASIC MISTAKES

Basic mistakes, part of the lifestyle, are habitual, self-defeating cognitions that allow avoidance of life tasks or are reflective of low social interest or high needs for power. Mosak (2005, p. 71) identified five categories of basic mistakes:

1. Overgeneralizations
2. False or impossible goals of security

3. Misperceptions of life and life's demands
4. Minimization or denial of one's worth
5. Faulty values

Sandy thinks that James is harboring more than one of the basic mistakes. He seems to have the idea that the world is totally unfair and should change, not him, although he is beginning to recognize the problem with this attitude. He overgeneralizes that people are all dangerous, so it is therefore likely that he has difficulty trusting anyone. Although he does not show it, he probably believes that he is not a very worthwhile person. His methods of operation (e.g., physical aggression and stealing) have been faulty. These behaviors also suggest that he values a stereotypical picture of masculinity—the "real man" image of the masculine protest (discussed later).

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

As noted earlier, Adler believed that the pattern of an individual's life was set by about age 5. As a result of heredity, environment, and the individual's own creative work, the lifestyle is developed very early on and is difficult to change (Adler, 1929/1969).

The child begins life as a small and relatively helpless creature. This observation prompted Adler to assume that we all begin life with significant inferiority feelings (Ansbacher & Ansbacher, 1956). As the child observes the environment around him, he forms his own impressions (interpretations of life), which are the beginnings of the lifestyle. Looking around at the immediate environment, the child observes the ways of adults and figures out how to gain power within this system. The child's physical condition and family situation contribute to how he meets the problems of life, but Adler emphasized that the creative power of the individual is most important in how he solves these problems. Because children are immature, they often do not use common sense, instead resorting to their own interpretations, which are more idiosyncratic in nature. This reasoning, which Adler (1929/1969) called *private logic*, is contrasted with common sense (Carlson et al., 2006). These misunderstandings may lead to mistaken goals of superiority (for those with low social interest), such as the need to always be taken care of or to defeat others. The opposite situation also occurs when individuals triumph over horrible life circumstances and become socially contributing people. Adler gave the following example:

> One man with unhappy experiences behind him will not dwell on them except as they show him something which can be remedied for the future. He will feel, "We must work to remove such unfortunate situations and make sure that our children are better placed." Another man will feel, "Life is unfair. Other people always have the best of it. If the world treated me like that, why should I treat the world any better?" . . . A third man will feel, "Everything should be forgiven me because of my unhappy childhood." In the actions of all three men, their interpretations will be evident. (Ansbacher & Ansbacher, 1956, p. 209; quotes in original)

Family influences therefore are very important in the development of children and fall under the general term *family constellation*. Perhaps the most familiar construct from IP theory is *birth order*. Adler believed that the position of a child in the family could have a marked impact on his development. There are at least two ways to look at the phenomenon of family position (Shulman & Mosak, 1977). First, we can consider simple ordinal position—whether the child

was born first, second, third, and so forth. A second system is that of birth order—first, middle, last, or only. Adler tended to use the second system (Ansbacher & Ansbacher, 1956), and it is important to note that Adlerians emphasize the *psychological* position of the child, not the actual ordinal position (Carlson & Englar-Carlson, 2013). For example, if for some reason the first-born child becomes incapacitated, the second-born may take over that role (Dinkmeyer, Dinkmeyer, & Sperry, 1987). Likewise, children who are born many years after their sibling(s) are thought to constitute a "new" family (Adler, 1931/1998b). It is also very important to remember that Adler saw the characteristics typical of the different birth orders only as "tendencies; there is no necessity about them" (Adler, 1929/1969, p. 92). Other variables such as the sex of the child and the size of the family also influence birth order tendencies. Therefore, it is with some trepidation that I present a summary of the characteristics thought to be associated with the various birth orders.

First-born children are monarchs, basking in the undivided attention of their parents. Because they receive so much attention, they are generally very good at interacting with adults. They are then "dethroned" by a new child, a very unfortunate occurrence from the first child's perspective (Adler, 1929/1969, p. 12). As a result, the first-born may conclude that power is a very important thing. Also, the first-born is often given responsibility within the family, such as taking care of later siblings. These factors create a tendency for first-borns to seek positions of authority later in life (Adler, 1927/1998a). The first-born tends to love rules and may be quite conservative in his approach to life (Ansbacher & Ansbacher, 1956). Paradoxically, Adler thought that first-borns were the most likely to be problem children, with the next most likely troublemakers being youngest children. The tendency to rebel comes when the first-born is unable to accept his changed situation when a second child is born (Ansbacher & Ansbacher, 1956).

The usurpers, the second-borns, spend their lives trying to catch up to the first-borns. They are likely to live their lives in opposition to the first-borns (Sweeney, 2009). The outcome of this competition can be that the second-born surpasses all others in the family. However, if the first-born is too outstanding, the second child may give up and become discouraged.

Middle children often feel "squeezed" between older and younger siblings (Sweeney, 2009). Lacking access to the advantages (e.g., parental attention, caretaking by elder children) offered to the other children, they may feel especially disadvantaged. They tend to dislike conflict and are often diplomats who desire justice for all (Carlson & Englar-Carlson, 2013).

Youngest children are the center of attention, but still the smallest, and Adler pointed out that "no child likes to be the smallest, the one whom one does not trust, the one in whom one has not confidence, all the time" (Adler, 1927/1998a, p. 150). They are used to everyone doing things for them and get good at inducing folks to do this (Carlson & Englar-Carlson, 2013). Thus, although these kids occupy a privileged position in some sense, they may develop extreme power urges, trying to be the very best. A second type of youngest is the one who does not have the self-confidence to strive or whose older siblings are unsurpassable. This child may give up and become cowardly and evasive (Adler, 1927). Sometimes this child, because he has so many parents, becomes pampered (Stein, 2000).

Only children grow up in the world of adults and like being the center of attention. They may not learn how to cooperate with other children (Stein & Edwards, 1998). Only children have a competitor, but it is not a sibling—it is father (Adler, 1931/1998b). Often they are very sophisticated, using advanced language and interacting well with adults (Stein, 2000). Some of these children may grow up in a very conservative environment, according to Adler (1927/1998a, p. 155),

because their parents have experienced life as dangerous. These children are often overprotected, resulting in their having difficulty achieving independence; they lead self-centered, socially useless lives (Adler, 1927/1998a; Stein, 2000).

Other aspects of the family constellation include family values and atmosphere, examples set by parents, and the child's role in the family (Peven & Shulman, 1986). Adler (1931/1998b) asserted that it is the mother's job to teach the child cooperation, yet she must also relate to her husband and the world around her, facing all of these tasks "calmly and with common sense" (p. 101). She gives the child his first experience with a trustworthy human being.

The father's influence comes into play later in the child's life, and his role is to "prove himself a good companion to his wife, to his children, and in society" (Adler, 1931/1998b, p. 106). He needs to be aware of the overvaluing of the male position and avoid perpetuating the myth that his work is superior to his wife's.

Adler maintained that it is the parents' job to teach children social interest and to "learn to lessen the family egoism" (Adler, 1927, p. 122). Mistakes made in the family will come back to haunt in later life; failing to learn cooperation and courage will result in the development of problems. The child will not develop the feeling of belonging that characterizes a healthy individual (Ferguson, 2010).

The parental relationship is the model for other relationships in the family (Dinkmeyer & Dreikurs, 1963). In addition, Adler argued that what children see in their parents' relationship will influence their views of partnership and the nature of the other sex (Adler, 1931/1998b). Adler pointed out that children will be quick to exploit differences between parents, so parents must model cooperation with each other.

Gender is another very important influence in how kids develop. Adler's frequent discussions and condemnation of the male bias in society make him seem like the very first feminist (Bitter, Robertson, Healey, & Cole, 2009). At first glance, Adler can seem quite sexist because he equated superior and inferior to masculine and feminine. What he was really doing was describing how society perceived the sexes (Mosak & Schneider, 1977). Both sexes struggle with this social pressure in the form of the *masculine protest*: "Our civilization is mainly a masculine civilization, and the child gets the impression that while all adults enjoy superior powers the man's position is superior to the woman's" (Dreikurs, 1953, p. 47). According to Mosak and Schneider (1977), what Adler meant by the confusing use of the term *protest* was that, because of the valued male role, both sexes are prompted to declare (protest) their masculinity. The little boy resolves, "I'm going to be a real man," and he protests against anything that seems to imply that he is not and thereby not superior (Dreikurs, 1953, p. 47). Adler (1931/1998b) pointed out that "almost everywhere the women's part in life is undervalued and treated as secondary" (p. 98) and argued that this societal attitude had grave consequences. He said, "One must therefore keep in mind the difficulties under which a girl's development takes place. We cannot expect a complete reconciliation with life, with the facts of culture and the forms of our living together, as long as women are not granted equal rights with men" (1982, p. 15).

Confronted with the biases of society, girls may take several paths. The masculine protest can be transformed so that it is "covered and changed, and [she] seeks to triumph with feminine means. Very often one finds during the analysis the wish to change into a man" (Adler, 1982, p. 36). Other women become resigned to their inferior status. Still others dislike and resist the traditional female role and may become lesbians as a result (Ansbacher & Ansbacher, 1956). According to Dreikurs (1953), women who are unwilling to accept their defined roles are adopting masculine goals.

Dreikurs (1953), however, added that most people have some form of a masculine goal because they desire strength and power. This last position is the one Adler eventually came to; he concluded that the masculine protest was a special case of the more general human tendency to strive for power. Further, not all individuals are beset by the need to protest; some are quite comfortable with their respective genders, presumably because they are relatively low in inferiority feelings and high in social interest (Mosak & Schneider, 1977).

Adlerian theorists recognize four types of personalities that are the function of social interest and the individual's activity level. Because the terms used to label these are fairly descriptive, I will simply list them here, following Sollod et al. (2009, p. 138): (a) the ruling-dominant type, (b) the getting-leaning type, (c) the avoidant type, and (d) the socially useful type. I am sure that you recognize that the last one is considered to be the healthiest in IP theory.

James is a second-born male. His situation, in Sandy's view, is a good illustration of the dangers of taking birth order hypotheses as literal truth. James does not exhibit the typical striving of the second-born. Instead, he looks more like a first-born who is rebelling to achieve power. James and his siblings experienced a chaotic family environment until James was 8, which clearly would have confused roles and responsibilities among children and adults. The series of foster placements following James's seventh year probably exacerbated his confusion and at the same time reinforced his rebellion against the hostile environments he experienced. His acting out gained him power and attention. Sandy guesses that James's first family environment provided role models for masculinity that demonstrated the typical "he-man" picture, including the use of physical force to gain power. In fact, his stepfather physically abused him, suggesting that James learned early that physical aggression is a way to gain notice and control over others. Sandy thinks that James is mostly displaying the ruling-dominant type, although at times he seems to do a little getting-leaning.

HEALTH AND DYSFUNCTION

Healthy people, according to individual psychology, have well-developed social interest and therefore contribute to society as they go about solving the tasks of life. They are able to meet problems head on, courageously, and solve them in socially constructive ("useful") ways. The healthy person succeeds at the tasks of life, contributing to the community and finding a partner of the other sex and socially useful work. The healthy person has the courage to be imperfect because that is the normal state of human life (Dreikurs, 1953).

Adler saw dysfunction as characterized by a lack of social interest (Ansbacher & Ansbacher, 1956, p. 156). The individual who is psychologically unhealthy has the goal of personal superiority, and his lifestyle is consequently aimed at protecting self-esteem, a process called *safeguarding* (Rule, 2006). Psychological dysfunction equals discouragement because the individual has lost the "courage to proceed on the useful side of life" (Adler, quoted in Ansbacher & Ansbacher, 1956, p. 255). These individuals have underdeveloped social interest and strive for power and superiority in ways that are socially useless.

Safeguarding, the defense against inferiority feelings and discouragement, can take many forms (Carlson et al., 2006). Psychological symptoms are unconscious forms of safeguarding. Forms of safeguarding that are more accessible to consciousness are making excuses, being aggressive, distancing oneself from tasks perceived as threatening, and restricting one's possibilities in life.

Adler discussed a range of psychological dysfunction, but he saw all as the result of mistaken lifestyles that are selfish rather than socially oriented and characterized by a drive to protect the person's sense of power or value in the face of challenging life tasks. Most generally, Adler saw

neurosis (anxiety, depression) as failure in life (Ansbacher, 1970). Identified by their hesitating attitudes, neurotics display a marked tendency to evade life tasks (Dreikurs, 1953). As Dreikurs (1953) put it, "Neurosis is like a mock battle field outside the war zone—a long way behind the front of life, a side show" (p. 88). Adler called the neurotic the "yes, but" personality—always wanting to achieve, but finding reasons why he can't (Ansbacher & Ansbacher, 1956). The neurotic uses excuses to evade responsibility for life tasks, at which his inferiority feelings tell him he will fail. The neurotic tolerates suffering from symptoms to avoid the even more traumatic outcome of failure.

Neurotics are striving for superiority, but because their life plans lack social interest, they choose to walk on the "useless" side of life (Ansbacher & Ansbacher, 1956), pursuing goals that are individualistic rather than contributing to the collective good. "The common function of neurotic behavior in all its varied forms is . . . to provide safeguards for the self-esteem which is bound up with the hidden goal of superiority" (Adler, quoted in Ansbacher & Ansbacher, 1956, p. 263).

Neurosis has its roots in childhood. In some way, children become overburdened and lose courage. Three general kinds of children have high potential to be neurotic (Ansbacher & Ansbacher, 1956): (a) the child who experiences *organ inferiority* early in his development; (b) the child who is *pampered*, or spoiled; and (c) the child who is *neglected*. However, whether these children become troubled depends on an *exogenous factor*, which is a task that demands cooperation (Ansbacher & Ansbacher, 1956, p. 296). If the child or adult is overwhelmed by a challenging cooperative task that he believes he can't meet, neurosis will surface.

Children who experience physiological problems, or organ inferiority, become focused on their bodies and have difficulty seeing that life meaning is achieved by contributing to others. The natural process of comparing oneself to others may make the situation worse, and if others pity, ridicule, or avoid the child, the situation becomes even more damaging (Ansbacher & Ansbacher, 1956). It takes exceptional creativity and the presence of strong social training for the child with organ inferiority to grow up psychologically healthy.

The pampered child achieves superiority by having others do everything for him. Experiencing instant gratification, he never learns how to tackle and solve life problems, and thus his feeling of inferiority is intensified. Also, many pampered children develop behaviors that are disliked by adults but that compel attention, such as extreme discouragement, oversensitivity, and physical and psychological disturbances that indicate the need for help (Ansbacher & Ansbacher, 1956). Adler cautioned against blaming the parents for the pampered child's style because very often there is no evidence of the parents pampering the child—the lifestyle is the individual's creation (Ansbacher & Ansbacher, 1956). An example of the IP conceptualization of parenting is illustrated in Box 4.2. Another interesting note is that Adler once speculated that Sigmund Freud was a pampered child (Adler, 2004).

Box 4.2

The Case of Little Hans: Fear of Castration or Pampered Child?

> When we examine the facts they tell us only that the name Oedipus is poorly chosen; the complex characterizes a pampered child who does not want to give up his mother. (Adler, quoted in Ansbacher & Ansbacher, 1956, p. 185)

(continued)

Box 4.2 *(continued)*

One of Sigmund Freud's most discussed cases was that of Little Hans, the boy who developed a phobia of horses (Schoenewolf, 1990). Freud, who was seeking information about childhood sexuality, served as a consultant to Hans's father, Max, who attempted a kind of psychoanalytic treatment of his son. The father recorded what Hans said and reported to Freud. Based on advice from Freud, the father then interpreted Hans's statements or behaviors to Hans. For Freud, Hans showed all of the normal developmental signs. He became obsessed with his "weewee-maker" at about age 3 and evidenced significant distress upon the birth of his sister around the same time. During the year after his sister's birth (at about age 4), Hans developed a phobia of horses, fearing that they would bite him or fall down while pulling a cart and kill him.

Working through the father, Freud proceeded to analyze Hans and eventually published the story of the analysis as "Analysis of a Phobia in a Five-Year-Old Boy" (1909). Concluding that the horses represented the father, Freud interpreted Hans's symptoms as stemming from the Oedipus complex. Hans's fears of his father (the horse) stemmed from his sexual desires for his mother. If his father found out about Hans's feelings about his mother, his father might go so far as to bite him (i.e., castrate him). Hans's particular fear of horses falling down while pulling a cart was given two interpretations: (a) that the kicking and thrashing of the prone horse represented the boy's wish for his father to die and (b) that the overturned cart represented his mother's womb, carrying the competitors (other possible siblings) who would fall out if the cart fell.

Taub (1995) reconceptualized the case of Little Hans from the individual psychology perspective. As you might expect based on the different views of development held by Adler and Freud, Taub's conceptualization emphasized striving for significance rather than Oedipal drives. Hans was a very pampered child who was greatly affected by the birth of his little sister. His lifestyle formed around his efforts to do everything he could to regain his throne, which was lost when his little sister was born. Taub described a hypothetical course of IP therapy for Little Hans, beginning with two sessions with his parents and progressing to play therapy for Hans.

Counseling with the parents revealed that Hans had been told that a natural expression of his curiosity about sex (masturbation) would result in his penis falling off or the doctor removing it. This information scared Hans and at the same time intensified his preoccupation with weewee-makers. His father's interpretation of Hans's fear of horses (relating it to Hans's wish to sleep with his mother and his resultant fear of his father) further confused and scared Hans. At the same time, Hans's fears and curiosity about sex became a "family project" (Taub, 1995, p. 339). His father dutifully wrote down everything Hans said about sex, and Hans received much parental attention for his behavior. From an IP perspective, Hans's anger and anxiety were understandable because they were associated with the loss of his superior position in the family and his bed being moved out of his parents' room. As a result of Hans's distress, his parents focused on his every behavior, and he became a pampered child.

Looking at the family environment in which Hans's behaviors appeared, Taub conjectured that his mother encouraged Hans's increased desires for comfort and cuddling because she wished to avoid her relationship with Hans's father. The father was understandably upset with the disruption Hans caused in their sexual relationship; the mother was upset about the father's

criticism of her affection for Hans and generally angry about the father's critical behavior. Taub maintained that, if the parents ignored some of Hans's behaviors (i.e., masturbation) and worked out their own relationship, the overall situation would improve. Hans also needed to be given age-appropriate, accurate information about weewee-makers and the origins of babies. Play therapy would allow Hans to experience a safe and nonjudgmental relationship. Hans liked play therapy because in this environment he was special and was allowed to express his fears and jealousy about his sister. However, the therapist took care not to excessively praise or dote on Hans, but to treat him with "respect, confidence, and encouragement" (Taub, 1995, p. 343). Working with Hans and his family allowed the therapist to encourage in Hans both social interest and other modes of seeking significance.

Psychoanalysis and individual psychology thus generate two very different views of Little Hans. We are fortunate to have such exemplar cases to provide us with very real lessons about the effects of theoretical structure on our thoughts about clients. It is indeed exemplary of Freud that he was willing to expose his clinical work to public scrutiny, and it is courageous of Taub to present the individual psychology perspective on this famous case.

Neglected or "hated" children have never had the chance to learn about love and cooperation (Adler, 1930/2009, p. 106). They see the world as hostile and withholding because they have never found a trustworthy other. As a result, neglected children are likely to resist the attempts of others to influence them and are often openly rebellious. In other instances, they become passively resistant (Dreikurs, 1953).

Unlike many counseling theorists, Adler proposed an understanding of the most difficult cases, the psychotics: "The loftiest goals are to be found in the most pathological cases, that is, in the psychoses" (Adler, quoted in Ansbacher & Ansbacher, 1956, p. 314). Schizophrenics, and particularly paranoiacs (it is not clear whether Adler was including paranoiacs under the general heading of psychoses), have the goal to be godlike in order to fend off their very deep inferiority feelings. The goal is so high that they almost completely lose interest in others and so lose their common sense and contact with reality as it is seen by most of us. Adler wrote "insanity is the highest degree of isolation" (in Ansbacher & Ansbacher, 1956, p. 316). Adler portrayed the psychotics' withdrawing from others as the result of being badly unprepared for life. Psychotics lack interpersonal skills and occupational interests and are afraid that they will fail in everything, including relations with the other sex. Finally, they retreat so far that others cannot understand them. In the case of the paranoid person, his distrust of others leads him to oppose socially accepted views of reality by creating his own reality, politics, and religion (Ansbacher & Ansbacher, 1956, p. 318).

James is a neglected child. His early life circumstances were chaotic and impoverished, lacking a stable family structure. Some evidence indicates that he has been abused, both in his first family and in subsequent foster families. Sandy thinks it is remarkable that James is not more hostile than he is. Perhaps he was able to trust someone in his early environment so that he did not totally lose his faith in others.

Until recently, James has displayed a disinterest in contributing to society, walking on the useless side of life. Sandy knows that this life pattern would classify James as neurotic—he strives for

self-esteem at the expense of others. On the surface, little of the hesitating, discouraged attitude of the neurotic is visible in James, but when he relaxes in therapy sessions, he admits to Sandy that he is a little scared to really try hard in school or to become more deeply involved with people around him. Sandy knows that he is harboring the feelings of unworthiness characteristic of neurotics and that he is afraid to fully engage in the tasks of life because he might fail. Instead, he puts up his macho front so that no one can tell that he truly feels inferior and at the same time is angry at the world for treating him so badly.

NATURE OF THERAPY

ASSESSMENT

Individual psychologists advocate two types of assessment, formal and informal. Each will be discussed separately even though the informal type certainly occurs during formal assessment.

Formal Assessment. Formal assessment consists of obtaining information that helps the counselor understand the lifestyle through relatively structured means. M. F. Schneider (2007) noted that the lifestyle assessment process is typically a significant contributor to the therapeutic alliance. Several techniques are used.

Adler developed an *interview* structure for assessing lifestyle (Ansbacher & Ansbacher, 1956). Formulating different interview guides for use with children and adults, Adler recommended using a series of questions covering various life areas (e.g., assets, social relationships, interests, discouraged behaviors) only loosely when attempting to understand a client (Ansbacher & Ansbacher, 1956, p. 405). Example questions might be "How many siblings do you have?" and "What jobs did you consider before deciding on the one you have now?" Eckstein, Milliren, Rasmussen, and Willhite (2006) indicated that nowadays some IP therapists will use the full formal interview method, but others will use a less-structured and briefer method.

The question is another important IP assessment technique. The client is asked, "What would be different in your life if (the symptom disappeared)?" (Mosak & Maniacci, 1999, p. 135). Responses to the question can tell the counselor two things. First, if the client says something vague such as "I'd feel better," the counselor should consider the possibility of a physical basis for the presenting problem. However, many times the client's answer will not involve such responses; it will instead be more detailed and give hints to the client's lifestyle goals, or what the presenting problem is allowing the client to avoid (Carlson & Englar-Carlson, 2013).

IP counselors are very interested in *family constellation*, or the characteristics of the client's family, including birth order, parental influences, and family dynamics (Maniacci, Sackett-Maniacci, & Mosak, 2014). These qualities can be assessed casually or through a structured interview developed by Dreikurs (1952–1953). The interviewer asks the client to describe himself, his siblings, and his parents and includes questions about relationships among family members.

Sandy prefers to use the informal mode of assessing lifestyle and family constellation. She gently encourages James to talk about his family life, both before his foster placements and after. She looks for clues about how James learned to strive for significance in his self-centered, aggressive style. These hints are found in his very early environment and his success using such behaviors to get what he wanted, particularly the attention of important others. Because James sees his problems as mostly the result of other people and

therefore does not present symptoms, Sandy asks James the question this way: "What would be different in your life if folks got off your back?" James's initial response is "Then I'd be able to do what I want whenever I want without anyone hassling me." Sandy sees this answer as reflecting James's self-centered lifestyle because he wishes to pursue his own agenda without consideration for or contribution to others. However, when James begins to relax and trust Sandy, he indicates that he'd like to finish school, get a job, and maybe find a real girlfriend. These goals seem much more responsible and socially useful.

Adler (1927/1998a) believed that "there is no such thing as a random or meaningless recollection" (p. 41). Thus, the IP counselor is very interested in *early recollections* (ERs; Carlson et al., 2006; Mosak & Di Pietro, 2006). The client's memories of his early childhood are considered reflective of his *current* views on life, or lifestyle (Mosak & Di Pietro, 2006). It does not matter if they are real—they nonetheless provide valuable clues about the individual's life plan and goals (Ansbacher & Ansbacher, 1956). ERs also reveal information about the person's level of social interest. For instance, Louise remembers building a sand castle at the beach. If she remembers helping her little brother build the castle, her social interest would be more evident than if she remembers building it alone. Carlson and Englar-Carlson (2013) recommend that the ER should be a memory of a single event, a one-time occurrence. It should be a vivid memory that the client can visualize and clearly describe what feelings he was having. Somewhere between eight and ten ERs are typically requested.

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Video Example 4.2 Watch Adlerian therapist Jon Carlson explore early memories with a client, Gina.



One of James's earliest memories is of his mother and stepfather fighting. The stepfather threw a chair across the room and then stormed out of the house. A second memory is of playing in a field with his older sister, Karen, and falling down after stubbing his toe. Karen kissed the toe and made it better.

Sandy is both disturbed and encouraged by these early recollections. The first memory indicates a negative view of adult relationships and a view that problems are solved through fighting and physical aggression. The second memory, however, suggests that James can recognize and accept caring in others. Maybe he does know something about cooperation with others because it takes some cooperation for two children to play together.

Adler carefully distinguished his theory about *dreams* from that of the psychoanalytic perspective. Rather than dealing with the past, in the IP system dreams are seen as future oriented. Dreams are thought to represent some problem currently confronting the person and are filled with private logic (Bird, 2005). They often offer solutions to the problem, but these solutions are sometimes simplistic (Ansbacher & Ansbacher, 1956). For instance, if you dream about flying, Adler would contend that you are struggling with whether to take a particular action. The dream gives you a sense of buoyancy as well as the sense that you can do what others cannot (fly). Thus, this dream conveys an inflated sense of superiority (Ansbacher & Ansbacher, 1956, p. 363). Because of the influence of the individual's private logic on dreams, dream symbols cannot be interpreted through a fixed system such as Freud's (Bird, 2005).

James tells Sandy that he had a dream that he was LeBron James. Because James does not play sports at all, much less basketball, Sandy assumes that his dream reflects his exaggerated superiority feelings.

Informal Assessment. From an IP perspective, assessment begins the instant the counselor meets the client. Adler thought that every action of the client, right down to the client's handshake, provides information about the client's person. The counselor watches carefully all of the client's behavior, both verbal and nonverbal.

The first time James appears for his appointment, Sandy closely observes the way he presents himself. She notices that he carries himself in a confident, almost cocky way and that he is dressed in a hip fashion. He does not offer to shake hands with Sandy, and when he sits down he leans back and crosses his legs. Although he is not actively hostile, he does not seem engaged in the counseling process. Sandy tentatively hypothesizes that James has some stake in appearing "cool" and that his general manner of relating to others is "cooler than you." She wonders if he uses this display to keep people away from him.

Overview of the Therapeutic Atmosphere

The Adlerian counselor is certain that the client can change (Carlson & Englar-Carlson, 2013). IP counseling is guided by three important factors: faith, hope, and love (Mosak & Maniacci, 2011). Faith in the counselor is encouraged by the therapist's confidence in herself and her willingness to listen nonjudgmentally to the client. Hope is also essential for the discouraged client. The counselor should encourage the client to accept the challenges of life and therapy. Hope may also come from feeling understood by the counselor. Love for the client is in the most general sense, of course. The client must feel that the counselor cares for him. The counselor's empathic listening is important in establishing this condition, but she must avoid the "pitfalls such as infantilizing, oversupporting or becoming a victim of the patient" (Mosak & Maniacci, 2011, p. 84).

A critical goal of the therapist in IP counseling is to understand the client through understanding his lifestyle. To this end, IP counselors use active listening, empathy, and observation in their attempts to build a picture of the client's ways of operating in the world (Mosak & Maniacci, 2011).

Adler thought that the length of therapy depends on the level of cooperation displayed by the client. However, he thought that in most cases clients would show progress within 3 months.

Sandy works very hard to understand James's views on life. She asks him to tell his story and uses her basic counseling skills to let James know that she is actively trying to enter his world as best she can. Telling him that she is sure that his life can get better, Sandy tries to give James a sense of hope for his future. She has faith in his ability to change. Sandy's confidence in him and true expression of acceptance, understanding, and caring create a relationship in which James can begin to trust himself and his counselor.

Roles of Client and Counselor

The relationship in Adlerian counseling is egalitarian (Carlson & Englar-Carlson, 2013); the therapist must avoid any semblance of superiority (Dreikurs, 1953). Manaster (1990) asserted that IP counseling is a "face-to-face, cooperative learning endeavor with, it might be said, two experts—the patient, the expert on himself or herself; and the therapist, the expert on helping the patient to relate to the theory and its emphasis on social interest" (p. 46).

The IP counselor is an educator and encourager (Sweeney, 2009). The educational function requires the counselor to be active and directive. To be a good encourager, the counselor should be warm and human (Peven & Shulman, 1986). As part of being human, the counselor admits her own fallibility and models a courageous approach to life by being willing to make mistakes and acknowledge them.

Despite the egalitarian roles espoused by the IP approach, the client is still a learner in the process of counseling (M. F. Schneider, 2007). The client has choices in his life, but first he must recognize his faulty lifestyle. The therapist's job is to point out the client's mistakes.

GOALS

Adler said, "In practice we attempt to undo the great errors, to substitute smaller errors, and to reduce these further until they are no longer harmful" (Ansbacher & Ansbacher, 1956, p. 187). An IP therapist tries to help the client understand and change his faulty lifestyle and selfish goals so that he can achieve success in the tasks of life. Dreikurs (1953) observed that the way to psychological health is through correction of "attitude to their fellow beings" (p. 85) and modification of life goals. Further, "success in psychological treatment depends on the therapist's ability to make fearless co-operators in life out of timid and discouraged people" (Dreikurs, 1953, p. 85). In summary, the goal of IP counseling is to give the client insight into his lifestyle, allowing the possibility of change in the direction of increased social interest.

Sandy approaches James with respect, assuming that he has choices in this relationship as in any other. She treats James as an equal, even though she knows that part of her job is to help him understand his faulty lifestyle. Working in a cooperative and encouraging manner with James helps him assume responsibility for his situation and at the same time exposes him to a relationship high in social interest.

PROCESS OF THERAPY

Adlerians see counseling as progressing through four phases: (a) establishing the relationship, (b) assessment, (c) interpretation and insight, and (d) reorientation (Carlson & Englar-Carlson, 2013). In the relationship phase, empathy is critical; Adler maintained that "it is essential for the practitioner to possess, in a considerable degree, the gift of *putting himself in the other person's place*" (Adler, 1929/1969, p. 25; emphasis in original). The IP counselor uses attending behavior and active listening to develop a trusting relationship with the client that is based on the client feeling understood. Conveying the certainty that the client has the power to change is also critical; encouraging the client begins from the very start of therapy and is an important process throughout the relationship (Dinkmeyer et al., 1987). Clear goals need to be agreed on because a mismatch between client and counselor goals can lead to resistance (the sources of resistance are discussed later). Dinkmeyer et al. (1987) suggested that in this first stage the counselor can also begin to offer some tentative hypotheses about the purpose of the client's behavior as one form of empathy.

James would be most happy if people would just let him do what he pleases. Sandy begins her work with him in an accepting way, trying very hard to understand his perspective and actively communicating her understanding to James. She tries to determine how she and James can agree on goals for their meetings and concludes that she can go along with James's idea to get people "off his back" because that probably involves his taking responsibility for his actions and acting in more socially contributing ways.

An important part of the assessment stage of counseling is lifestyle analysis (Dinkmeyer et al., 1987). The IP counselor asks questions about the life tasks and tries to understand the client's lifestyle and associated goals. Adlerian counselors recognize that clients' lifestyles come into the therapy session with them (Mosak & Maniacci, 1999). The therapist is ever alert for the client's *movement*—that is, she is always watching the client's efforts to achieve his goals. Another way of saying this is that the counselor is trying to understand the client's private logic (Sweeney, 2009). For instance, a depressed client's behavior will include speaking negatively about himself. The IP therapist might interpret this behavior as movement toward a goal that includes being the center of attention or avoiding responsibility for life tasks. After all, if the client is a worthless unit, he can hardly be expected to attempt to tackle the serious, difficult challenges of life. At the same time, the client is achieving the socially useless goal of superiority by commanding the undivided attention of others.

Dinkmeyer et al. (1987) suggested that discovering the person's "number one priority" is helpful in understanding lifestyle (p. 96). According to these authors, there are four types of priorities: ruling, getting, avoiding, and socially useful (p. 97). The client's goals and basic mistakes are connected to the relative importance he places on these priorities.

Sandy works to try to understand James's ways of achieving significance. In his very early environment, he probably was praised for being the "tough guy" or was ignored. He likely felt neglected and scared. James apparently received parental attention when he acted out. As a result, James's past behavior seems to have prioritized ruling and getting over other things. Now he appears to be changing his focus and placing more socially useful goals in the forefront. He wants to finish school, get a job, and learn to relate more productively with others. These goals clearly indicate a shift in priorities.

The third stage of counseling is interpretation and insight, in which the counselor helps the client understand his lifestyle and become aware of how he chooses to function and why (Carlson & Englar-Carlson, 2013). Interpretation therefore plays a major role in this phase. To be most facilitative, interpretation is usually offered tentatively, in a questioning manner. "The counselor is modeling the courage to be imperfect, which often teaches as much as an insightful interpretation" (Dinkmeyer & Sperry, 2000, p. 101). Occasionally, the counselor will offer a deliberately exaggerated version of the client's life goals or priorities, hoping to get the client to laugh at himself.

Sandy approaches James gently and tentatively with interpretations about his lifestyle. She empathizes with his tough early environment and indicates that she understands how he became so active and rebellious as a way of offsetting the feelings induced by neglect and abuse. Sandy might say, "Y'know, it seems a little bit like in the past you've felt cornered, so that you had to 'get' folks before they 'got' you—you had to be the most powerful, so they wouldn't mess with you." She might joke with him about his presentation as a really cool dude, showing the world that nothing affects him. She would only very carefully approach the feelings of fear that he experienced early on; in the best case, she would let James express these himself before working with them.

If the insight stage is successful, the counselor and client enter the reorientation phase. The client, accepting the counselor's interpretations and aware of his mistakes and faulty goals, works with the counselor to find ways to behave differently. New, more realistic, and socially appropriate goals are established (Dinkmeyer & Sperry, 2000).

James slowly becomes aware of how his mistaken goals have led to a troubled existence. He concedes that he has bullied people, trying to boost his sense of power and worth. Even though James has difficulty acknowledging this motivation, Sandy senses that he is truly struggling with his life and tells him so.

Resistance in IP counseling is seen as arising from several possible situations. Adler thought resistance represented "lack of courage to return to the useful side of life" (Ansbacher & Ansbacher, 1956, p. 338). Other individual psychologists have suggested that resistance can also arise when the client and therapist are working toward different goals—for example, when the client tends to continue moving toward his faulty goals and the counselor wants to discuss the underlying dynamics of the client's behaviors (Peven & Shulman, 1986). A second source of resistance, according to Peven and Shulman, is found in the therapist's challenging interpretations, which can call forth some clients' animosity toward society.

Because Adler was interested in child development, he devoted much thought to how to understand and help the parents of dysfunctional children. He emphasized that parents who consult the counselor should never be blamed for the misbehavior of the child (Ansbacher & Ansbacher, 1956). The parents come to the counselor already feeling insecure and inferior, and Adler advised that the counselor support and encourage them. This support allows the counselor to create an atmosphere in which she can offer suggestions tentatively to the parents.

James may resist Sandy's attempts to help him understand his lifestyle, particularly if she rushes him. He has been neglected and abused and is probably very sensitive to others' attempts to control him. He does not trust easily. James verbalizes that he is working toward taking more responsibility for himself and his actions; Sandy thinks that it might be better to work in this area first with James to avoid engaging his rebellious tendencies.

THERAPEUTIC TECHNIQUES

Although this section's list of techniques available to the IP counselor is quite lengthy, it is not totally inclusive. IP therapists are technical eclectics because "Adlerian theory allows, if not demands, that therapists use any and all techniques that hold promise and can be understood as in keeping with the theory" (Manaster, 1990, p. 46). For example, Carlson et al. (2006) suggested using a two-chair dialogue (a technique more characteristic of the Gestalt approach; see Chapter 7) to help clients resolve decisional conflict. The client switches back and forth between chairs as he expresses the pros and cons of the situation. Interestingly, these authors maintained that the client's real choice is indicated by the chair in which he finally stops.

With that said, I present a brief description of some of the major techniques endorsed by IP counselors. Further and more elaborate discussions of IP techniques can be found in Carlson et al. (2006) or Mosak and Maniacci (1998).

INTERPRETATION

Interpretation of the client's behavior is one of the key interventions in the IP counselor's arsenal. The counselor uses all the information she has collected to form hypotheses about the client's lifestyle and associated goals and then carefully and tentatively offers these insights (Sweeney, 2009). Adler cautioned that hitting the client over the head with interpretation would not be helpful, saying, "Nobody who has understood anything of Individual Psychology

would attempt to cure by upbraiding the patient, as if we could do good by taking up a moralistic attitude" (Ansbacher & Ansbacher, 1956, p. 335). According to Dinkmeyer and Sperry (2000), interpretation is intended to create awareness of "(1) lifestyle, (2) current psychological movement and its direction, (3) goals, purposes, and intentions, and (4) private logic and how it works" (p. 99).

James will not easily accept that his "attitude" is a dysfunctional way to gain significance in the world, devoid of courage and social interest. Sandy must be very careful in helping James to see that he seeks power over others to defy the feelings of inferiority he harbors. Sandy will gently and carefully help him see that his lifestyle has been one in which he had to gain power by deceiving or hurting others before they hurt him. His logic seems to be that others are evil anyway, so they deserve what they get. However, his current movement seems a little more useful; he is verbalizing more responsibility for his life and more useful goals. Sandy would be sure to point this part out and encourage James to do more.

Encouragement

Equally as important as interpretation is encouragement because it helps the client find his own strengths and recognize his power to affect the world through choice (Eckstein et al., 2006). Encouragement is not the same as praise; ideally, it happens before the client attempts a desired change or action (C. L. Thompson & Rudolph, 2000). Encouragement can also be used to combat the sense of discouragement that some clients bring to counseling. Encouragement gives clients hope that they can have better lives (Mosak & Maniacci, 2011).

Sandy would let James know that she has confidence in him as a human being. She thinks that he could achieve the goals he talks about, but is careful not to set him up by placing too much emphasis on them. She is genuinely supportive of him, encouraging him when he takes actions directed toward doing better at school and relating to others. She searches for instances in his life that were successful so that she can help him build on these. For instance, Sandy might compliment James on getting his job or getting through a day at school without fighting.

Natural and Logical Consequences

One way to encourage clients to assume responsibility for their choices is to allow them to experience the consequences of their behaviors. Natural consequences refer to simply letting events take their course; that is, the world imposes these consequences. Too often we try to "save" others by preventing negative consequences. Parents who call the teacher to excuse Mariah's missing homework are doing just this. Often, we have to stand a little discomfort to let natural consequences happen. For instance, I once counseled a family in which the parents were very upset with their teenage daughter for leaving her dirty clothes on the bathroom floor. Even though it was not pleasant for the parents to do so, I advised the natural consequence of simply leaving the clothes where the daughter had left them. Imagine the effect on a 13-year-old of not being able to wear her favorite items of apparel because they are dirty! This young woman quickly learned to pick up her clothes and place them in the laundry hamper, I can assure you.

Logical consequences are those resulting from an intervention by another person (Sweeney, 2009). They teach the social rules of life (Mosak & Maniacci, 1999). In the previous example, the parents who decide to pick up their teen's clothes could also decide where to place them, thereby

depriving her of the valuable articles for some period of time. Logical consequences are different from punishment (in which Adlerians do not believe) because they are based on social rules logically related to the undesirable behavior. They are imposed with a friendly attitude and an emphasis on the target's choice (Sweeney, 2009). Adler (1931/1998b) maintained that "punishment, especially corporal punishment is always harmful to children. Any teaching that cannot be given in a spirit of friendship is wrong teaching" (p. 106).

James experienced the natural consequences of his irresponsible behavior when he lost his job after getting drunk at work. His foster parents, if they caught him stealing something, could take something of his away for a period of time as a way of imposing logical consequences.

ACTING AS IF

Many clients excuse their behavior by saying, "If only . . . " The technique of acting as if is designed for this situation. Whatever the "if only" is, the client is asked to act as if it were true (R. E. Watts, Peluso, & Lewis, 2005). Tracy might bemoan the fact that she is not pretty and confident when explaining why she has so few friends and is therefore miserable all of the time. Rashanda, the IP counselor, might then ask her how she would act if she were pretty and confident. Then she would direct her to act that way for the next week. The IP counselor's use of this technique helps the client change her view of herself and also learn or exhibit previously unexplored behaviors.

Initially, James is not a good candidate for the "acting as if" technique because he presents a tough guy front. He tends to blame others for his behaviors, rather than saying, "If only I were . . . I could do better." However, over time James becomes more comfortable with Sandy and is able to trust her. At this point, he is able to acknowledge that he feels insecure in "normal" social situations, such as at work or school. He says, "If only I were more confident with people, I wouldn't have to dis them so much." Sandy asks James to act as if he is confident for the next week, just to see what happens.

PUSHING THE BUTTON

Mosak (1985) devised the push-button technique for clients who think that they don't have control of their emotions. The client is instructed to visualize a pleasant scene or event and to study the accompanying feeling. Next, the client imagines a scene that evokes a negative feeling (e.g., pain, embarrassment, anger) and attends to that feeling. Finally, the client is asked to revert back to the original, pleasant emotion. Thus, the counselor teaches the client that he creates his emotions by choosing what to focus on.

Sandy asks James to conjure up the feelings he has when he's around a girl he likes. Then she instructs him to think about being fired from his job and focus on those emotions. Next, Sandy asks him to refocus on the first set of feelings. Sandy and James then discuss how he was able to change his mood by changing his thoughts.

CATCHING ONESELF

Once the client has accepted the counselor's interpretation, he can practice catching himself in his unique way of achieving power. With a little practice, he can even catch himself before beginning to engage in the undesirable behavior. Tamera tends to avoid playing sports by

putting herself down. In this way, she avoids the failure that she fears. If she could catch herself when she begins to disparage herself and reorient herself with "It's OK if I'm not perfect," she might improve her relationships with others, not to mention her physical skills.

James has a tendency to fly into temper tantrums and throw things. Sandy thinks that this is one way he fights off his inferiority feelings—by proving how powerful he is. He also verbally puts others down, with the same motive. Sandy asks James to observe his thoughts and feelings closely to perhaps learn to recognize when he is feeling that he is inferior or that someone has put him down. Eventually, he might be able to interrupt his patterns and change how he relates to others when feeling insecure.

Creating Images

Mosak (2005) discussed helping the client use imagery to exemplify his faulty goals. In many cases, these images can even be used humorously, allowing the client to laugh at himself. For example, a client who controls others through constantly failing and needing help could be instructed to think of himself as Charlie Brown, who battles the tree-eating kite. Every time Charlie tries to fly his kite, the tree somehow wins. Then he has to visit Lucy, the 5-cent psychiatric professional!

Sandy has James think of himself as Arnold Schwarzenegger any time he feels the impulse to overpower others through intimidation. She winks and calls him Arnold when he starts speaking in these ways and then says, "Hasta la vista."

Pleasing Someone

Adler advocated confronting the client's faulty lifestyle by advising him to think daily about how to please someone (Ansbacher & Ansbacher, 1956, p. 347). If the client obeys this directive immediately (which is rare, according to Adler), the counselor has succeeded in turning his interest toward others and thereby increasing social interest. If the client refuses, the real motivations (purpose) behind the symptoms emerge. Rather than confronting those motivations, the counselor continues to insist on attending to others. For instance, Adler related an instance in which the client responded to the directive to please others by objecting that others did not please him. Adler simply told the client that he need not worry about others, but that he (the client) must accomplish the task for his own health (Ansbacher & Ansbacher, 1956, p. 347).

Sandy decides to have James do a pleasing task. Even though it might be difficult and new for James, she asks him to do something nice for his foster mother in the next few days. James struggles with what this task might be, but finally settles on offering to take on a small task around the household, taking out the garbage. He surprises Sandy by saying that he might be willing to take on this duty on a permanent basis.

Paradoxical Intention

In this counterintuitive technique, sometimes called antisuggestion (Carlson et al., 2006), clients are encouraged to intensify their symptom. For instance, Billy could be asked to practice his temper tantrums to become even better at them. Billy might also be told that his tantrums are very effective in distracting his mother from making him take responsibility for household

tasks, so he should practice even harder. Using this kind of rationale is what Adler called "spitting in the soup" or reframing the symptom in a way that makes it distasteful to the client (Maniacci, Sackett-Maniacci, & Mosak, 2014). The idea behind paradox is to increase the client's awareness of the symptom and its consequences (Dinkmeyer et al., 1987). Also, paradox can help clients give up symptoms because they begin to look absurd.

Sandy can't think of a really good paradoxical directive for James. She could have him practice getting angry only at a certain time of the day. If James complied, the social function of the anger would be removed. If James did not comply, he'd have a smooth day, which might not be a bad thing for him. Another option is to tell James that he is cool, but not quite cool enough, because others don't seem to fully appreciate his coolness. She asks him to find some ways to be even more cool and observe others' reactions to him. Sandy hopes that James will start to examine what cool means and how putting others down prevents him from truly connecting with them.

EVALUATION OF THE THEORY

IP theory is a "grand" theory that, like psychoanalysis, tries to explain everything. Many of its assumptions are difficult to test. An active community of researchers and writers, however, is busily advancing Adler's work. The level of devotion of these adherents could be considered either a strength or a weakness.

Adler's thoughts had significant influence on many subsequent theorists, including Carl Rogers, Albert Ellis, and Abraham Maslow (E. Hoffman, 1994). The influence of Adler's description of the basic mistakes can be clearly seen in contemporary cognitive and cognitive-behavioral theory.

Perhaps Adler's greatest contribution is that he developed a theory that recognized and even emphasized the effects of social class, racism, and sex on the behavior of individuals. Adler was far ahead of his contemporaries in this sense, and his ideas are even more salient in our increasingly pluralistic society.

Some critics contend that IP theory is too simple and that it is only common sense (Mosak & Maniacci, 1999). All behavior is explained by referring to inferiority feelings, striving for power, and social interest. Of course, Adler would reply that common sense is the highest form of reasoning.

QUALITIES OF THE THEORY

Precision and Testability. IP theory has many of the same weaknesses as psychoanalysis in terms of testability. Many of the constructs in IP theory are difficult to operationalize and measure, at best. Sollod et al. (2009) observed that the major ideas in IP theory (e.g., inferiority feelings and safeguarding strategies) are not very open to disconfirmation. Much like psychoanalysis, IP theory can explain almost any pattern of behavior. If a client acts out, it is because of a superiority complex that is compensating for feelings of inferiority. If a client is passive, it is because he is afraid to risk exposing himself to failure, naturally because he feels inferior. No specific predictions can be derived that would specify which behavior will result. Both stem from the basic inferiority complex.

IP theory is not the most precise theory in the bunch. Adler seemed to rely on common sense terms that most people think they understand rather than clearly defining his constructs.

For instance, what exactly constitutes pampering? Many of IP theory's constructs are so broad that they are difficult to define or measure. An example would be lifestyle, which, as noted earlier, has been defined in many different ways by Adler and those who followed him. On the other hand, some aspects of the theory are definitionally clear, and predictions can be generated about them. For instance, Adler provided very clear predictions about the behaviors of children in the various birth orders. Unfortunately, we can't seem to agree on the right way to measure these. Similarly, social interest has been measured in several different ways, as has lifestyle.

In spite of these problems, researchers have worked hard to define some of the IP constructs, mostly through self-report measures (Watkins & Guarnaccia, 1999). For instance, researchers have developed measures of social interest, early recollections, and lifestyle. General hypotheses can be derived from the theory, but as noted earlier they are not always as precise as we would like. When more specific predictions can be derived, such as those about the personality correlates of the various birth orders, there is often great disagreement about how to define and measure the constructs. Illustrating this controversy, E. W. Jordan, Whiteside, and Manaster (1982) presented seven different schemes for birth order based on the number of children and the sex of siblings as well as ordinal position.

Empirical Support. Some research seems to support the major constructs and predictions of IP theory. Most of this research is published, however, in the *Journal of Individual Psychology* rather than more generic psychological journals, leaving open questions about potential bias. Very little organized outcome research has appeared in the literature, and IP counseling has not been a subject of the major psychotherapy outcome studies. Major constructs such as superiority and inferiority complexes have received little attention, probably because they are so hard to measure.

RESEARCH SUPPORT

Outcome Research. Outcome research testing IP counseling is scarce; the few outcome studies I could locate are very dated. For instance, Shlien, Mosak, and Dreikurs (1962) reported on an outcome test of time-limited therapy (with a maximum of 20 sessions) in which one of the approaches was IP (the other was person-centered therapy). A Q-sort method was used to measure outcome in which clients sorted adjectives into two piles, one for their "real" selves and one for their "ideal" selves. Shlien et al. (1962) reported that these two sorts matched more closely after counseling compared to before counseling and concluded that IP theory was supported. Although a case could be made that increases in self-ideal are supportive of IP theory, it is more directly predicted by person-centered theory.

Several smaller studies have provided some support for IP theory. Zarski, Sweeney, and Barcikowski (1977) examined the relations among counselor social interest, client satisfaction with counseling, and client outcome as measured by the California Psychological Inventory (CPI). Results showed a positive correlation between counselor social interest and counseling outcome as measured by a client satisfaction inventory and client self-acceptance and sociability as measured by the CPI scales. This study would seem to support IP theory in that good counselors would be those with high social interest. However, it is important to note that (a) client self-acceptance and sociability may not be the best measures of client outcome and (b) this study was not experimental in nature, so no causal relationships between counselor social interest and client outcome can be assumed.

Krebs (1986) and Burnett (1988) reviewed the literature on the effectiveness of Adlerian parenting programs and found some support for these interventions, but the majority of the studies reviewed could be criticized on methodological grounds. Overall, then, I tend to agree with Watkins and Guarnaccia's (1999) contention that IP researchers need to do more—and more rigorous—outcome research.

Theory-Testing Research. Watkins and Guarnaccia (1999) reviewed research on four major constructs of IP theory: birth order, social interest, early recollections, and lifestyle; they concluded that the evidence supports IP theory. In an earlier review, Watkins (1982) came to a similar conclusion. However, overall most of the research on IP theorists is conducted by IP advocates and is therefore subject to potential investigator bias. As noted earlier, much of the research has been published in the *Journal of Individual Psychology*, an obviously IP-oriented journal. Many of the studies of IP constructs seem to suffer from a lack of specificity of predictions based on the theory. That is, an investigator will study a construct (e.g., early recollections), discover some findings (that accounting students' recollections include more references to non-family members than music students'), and then explain how these fit the theory. More convincing results would be obtained if strong theoretical predictions could be made at the outset. Finally, significant methodological problems can be found in many of the studies that are cited in support of IP theory.

That said, I think it is important to commend the Adlerians for the energy they devote to extending and applying their theoretical approach. However, it does seem that they are more interested in exploring new applications of IP theory than in scrutinizing their approach (Carlson & Englar-Carlson, 2013). For example, I would predict that we could find many studies of inferiority feelings. In fact, very few appear in the literature. One established a relationship between inferiority feelings and neurotic perfectionism (Ashby & Kottman, 1996), which is somewhat supportive of IP theory. Strano and Petrocelli (2005) examined the relationship between inferiority feelings and academic achievement, predicting that moderate inferiority would lead to the highest achievement levels. Their predictions were only partially supported.

More research on IP appears in the areas identified by Watkins and Guarnaccia (1999). To illustrate, I will briefly review some of the findings in each of these areas.

Social interest. Social interest has been found to correlate positively with altruism, trustworthiness, religious belief, increasing age, volunteerism, vigor, marital adjustment, and a number of other personality variables (P. Johnson, Smith, & Nelson, 2003; Leak, 2006; Sweitzer, 2005; Watkins, 1994). Also, social interest has been found to be related in predicted directions to characteristics such as parenting styles, stress coping, depression, and anxiety (Curlette & Kern, 2010). For example, Johnson et al. (2003) tested the relations among birth order, family characteristics, and social interest. Although birth order was not related to social interest, family characteristics such as level of conflict and cohesiveness were. Thus, these results partially support IP theory. Sweitzer (2005) found that the relationship between social interest and self-concept was weaker in conduct-disordered adolescents than in a comparison group, again providing some support for the theory. Providing cross-cultural evidence for the validity of IP theory, Foley, Matheny, and Curlette (2008) demonstrated that social interest predicted life satisfaction in a sample of individuals in China. Further, they found a small decline in social interest in comparing older and younger generations, a finding they attributed to the increasing

individualization of Chinese culture. Highland, Kern, and Curlette (2010) reported that a sample of convicted murderers had lower social interest than a sample of nonviolent offenders and higher levels of childhood activity; these patterns are consistent with IP theory. Predictions about parenting derived from IP theory did not hold up in this study.

One caution when surveying the literature in social interest, however, is that measures of the construct have been criticized on psychometric grounds (Bass, Curlette, Kern, & McWilliams, 2002; Watkins, 1994). However, one of the most often used instruments, the Basic Adlerian Scales for Interpersonal Success–Adult (Curlette, Wheeler, & Kern, 1997), has received strong empirical support for its five-factor structure (Peluso, Stoltz, Belangee, Frey, & Pelus, 2010).

Logically, part of social interest is the need to belong, so theory and research on this construct likely has implications for IP theory. Generally, research has supported the need to belong as a basic human motivation (Baumeister, 2012; Baumeister & Leary, 1995; Gere & MacDonald, 2010). When individuals' belongingness is threatened, they show increased attention to social events and processes (presumably as a way of regaining connection with others) and negative behavioral reactions (such as increased aggression and decreased tendencies to help others). Also, chronic low belongingness is linked to a range of negative life events, including health problems (Baumeister, 2012; Gere & MacDonald, 2010).

Birth order. Birth order is by far the most controversial area of IP theory and research. Large amounts of research have been conducted on the effects of birth order, and it is generally concluded that birth order is related to personality, but that many other factors are involved in the relationship between birth order and other variables (Sollod et al., 2009). Because there is so much research in this area, I will present only a selective review.

Much of the controversy around studying birth order is centered on how to operationalize it. The simplest method is to use actual birth order (ABO), but as you are already aware Adler thought that the meaning one makes of his position is more important, so psychological birth order (PBO) should be more important and predictive of behavior (Stewart, 2012). Things get even more complicated when researchers start arguing about which positions are important (i.e., can you compare first-borns to later-borns, or must you compare all positions, first, only, middle, last?) and how sex, age spacing, cultural factors, and family structure should be taken into account. For instance, Watkins (1992b) reviewed 25 studies of birth order published in the *Journal of Individual Psychology* from 1981 to 1991. He concluded that, although many of these studies could be criticized for not accounting for intervening variables (e.g., sibling sex, age spacing, cultural factors, and socioeconomic status, or SES), support was found for some birth order predictions. The clearest support is found in studies of first-borns—they are, consistent with the theory, generally found to be more dominant and responsible (Watkins, 1992b, p. 365). However, as Ernst and Angst (1983) pointed out, comparisons of first- to later-borns are risky because these birth positions tend to be confounded with SES (higher-SES families tend to have fewer children) and many other factors. Thus, differences that are found between first- and later-borns may be the result of some of these other factors, not birth order.

Eckstein et al. (2010) used a traditional tally method to review 200 studies of birth order: They counted studies that showed significant differences (presumably in the theoretically consistent direction). For instance, they found many studies that supported the hypothesis that first-borns are high achievers and likely to be dominant. Youngest children were likely to have high social interest, and middle children demonstrated feelings of not belonging.

However, many other relationships reported were not particularly related to IP predictions. Further, in this type of review methodological features of the studies are not obvious, so it is difficult to know whether researchers were using ABO or PBO, which is important because the latter is more consistent with IP theory.

Other recent research seems to be less supportive of IP predictions. For example, Kirkaldy, Richardson-Vejlgaard, and Siefen (2009) tested Adler's proposition that first-borns and only children would have more emotional difficulties as a result of being dethroned or pampered. Contrary to IP theory, they found that middle children were more likely to have attempted suicide compared to first-borns, onlys, or last-borns.

Mixed findings have also been the norm with regard to the hypothesis that first-borns are more dominant than later-borns (Pollet, Dijkstra, Barelds, & Buunk, 2010). Most birth order research compares the personality characteristics of individuals across families—for example, are the first-borns in this sample more dominant than later-borns? Taking a different approach, Bleske-Rechek and Kelley (2014) used within-family methods to test for differences in personality according to birth order. They asked siblings to self-report and also asked parents to rate their adult children's personalities and did not find any systematic differences across birth orders. However, one could question their methods, because they were using ABO and some of the personality dimensions assessed were not exactly those specified by IP theory (e.g., openness, extroversion) although some were (i.e., conscientiousness, neuroticism). Likewise, Cundiff (2013) found no differences in delinquency between birth orders, using within- and between-family comparisons.

In an attempt to meet concerns about ABO versus PBO, an instrument has been developed to assess psychological birth order: the Psychological Birth Order Inventory (Campbell, White, & Stewart, 1991). It yields scores that measure psychological characteristics thought to be associated with the various ordinal positions (e.g., the "oldest" scale measures feelings of powerfulness and desire to achieve). However, it appears that this instrument has not been used a great deal, and some studies report less-than-desirable psychometric qualities (i.e., low reliability).

Neglecting the sex of siblings and intervals between children is also a problem with the birth order research (E. W. Jordan et al., 1982; Watkins, 1992b). Whether your older sibling is female or male would seem to make a difference in how you related, competed, or affiliated with them. One study (Lawson & Brossart, 2004) attempted to address this issue, examining sibling structure and relationship with parents. These authors found that younger brothers of brothers were more intimate with their parents yet experienced more intimidation from them. Older sisters with brothers were observed to be less intimate and to experience less parental intimidation. As you probably have noted, these results do not seem to directly bear on IP theory except in a very general way. Similarly, Dixon, Reyes, Leppert, and Pappas (2008) looked at birth order and personality in larger families (six or more children) and found that younger children were more extroverted than older children; gender and family size did not affect this finding.

Other difficulties in birth order research include the issue of the overall frequencies of the different birth orders. Studies that examine the relative proportions of a particular birth order in an expected situation (e.g., are first-borns more likely to become politicians?) often overlook the fact that, in general, birth orders are not distributed equally in the population (i.e., in a country with an increasing population, there are more first-borns than later-borns; B. N. Adams, 1972). In addition, the variety of family configurations that are common today add a great deal of complexity to the study of birth order (G. McKay, 2012). Adler's observations about birth order

probably reflect the bias that they were made in the context of his clinical practice, as pointed out by Falbo (2012) in her review of the research on only children. She contended that the research support for Adler's characterization of onlys as pampered and spoiled was nonexistent. In summary, conclusions about the influence of birth order on later life derived from IP theory should be regarded with great caution.

Early recollections. Recent empirical studies of early recollections are rare. A previous review showed more research in this area, but with inconclusive results (Watkins, 1992a). At a very basic level, some argue that attempting to create standardized scoring systems for ERs is contrary to Adler's conception of the individualistic, holistic approach to people (Kal, 1994). Others (e.g., Bishop, 1993) disagree, and it is noteworthy that attempts have been made to standardize the measurement of ERs. The most often used system in this research is the *Manaster–Perryman Manifest Content Early Recollection Scoring Manual*, which includes 42 variables that form seven clusters: characters (family, mother, father), themes, concern with detail, setting, active/passive, internal/external control, and affect (positive/negative) (Manaster & Perryman, 1974). Note that these variables do not seem especially linked to IP theory, except in very general ways.

Watkins (1992a) maintained that the ER research is supportive of IP theory in that the ERs of counseling clients are more negative and anxiety ridden than those of individuals not in counseling and, further, that they tend to change when clients receive treatment, becoming more positive in theme. Watkins cited other findings that are somewhat supportive of IP theory, but also points out a number of weaknesses in the research, including the lack of theoretical specificity noted earlier. So support for the ER construct can be said to be weak, at best.

Lifestyle. As noted earlier, several measures of lifestyle have been developed—for the most part by the same set of researchers. In what seems to be the earliest attempt to measure lifestyle, Kern (1976) developed the Life Style Inventory Questionnaire (LSIQ). A self-report measure, the LSIQ provides information about birth order, sibling relationships, and so forth that allows judges to classify people into one of eight categories of lifestyle (e.g., intellectualizer, rebel, getter, driver, superior). In a study of Catholic priests, Newton and Mansager (1986) found that judges using this instrument classified the priests reliably into a lifestyle termed "the right, superior, or good life-style" (p. 369).

The Life-Style Personality Inventory (LSPI; Wheeler, Kern, & Curlette, 1991) measures seven lifestyle themes (conforming/active, conforming/passive, controlling/active, controlling/passive, exploiting/active, exploiting/passive, and displaying inadequacy). The LSPI also includes a measure of social interest. Reliability data for the scales were found to be acceptable; validity data were more sketchy. An extension of the LSPI is the Basic Adlerian Scales for Interpersonal Success–Adult (BASIS–A; Wheeler, Kern, & Curlette, 1993). Both the LSPI and the BASIS–A ask respondents to answer items as they recollect childhood experiences rather than in reference to current functioning. The assumption is that by asking about childhood perceptions, defensiveness is reduced, thereby avoiding social desirability bias in responding (Wheeler et al., 1991). Also, Adler maintained that it is the person's interpretation of his life that matters rather than the reality.

Research using the lifestyle inventories seems inconsistent, probably partly because of the differing structures of the instruments. Lifestyle has been related to coping styles, patterns of substance use, and relationship functioning (Herrington, Matheny, Curlette, McCarthy, & Penick, 2005;

Keene & Wheeler, 1994; Kern, Gfroerer, Summers, Curlette, & Matheny, 1996; Lewis & Osborn, 2004; E. Logan, Kern, Curlette, & Trad, 1993). In general, research on lifestyle seems sparse, is sometimes beset by methodological problems, and provides only modest support for IP theory. For example, Lewis and Osborn (2004) found that the belonging/social interest lifestyle theme (as measured by the BASIS–A) was positively correlated with problematic alcohol use among college students. They saw this result as counter to the theoretical prediction that this relationship would be negative. However, they did note that one possible explanation for the finding was that the belonging/social interest scale was actually measuring extroversion or sociability instead of the Adlerian construct. In contrast, Herrington et al. (2005) confirmed expected relationships between lifestyle (belonging) and anxiety. Studying school counselors, Wachter, Clemens, and Lewis (2008) found that perfectionism and self-esteem were related to counselor burnout in expected ways, but lifestyle was not related to the extent counselors reported that they would involve stakeholders in their work (which would seem to be related to social interest). Stoltz, Wolff, and McClelland (2011) looked at the relationship between lifestyle (BASIS–A scores) and career development variables among a sample of predominantly African-American rural high school students. Although they found two lifestyle variables were related to career indices (wanting recognition and taking charge), one of the relationships (taking charge and career indecision) was the opposite of what was expected. These results may well be reflective of the small sample size in the study (44 students), which resulted in low statistical power to detect significant effects.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Adler was probably one of the first theorists to recognize the effects of class differences, and he was certainly an early advocate of equality between the sexes. He recognized the socially based constraints that women experienced and clearly acknowledged the devaluation of the female role in the majority culture of his time. From this perspective, then, we could say that his theory might be somewhat less biased than other approaches in terms of gender considerations. However, he did have fairly stereotypical views of women's roles, characterizing them as demonstrating "masculine" goals if they pursued traditionally male occupations. Feminists would see these values as upholding the patriarchy. At the same time, contemporary feminists see many similarities between IP counseling and feminist therapy (Bitter et al., 2009).

IP theory's focus on social involvement and the importance of relationships is consistent with the values of cultures that hold collectivistic as compared to individualistic worldviews, such as Asian and Native American cultures (C. L. Thompson & Rudolph, 2000). For example, Johansen (2005) argued that the basic philosophy of IP is consistent with that of individuals who are of Islamic faith. In their introduction to two special issues in the *Journal of Individual Psychology* on culture and IP, Sperry and Carlson (2012) highlighted the worldwide presence of Adlerian thought and counseling, noting that although sometimes adaptations need to be made to fit with cultural practices, much of the theory is seen as helpful in many countries. Articles in these issues describe the use of the IP approach in many countries, including Bulgaria, South Africa, Japan, China, South Korea, and Israel.

Adler was aware of the negative effects of racism and classism; this quality clearly differentiated him from his contemporaries. The egalitarian therapeutic relationship and the emphasis on cooperation among individuals and with society are also strengths of this theory when working

with women and clients from diverse backgrounds. At the same time, the theory emphasizes individual choice, control, and responsibility—constructs that are Western in orientation. Adler's emphasis on the equality of the sexes might be inconsistent with some culture's values (Sperry & Carlson, 2012). Insight (into lifestyle) is also important in IP counseling; this orientation may be inconsistent with the values of cultures that are action oriented (such as the African-American community; Sue & Sue, 2013). On the other hand, Perkins-Dock (2005) argued that several principles of IP, such as "(a) concept of collective unity and social interest, (b) importance placed on the family atmosphere, (c) emphasis on collaborative goal setting, (d) influence of a multigenerational legacy, and (e) flexibility of intervention strategies" (p. 235), make it appropriate for work with African-American families.

One significant criticism of Adler concerns his views on homosexuality. Referring to these lifestyles as perversions (Ansbacher & Ansbacher, 1956), Adler characterized the choice of a LGBT lifestyle as evading the task of love. Modern Adlerians do not take this position; in fact, they understand that prejudice and discrimination can understandably lead to inferiority feelings that should be seen as the result of this oppression (Maucieri & Stone, 2008; Trail et al., 2008; Yang et al., 2010). There is also some evidence that Adler was more tolerant in his views than his writings would suggest. McDowell related an anecdote in which a social worker consulted Adler about a client who was gay. According to this account, upon learning that the client was homosexual, Adler inquired if the client was happy. When McDowell responded that he was, Adler replied, "Well . . . why don't we leave him alone? Eh?" (quoted in Manaster, Painter, Deutch, & Overholt, 1977, p. 82).

THE CASE STUDY

IP theory fits James's presentation well because of its emphasis on the influence of the early environment and on the client's ways of operating in the world, or lifestyle. Adler's ideas seem to help in understanding James's story. James is African-American, and Adler's recognition of racism clearly applies to this case. IP theory would recognize that as a young African-American male, James has likely experienced some aversive interactions with people that were largely based on his race. However, this theory's emphasis on the development of life goals before the age of 6 may overlook the effects of experiences James had subsequent to his first foster placement. Adler had little to say about nontraditional family structures, but he would insist that it was James's interpretation of his environment that was most influential in determining his current functioning.

Summary

IP theory teaches that human life is intricately tied to two basic motivations: the striving for power, or superiority, and the need for belonging, or social interest. An individual develops a unique lifestyle, which is the blueprint for how these needs are met. The lifestyle is formed by the age of 6 and is influenced by the early environment of the child (i.e., birth order, sex, family values). However, what the individual makes of his experience is a creative process; the influences of family, physical environment, and heredity are only part of the equation.

Individuals who are healthy fulfill the basic tasks of life: love, work, and community. They are courageous and able to take responsibility for their lives. Dysfunctional individuals are discouraged.

They are selfish and often timid, "yes but" personalities. They walk on the useless side of life and avoid challenge and responsibility.

The goal of IP therapy is to help the client understand his faulty lifestyle. The counselor takes an optimistic outlook, and the relationship is egalitarian. Faith, hope, and love are important qualities of the counseling relationship. Numerous techniques are available to the IP counselor.

Adler was the first major theorist of counseling to recognize the power of social conditions. However, IP theory has been criticized for being common sense and simplistic. Many of the major assumptions of IP theory are difficult to test, and the research evidence for the system is questionable methodologically.

MyCounselingLab

Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy*, Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 1.

CHAPTER 5

Person-Centered Therapy



Carl R. Rogers

Richard is a 48-year-old White male. He is a high school graduate and has worked as an insurance salesperson for the past 3 years. Prior to this period, he worked at the management level for a telecommunications company, but left that job because he found it too stressful.

Richard presents with depressed mood that affects his physical, social, and occupational functioning. He reports experiencing this depression for about the past 2 years. During this period, Richard characterizes himself as often fatigued, socially withdrawn, and ineffective at work. His income has dropped significantly during the last 2 years. Richard feels guilty for having to rely on his wife, Sandy, as the primary income provider. According to Richard, Sandy often expresses disapproval of him nonverbally, such as when she is writing checks for the monthly bills. The couple argues quite frequently about financial matters.

Richard and Sandy have two adult children (Natalie and James), who have completed college within the past 5 years. Richard reports that both children currently earn more than his present income. This situation makes him feel inadequate. As a result, Richard feels emotionally distant from Natalie and James and sees them as closer to Sandy.

Richard's social activities typically involve his wife and are work related. He spends his spare time with his computer or reading. He reports having no close friends.

During counseling sessions, Richard seems uncomfortable, has difficulty maintaining eye contact, laughs nervously during the shortest periods of silence, and comments on his discomfort with the lack of structure. Although he seems motivated to change, Richard seems to have difficulty discussing his situation.

BACKGROUND

Person-centered (PC) therapy is the creation of Carl Rogers (1902–1987). Developed over a span of more than 40 years, the approach has been known by three different names. Rogers first called his theory nondirective therapy, but as his ideas continued to evolve he renamed it client-centered therapy. In the 1980s, he began using the term *person-centered approach* in recognition that the theory applied far beyond the counseling situation (e.g., teaching, group leadership, international affairs; C. R. Rogers, 1980; Zimring & Raskin, 1992).

Rogers was born into what he described as "a home marked by close family ties, a very strict and uncompromising religious and ethical atmosphere, and what amounted to a worship of the virtue of hard work" (C. R. Rogers, 1961, p. 5). His family moved to a farm when Rogers was 12, and as a result Carl became interested in agriculture, particularly the scientific aspects (C. R. Rogers, 1961). He majored in agriculture in his first 2 years of college, but then found his interests changing; he eventually began theological training at Union Theological Seminary in New York. However, after taking courses in psychology at Columbia University, he changed his path again and entered the clinical psychology program there.

After receiving his degree in 1931 (from a program that emphasized traditional experimental psychology and testing), Rogers took his first job as a staff psychologist in the Child Study Department of the Society for Prevention of Cruelty to Children in Rochester, New York. There the beginnings of PC therapy were established as Rogers struggled to help the underprivileged clients of this agency. Finding the traditional psychoanalytic methods favored at this clinic increasingly unsatisfactory in his work, Rogers slowly began to develop his theory of counseling. He described several incidents that spurred his growth, and perhaps the most touching occurred when he had all but given up on a troubled boy and the boy's mother. He had struggled mightily to get them to understand the Oedipal roots of their problems and had finally become resigned to his inability to help them. At the end of what was to be the final session, he was explaining the situation to the boy's mother. Suddenly, she asked if Rogers would accept adults for counseling and launched into an anguished description of her troubles. As Rogers (1961) put it, "Real therapy began then and ultimately it was highly successful—for her and for her son" (p. 11). These early experiences led Rogers to conclude that it was really the client who knew what the problem was and where to go to solve it. This assumption is the foundation of the PC approach. The major portions of the theory were developed in the late 1950s and 1960s, mostly in reaction to two influences: (a) the psychoanalytic model that dominated the atmosphere at Rogers's first job (C. R. Rogers, 1961), and (b) the positivistic, behaviorist tradition that was becoming prominent during that time period (C. R. Rogers, 1977).

From Rochester, Rogers moved to Ohio State University in 1940 and then to the University of Chicago (1945–1957), where he established the Student Counseling Service, later renamed the Counseling and Psychotherapy Center. An account of the development of the center and the beginnings of Rogers's research program can be found in Cornelius-White and Cornelius-White (2005). An interesting tidbit: The technology at the time was so primitive that the famous first-ever recording of a therapy session (in which the therapist was anonymous, but according to Patterson, 2000, was surely Rogers) was accomplished using glass disks, and it took 10 of these to record *one* therapy session.

Rogers's last traditional academic appointment was at the University of Wisconsin (1957–1963). He then moved to the Western Behavioral Sciences Institute in La Jolla, California, and later founded the Center for Studies of the Person in La Jolla, where his professional career ended. Along the way, he wrote many articles and books, the most prominent of which are probably *Counseling and Psychotherapy* (1942), *Client-Centered Therapy* (1951), *On Becoming a Person* (1961), and *A Way of Being* (1980). You can read an excerpt from one of Rogers's well-known articles in Box 5.1.

Box 5.1

An Excerpt from "The Necessary and Sufficient Conditions of Therapeutic Personality Change"

THE CONDITIONS

As I have considered my own clinical experience and that of my colleagues, together with the pertinent research which is available, I have drawn out several conditions which seem to me to be necessary to initiate constructive personality change, and which, taken together, appear to be sufficient to inaugurate that process. As I have worked on this problem I have found myself surprised at the simplicity of what has emerged. The statement which follows is not offered with any assurance as to its correctness, but with the expectation that it will have the value of any theory, namely that it states or implies a series of hypotheses which are open to proof or disproof, thereby clarifying and extending our knowledge of the field.

Since I am not, in this paper, trying to achieve suspense, I will state at once, in severely rigorous and summarized terms, the six conditions which I have come to feel are basic to the process of personality change. The meaning of a number of the terms is not immediately evident, but will be clarified in the explanatory sections which follow. It is hoped that this brief statement will have much more significance to the reader when he has completed the paper. Without further introduction let me state the basic theoretical position.

For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow.

A Relationship

The first condition specifies that a minimal relationship, a psychological contact, must exist. I am hypothesizing that significant positive personality change does not occur except in a relationship. This is of course a hypothesis, and it may be disproved.

Conditions 2 through 6 define the characteristics of the relationship which are regarded as essential by defining the necessary characteristics of each person in the relationship. All that is intended by this first condition is to specify that the two people are to some degree

in contact, that each makes some perceived difference in the experiential field of the other. Probably it is sufficient if each makes some "subceived" difference, even though the individual may not be consciously aware of this impact. Thus it might be difficult to know whether a catatonic patient perceives a therapist's presence as making a difference to him—a difference of any kind—but it is almost certain that at some organic level he does sense this difference.

Except in such a difficult borderline situation as that just mentioned, it would be relatively easy to define this condition in operational terms and thus determine, from a hard-boiled research point of view, whether the condition does, or does not, exist. The simplest method of determination involves simply the awareness of both client and therapist. If each is aware of being in personal or psychological contact with the other, then this condition is met.

This first condition of therapeutic change is such a simple one that perhaps it should be labeled an assumption or a precondition in order to set it apart from those that follow. Without it, however, the remaining items would have no meaning, and that is the reason for including it.

The State of the Client

It was specified that it is necessary that the client be "in a state of incongruence, being vulnerable or anxious." What is the meaning of these terms?

Incongruence is a basic construct in the theory we have been developing. It refers to a discrepancy between the actual experience of the organism and the self picture of the individual insofar as it represents that experience. Thus a student may experience, at a total or organismic level, a fear of the university and of examinations which are given on the third floor of a certain building, since these may demonstrate a fundamental inadequacy in him. Since such a fear of his inadequacy is decidedly at odds with his concept of himself, this experience is represented (distortedly) in his awareness as an unreasonable fear of climbing stairs in this building, or any building, and soon an unreasonable fear of crossing the open campus. Thus there is a fundamental discrepancy between the experienced meaning of the situation as it registers in his organism and the symbolic representation of that experience in awareness in such a way that it does not conflict with the picture he has of himself. In this case to admit a fear of inadequacy would contradict the picture he holds of himself; to admit incomprehensible fears does not contradict his self concept.

Another instance would be the mother who develops vague illnesses whenever her only son makes plans to leave home. The actual desire is to hold on to her only source of satisfaction. To perceive this in awareness would be inconsistent with the picture she holds of herself as a good mother. Illness, however, is consistent with herself concept, and the experience is symbolized in this distorted fashion. Thus again there is a basic incongruence between the self as perceived (in this case as an ill mother needing attention) and the actual experience (in this case the desire to hold on to her son).

When the individual has no awareness of such incongruence in himself, then he is merely vulnerable to the possibility of anxiety and disorganization. Some experience might occur so suddenly or so obviously that the incongruence could not be denied. Therefore, the person is vulnerable to such a possibility.

(continued)

Box 5.1 *(continued)*

If the individual dimly perceives such an incongruence in himself, then a tension state occurs which is known as anxiety. The incongruence need not be sharply perceived. It is enough that it is subceived—that is, discriminated as threatening to the self without any awareness of the content of that threat. Such anxiety is often seen in therapy as the individual approaches awareness of some element of his experience which is in sharp contradiction to his self concept.

Source: From Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95–103.

Going beyond individual counseling, Rogers became one of the leaders of the encounter group movement in the late 1960s and 1970s (Kirschenbaum, 2004). In the last years of his life, Rogers led large workshops all over the world aimed at resolving conflict, for which he was nominated for a Nobel Peace Prize in 1987 (Cain, 2013). The same day he was nominated, Rogers fell and broke his hip and a few weeks later died of a heart attack during surgery to repair it (Weinrach, 1990). Rogers was survived by two children; his wife had died in 1979. His daughter, Natalie, became a therapist, eventually developing her own approach, integrating PC theory with expressive modalities (e.g., art, movement; N. Rogers, 1993; Sommers-Flanagan, 2007).

Carl Rogers was a pioneer in many ways. He was the first to use the term *client* to refer to someone seeking psychotherapy. In explaining his use of this term, he said, "The client . . . is one who comes actively and voluntarily to gain help on a problem, but without any notion of surrendering his own responsibility for the situation" (1951, p. 7). Perhaps Rogers's most significant contribution was his willingness to submit the counseling process to the rigors of research. He was the first to record counseling sessions, and he used these recordings to test his ideas. Many times the transcripts or recordings used in research and publications featured Rogers as the counselor. One of these recordings was the basis for the book *Counseling and Psychotherapy* (1942), which presented the first complete transcription of a counseling case ever printed. Braving the psychotherapeutic unknown, Rogers designed and conducted an extensive study of PC therapy with schizophrenics while he was on the faculty of the psychology and psychiatry departments at the University of Wisconsin (see Box 5.2).

Box 5.2

The Wisconsin Schizophrenia Project

In 1957, Carl Rogers was looking for new challenges. He moved to the University of Wisconsin and became a member of the departments of psychology and psychiatry. He wondered if the client-centered therapeutic approach that was so successful with the college students at the University of Chicago would be as helpful with other kinds of clients. In collaboration with

the members of the Psychotherapy Research Group at the University of Wisconsin Psychiatric Institute, he set out to test whether client-centered therapy would work with schizophrenic clients (C. R. Rogers, 1967).

The study took place over a 5-year period. Eight therapists, all of whom were essentially person-centered in their orientations, volunteered to provide counseling. Rogers was one of the therapists. Three groups of participants were identified: acute schizophrenics, chronic schizophrenics, and normal individuals (not hospitalized and reporting no dysfunction). A total of 48 participants entered the study and were randomly assigned to therapy or control groups. Multiple measures were used, including a battery of psychological tests (the Rorschach and the Minnesota Multiphasic Personality Inventory, among others) and measures of the therapeutic relationship. Rating scales were developed to measure the important constructs of PC theory, including empathy, unconditional positive regard, and therapist congruence. Measures of the therapy process included the level of client experiencing and the ability of the client to engage in relationships. Overall, this study was a tremendous undertaking.

Unfortunately, the study did not flow as well as Rogers had planned. One member of the research team committed an ethical violation. It is not absolutely clear what happened from Rogers's (1967) account, but some of the data apparently disappeared and much of the statistical analysis had to be repeated. Discord was rampant among the research team, and although the study was eventually completed and published, Rogers (1967) characterized the period as "without doubt the most painful and anguished period in my whole professional life" (p. 371).

The results of the study were mixed. Analyses showed some isolated differences between the treatment and control groups (e.g., treated hospitalized clients showed a slightly higher release rate than nontreated hospitalized clients), but overall the therapy group showed no greater improvement when compared to the control group. All hospitalized individuals showed positive change regardless of whether they received PC counseling. Some support for the theory was found in that clients who perceived higher degrees of two of the therapeutic conditions, empathy and congruence, showed better outcomes on two indicators (objective test scores and ratings by clinicians) than did clients who perceived low levels of these conditions. One interesting finding was that clients' and independent observers' ratings were similar in their evaluations of the therapeutic relationship, but therapists' ratings were negatively correlated with the ratings of the other two groups. That is, the therapists' ratings tended to be high when the clients' (or the observers') ratings were low, and vice versa.

Rogers and his colleagues found the results of the study somewhat encouraging. The link between the relationship conditions and outcome seemed promising, and the fact that the researchers were able to develop reliable measures of these indicators was significant. Rogers concluded that the same conditions of good therapy work with schizophrenic clients as well as neurotics. In fact, Rogers suggested that one of the most important insights gained from the study might be that generally the schizophrenic clients were more like the typical clients he worked with than they were different (C. R. Rogers, Gendlin, Kiesler, & Truax, 1967, p. 93).

Carl Rogers is one of the most influential American psychologists of all time (Cain, 2013). His impact on his profession was recognized by the American Psychological Association (APA) when, in 1956, he was chosen as one of the first three individuals awarded the APA award for distinguished scientific contribution. In 1972, he was given the APA award for distinguished

professional contribution, becoming the only person ever to receive both awards. He served as president of the APA in 1946.

Seeman (1990) argued that a theory is by necessity the theorist's autobiography. Sollod, Wilson, and Monte (2009) commented that Rogers's emphasis on personal freedom likely had its roots in reaction to his strict early environment. The comparability between Rogers's theory and his life was quite evident in his increasing willingness to reveal his person in both his writings and his work with clients. Over his professional career, he became more and more convinced that the genuineness of the therapist is critical to the therapeutic process, and he applied this assertion to his life as well. At least four times (in 1961, 1972, 1980, and 1987; see Kirschenbaum & Henderson, 1989), he wrote accounts of his personal experiences, which are excellent demonstrations of the PC philosophy in action.

Carl Rogers applied PC concepts in areas beyond counseling and psychotherapy, coming to see his theory as more of an approach to interpersonal relations and learning than simply as a theory of client change. For instance, he wrote about marriage (C. R. Rogers, 1972) and education (C. R. Rogers & Freiberg, 1994) and conducted encounter groups all over the world in the interests of contributing to world peace (C. R. Rogers, 1980). Rogers lives on in the *Three Approaches to Psychotherapy* videos, in which he demonstrated PC therapy with a client named Gloria (Shostrom, 1965). The session with Gloria is considered a classic demonstration of the ideal therapeutic relationship and is still avidly watched by counseling students today. Box 5.3 describes a controversy associated with the video.

Box 5.3

The Meaning of the Missing 249 Words

In 1965, a film series was presented that changed the world of counseling and psychotherapy. In the *Three Approaches to Psychotherapy* (Shostrom, 1965), a courageous woman named Gloria served as a client for three therapists, Carl Rogers, Fritz Perls, and Albert Ellis. Each of the three segments begins with the theorist explaining his views, proceeds to a 20-minute counseling session with Gloria, and concludes with the theorist's evaluation of his work. At the end of the third interview, Gloria presents her reactions to the three theorists. Gloria's interaction with Rogers has been characterized as exemplifying his incredible ability to form intense, satisfying relationships with people, a demonstration of his almost uncanny therapeutic ability (Weinrach, 1990). Gloria and Carl corresponded for 15 years after the interview until her death at age 45, and met once during this period.

One section of the Gloria–Carl interaction has been the subject of controversy. Toward the end of the film, Gloria tells Carl, "I'd like you for my father." Carl responds, "You look to me like a pretty nice daughter." In his taped discussion after the session, Rogers mentions that this interaction might be labeled transference and countertransference, but dismisses that conceptualization as intellectualizing and a disservice to the value of the relationship.

As a result of a rather surprising discovery, the meaning of Gloria and Carl's interchange was the topic of a hot debate in the journal *Psychotherapy* (Bohart, 1991; Weinrach, 1990). Six months after Carl Rogers's death, Weinrach (1990) located a 249-word segment of the

interview that was not included in the film. Evidently, the film ran out, but a separate audio recording of the session continued. In the segment, Gloria and Carl had continued their conversation, and Gloria indicated that her search for a loving father figure was a "neurosis." Weinrach (1990) suggested that, if it had been known that Gloria's longing was, for her, a typical pattern, "or worse yet, a long-standing neurotic need" (p. 283), Rogers would have lost the therapist-guru status that he gained from the film. Instead, Rogers would have been seen as merely a human therapist who missed the boat in failing to interpret Gloria's transference reaction. Even more problematic, in Weinrach's view, was the fact that Rogers appeared to be bound up in countertransference feelings for Gloria, which was what caused his failure to respond to her transference. Also, Weinrach maintained that if Rogers had acknowledged these dynamics he would have been supporting a theory against which he had argued for a long time (psychoanalysis), thereby questioning his own theory. In essence, Weinrach implied that had the missing 249 words been included in the film, Rogers would have been discredited.

Bohart (1991) defended Rogers, contending that Weinrach's views are based in a theoretical perspective (psychoanalytic), not absolute truth. Agreeing with Rogers that reference to transference processes is not productive, Bohart (1991) maintained that "what Weinrach is really saying is that he prefers a transferential interpretation of the Rogers–Gloria interaction" (p. 497). Further, he wrote, "To accuse Rogers of making a therapeutic mistake because he did not deal with transference is equivalent to saying that Rogers made a mistake because he did not operate in terms of the theoretical constructs that Weinrach . . . ascribe[s] to" (p. 497). Pointing out that Gloria tends to discount her experience (when she calls her wish for an accepting male figure neurotic), Bohart noted that classifying Gloria's feelings as transferential would validate her mistrust of her person, a damaging event from a PC perspective. With regard to Rogers's responses to Gloria, Bohart questioned if it is "'countertransferential' to like and respect one's client, or (heaven forbid) to actually *express* such sentiments" (p. 501; emphasis in original).

In responding to Bohart, Weinrach (1991) defended his conceptualization of the transferential nature of the Gloria–Carl interaction. He acknowledged that Rogers had always elicited in him a wish to have such a grandfather and wondered "what feelings Rogers' persona has evoked in Bohart that influenced him to write such an impassioned defense of Rogers" (1991, p. 505). Further, Weinrach (1991) wrote, "Bohart appears to be applying the therapeutic principle of unconditional positive regard to everything Rogers did, including Rogers' demonstration with Gloria" (pp. 505–506). Weinrach concluded by suggesting that the film be regarded only as a historical artifact at best and as a negative example at worst. Evidently, Bohart chose not to respond to Weinrach's rebuttal.

This entertaining interchange is probably best viewed as a good demonstration of the way theoretical lenses can influence the interpretation of events. Working from a psychoanalytically influenced view, Weinrach saw Gloria and Carl's interaction as transference and countertransference. This perspective, with its attention to client–counselor interaction as a recapitulation of early experience, would evaluate the interchange as a negative therapeutic event because Rogers did not recognize the processes and intervene. In contrast, Bohart endorsed a PC approach, seeing the Gloria–Carl interaction as an authentic exchange of intimate feelings, a positive event from this perspective. Until the unlikely time that one of these two theories is elected as the "truth" of psychotherapy, the lesson to be learned is that what we know as "reality" can be viewed from multiple perspectives.

The Center for Studies of the Person continues Rogers's work and has a website, www.centerfortheperson.org. Other Internet sites of interest are the World Association for Person-Centered and Experiential Psychotherapy and Counseling (WAPCEPC; www.pce-world.org), the Association for the Development of the Person Centered Approach (ADPCA; http://adpca.org), and the webpage of Person-Centered Expressive Arts, the organization founded by Rogers's daughter, Natalie Rogers (http://personcenteredexpressivearts.com), who characterizes herself as an arts therapist philosophically grounded in her father's ideas. The scholarly journal *Person-Centered Review*, launched in 1986 as a result of the first meeting of ADPCA, became the *Person-Centered Journal* in 1992 (Raskin, Rogers, & Witty, 2014). WAPCEPC currently publishes *Person-Centered and Experiential Psychotherapies*.

It appears that the prominence of the PC approach has decreased in the United States in recent years, but in Europe there is still lots of interest in PC theory (Cooper, O'Hara, Schmid, & Bohart, 2013). Lively programs of research and intervention continue in other countries, such as Germany and the United Kingdom, and there are PC organizations in many countries around the world (Kirschenbaum & Jourdan, 2005, presented a list of 18). Elements of Rogers's approach can also be clearly seen in contemporary programs of training for interpersonal and counseling skills (Hill, 2014; Ivey, Ivey, & Zalaquett, 2016).

BASIC PHILOSOPHY

The hallmark of PC theory is the basic premise that given a supportive environment, humans have a tendency to be good. Carl Rogers (1961) was quite clear about this conviction, writing that "the basic nature of the human being, when functioning freely, is constructive and trustworthy. . . . We do not need to ask who will control his aggressive impulses; for as he becomes more open to all of his impulses, his need to be liked by others and his tendency to give affection will be as strong as his impulses to strike out or to seize for himself. He will be aggressive in situations in which aggression is realistically appropriate, but there will be no runaway need for aggression" (p. 194). Statements such as these provoked accusations of an overly positive view of humans, most famously a debate between Rogers and Rollo May concerning the potential for evil in human nature (see May, 1982; C. R. Rogers, 1982). Discussions of this issue continue currently, with Bohart (2013) and Schmid (2013a) pointing out that Rogers never denied the human capacity for bad behavior. What Rogers meant, they argue, was that if the conditions in which an individual functions are not destructive, the actualizing tendency will push the person in a positive, constructive direction.

In Rogers's (1980) view, human behavior is the result of an innate need to grow and develop that is common to all living organisms. If left alone, the person will follow the road to full human potential, showing none of the negative tendencies postulated by other theorists (e.g., Freud's aggressive instinct). Rogers (1966) wrote, "Contrary to those therapists who see depravity at men's core, who see men's deepest instincts as destructive, I have found that when man is truly free to become what he most deeply is, free to actualize his nature as an organism capable of awareness, then he clearly appears to move toward wholeness and integration" (p. 193). The PC therapist recognizes that humans sometimes act in destructive or antisocial ways, but maintains that these tendencies are a product of experience in the environment, not built into the human psyche (Bohart, 2013).

Daryl, Richard's PC therapist, begins with the assumption that Richard is inherently a positive, forward-moving individual. Even though Richard is exhibiting some emotion and behavior that might

be labeled by others as dysfunctional, Daryl is sure that within Richard is the potential to grow and actualize, establish meaningful and productive relationships with others, and work effectively. He sees glimmers of this in Richard's evident willingness to engage in counseling and small sparks of hope that appear when Daryl responds supportively to him.

PC counselors are committed to the notion that clients are self-directing and able to accept full responsibility for their actions (Bohart, 2013). Each person has within him the resources and strengths to grow and become a better person. This respect for the individual's autonomy leads to an attitude of equality in the therapeutic interaction, and this mutuality of involvement is critical in any context to which PC theory is applied (van der Veen, 1998). Rogers spoke of freedom as an important element of the counseling relationship. He believed that the client (and the counselor as well) should be free to explore every aspect of the self within the therapeutic environment. "There is also a complete freedom from any type of moral or diagnostic evaluation, since all such evaluations are, I believe, always threatening" (C. R. Rogers, 1961, p. 34).

PC therapy is characterized as humanistic and phenomenological (Ruthven, 1992). Proponents of humanistic approaches trust the individual, viewing people as oriented toward growth and harmony with others. Rogers's approach is phenomenological in that he argued that the most important factor in understanding a given individual is his (the individual's) perceptions of reality, because for the person, perception is reality.

Daryl approaches Richard as an equal and encourages him to determine the nature and content of the counseling relationship. He relies on Richard to provide the basic material of counseling, asking Richard what he wants to discuss. Although this attitude seems somewhat surprising to Richard and tends to make him a little uncomfortable, Daryl persists in his gentle support of Richard's choices and decisions within the counseling session. In no way does Daryl assess, diagnose, or evaluate Richard; he simply does his best to understand Richard's world.

HUMAN MOTIVATION

PC theorists believe that the only motivation of human behavior is the tendency to grow to full potential in constructive, positive ways. Living beings strive to maximize the *organism* (a term used by Rogers to mean the whole person or other living entity) and avoid experiences that are detrimental to it. PC theorists see no inherent aggressive or destructive tendencies in people, although aggression or assertion may sometimes be used as a means to grow, such as when an individual asserts himself to obtain something that enhances his existence. For example, killing animals for food would be seen as an aggressive act directed toward the actualization of the organism.

Daryl knows that Richard is motivated to grow and enhance himself and live in harmony with his environment, which includes other people. At the beginning of counseling, Richard's behavior may not seem to consistently stem from this tendency—he seems somewhat stuck at present—but Daryl knows that it is there and needs only to be released from interference. Daryl will constantly look for and respect Richard's growth tendencies throughout the counseling interaction.

CENTRAL CONSTRUCTS

EXPERIENCE

Rogers (1959) used the term *experience* in two ways. Experience as a noun refers to everything that is going on in the individual at a given moment. Of particular importance in experience are emotions, because we tend to suppress, deny, or distort these in the service of social rules. Although Rogers (1959) recognized that unconscious processes might exist, they are not considered in the definition of experience because they cannot be studied objectively; thus, experience is confined to events that are potentially available to consciousness.

The use of the term *experience* as a verb means the process of the person receiving what is going on around and within him, the "sensory or physiological events which are happening at the moment" (C. R. Rogers, 1959, p. 197). This term is special to PC theory because in order to grow, humans must experience accurately, discriminating between events that contribute to the organism's well-being and those that are harmful. The degree to which experience is perceived without distortion or disruption determines the level of the individual's functioning.

Daryl is aware that accurate perception and symbolization of experience are critical to Richard's psychological well-being. Richard is clearly attending to what is going on in the environment around him as well as his psychological experience (he can report feelings of depression). However, Richard's desire to come to counseling and his admission that he is depressed suggest that Richard's experiencing is derailed in some way.

ACTUALIZING TENDENCY

The most basic human process is the actualizing tendency, which is the "inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism" (C. R. Rogers, 1959, p. 196). This process involves both the person's biological and psychological growth. Growth is always in the direction of autonomy and thus leads to internal regulation of the individual's existence. Growth is also toward greater levels of complexity (C. R. Rogers, 1980).

Daryl looks for signs of the actualizing tendency in Richard. Even though Richard's uncomfortable presence and evident depression seem less than growthful, when Richard talks about his struggles Daryl can sense the presence of a tendency to grow in Richard's desire to live a better, less isolated life.

ORGANISMIC VALUING PROCESS

Rogers thought that humans engage in an ongoing process of evaluating experience, measuring it event by event to determine if it contributes to one's growth or detracts from it. Humans move toward growth-producing experiences and away from those that do not contribute to or that interfere with growth. In the healthy person, the basis for this constant evaluation of experience is the actualizing tendency. To take a simple example, when 3-year-old Sasha touches a hot stove, she snatches her hand away because it does not promote the growth of her organism to get burned!

Ideally, Daryl would look for signs of the operation of the organismic valuing process in Richard's behavior. Signs of this process are observable at times, but at other times Richard's behavior might seem to be motivated by other influences. For example, Richard seems to fully enjoy his leisure pursuits

(reading and working on his computer), but he avoids his family and other social relationships. Because healthy interpersonal relationships are growth-enhancing, Daryl hypothesizes that in those situations Richard is not acting in accordance with his organismic valuing process. Daryl knows that fluctuations of this type are natural—and perhaps even more pronounced in individuals coming to counseling because the need for counseling suggests that some processes are awry.

SELF

As humans grow and experience the world, a portion of this experience becomes labeled as the self. All experiences that the person recognizes as "me" and the values that are attached to them become the *self-concept* (C. R. Rogers, 1959). For instance, if I discover that I am good at doing the tango, this experience becomes a part of my self-concept. If I value tango dancing, then this experience contributes to a positive self-concept.

Rogers thought that, if experiences are inconsistent with our self-concepts, or negatively valued, we will have difficulty allowing ourselves to perceive them. For example, if it is difficult for me to get up in the morning, then my self-concept could include the construct that I am not a morning person. If there are negative values associated with not being a morning person, this experience will contribute to a negative self-concept to the degree to which I allow myself to acknowledge it. I could, in fact, insist that I always get up at 5:00 a.m., but none of my friends would believe me! A third self-construct important in PC theory is the *ideal self*, the self the person would like to be. My ideal self may contain the characteristics "tango dancer" and "morning person," only one of which is consistent with my actual experience.

Richard probably has a negative self-concept. He is able to recognize and reveal several "negative" aspects of himself—he is socially withdrawn and ineffective at work. Because he unfavorably compares himself with his children, Richard feels inadequate. Very little in Richard's self-description seems positive, and Daryl also guesses that Richard's ideal self is so close to perfection as to be unobtainable by a human being.

SELF-ACTUALIZING TENDENCY

An aspect of the general actualization tendency, the self-actualizing tendency, refers to the propensity of the self to grow and maximize. When the individual is functioning well, the actualizing and self-actualizing tendencies function in concert. What is good for the organism is also perceived as good for the self; what is bad for the organism is therefore bad for the self. Hugging another person is good for me both physically and in terms of self needs.

No matter how gloomy or rigid he seems, Daryl is convinced that Richard has within him the potential to self-actualize. Given the right support, Richard's organismic and self-actualizing tendencies can align so that he functions at the top of his game.

NEED FOR POSITIVE REGARD AND SELF-REGARD

All human beings have a need for positive regard, and this need extends to the self-system. We value the love of others and also have a need to positively value ourselves. Rogers (1959) was not clear whether the need for regard is innate or learned, but he was quite specific in saying that the need for positive regard of the self is learned through experiencing it from others important to the individual.

Richard's need for positive regard is evident in his reactions to his wife's disapproval. He is falling short in the area of positive self-regard, as seen in his feelings of inadequacy when he compares his achievements to those of his children.

CONDITIONS OF WORTH

The need for positive regard motivates individuals to seek love from important others around them (C. R. Rogers, 1959). When the individual perceives that some aspect of himself (whether it is perception, feeling, or behavior) is evaluated positively by someone important to him and other aspects are not, conditions of worth arise. The need for love is so intense that we will deny parts of our experience that are deemed unacceptable (unlovable) by significant others. A classic example of this dynamic is when Toni becomes frustrated and angry. From a PC perspective, anger is a natural part of human existence; it does not detract from the growth of the organism. If her parents consistently display negative reactions to Toni's anger, she will tend to deny or distort the experience of anger in the future. She will begin to feel anxious or "bad" when she begins to get angry, and in an attempt to align her perceived and ideal selves, she may even start to view herself as someone who never gets angry. In contrast, if Toni's parents accept her anger nonjudgmentally, she will have no need to distort or disown the experience. She can experience the anger and then go about her business.

Initially, conditions of worth are external; that is, they are the reactions of others (such as parents) who value behaviors differentially, often based on societal norms (e.g., boys don't cry, girls don't shout). What happens quite often, however, is that individuals repeatedly gain the approval of important others for displaying behaviors that are consistent with conditions of worth, and after a while the conditions are internalized as parts of the self (C. R. Rogers, 1959). When this transformation happens, the individual is not evaluating experiences through the organismic valuing process; rather, he is valuing experiences based on whether they are consistent with the internalized conditions of worth. He is said to be operating on an *external* locus of evaluation (because his values are not self-generated) rather than an *internal* locus of evaluation (the organismic valuing process). Because conditions of worth are based on societal rules, they are not always consistent with the actualizing tendency. In fact, they are often at odds with the actualizing tendency.

MyCounselingLab

Video Example 5.1 Think about how this segment illustrates Gloria's conditions of worth.



https://www.youtube.com/watch?v=m30jsZx_Ngs

Daryl knows that Richard's self is conditional. His guilt and depression are likely the result of aspects of his experience that are inconsistent with his internalized conditions of worth. For example, Richard apparently holds the value that to be worthwhile, he should earn a certain amount of money—specifically, that he should be the primary provider for his family. He is not fulfilling the condition that men are strong and provide for their families. That his children make more money than he does only confirms his negative perceptions of self. Daryl also guesses that Richard's decision to change occupations was inconsistent with his conditional self, which dictates that men don't buckle under stress and do not show "weak" emotions. He is just not good enough.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Life is an active process (C. R. Rogers, 1980, p. 118). "In short, organisms are always seeking, always initiating, always 'up to something'" (p. 123; quotes in original). Even in the worst conditions, all organisms strive to grow in positive directions. So begins the journey of the infant.

The infant, motivated by the actualizing tendency, evaluates experience based on the organismic valuing process. "Experiences which are perceived as maintaining or enhancing the organism are valued positively. Those which are perceived as negating such maintenance or enhancement are valued negatively" (C. R. Rogers, 1959, p. 222). Babies naturally move toward the positive and away from the negative.

As the child grows, part of the experience becomes defined as the self. The differentiation of self is an offshoot of the actualizing tendency—that is, reaching full human potential involves developing a sense of who one is. Further experience leads to establishing a defined self-concept. With the development of the self, the need for positive regard from others emerges along with the need for positive self-regard.

Gradually, the child becomes aware that certain self-experiences are valued positively or negatively by others around him. Parents, teachers, and other important figures in the child's life have reactions to the child's behaviors that are essentially "good boy" or "bad girl." Because the need for positive regard is so compelling, these evaluations are internalized, and conditions of worth are established. The child begins to seek self-experiences that are consistent with the conditional self and avoid or deny those that are inconsistent. For example, Margarita might initially find the experience of playing in squishy mud pleasurable (i.e., consistent with the organismic valuing tendency). However, Margarita's mom berates her for messing up her beautiful white dress and shoes. The pleasurable experience of mud-playing then becomes a negative one because Margarita experienced negative regard from her mother. Eventually, Margarita internalizes this condition of worth and can never again be dirty; in fact, she might even develop a compulsive tendency to wash her hands.

In a perfect world, individuals could develop in an atmosphere of unconditional positive regard. Rogers (1959) was careful to say that unconditional positive regard does not mean positively valuing all of a child's behaviors, writing that "a parent 'prizes' his child, though he may not value equally all of his behaviors" (p. 208). Given an accepting environment, children could develop unfettered by conditions of worth, and the needs for positive regard and positive self-regard would not be at odds with the organismic valuing process.

Richard is clearly conditional in his self-regard. Daryl does not have much information about Richard's early experiences, but Daryl speculates that people important to Richard early in his life were conditional in their evaluation of him. For example, Richard's current discomfort with his occupational situation (the change in jobs and income) probably results from his early internalization of the value that work is an important definition of who he is as a man. The change of jobs, which could be perceived as taking care of himself, is probably viewed as inconsistent with traditional values of "never give up" and "tough it out." Daryl guesses that Richard might have been raised in an environment in which feelings were off limits, and therefore he is hesitant and uncomfortable disclosing them to those close to him, including Daryl.

HEALTH AND DYSFUNCTION

The "good life," according to Rogers (1961), is a process, not a destination. The healthy person is a *congruent* person; put simply, his perception of self is consistent with what he experiences. He is open to experiences and has an internal locus of evaluation (the organismic valuing process). The individual trusts himself to follow the right paths, guided by his organismic valuing process (C. R. Rogers, 1961). Because the individual has no internalized conditions of worth, experiences can be accepted freely into awareness and evaluated on the basis of the needs of the organism. The individual has a positive self-concept and unconditional self-regard. All experience is perceived accurately, without distortion; the person naturally orients toward experiences that actualize and away from those that do not contribute to the maximization of potential (Raskin et al., 2014).

Healthy individuals are creative and take risks in life. Rogers wrote that the healthy person "would not necessarily be 'adjusted' to his culture, and he would almost certainly not be a conformist. But at any time and in any culture he would live constructively, in as much harmony with his culture as a balanced satisfaction of needs demanded" (C. R. Rogers, 1961, p. 194; quotes in original). An important part of accepting all of one's experience is the authentic expression of the self, with all of the feelings that accompany being human.

In PC theory, dysfunction is defined as *incongruence* between self and experience. The individual's self is conditional; some experiences are inconsistent with internalized conditions of worth. The actualizing and self-actualizing tendencies are in conflict because the individual is busily trying to evaluate self-relevant experiences according to conditions of worth rather than via the organismic valuing process. The conditional self and the organismic experience are inconsistent, and therefore the actualizing and self-actualizing tendencies are divorced from each other.

When a person encounters experiences that are inconsistent with the conditional self, the experiences are generally "subceived"—that is, only dimly perceived. A clear recognition of the incongruent thought, emotion, or perception could cause a change in the self-concept, and people who are conditional do not welcome such changes. Experiences such as these are threatening to the self because they endanger the person's ability to obtain positive regard from others (and to positively regard the self). The incongruent information results in anxiety. As a result, the individual becomes defensive and rigid, either denying or distorting the experience. Defensiveness is the hallmark of the person traditionally described as "neurotic" (C. R. Rogers, 1959). The incongruent person's behavior is inconsistent; sometimes his behavior is guided by the conditional self and sometimes by the organismic valuing process. The individual is vulnerable because he is constantly defending against experiences deemed unacceptable. He is anxious, rigidly protecting the self-concept. The locus of evaluation is external (paradoxically, because it resides in internalized conditions of worth) rather than internal (i.e., the organismic valuing process; C. R. Rogers, 1959).

If the person is very incongruent (i.e., a lot of experiences are unacceptable to the self) and if incongruent experiences are very powerful or sudden, the individual's defenses can become overwhelmed, and the experience is symbolized in awareness (C. R. Rogers, 1959). The self-structure is damaged, so the individual becomes disorganized. Similar to the neurotic, sometimes his behavior is guided by the conditional self, and at other times the "real" self (i.e., the organismic valuing process) rallies and directs behavior, but these swings are much more severe. The result looks much like what we typically describe as psychosis. Rogers (1959) gave the example of the acute psychotic exhibiting sexual behavior that is typically deemed inappropriate in social situations. Such a person is simply following his actualizing tendency (i.e., sex is good for the organism),

but conditions of worth have led him to deny his sexuality. When the self is shattered by too much incongruence, these behaviors are expressed because the need for sexual experience is symbolized in awareness (C. R. Rogers, 1959).

Despite his use of terms such as *neurotic* and *psychotic*, Rogers did not have much use for traditional diagnostic procedures and systems. Referring to the previously discussed categorization of individuals into defensive versus disorganized, Rogers (1959) said, "This seems to be a more fundamental classification than those usually employed, and perhaps more fruitful in considering treatment. It also avoids any concept of neurosis and psychosis as entities in themselves, which we believe has been an unfortunate and misleading conception" (p. 228).

Translating a bit, then, in PC theory, the roots of all dysfunction are found in incongruence. Depression, for example, would be seen as probably involving a negative self-concept that resulted from an excess of conditions of worth. Experiences inconsistent with the conditions would be subceived, and the extent of the depression would depend on the type and nature of the experiences perceived. Anxiety would be seen as resulting from the subception of incongruence and the need to defend the conditional self.

Richard is incongruent. In his session with Daryl, he behaves uncomfortably, showing signs of anxiety in his nervous laugh. He seems unwilling to reveal himself, possibly because his internalized conditions of worth disallow the authentic expression of feelings. He dares not talk about his anxiety or the feelings behind it because they are contrary to his conditional view of himself, which probably involves being strong. He is fearful of showing Daryl who he really is because he fears conditional reactions from others and as yet has no reason to believe that Daryl is different. He reports being depressed, and Daryl sees this sadness as resulting from Richard's inability to realize his conditional self.

NATURE OF THERAPY

Assessment

PC counselors do not use any form of assessment. Many are adamantly antidiagnosis. Rogers thought that assessing and diagnosing clients turned them into objects and distanced the counselor from the therapeutic interaction.

After welcoming Richard to counseling, Daryl asks how he can help. Daryl does not conduct an "interview" or direct the flow of Richard's conversation in any way.

Overview of the Therapeutic Atmosphere

Rogers saw therapy as an encounter between two individuals. He vehemently rejected the idea that the counselor was an expert and argued that the therapist's attitude, or philosophy, was critical to the success of the relationship. PC counselors emphasize the freedom and autonomy of the client in counseling, "with the therapist's person playing a real but primarily catalytic part in that relationship" (Rogers, 1977, p. 21). The client is in the driver's seat, choosing the frequency and length of sessions, the type of therapist, and ultimately whether to engage in therapy at all. As you might expect, PC therapists dislike the term *treatment* because of the medical connotations the term brings (Raskin et al., 2014).

ROLES OF CLIENT AND COUNSELOR

In PC counseling, the counselor and client are equals, with the therapist serving as a companion in the client's search for himself (C. R. Rogers, 1986a). Describing his experience, Rogers (1986a) said, "As a therapist, I do not want to lead the client, since she knows, better than I, the pathway to the sources of her pain. . . . What I wish is to be at her side, occasionally falling a step behind, occasionally a step ahead when I can see more clearly the path we are on, and taking a leap ahead only when guided by my intuition" (pp. 207–208).

The counselor's job in PC theory is to provide the climate that will release the client's potential. Two tasks of the therapist—struggling to understand the experience of the client while at the same time being open to his own experience in the therapeutic relationship—are critical. Raskin et al. (2011) commented that "to be a client-centered therapist is to risk meeting the client as a person, to be of service in an authentic, collaborative relationship. It is the difference between *using* techniques . . . and *being* oneself in relation to another person" (p. 149; emphasis in original).

The role of the client is to be who he is. He is expected to be in contact with his experience as much as possible and is the guide in the therapeutic journey. Initially, the degree to which the client is able to experience and express is directly related to the level of incongruence present. Clients who are in extreme incongruence will be less comfortable verbalizing their experiences than will those who are more congruent.

Daryl approaches Richard as a partner in an interpersonal encounter. In no way does Daryl take a teaching, evaluating stance or offer any advice to Richard. Instead, Daryl attempts to engage with Richard in a personal, authentic way and to understand Richard's experience as much as possible. Richard is expected to reveal himself to the extent he feels comfortable.

GOALS

The goal of PC therapy is to facilitate the client's journey toward full potential. If the right conditions are achieved, the client experiences the counselor's acceptance and is in turn able to accept his experience more fully and thereby become more in touch with his actualizing tendency. A narrower version of the goal of PC counseling is for the client to move from being incongruent to being congruent. Successful PC counseling should result in diminishing or eliminating conditions of worth—and thus incongruence between self and experience.

Daryl hopes that Richard can become aware of the experiences that are incongruent with his conditional self and accept these experiences as valuable aspects of himself. If counseling is successful, Richard will embrace all aspects of himself, freely living aspects of himself that he subceives and denies or distorts, such as his "failure" to live up to the ideal of the strong, supportive male. Getting in touch with his natural organismic valuing process will allow Richard to evaluate his experiences as negative or positive based on whether they contribute to his actualization. For example, Richard would value his taking care of himself by changing jobs to reduce stress rather than feeling bad about it. Once Richard is able to experience and express his feelings to others authentically (because he is not rejecting them to achieve positive self-regard in concert with his internalized conditions of worth), he will be able to relate in more unconditional and open ways with others, including his wife and kids.

PROCESS OF THERAPY

Dryden and Mytton (1999) identified three historical stages in the evolution of PC theory. The earliest stage (in the 1940s and 1950s) emphasized the nondirective nature of the counseling interaction. In a cathartic model, the client expresses and releases emotion, and the therapist is prohibited from offering any advice or interpretation. Insight is to be achieved by the client on his own. The counselor, through his reflection of the client's feelings, conveys understanding and acceptance of the client.

The attitude of the therapist was the emphasis of the second stage in the development of PC theory (in the late 1950s and early 1960s). During this stage, Rogers decided that the "techniques" of the nondirective approach (e.g., repeating the client's words, avoiding giving advice) were becoming the approach. Dissatisfied with this characterization of his system as mechanical and passive, Rogers began to focus on the attitude of the counselor in relation to the client—and particularly the belief that the impetus for change was within the client. The counselor needed only to accurately understand and support the client in his journey inward.

Dryden and Mytton maintained that the spark for the third transformation of PC theory (in the mid- to late 1960s) came out of Rogers's experience as a therapist. They explained that Rogers was working with a very disturbed client that he did not like; he felt "trapped by her dependence upon him" (1999, p. 64). Eventually, Rogers realized that he felt so immersed in the relationship that he could not separate himself from the client. The crisis was so severe that he referred the client and found a temporary geographic cure. After literally fleeing with his wife for a period of time, Rogers then entered therapy with a colleague. This incident led to his recognition that it was critical to be honest in the therapy relationship. He believed that, if he had been honest with his client, the relationship might not have become so destructive. Rogers's later versions of PC theory therefore placed great emphasis on the congruence, or genuineness, of the therapist.

For Rogers, all that was needed to release the innate growth tendencies of the client was for the therapist to provide the optimum atmosphere and for the client to perceive it. The counselor creates this environment by holding the right attitudes toward the client and the counseling venture. Simply put, the counselor works to create the facilitative climate for the client's growth by providing what Rogers (1957) called the necessary and sufficient conditions for change: congruence, unconditional positive regard, and empathic understanding (also called the *core conditions*). Because these concepts are so vital to the theory, they will be discussed separately.

Before discussing the conditions of therapy, however, it is necessary to note that the precursor to counseling is that the client and the counselor must be in psychological contact. When two individuals "make a difference" (C. R. Rogers, 1959, p. 207) in each other's experiential field, they are in contact. If you have read the excerpt from Rogers's writing at the beginning of this chapter, you will also know that it is critical that the client perceive the unconditional positive regard and empathy of the therapist.

CONGRUENCE

Also called *genuineness*, *transparence*, and *realness* (C. R. Rogers, 1980), *congruence* refers to the counselor's freely flowing awareness of his experience in the therapeutic moment. "The more the therapist is himself or herself in the relationship, putting up no professional front or personal façade, the greater is the likelihood that the client will change and grow in a constructive manner"

(C. R. Rogers, 1980, p. 115). Not only is the therapist aware of his own experience, but also this awareness is apparent in both verbal and nonverbal expression; feelings and reactions can be communicated to the client if this seems helpful. As his theory developed, Rogers became convinced that congruence is the key to good therapy, writing that "for more than a decade I have been trying to state that genuineness, or congruence, and the expression of such genuineness, is probably the most important part of the therapeutic relationship" (C. R. Rogers et al., 1967, p. 511).

Rogers attempted to clarify what he meant by congruence, writing

> It might be well to state some of the things that it does not imply. It does not mean that the therapist burdens his client with the overt expression of all of his feelings. It does not mean that he blurts out impulsively anything which comes to mind. It does not mean that the therapist discloses his total self to the client. It does mean, however, that he does not *deny* to himself the feelings that he is experiencing, and that he is willing *transparently* to be any persistent feelings which exist in the relationship and to let these be known to the client if appropriate. It means avoiding the temptation to present a façade or hide behind a mask of professionalism to adopt a confessional-professional relationship. (Rogers, 1967, p. 101; emphasis in original)

Although Rogers (1966, p. 185) thought it would be best if the therapist did not experience any persistent negative feelings about the client, if they happen these, too, should be expressed, because negative feelings would be more harmful if they were hidden. To hide negative feelings would be to put up a false front, which would surely be picked up by the client. Contemporary PC theorists have developed guidelines for expressing the therapist's negative feelings: The therapist must be clear, tentative, own the feelings as a personal reaction and the helpful, affirming attitude behind the expression of them must be clearly conveyed (Elliott, 2013a).

Rogers (1959, 1980) did recognize that it is impossible to be congruent every minute of one's life. He said, "Indeed if this were a necessary condition there would be no therapy" (1959, p. 215) because no one can be completely aware of his experience all of the time. What is critical is that the therapist be present and aware of his experience in the moment of interaction with the client: "[T]hus it is that imperfect human beings can be of therapeutic assistance to other imperfect human beings" (p. 215).

Daryl strives to be fully himself in his sessions with Richard. He attends to what Richard is communicating, both verbally and nonverbally, but is also aware of his own experience in the relationship with Richard. At times Daryl reveals to Richard what he is feeling in the interaction as, for example, when he tells Richard that he feels distant from him.

UNCONDITIONAL POSITIVE REGARD

The counselor approaches the client with complete acceptance and caring (C. R. Rogers, 1980). Rogers spoke often of "prizing" to describe this attitude and added that it is risky to experience these feelings because we fear being trapped by them. It is scary to invest such feeling in others because they could disappoint us or they could become demanding. In fact, Rogers (1961, p. 52) thought that these fears were primarily responsible for our adoption of the "professional attitude" toward clients, which creates distance between counselor and client and protects against hurt. He said, "It is a real achievement when we can learn, even in certain relationships

or at certain times in those relationships, that it is safe to care, that it is safe to relate to the other as a person for whom we have positive feelings" (1961, p. 52). Rogers (1966) did note one exception to the rule of unconditional positive regard: In working with the "extremely immature or regressed individual, a conditional regard may be more effective in getting a relationship under way . . . than an unconditional positive regard" (p. 186).

In order to be effective, Daryl must accept Richard without any conditions or evaluations. He finds himself prizing Richard as another human being and communicates this to Richard in a genuine, caring way.

Empathy

Empathy is achieved when one individual perceives the internal experience of another as if he were that person, "without ever losing the 'as if' condition" (C. R. Rogers, 1959, p. 210; quotes in original). Rogers (1980) conceived of empathy as a process, rather than a state, saying that it meant "temporarily living in the other's life, moving about in it delicately without making judgements" (p. 142). If the counselor achieves truly accurate empathy, he can even perceive meanings and feelings with which the client is not totally in touch.

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Video Example 5.2 Carl Rogers on empathy



https://www.youtube.com/watch?v=iMi7uY83z-U

The counselor must communicate empathic understanding to the client. However, Rogers (1980, p. 142) warned against trying to make the client aware of totally unconscious feelings because that would be too threatening. Instead, the counselor "aims to dip from the pool of implicit meanings just at the edge of the client's awareness" (C. R. Rogers, 1966, p. 190).

Unfortunately, according to Rogers (1980) the early concept of accurate empathy grew into a rigid focus on the counselor's responses. "Reflecting the client's feelings" became synonymous with the PC approach. Teaching reflection of feelings as a skill became popular, and Rogers (1986b) thought that this approach often led to robot responses; when I was in graduate school, "I hear you saying . . . " was a kind of joke phrase. Rogers (1980) said, "I was so shocked by these complete distortions of our approach that for a number of years, I said almost nothing about empathic listening, and when I did it was to stress an empathic attitude, with little comment as to how this might be implemented" (p. 139). Instead, Rogers (1986b) emphasized that when he appeared to be "reflecting feelings," what he was really doing was trying to check whether his "understanding of the client's inner world [was] correct" (p. 376). Merry and Tudor (2006) further clarified that the PC counselor would never focus on feelings to the exclusion of other aspects of the client's experience, such as thoughts, physical sensations, or fantasies.

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Video Example 5.3 Think about how Carl Rogers exhibits empathy in this video.



https://www.youtube.com/watch?v=tz1dBPrMz9E

Daryl strives to fully understand what it is like to be Richard. He attempts to "walk in Richard's shoes" as much as possible without losing the boundaries between himself and Richard. At times, Daryl finds himself wanting to mention to Richard something he is not quite sure Richard has recognized—feelings that Richard has denied or distorted. For instance, Daryl senses Richard's feelings of inadequacy around his role as husband and provider. Richard becomes anxious if these feelings and their meaning start to surface. In the supportive atmosphere of their relationship, Daryl tries to help Richard move toward experiencing these feelings. He does not, however, push Richard into experiencing these feelings or in any way insist that Richard acknowledge them if Richard is not ready.

A Fourth Condition?

In his last writings, Rogers (1986a) began to discuss a fourth characteristic of helping relationships. Acknowledging that he had no scientific basis for his idea, Rogers (1986a) maintained that when he was at his best as a therapist, he believed that he entered a "slightly altered state of consciousness . . . full of healing" (p. 198). This transcendent state leads to behaviors that are impulsive, but they almost magically fit with the client's experience. "At those moments it seems that my inner spirit has reached out and touched the inner spirit of the other" (p. 199). Despite Rogers's discussion of this transcendent state, subsequent treatments of his theory have paid little attention to this fourth condition.

Stages of the Therapeutic Process

Rogers saw the counseling process as a gradual progression from incongruence to congruence and observed stages through which clients passed on this journey. An interesting side note is that Rogers (1958) developed this "process conception" (p. 142) at a time when he was preparing his address to be given when he was awarded the APA award for distinguished scientific contributions. He did not want to discuss his previous work; instead, he wanted to take a new look at personality change, and what emerged was a view of the change process from an observer's perspective (C. R. Rogers, 1961). Spending numerous hours reviewing audiotapes of counseling sessions, Rogers (1958) said that he was "trying to listen as naively as possible. I have endeavored to soak up all the clues I could capture as to the process, as to what elements are significant in change" (p. 142). Through this study, Rogers (1958) identified seven stages of the change process. As I describe these in the following sections, I quote liberally from Rogers's (1958) writing in an attempt to convey the rich and vivid description for which he was known.

Stage 1. The individual in this stage is not likely to show up in the counselor's office voluntarily. Change is not on the agenda because he typically does not see that any problems exist. "Feelings and personal meanings are neither recognized nor owned" (p. 143), and the person is afraid of intimate relationships. He tends to talk about externals, not himself, and has a rigid self-structure.

Stage 2. "When a person in the first stage can experience himself as fully received then the second stage follows" (p. 144). Rogers was not certain about how this contact is made, but once it is the individual moves a little further along the continuum of experiencing. He begins to talk about subjects that are not related to the self, but he displays no sense of responsibility for problems—they are external to him. Although people do come to counseling when they are in this stage, Rogers considered them very tough customers.

Stage 3. Many clients who come to counseling on their own power are in this stage. If the person continues on the path established in stage 2, he takes small steps toward more fluid experiencing and expression. In stage 3, the client discusses self-experiences and feelings, but in a largely distant and objectified manner; he does not experience them fully. Feelings are perceived, but as bad things. Although the self is still rigid, it is dimly recognized. The client also recognizes contradictions in experience.

Stage 4. In this stage, the individual begins to express more intense feelings, but they are still largely from past experience. The client begins to become aware of incongruence between the self and experience and to take some responsibility for his difficulties. Sometimes feelings even sneak into the present, but this experience is scary and the person has difficulty accepting them.

Stage 5. If the proper climate of acceptance is established, the fourth stage then "sets in motion still further loosenings, and the freedom of organismic flow is increased" (p. 144). Stage 5 clients experience feelings and express them freely as they experience them. This experiencing is not completely without fear, and the feelings that sneak through are sometimes surprising to the client. The person more frequently expresses "ownership of self feelings" (p. 145) and an accompanying urge to be authentic in accepting the feelings. The client begins to sense an internal frame of reference (the organismic valuing process) for experience. Rogers characterized this stage as "several hundred psychological miles from the first stage described" (p. 145).

Stage 6. Rogers described stage 6 as a "very distinctive and often dramatic phase" (p. 146). The client experiences "with immediacy and richness" a feeling that has been previously "stuck" (p. 146). The feeling is fully accepted by the client. In this moment, the self is no longer an object—it "*is* this feeling. This is a being in the moment, with little self-conscious awareness" (p. 146; emphasis in original). Incongruence between self and experience is dramatically symbolized in awareness and is thereby transformed to congruence. In essence, the client becomes the aspect of the self that was denied because of conditions of worth. According to Rogers, once the client experiences this process it is irreversible.

Stage 7. The last stage identified by Rogers is seen both within and outside of the counseling relationship. "There is a growing and continuing sense of acceptant ownership of . . . changing feelings, a basic trust in his own process" (p. 148). The client, having learned to trust himself, consistently uses the organismic valuing process as the basis for living. The self becomes the process of experiencing rather than a perceived object. Conditions of worth are replaced by values and constructs loosely held, generated from within. "The client has now incorporated the quality of motion, of flow, of changingness into every aspect of his psychological life" (p. 149). Genuineness and free, consistent, and clear communication characterize relationships.

Not every client will reach the final stage of change (C. R. Rogers, 1961). In fact, Rogers was aware that some people do not value fluidity and would disagree with his ideas altogether. If a client started at stage 1, Rogers indicated that it could take years to get to stage 7 and that this progression would be a rare event. More likely, clients would come to counseling at stage 2 and end at stage 4, with both parties in the relationship being justifiably satisfied with this outcome.

Rogers (1987) recognized two kinds of client *resistance* to the therapy process. First, there is the natural reluctance to undergo the painful experience of divulging to one's self and to the

counselor feelings previously denied. After all, these feelings have been denied for a reason. The second type of resistance, however, is created by the counselor and arises as a result of "offering interpretations, making diagnoses and other judgments" (C. R. Rogers, 1987, p. 186). If the counselor creates a safe relationship through providing the core conditions, the client will have no need to protect himself by resisting.

Richard appears to be in stage 3. He experiences depression and feelings of inadequacy, "bad" feelings. Uncomfortable with the lack of structure and apparently avoiding self-relevant topics, Richard seems hesitant to make real contact with Daryl. If Daryl is able to remain accepting, genuine, and empathic, Richard will begin to lose the rigid structure that protects him from experiences not allowed into his conditional self. He will begin to experience feelings in the present (such as pain or anger) and will begin to accept these experiences into himself.

THERAPEUTIC TECHNIQUES

There are no techniques in PC therapy! In fact, techniques as we typically view them (things such as challenging the client, interpretation, and so forth) are seen as guiding and objectifying the client instead of allowing him to find his own experience—and thus solutions. As noted earlier, when the professional world began to focus on "reflection of feeling" as the primary technique in PC counseling, Rogers objected, seeing the *attitude* conveyed by the counselor as what was truly important.

Over the years, the lack of specific techniques connected to the nondirectiveness of PC theory has been perceived as a significant weakness of this approach. Variants of PC theory have evolved that include the use of directive, active interventions by the counselor that are intended to increase clients' levels of experiencing (e.g., Gendlin, 1996; L. S. Greenberg, 2011). Josefowitz and Myran (2005) discussed the role of activity in PC counseling and identified two general "types" of PC therapists. They called the first "experientialists" and include here those interested in Gendlin's (1996) focusing approach and proponents of emotion-focused therapy (Goldman & Greenberg, 2015; S. M. Johnson, 2004). These therapists are likely to allow for greater therapist activity and directiveness as compared to the "non-directive client-centred group," which, as the name implies, emphasizes the need to give the client control of the direction of therapy (Josefowitz & Myran, 2005, p. 330). Emotion-focused therapy weaves together and draws techniques from the PC, Gestalt, and existential approaches, including interventions such as empty-chair dialogues (L. S. Greenberg, 2011; Goldman & Greenberg, 2015; see Chapter 7, Box 7.3 for a brief description of this approach). Gendlin (1990, 1996) emphasized the experience of the client, developing a technique called focusing, which directs the client's attention to the physical sense of their problems (the "felt sense"; Cain, 2013, p. 172). Again, all of these techniques are aimed at intensifying client experiencing within counseling sessions with the goal of loosening up "stuck" feelings.

Another identified strain of contemporary PC theory is the relational view, which like relational psychoanalysis emphasizes the joint construction of therapy, the two-way nature of the therapeutic alliance (Schmid, 2013b). However, I should note that there are arguments within the PC community whether approaches that are more directive or integrate techniques from other systems are "true" PC approaches, resembling the antics of the psychoanalytic camp's proponents as they debated what is proper and what is "not psychoanalytic" (Bohart, 2012). Some of the current leaders of the PC community, who knew Carl Rogers well, opine that he would

have been fine with such integration, as long as the key attitudes of the PC therapist remained and there was not too much directivity (Bohart, 2012; Kirschenbaum, 2012). It could be noted that Natalie Rogers's expressive therapy is directive by nature, and according to Kirschenbaum (2012) Carl Rogers approved of her efforts.

On the other end of the spectrum is Prouty's pre-therapy (Prouty, 1998; Werde & Prouty, 2013). Noting that the first problem of PC counseling is to establish psychological contact, Prouty focused on this process in individuals who are "contact impaired" (p. 389)—those who are labeled schizophrenic and mentally challenged. This interesting theory includes a detailed description of the very concrete types of reflections that are helpful in establishing contact (e.g., situational, facial, word for word, body). An example of such a reflection might be "You are sitting on the floor with your arms wrapped tightly around your body."

Another interesting approach that situates itself within the PC camp is motivational interviewing (MI; W. R. Miller, 1983). Developed primarily for use with individuals who abuse substances, MI combines the unconditional acceptance and empathic stance of PC with a sort of Socratic questioning designed to help individuals become motivated to change (Hettema, Steele, & Miller, 2005). Oddly enough, MI also sounds a little like solution-focused therapy (see Chapter 14), for, in exploring the client's thoughts and feelings, the MI counselor "seeks to evoke . . . 'change talk'—expressions of the client's desire, ability, reasons, and need for change—and responds with reflective listening" (Hettema et al., 2005, p. 92; quotes in original). It is a short-term approach designed to enhance commitment to change, and it usually consists of one to two sessions.

The PC approach has also proven quite useful in play therapy with young children (Raskin et al., 2014). First developed by one of Rogers's students, Virginia Axline (1947), child-centered play therapy is based on the notion of the positive potential residing in the actualizing tendency. Through play, children are able to express difficult feelings, such as anger and fear, and of course happy feelings are always welcome, too. The accepting therapist then recognizes the feelings and reflects them to the child (Bratton, Ray, Edwards, & Landreth, 2009). The child's experience in the nondirective, accepting, safe relationship is expected to help the child gain knowledge about and acceptance of self.

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Video Example 5.4 Watch this video of play therapy.



Daryl is a traditional PC therapist and will simply try to provide the right conditions for Richard. He will unconditionally accept Richard and strive to understand Richard's experience and communicate this to him. Therapist congruence is also important to Daryl, so he will attempt to be genuine and in the moment with Richard.

EVALUATION OF THE THEORY

PC theory has been one of the most influential theories in the profession of counseling and psychotherapy. It can be seen as forming the basis for most approaches to counseling because almost every approach to therapy acknowledges the impact of the therapeutic relationship on counseling outcome. Beginning counselors are taught good listening skills and are often drilled in responses that convey active listening and empathy (e.g., Hill, 2014; Ivey et al., 2016).

Despite his impact on the profession, Rogers has also been criticized for wearing "rose-colored glasses"; his view of people is characterized as overly positive and ignorant of the "darker side of human nature" (Coleman, 1988, p. 23). Bohart (2007) responded that this is a misunderstanding of the theory: the tendency to self-actualization is directed at enhancing the self and can, unfortunately, be directed to the growth of a destructive self. A related issue for some is Rogers's neglect of unconscious motivations and dynamics (Cooper, 2007).

Seager (2003) argued that "unconditional positive regard is impossible in any human relationship" (p. 401), and the current view seems to be that this attitude is an ideal that will never be attained by any counselor (Cain, 2010). Weaver (2008) discussed using PC theory with men who are perpetrators of domestic violence and argued that seeing unconditional positive regard as equivalent to accepting such behavior is a simplistic view. She makes two arguments about this issue: First, unconditional positive regard does not mean that the counselor unconditionally accepts the client's behaviors. Second, the therapeutic principle of congruence would allow the counselor to express his discomfort with the client's behavior.

Some writers have been concerned that the PC approach is not effective with clients who display severe levels of psychopathology (van Blarikom, 2008). However, efforts such as Prouty's pre-therapy and a recent relational turn in PC theory, which emphasizes the interpersonal aspects of the PC therapy relationship, would suggest that PC theorists are extending the theory in ways that would be applicable to these clients (Cooper, 2005; Cox, 2009; Mearns & Cooper, 2005). Quinn (2011) pointed to the results of several empirical studies of PC therapy with individuals diagnosed with borderline personality disorder (including Cottraux et al., 2009, reviewed in the section on outcome research) that demonstrated that PC therapy produced favorable outcomes as evidence of the effectiveness of PC counseling, despite the fact that two out of three of these studies classified PC therapy as "supportive" therapy. He notes that the client centeredness of PC allows for the therapist to use directive or teaching techniques if the client requests these and that the principle of genuineness requires that the therapist feed back to the client his experience of persistent negative reactions, both of which are qualities in common with well-known approaches to borderline personality disorder (such as dialectical behavior therapy and transference-focused therapy; see Chapters 16 and 3, respectively).

As noted earlier, some find a weakness in the nondirective approach emphasized in classic PC counseling. In my experience teaching this approach, I have similarly found that students struggle with the concept of trusting the client's growth tendencies; instead, they want to "do something." The activity level of the therapist is directly tied to arguments about whether PC theory's necessary and sufficient conditions are really that: "Sufficient" implies that all one has to do is be empathic, be congruent, and provide unconditional positive regard and the client will get better. Tudor and Worrall (2006), PC proponents, stated flatly that "Rogers' therapeutic conditions are neither necessary nor sufficient" (p. 10). Citing empirical data that suggest that many variables, and most especially the resources of the client, influence the outcome of therapy, they concluded that "the [therapeutic] conditions are intrinsically helpful and often implicated in therapeutic growth" (p. 20).

QUALITIES OF THE THEORY

Precision and Testability. Rogers was a pioneer of research on the psychotherapy process, and he and his associates generated many studies testing PC theory. Despite this legacy, disagreements abound over how to measure PC constructs, which bears directly on the testability of the

theory (Beutler, Machado, & Neufeldt, 1994; Hill & Corbett, 1993). In early research, congruence, for instance, was measured by differentials in adjective sorts of clients and experts (e.g., the client description was assumed to be of the distorted, incongruent self, whereas the observing expert could discern the more realistic self-experience of the client). However, it could be argued that this approach does not adequately capture the internal processes that create incongruence; observation by others, even experts, will not yield an accurate picture of an individual's self-experience because this can be experienced only by the individual. Other early efforts to measure empathy, unconditional regard, and congruence seemed successful because raters could generally agree on what they were observing (C. R. Rogers et al., 1967). However, the reports of observers, clients, and therapists were sometimes found to be discrepant, as they were in the Wisconsin Schizophrenia Project (Rogers et al., 1967; see Box 5.2).

PC theory provides clear and simple predictions. For example, PC theory predicts that, if clients receive empathy and unconditional positive regard from a congruent therapist, they will change in favorable directions. However, the theory has been criticized as imprecise because the predictions derived are too general (Lietaer, 1990). For instance, it is possible that the core conditions are differentially effective depending on the stage of counseling—they might be much more important in the early rather than the later stages (Lietaer, 1990). Few predictions are offered about the other constructs of the theory except in general ways (e.g., if parents are not accepting of children, children will develop conditions of worth).

Empirical Support. PC theory has received a good deal of research attention. Most of these efforts have focused on the predictions about therapy rather than those derived from the personality theory. In general, research has supported the effectiveness of PC therapy, but Rogers's core conditions are considered necessary but not sufficient.

Research Support

Outcome Research. Over the years, many reviews of the outcome effects of PC therapy have appeared. For instance, Bozarth, Zimring, and Tausch (2001) presented a traditional summary review of PC research, breaking it into four time periods and describing the research within each. They maintained that common factors research that emphasizes the power of the therapeutic relationship and the resources of the client in producing positive outcomes (see Chapter 1) supports PC theory's basic assumptions. Bozarth et al. concluded that "the clear message of five decades of research identifies the relationship of the client and therapist in combination with the resources of the client (extratherapeutic variables) . . . [which] respectively account for 30% and 40% of the variance in successful psychotherapy" (p. 168).

More recently, Elliott, Greenberg, Watson, Timulak, and Freire (2013) conducted a meta-analysis of 195 studies of humanistic/experiential therapies and reported that overall clients demonstrated significant amounts of change. These gains were found to be maintained for up to a year. This analysis was of a set of studies that included a number of approaches, such as classic or "pure" PC therapy, variants of it (e.g., Gendlin's focusing approach), and the emotion-focused hybrid approaches developed recently (e.g., emotion-focused therapy). Therefore, these positive conclusions cannot be taken as specific to PC theory. However, R. Elliot (2013b) separated out a subset of studies that tested PC counseling and found comparable effect sizes, indicating that clients improved from pretest to post-test, and outcomes were more favorable than those of

clients who received no treatment. Comparisons in 43 studies of PC and other forms of therapy showed no differences in outcomes. However, in 22 studies that compared PC therapy and cognitive-behavioral therapy (CBT), a slight advantage was found in favor of CBT. Elliott argued that the advantage is small enough to be insignificant for practical purposes, and also that factors such as investigator allegiance and the manner of delivery of the treatments might account for the difference (see the comments about Cottraux et al., 2009, that follow, which was likely one of the studies in the meta-analysis). Elliott et al. (2013) further looked at the meta-analytic evidence for the effectiveness of humanistic/experiential therapies across various diagnostic categories, finding strong support for pre- to post-test change, including, interestingly, for psychosis (a set of studies that included several of Prouty's pre-therapy).

A recent large-scale study that included PC counseling was conducted by Stiles, Barkham, Mellor-Clark, and Connell (2008). They compared the outcomes of over 5,000 clients in the United Kingdom who received PC, psychodynamic, or CBT and found no differences in the effectiveness of these three approaches. Similar results were found in an earlier study with a subset of this client sample (Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006). Note that both of these studies are effectiveness studies rather than controlled clinical trials (see Chapter 1), so they can be criticized for lack of random assignment to treatment and other issues.

A version of PC therapy was tested in a randomized controlled trial (RCT) comparing its effectiveness to that of cognitive therapy (CT; see Chapter 10) for clients diagnosed with borderline personality disorder, and although clients stayed in CT longer than in PC therapy, the effects of the two approaches were equivalent at immediate post-test. However, a 2-year follow-up showed that CT was more effective (Cottraux et al., 2009). An RCT comparing the same two treatments for post-traumatic stress disorder conducted by the same research group using the same methods found virtually no differences in effectiveness (Cottraux et al., 2008). In the study of borderline personality disorder, a finding that might seem somewhat surprising is that the therapeutic relationship was more positive in CT than in PC counseling. However, it should be noted that PC treatment in both of these studies was "Rogerian supportive therapy" administered by therapists who had significant amounts of training in CT and comparatively little training in the PC mode. They were also instructed to ignore or refuse client requests for any advice or other form of directive intervention. The latter feature, I suspect, would enlighten us on the finding regarding the ratings of the therapeutic alliance. As I have noted earlier in this chapter, contemporary PC counselors would probably not refuse a client requesting directive intervention unless they didn't feel competent to deliver it.

Studies of motivational interviewing can be seen as relevant to PC theory as it is currently practiced in the United States. Recall that MI was one of the therapeutic approaches used in Project MATCH (see Chapter 1). Hettema et al. (2005) conducted a meta-analysis of 72 studies of MI and found that effect sizes were generally positive, but they varied across samples and therapists and decreased rapidly over follow-up periods of up to 12 months. For example, they reported that the average effect size right after treatment was 0.77, which is strong. However, over a year the effect size dropped to 0.11. It is interesting that effect sizes for MI were stronger in minority as compared to White client samples (Hettema et al., 2005). A recent RCT of MI examining the outcomes of individuals in cardiac rehabilitation also found minimal long-term effects. Chair et al. (2013) found few and very small differences between treated and treatment as usual groups at 6, 9, and 12 months in terms of quality of life, bodily pain, and emotionally related restriction of activities. Similarly, Ang et al. (2013) found significant immediate but

limited long-term benefits of MI in an RCT attempting to increase exercise and decrease pain severity among individuals with fibromyalgia.

Empirical studies of play therapy support the effectiveness of PC counseling with kids. Bratton, Ray, Rhine, and Jones (2005) meta-analyzed 93 controlled studies of play therapy, of which 73 were classified as humanistic and nondirective, which would seem to represent something similar to a PC approach. Over all studies, they found an effect size of 0.80, similar to that found for psychotherapy in general (see Chapter 1). The humanistic–nondirective studies produced a significantly larger effect size than the nonhumanistic–directive approaches. In a more general (non-meta-analytic) review of research with children and adolescents, Hölldampf, Behr, and Crawford (2010) found good support for PC and experiential approaches across a wide variety of diagnostic categories. Of course, some of the research reviewed involved other experiential approaches, such as emotion-focused therapy. Still, the evidence seems to indicate that PC approaches work with young people.

Theory-Testing Research. Much energy has been devoted to testing the theoretical propositions of PC theory, at least those pertaining to the necessary and sufficient conditions. Rogers was the first investigator to systematically use recordings and transcripts of counseling sessions to understand the counseling process. Although this research is, of course, dated, I will briefly summarize a few examples of Rogers's and his colleagues' early efforts.

At the University of Chicago Counseling Center, Rogers and his colleagues designed an intensive study of clients in counseling that exemplified some of the most important tenets of experimental design. Twenty-nine clients and a matched control group (no treatment) were assessed, and audio recordings and other measures were gathered. Raskin (1952) reported his test of the locus of evaluation hypothesis on 10 of these cases. PC theory predicts that the locus of evaluation should shift from external (based on others' perceptions) to internal (based on the client's own perceptions) over the course of therapy. Using ratings made of client statements of evaluation, Raskin demonstrated that the shift along the internal–external dimension among the clients was significant and in the predicted direction. That is, clients were rated as having made judgments based more on their own values at the end of counseling compared to the beginning. Using the same 10 cases, Bergman (1951) studied counselors' responses to client requests for evaluation by the counselor (e.g., requests for advice, evaluation of progress). After classifying counselor responses to these requests, Bergman demonstrated that when the counselor responded with reflection of feeling, clients were more likely to continue significant self-exploration than when counselors chose other responses.

Rogers and his associates conducted many other studies of the process of counseling over the years, and most supported the basic tenets of PC theory. Of particular interest are Barrett-Lennard's efforts to operationalize the core conditions by creating the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1959). This study was Barrett-Lennard's doctoral dissertation and produced a measure that is still used in research today. Rogers argued, with some justification, that the fact that these conditions could be reliably measured was, in itself, support for the theory (C. R. Rogers, 1967).

Early studies conducted by other investigators also supported PC theory. Truax and Carkhuff (1965) experimentally manipulated levels of empathy and unconditional positive regard in a small sample (three clients) case study. Their examinations of levels of client experiencing supported PC predictions—clients' levels of experiencing appeared to decrease in tandem with the decrease in therapist conditions. The Wisconsin Project (see Box 5.2) provided a wealth of data

on PC theory and supported the contention that the level of the PC therapeutic conditions (i.e., empathy, congruence, and unconditioned positive regard) was related to client outcome (C. R. Rogers, 1967; van der Veen, 1967).

Later research focusing on Rogers's statement of the necessary and sufficient conditions generally finds that these conditions are correlated with client outcome, but are not sufficient. Patterson (1984), a well-known advocate of PC therapy, reviewed nine major review articles on the conditions and concluded that we can be fairly certain that they are necessary, but not as positive that they are sufficient. However, most research does not test the three conditions simultaneously, which would be necessary to clearly address Rogers's necessary and sufficient hypothesis, and most of the research uses methods that are insufficient to establish causal statements (e.g., Do facilitative conditions lead to good outcome, or vice versa?). On the other hand, meta-analytic findings have consistently demonstrated that the working alliance (across various general measures of positive collaborative relationships) is moderately related to outcome in psychotherapy (Hovarth, Del Re, Fluckiger, & Symonds, 2011). The support for the impact of the therapeutic relationship, however, can also be seen as only weak support for PC theory because this effect is seen across theoretical orientations (Hovarth et al., 2011).

Arguments about how to operationally define the constructs in PC theory further weaken the empirical support for the theory—that is, researchers disagree about how best to measure empathy, unconditional positive regard, and congruence (Elliot, Bohart, Watson, & Greenberg, 2011; Hill & Corbett, 1993). Nonetheless, relatively recent meta-analyses of research relevant to all three PC constructs are available. Farber and Doolin (2011) meta-analyzed 18 studies of positive regard and found an effect size of 0.27, a moderate relationship. Likewise, Kolden, Klein, Wang, and Austin (2011) found a moderate relationship between congruence or genuineness and counseling outcome.

By far the most popular and controversial construct has been empathy. There is much disagreement about how to define, operationalize, and measure this important PC construct (Duan & Hill, 1996). Generally, when research has attempted to relate empathy to outcome, these results have been supportive of PC theory (Bachelor, 1988; Barrett-Lennard, 1986). In a meta-analysis of 57 studies, Elliot et al. (2011) found that empathy (measured in a variety of ways) was moderately related to outcome. Similar to previous research (Bohart, Elliot, Greenberg, & Watson, 1992; L. S. Greenberg, Elliot, Watson, & Bohart, 2001), ratings of empathy from clients, counselors, and independent observers all correlated with client outcomes, but the strongest relationship was found between client ratings and outcome. In contrast to Bohart et al. (1992), Elliot et al. (2011) found that the relationship between empathy and outcome did not differ across theoretical orientations.

An interesting study was performed by Murphy and Cramer (2014) in which clients and therapists in 62 dyads rated each other on empathy, unconditional positive regard, and genuineness after the first and third sessions of therapy. Client distress decreased over the three sessions and progress was even more pronounced when clients and therapists rated each other as offering high levels of the three conditions. These results suggest that therapy may be a two-way street—that clients' progress is better when they are empathic, unconditionally positive, and genuine, too.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

PC theory has been both villainized and praised in addressing its utility with individuals from diverse backgrounds. Like many theories of counseling, PC theory can be criticized for placing too much emphasis on the individual and paying relatively little attention to family and cultural effects on people's lives and behaviors (Cooper, 2013). Sue, Ivey, and Pedersen (1996) noted that

"many psychologists fail to realize that the majority of societies and cultures in the world have a more collectivistic notion of identity; they do not define the psychosocial unit of operation as the individual" (p. 5). Values such as duty to family and cultural groups are largely neglected, given the strong emphasis on the internal locus of evaluation prized by PC therapists (Usher, 1989).

Poyrazli (2003) flatly stated that "despite its popularity, Rogerian therapy clashes with and is inappropriate for Turkish culture" (p. 111). She cited most of the major problems noticed by others in PC theory: the emphasis on individualism and emotional expression, the disregard of the power of the family, and the lack of structure and authoritative stance on the part of the counselor. Similar to other critics, however, Poyrazli cited the utility of the core conditions in working with Turkish clients. Spangenberg (2003) agreed that these conditions are useful in working with South African clients and noted that successful PC counseling with these clients would focus on the client in the context of family, community, and culture. In contrast to Poyrazli, Spangenberg saw the nondirectiveness of the PC counselor as respectful to the client and cautioned therapists not to succumb to the temptation to give advice and suggestions without providing the opportunity to process them. Oyama (2014) described the transformation of PC theory in Japan. Since its introduction after World War II, the approach has gradually mutated to one that is more culturally consistent with less emphasis on individuation.

The stress on individualism in PC theory can lead to an attitude that the person must change, not the environment, organization, or society in which he exists. The notion that an individual can actualize without the recognition that social structures sometimes oppress is seen as detrimental to women, racial and ethnic minorities, and individuals who are gay, lesbian, or bisexual (Sue & Sue, 2013).

Chantler (2005, 2006) joined in these kinds of criticisms of PC theory and suggested an extension of the concept of conditions of worth to include "gender, class or race dimensions of conditions of worth" (2006, p. 51). In doing so, the internalization of societal stereotypes and the often negative impact that they have would be recognized. Chantler also advised counselors who are of dominant group backgrounds working in an enlightened PC mode to examine their own lives for the effects of privilege and how these factors influence their work with clients. Consistent with feminist theory, Chantler emphasized the issue of socially conferred power, particularly when counseling those of backgrounds other than the dominant group. She pointed out that, although PC therapists attempt to create a symmetrical therapeutic relationship, "the desire to equalize counseling relationships does not mean that they will be equal" (2005, p. 253).

Gillon (2008) called for an examination of how PC theory works for men. Exploring traditional male sex-role stereotypes, he argued that, because of the PC emphasis on vulnerability, experiencing, and relationship, men who are strongly socialized into traditional masculine roles may not fully engage in therapy. He noted that, because men are encouraged to "think and do, rather than feel" (p. 127), the empathic, emotion-focused atmosphere of PC counseling is inconsistent with traditional masculine ways of relating. The PC therapist's congruence may be perceived as weakness, according to masculine stereotypes, leading to decreases in trust and therapist credibility for male clients. However, Gillon does think that PC therapy can be saved, noting that PC counseling can provide an environment in which men are not required to perform behavior that is consistent with masculine stereotypes. Other suggestions involve educating male clients at the start of therapy, using language that is characteristic of masculine tendencies (e.g., distancing or objectifying) in pinpointing clients' meanings, and empathizing with any difficulties in expressing and experiencing that men might experience.

Clients from cultures other than White European cultures may expect and desire more guidance from the counselor than is provided by traditional PC therapists. MacDougall (2002) suggested that this lack of direction may produce frustration for these clients and recommended that PC counselors consider alternative behaviors, such as giving advice and making suggestions. Quinn (2013) argued that two adaptations are needed when using a PC approach with clients from non-White cultures. First, the therapist needs to understand the client's culturally based understanding of illness (in the broadest sense). Second, the counselor needs to be very attentive to how the client is perceiving him, to make sure that the facilitative conditions are being received.

Sue and Sue (2013) noted that the emphasis on self-disclosure in psychological theory can be problematic for clients from non-European cultures. Clearly, self-disclosure is a cornerstone of PC theory, and clients from cultures that do not value such disclosure (such as Asian individuals) may not respond well to this approach. Also, clients who for good reasons mistrust "majority" individuals may be reluctant to invest in PC counseling. Insight is highly valued in the PC approach; individuals from cultures or groups other than European and of lower socioeconomic status (SES) may not share this value. The latter clients, particularly, may be more concerned with concrete life problems (Sue & Sue, 2013).

PC theory does have some strengths that are relevant to working with clients who are of diverse origins (Cain, 2010). The assumption that the client, rather than the therapist, determines the goals of counseling avoids the imposition of culturally based notions of the healthy personality (Usher, 1989). In fact, Rogers probably would have argued that the PC credo of trusting the individual would create an atmosphere of respect for clients' culturally based values and personal history. Essentially, the PC counselor wants to walk in the client's world. Freire, Koller, Piason, and da Silva (2005) provided an example of such work in their description of the process and outcomes of using a PC approach with 98 lower SES, neglected children and adolescents in Brazil. At the publication of their report, 98 clients had participated in this ongoing program, attending a range of 1–39 sessions (the average was 12). Initially, the clients in this project were puzzled by the nondirective approach, but Freire et al. reported that they quickly began to learn to use the unique relationship to their benefit. Improvements in interpersonal, emotional, and academic functioning were noted by these authors. However, no data are presented to support these contentions, and it should be noted that this study in no way approached the standards of controlled outcome studies.

The valuing of real, egalitarian relationships in this approach is consistent with the values of a feminist approach to counseling (Waterhouse, 1993). However, feminists point out that PC theory can be seen as ignoring the social and political context in which women reside (Chantler, 2005; Waterhouse, 1993). The emphasis on autonomy and individual responsibility for change ignores the fact that social roles and norms often prevent women from realizing their potential and can result in blaming women for their problems. According to Waterhouse (1993), "There is within the Rogerian perspective a strong faith in the transformative powers of counselling which is at best overambitious and at worst reckless and irresponsible" (p. 62). Further, the construct of empathy is problematic—to empathize with women or members of other historically oppressed groups requires not just awareness in the here and now, but also an understanding of the historical influences on current social contexts.

From an LGBT perspective, many of the criticisms and strengths elaborated here apply. The total acceptance of the client by the counselor would be a positive. However, LGBT advocates

would also criticize the theory for ignoring cultural and historical influences that contribute to discrimination and prejudice, including the practice of psychological diagnosis (Livingstone, 2008). The conditions of worth construct might need to be broadened to include societal conditions of worth. Lemoire and Chen (2005) emphasized this latter idea in their discussion of the use of PC counseling with LGBT adolescents. While allowing that the core conditions provided by the therapist create a safe situation in which the adolescent can explore his sexual identity, Lemoire and Chen also noted that at least three elements need to be added to PC counseling when working with this group: deliberate validation of the adolescent's sexual identity, discussion of risks and benefits associated with the disclosure of sexual identity, and socialization into the LGBT community in ways appropriate to the ages of clients.

In a way, Rogers was ahead of professional psychology in terms of considering issues of diversity and oppression. Toward the end of his life, he became involved politically, conducting large encounter groups with individuals from conflicting social groups (such as in South Africa and South America), suggesting a greater awareness of group and social factors in human behavior. In his book *On Personal Power* (1977), Rogers discussed the utility of the PC approach with a wide variety of people, including African Americans; gay, lesbian, and bisexual individuals; Chicanos; Filipinos; and many others. He acknowledged that "minority group members feel tremendous rage and bitterness towards whites. . . . Rage needs to be *heard*. This does not mean that it simply needs to be listened to. It needs to be accepted, taken within and understood empathically. . . . To achieve this kind of empathic listening the white needs to listen to his own feelings too, his feelings of anger and resentment at 'unjust' accusations" (pp. 133–134; quotes and emphasis in original). However, some writers maintain that these experiences with diverse cultures had little influence on Rogers's thinking because he did not fully recognize the implications of cultural norms of interdependence and community (Holdstock, 1990).

Long-time PC advocate Patterson (2000) opined that the emphasis on cultural diversity leads to an excessively technique-oriented position in which counselors modify what they do on the basis of the client's background. Arguing that this stance is also detrimental because it emphasizes only differences between people, he said, "This approach only ignores the fact that we are rapidly becoming one world, with rapid communication and increasing interrelations among persons from varying cultures, leading to increasing homogeneity and a worldview representing the common humanity that binds all human beings together as one species" (2000, p. 310). Counterpoints to Patterson's arguments are offered by other PC advocates, who argue that attention to issues of diversity is essential so that PC therapists do not continue the historical patterns of oppression and discrimination seen in many areas of social service (Lago & Hirai, 2013),

THE CASE STUDY

Richard presents with depressive and anxiety symptoms, probably very common among the clients with whom Rogers worked as he was developing his theory. The theory accounts particularly well for anxiety and is generally useful in understanding individuals who have difficulty processing and expressing emotion. Richard is a member of a culture (White) that values individual choice and striving for the betterment of the person, values that are consistent with the PC approach. Once Richard gets past his hesitance to discuss and experience emotion, he might be quite comfortable with this approach and its goals.

Summary

PC therapy begins with an optimistic view of people. Humans are seen as growthful beings that attempt to maximize their potential. We inherently move toward experiences that contribute to our growth and away from those that don't, following our actualizing tendency, which is in turn guided by the organismic valuing process.

Part of actualization of the organism is the development of the self, which adopts part of the actualizing tendency. The urge to self-actualize can create problems, however, when it runs into the need for positive regard. In wanting the love of others, we may internalize conditions that brand aspects of the self as worthy or bad; these conditions of worth may be counter to the self-actualizing tendency. Once an individual internalizes conditions of worth, he is incongruent—he has a discrepancy between self and experience. He denies or distorts aspects of his experience that do not fit the conditions of worth.

PC counselors do not diagnose or assess. They simply provide the right atmosphere and trust the client to lead the way. Therapist congruence, empathy, and unconditional positive regard are the necessary and sufficient conditions for client change. Given these conditions, the client will progress from a state of incongruence to one of congruence and become fully functioning.

PC theory has been criticized for being simplistic and oblivious to the true qualities of human nature. Outcome research supports the theory, but theory-testing research is less convincing. The core conditions are likely to be necessary, but not sufficient, according to the data.

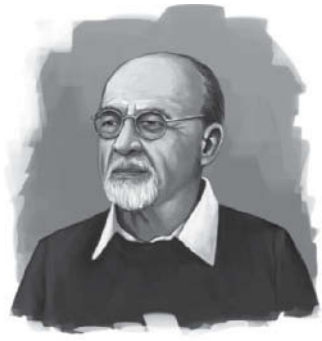
The individualistic emphasis within PC theory can be detrimental to clients who have experienced oppression. The lack of attention to familial and cultural factors in PC theory may be problematic in dealing with clients from other cultures. On the other hand, PC theory's trust in the individual to know what is needed can be helpful in working with clients from diverse backgrounds.

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CHAPTER 6

Existential Therapy



Irvin Yalom

Helen is a 43-year-old White woman who presents for counseling due to problems in her marriage. Helen holds a Master of Fine Arts degree in playwriting from Yale University. She and her husband, Steve, have three children, a 10-year-old boy named Luke, a 12-year-old girl named Grace, and a 14-year-old boy named Charlie. Helen met Steve, 48, while she was attending Yale and he was working in New York City as a bond trader.

Helen grew up in suburban Chicago, the third of five children. Helen's family had the appearance of the "perfect" family. Dad was a very successful surgeon, but not involved in the children's lives on a daily basis. Mom was loving and steady, yet also somewhat reserved; she was perhaps more concerned with what others thought than she would have liked to admit. In some ways, the family environment was one of benign neglect—the children behaved well, so no one thought there could possibly be anything wrong. In fact, two of Helen's sisters had eating disorders, and her brother has battled an alcohol addiction off and on.

Steve and Helen lived in New York City after they married. Helen had an administrative job with a theatre and wrote a bit at night, although she stopped writing when they had their son Charlie. They had plenty of money, but Steve began to gamble during a period when his work was not going as well as he would have liked. Helen was 8 months pregnant when she learned that Steve had gambled away large amounts of money, including most of their savings.

Helen was devastated, but having grown up in a family where you stick it out no matter what, she immediately began looking for treatment for Steve and housing options for their young family. Unable to deal with the strain, Helen called on her parents for assistance in spite of the fact that she believes that they never truly accepted Steve. They suggested she look in the Chicago area because it would have job options for Steve and perhaps less pressure than New York City. Helen's parents offered financial assistance in the form of a down payment on a house, and although it was never stated, it was understood that it was for a house in Chicago. The family moved and has lived in the same house now for 10 years.

On a recent trip to New York with some friends, Helen ran into a former professor from Yale. He asked about her work. She was pleased, but also embarrassed that she's done nothing, although in her mind this is no great loss because she isn't all that talented. He reminded her that she won a competition during graduate school and shared a couple of things faculty members said about her in which they praised her talent and insight. He is divorced, 8 years older than Helen, and very handsome.

He asked her to meet him for a drink and gave her his business card. She didn't call him, but kept the card and did not tell Steve about the encounter. Having survived a crisis in her marriage, she now

feels resigned to the humdrum existence of a woman whose husband does not support her career ambitions and has never really confronted his own demons.

Helen is a "good girl," a thoughtful woman and a good mother who has no interest in destroying her family by having an affair. However, she is troubled deeply by the way she feels right now: that her husband can "do no right" and that this is a permanent state for the rest of her marriage. She is surprised by the fact that for 10 years she has endured the crisis caused by her husband's gambling without its sounding the death knell of their marriage. Yet, out of the blue, she bumps into a former professor who displays interest in her and in her work, and her reaction to this—her interest in him, her irritation that her husband doesn't do the same thing, and her worry about the aimlessness she is feeling now that her children are older—brings her to a place where she decides to seek help.

BACKGROUND

Existential approaches to psychotherapy (existential therapy, or ET) are more philosophy than pragmatics, more attitude than specific theoretical orientation. ET's roots are in existential philosophy, or the study of being and phenomenology, which emphasizes that all we can really know is our own experience (Cooper, 2003). The ideas of many are represented in ET, yet they hang together quite well, as C. T. Fischer, McElwain, and DuBoise (2000) so aptly pointed out when they asserted that "existential psychology is an approach of like-minded persons looking for correctives to determinism, materialism, and realism" (p. 245). Therapists of many stripes probably employ ET ideas; Yalom and Josselson (2014) contend that, because all humans face the ultimate concerns, ET ideas should be a part of all acts of therapy.

Some time ago, Norcross (1987) warned us that "existential therapy's process is frequently ill-defined and widely misunderstood" (p. 43); this statement is probably still true today. You may believe that this is a less-than-promising start to your study of ET, but I am hopeful that things will soon get clearer. This may help: Irvin Yalom (an important existential therapist) defines ET as "a dynamic approach to therapy which focuses on concerns that are rooted in the individual's existence" (1980, p. 5). There seem to be two general orientations within the ET school. The first is the Continental or European, rooted in an analytic orientation (although not exactly accepting the content of psychoanalytic theory), which tends to emphasize the limitations and tragedy of the human condition (I. Yalom, 1980). The second arose in the United States in the 1960s and emphasizes human potential and encounter. It is closely related to the humanistic school exemplified by the work of Carl Rogers, James Bugental, and Abraham Maslow. In Box 6.1, you can read a bit about another well-known European existentialist, R. D. Laing, who had a unique perspective on psychosis.

Box 6.1

R. D. Laing's Existential Approach to Psychosis

A hallmark of the existential therapies is contesting conventional wisdom, whether it is pointing to the meaninglessness behind life's apparent purpose or to the inescapable loneliness that persists in spite of our social nature. Similarly, Ronald David (R. D.) Laing, a Scotch

psychiatrist whose theoretical association resides in limbo between existential therapy and psychoanalysis, sought to treat severe mental illness, especially schizophrenia, by approaching psychosis as a meaningful reality unto itself as opposed to the more common view of it as a collection of nonsensical symptoms that must be removed.

Trained as a psychoanalyst at the Tavistock Clinic in London from 1956 to 1960, Laing was heavily influenced by object relations theory, especially the work of John Bowlby, D. W. Winnicott, Wilfred Bion, and Charles Rycroft (Laing's training analyst), but also equally, if not more so, by existential philosophy, including the writings of Martin Heidegger, Jean-Paul Sartre, Martin Buber, and G. W. F. Hegel, among numerous others (M. G. Thompson, 2000; A. Laing, 2007). This blend of existentialism and psychoanalysis is apparent in Laing's first major work, *The Divided Self* (1960). Laing contested the conventional wisdom that schizophrenia represented a biological illness, positing instead that it was a complex defense mechanism—an elaborate false-self system—employed to protect the person from overwhelming, painful existential despair, an attempt to ward off severe alienation and invalidation of the authentic self that unwittingly drives the person deeper into a closed loop of interpersonal isolation.

Another major work of Laing's is *The Politics of Experience* (1967). Here, Laing committed to a chiefly existential perspective, insisting on the irreducible nature of individual experience and denouncing psychoanalytic theory, the divide between normal and abnormal, and the way society coerces individuals into roles that require them to betray the authenticity of their lived experience. Laing revealed himself to be an ardent humanist and unflinchingly client centered, but he was also a radical without boundaries, his vision implying a kind of experiential anarchy where there was no demarcation between health and dysfunction, no "reality" for the reader to hold on to except the phenomenon of experience itself.

So what would practice in a Laingian vein look like? Cooper (2003) noted that Laing wrote very little about his actual technique but highlights the rapt attention and seriousness Laing gave to his clients' every experience, reality-based or otherwise, as well as Laing's arresting presence and uncanny bluntness. For example, Laing was known to sit with catatonic patients for months, imitating their repetitive movements and symptoms, until they finally spoke to him, marking the movement from the cocoon of alienation to being in the world (Cooper, 2003). One of the more detailed accounts of what Laingian technique looks like comes from M. Guy Thompson (1997), an existential psychoanalyst who trained under Laing in the days of Kingsley Hall, a group home where clients and therapists, including Laing himself, lived together without hierarchy or professional boundaries. It was common for Kingsley Hall to house all sorts of individuals, from the relatively "sane" to people in the midst of severe mania or psychosis; it embodied the anarchy of experience that *Politics* theorized.

Thompson (1997) described the primary goal of Laing's approach as a "fidelity to experience," meaning that the therapist (or in this case, the treatment community of Kingsley Hall) abided by the clients' unique experience of suffering entirely as it is for him or her rather than how psychology, society, or anyone else would like to see it. Thompson told the story of Jerome, a young man with features of catatonic schizophrenia and anorexia who moved into Portland Road, another community home overseen by Laing and analogous to Kingsley Hall, where Thompson lived for some time. The treatment account is nothing short of harrowing, with the house members trying unsuccessfully, despite their best attempts at empathy, to get

(continued)

Box 6.1 *(continued)*

Jerome to connect with others, and even to eat. Jerome slipped deeper into isolation, began defecating in his room, developed awful bedsores, and became dangerously thin. Terrified but exhausted, the house members left Jerome alone, resigning to a complete acceptance of his dangerous behavior. One day, Jerome came down from his room to use the toilet, began talking to the other house members, and eating. Stunned, they asked Jerome what he was up to all this time, and Jerome said that "he had to count to a million, and then back to zero, uninterrupted, in order to *experience* his freedom," a task that was impossible with everyone interrupting him for so long (Thompson, 1997, p. 609). According to Thompson, Jerome never had another psychotic relapse and went on to live a very ordinary life.

As a person, Laing was as radical and contrarian as his theories and approach, becoming something of a celebrity and provocateur. He was ardently against psychiatry and psychology, despised formalized training, and was a major supporter of psychedelic drug use as a road to deeper understanding (Thompson, 1997; Cooper, 2003; A. Laing, 2007). Laing once told Thompson that he believed one of the prerequisites for psychoanalytic training should be, besides a personal analysis and reading the *Standard Edition* of Freud, taking LSD (Thompson, 1997). Laing was also known for using LSD with clients, as well as partying and vacationing with them (Thompson, 1997; Cooper, 2003). Laing died in 1989 in St. Tropez, France, of a heart attack while playing tennis, his final words when asked if he wanted a doctor, betraying, in vulgar fashion, some of his own philosophy: "Doctor? What fucking doctor?" (A. Laing, 2007). Provided one takes the boundlessness of Laing's thinking with a grain of salt, many useful perspectives can be gleaned from his work, not the least of which was an unyielding effort to render the inhuman human.

Source: Courtesy of Adam Hinshaw. Used with permission.

Another resource in existential psychotherapy is the International Society for Existential Psychology and Psychotherapy, a division of the International Network on Personal Meaning, which can be found on the web at www.meaning.ca. The society's official journal is the *International Journal for Existential Psychology and Psychotherapy,* which debuted in July 2004. A second organization of interest is the Society of Logotherapy and Existential Analysis, at www.existential-analysis.org.

BASIC PHILOSOPHY

The basic philosophy of ET theorists is that humans are free, are responsible for their own lives, and have the potential for self-actualization (Craig, 2008). It can sometimes appear to be a rather gloomy approach. Cooper (2003) reported that when asked what ET is, he sometimes resorted to "it's similar to person centred therapy . . . only more miserable!" (p. 1). Randall (2001) suggested that underlying ET is a philosophy that "the life of each human being is a finite drama enacted in a hostile or indifferent universe; that the purpose of life is not at all given, but must be selected afresh by each individual through conscious acts of willfulness tempered by responsibility, and that no matter how close a person may feel toward another, each ultimately must face life alone" (p. 260). Frankl (1984) added that "to live is to suffer, to survive is to find meaning in

the suffering" (p. 11). On the other hand, ET theorists recognize the human capacity for creativity and love. Frankl (1984) wrote that "love is the ultimate and the highest goal to which man can aspire . . . *the salvation of man is through love and in love*" (p. 57; emphasis in original).

ET theorists have a favorite phrase: "existence comes before essence" (M. Adams, 2013, p. 11). By this they mean that first we come to be, and then we use our creative powers to develop who we are, our essence. We have no control of the basics (e.g., genetics, gender, race, culture) and are thrust into the world with the fact of our death but no knowledge of when we will die. We have only choice and responsibility and the anxiety that accompanies them because it is hard for us to accept that beyond our initial basics, we are what we choose (M. Adams, 2013).

Lars, Helen's existential counselor, approaches her with the attitude that she is a free, responsible being who has the potential to grow and flourish. Helen may seem stuck right now, but her distress and sadness are signs of the potential within her to be creative and loving.

HUMAN MOTIVATION

Frankl (1984) contended that the principal motivation of human beings is the search for meaning, and most ET theorists would agree. However, there is some disagreement about the source of this meaning. For Frankl, meaning is inherent in each individual—each individual has an ultimate, true calling—and it is the task of the individual to discover it (Cooper, 2003). For other ET theorists, meaning is created; there is no discovery involved.

Frankl (1984) maintained that we discover life meaning through three routes: "(1) by creating a work or doing a deed; (2) by experiencing something or encountering someone; and (3) by the attitude we take toward unavoidable suffering" (p. 133). Despite statements like this one, some accuse Frankl of implicitly endorsing a religious aspect to meaning (I. Yalom, 1980).

Proponents of ET generally accept the idea of the unconscious and the dynamic nature of psychological functioning, but the content of the unconscious is not instinctual drives, as Freud proposed (Yalom & Josselson, 2014). Instead, what is relegated to the unconscious is the true nature of our existence: that we are finite beings alone in a meaningless world (Cooper, 2003).

Lars wonders about Helen's search for meaning. He guesses that in the past she has found meaning through her writing, her marriage, and raising her children. Lars guesses that the vague sense of anxiety that Helen is experiencing stems from her sense of mortality, which is just beneath the surface of awareness right now.

CENTRAL CONSTRUCTS

Modes of Being

ET theory is focused on the *being* of humans. ET theorists recognize distinct ways of being, although they often use different names for them and the classic terms are in German (van Deurzen, 2010). The first is *Umwelt*, or being in the physical world. *Mitwelt* is being in relation to others, the social/interpersonal world, and *Eigenwelt* refers to the inner psychological world (being in one's subjective experience). *Überwelt* is the final dimension, the spiritual world. Truly authentic existence means attending to all realms. However, at a given point in time, we typically have one or two ways of being with which we are most concerned (van Deurzen & Adams, 2011).

Helen appears to be functioning primarily in the Mitwelt*—or at least attending to that aspect of her being at the expense of the* Umwelt *and* Eigenwelt*. She had spent much time worrying about her family until the recent encounter with her former professor. She is tempted to enter the* Eigenwelt*, but her early training in her family of origin leads her to be uncomfortable with a self-focused orientation.*

ANXIETY

ET theorists assume that everyone experiences anxiety; indeed, May and Yalom (2005) argued that "anxiety arises from our personal need to survive, to preserve our being, and to assert our being" (p. 271). To experience anxiety is therefore normal and expected, and according to Yalom (1980, 2008), the most powerful anxiety is associated with the awareness of one's mortality, sometimes called *existential anxiety* (M. Frank, 2011). However, other theorists (e.g., Søren Kierkegaard) associate existential anxiety with the awareness that we are not living up to our potential (Arnold-Baker & van Deurzen, 2008). Anxiety can come in other forms, too, depending on which ET theorist you read, but for these theorists, "anxiety is a teacher, not an obstacle or something to be removed or avoided" (van Deurzen & Adams, 2011, p. 24).

Lars notes Helen's clear sense of loss of purpose and unrest. Clearly she is becoming aware of her existential anxiety, which he thinks stems from her sense of finiteness and also is related to her feeling that she is not using her talents.

THE ULTIMATE CONCERNS

Yalom identified four existential themes of human existence: death, freedom, meaning, and isolation (I. Yalom, 1980; Yalom & Josselson, 2014).

Death. The ultimate concern is death, because "death itches all the time," according to Yalom (1980, p. 29). We humans have a great propensity to avoid really facing the idea of our own mortality, but when we are able to we experience the ultimate terror. As a result, much of our psychological life is built around avoiding truly facing our fates: Death and the anxiety that it triggers are the source of most psychological dysfunction. However, the awareness of death leads us to live purposefully and with awareness of our humanity. From this perspective, "death . . . enriches life" (Yalom & Josselson, 2014, p. 269).

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Video Example 6.1 Irvin Yalom on death



https://www.youtube.com/watch?v=yMbklYpZ1v8

Freedom. From an ET perspective, an essential aspect of human existence is freedom—the notion, according to Yalom (1980), that "the individual is entirely responsible for—that is, the author of—his or her own world, life design, choices, and actions" (p. 9). May and Yalom (2005) pointed out the terrifying consequences of accepting one's freedom: If we are totally free to choose and act, then we must recognize that "there is no ground beneath us: there is only an abyss, a void, nothingness" (p. 280). Ultimately, freedom implies responsibility for ourselves—our actions, but also our failures to act.

Awareness of our freedom implies responsibility to choose. Even if we are not aware of it, we are constantly making choices and our actions reflect these (Norcross, 1987). The reality of freedom, choice, and responsibility brings to us the notion of *existential guilt*: guilt that we experience about possibilities unfulfilled. Existential guilt is unavoidable because every time we make a choice, we are discarding other possibilities (Cooper, 2003).

What if one is trapped in a situation and there is really no way out? Frankl (1984) had the answer; his thoughts were highly influenced by his experience in the Holocaust. He wrote movingly about prisoners in the concentration camps who gave their last food away to others, saying that "they offer sufficient proof that everything can be taken from a man but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way" (p. 86). Frankl describes his experiences in the Nazi concentration camps and how these experiences contributed to his theory of logotherapy; you can read a section of Frankl's book in Box 6.2.

Box 6.2

An Excerpt from Frankl's *Man's Search for Meaning*

Let us first ask ourselves what should be understood by "a tragic optimism." In brief it means that one is, and remains, optimistic in spite of the "tragic triad," as it is called in logotheraphy, a triad which consists of those aspects of human existence which may be circumscribed by: (1) pain; (2) guilt; and (3) death. This chapter, in fact, raises the question, How is it possible to say yes to life in spite of all that? How, to pose the question differently, can life retain its potential meaning in spite of its tragic aspects? After all, "saying yes to life in spite of everything," to use the phrase in which the title of a German book of mine is couched, presupposes that life is potentially meaningful under any conditions, even those which are most miserable. And this in turn presupposes the human capacity to creatively turn life's negative aspects into something positive or constructive. In other words, what matters is to make the best of any given situation. "The best," however, is that which in Latin is called *optimum*—hence the reason I speak of a tragic optimism, that is, an optimism in the face of tragedy and in view of the human potential which at its best always allows for: (1) turning suffering into a human achievement and accomplishment; (2) deriving from guilt the opportunity to change oneself for the better; and (3) deriving from life's transitoriness an incentive to take responsible action.

It must be kept in mind, however, that optimism is not anything to be commanded or ordered. One cannot even force oneself to be optimistic indiscriminately, against all odds, against all hope. And what is true for hope is also true for the other two components of the triad inasmuch as faith and love cannot be commanded or ordered either.

To the European, it is a characteristic of the American culture that, again and again, one is commanded and ordered to "be happy." But happiness cannot be pursued; it must ensue. One must have a reason to "be happy." Once the reason is found, however, one becomes happy automatically. As we see, a human being is not one in pursuit of happiness but rather in search of a reason to become happy, last but not least, through actualizing the potential meaning inherent and dormant in a given situation.

(continued)

Box 6.2 *(continued)*

This need for a reason is similar in another specifically human phenomenon—laughter. If you want anyone to laugh you have to provide him with a reason, e.g., you have to tell him a joke. In no way is it possible to evoke real laughter by urging him, or having him urge himself, to laugh. Doing so would be the same as urging people posed in front of a camera to say "cheese," only to find that in the finished photographs their faces are frozen in artificial smiles.

Source: From Frankl, V. E. (1984). *Man's Search for Meaning.* Reprinted by permission of Beacon Press, Boston.

Meaning. Most ET theorists accept that human existence does not come with built-in meaning (Yalom & Josselson, 2014). Frankl would be the exception to this philosophy, as described earlier (in the "Basic Philosophy" section); however, he believed that each individual's meaning is unique and is found only as a result of a difficult search and perhaps unavoidable suffering.

Isolation. We are always and ultimately alone, according to ET theorists. If we accept our mortality, freedom, and responsibility to create meaning, the realization of our isolation is unavoidable. People deal with aloneness in many ways, but it presents quite a dilemma, for "trying too hard to achieve security through merger may result in damage to the self; still, abandoning the effort to connect at all leads to emptiness" (Randall, 2001, p. 261).

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Video Example 6.2 Here's a session of existential analysis. Think about which of the four ultimate concerns this client is addressing in this session



https://www.youtube.com/watch?v=X6hdJ8dtilk

Helen, Lars thinks, is struggling with all of these concerns simultaneously. She is probably the least aware of her death anxiety, but it is surely the font for her discontent in the other areas of ultimate concern. Helen feels trapped in her current situation and yet guilty for feeling this way. Her sense of meaning has been for a long time invested in raising her children, and although she verbalizes her sense of self-worth tied to this aspect of her existence, now she finds that something is missing. She recalls the sense of meaning and purpose she found in her work as a playwright. Lars thinks that, because of these realizations, Helen probably feels isolated from others and a vague sense of guilt.

DEFENSES

No matter how hard we try to avoid it, awareness of ultimate concerns is inescapable. When we become aware of one of these issues, we experience anxiety. The result of anxiety is inevitably defense. According to Yalom (1980; Yalom & Josselson, 2014), the most important anxiety is associated with death, and we use two major defenses to ward off the awareness of it: specialness and the notion of the ultimate rescuer. If we are special, death does not apply to us as it does to others. If we have a magical rescuer, he or she or it will save us from the possibility of nonexistence.

Lars thinks that Helen's sense of specialness is not as prominent as her belief in the rescuer. Her disappointment with her husband and her surge of discontent after meeting her former professor would support this hypothesis.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Existential counselors are not interested in theories of personality because of their orientation toward the essential issues of human existence. They would contend that each individual has the choice, on a moment-to-moment basis, to determine who she is. We are always in the process of becoming, so to imagine a fixed self that can be placed in a diagnostic or personality category is not helpful (Arnold-Baker & van Deurzen, 2008). Theories of personality and development are based on normative patterns and therefore do not capture the unique experience of the individual client. In addition, the existential therapist is more interested in the client's present experience than her past. However, some ET theorists recognize the developmental sequence from attachment to separation or individuation as inherently tied to the existential dilemma of aloneness (I. Yalom, 1980). Thus, neoanalytic ideas such as those presented in Chapter 3 would fit with the ET perspective.

Lars is more interested in understanding Helen from her perspective than through any scheme describing personality types. He does, however, recognize the influence of Helen's early environment on the beliefs and ideals she holds as a woman, mother, and spouse.

HEALTH AND DYSFUNCTION

A good definition of health from an ET perspective would be *authentic* (Maddi, 2005). Authenticity involves courage and determination; it involves the willingness to face our own anxiety about not being (Vontress, 2013). Health, in this view, is to be able to deal with the anxiety that is unavoidable as part of being human. Being authentic means to not deceive oneself; such deception is known as *acting in bad faith* (Sartre, 1956, cited in Yoder, 1981).

In the most general sense, psychological dysfunction in the ET view is the result of living an unexamined life (Arnold-Baker & van Deurzen, 2008). We proceed merrily on our way, going along with the crowd, not thinking about the values and meaning in our lives. If my good friend Laura gets the latest iPhone, then acquiring one becomes a driving force in my life. This kind of existence is inauthentic and ET theorists call it *living in bad faith* (Vontress, 2013, p. 149).

For Yalom (1980; Yalom & Josselson, 2014), a major source of psychological dysfunction is conflict, but it is between the individual and the givens of existence, particularly the awareness of death. He proposed that, instead of the psychoanalytic notion that the surfacing of instinctual drives leads to anxiety and then to defense and dysfunction, the correct sequence is the following: The awareness of ultimate concerns (particularly death) raises anxiety, which then triggers the defense mechanisms. More simply put, people "fall into despair as a result of a confrontation with harsh facts of the human condition—the 'givens' of experience" (I. Yalom, 2003, p. xvi). Clients may be troubled by the paralysis of will that comes with human freedom. They may be responding to isolation by frantically fusing with others. Many clients present with feelings of meaninglessness.

However, the most important of the givens is death (Yalom & Josselson, 2014). In dealing with the notion of our own deaths, we rely mostly on two important defense mechanisms, described earlier: feeling special and believing in an ultimate rescuer. Yalom linked the defense of specialness to paranoia and, not surprisingly, narcissism.

The belief in an ultimate rescuer can also lead to dysfunction, and according to Yalom it is a less effective defense than specialness. Investing oneself in the ultimate rescuer can cause the loss of self and a lifestyle that is restricted. This defense is also more likely to break down when one is facing personal illness and sometimes when a special other is threatened.

Another way of looking at psychological dysfunction was presented by Bugental and Bracke (1992). They argued that popular culture in recent years has encouraged emptiness and narcissism by focusing on individual achievement without a sense of purpose or meaning. We experience emptiness because of this lack of meaning, which stems partially from the loss of connection associated with current lifestyles and norms. We define ourselves through the eyes of others and "are seduced into search for direction, completion, and meaning by seeking more *things*, desperately fabricating a fashionable appearance, and looking almost exclusively to others . . . to define ourselves" (Bugental & Bracke, 1992, p. 29; emphasis in original). In their version, the healthy person has a "centered awareness of being" (p. 29), which involves searching inwardly for an authentic self.

Maddi (2005) went even further, identifying three types of meaninglessness: vegetativeness, nihilism, and adventurousness (p. 108). The most severe form is vegetativeness, in which the individual has virtually no sense of life meaning. Nihilism involves feelings of disgust and anger because the individual, paradoxically, finds meaning in insisting that life has no meaning. The least severe form of dysfunction is adventurousness. In this presentation, the client is prone to take severe risks to establish life meaning, such as in gambling, substance abuse, or physical adventures. Maddi maintains that "many respected industrialists and professionals fall into this category, regardless of the socially acceptable nature of their activity" (p. 108).

Frankl (1984) explicitly contrasted "traditional" neuroses and existential neurosis. Traditional or psychogenic neuroses have their origins in the psychological processes identified by other theorists. Frankl was much more interested in what he called noogenic neurosis, difficulties related to existential frustration or the lack of life meaning. Logotherapy, Frankl's approach, derives its name from the word *logos*, which means "meaning."

Spinelli (2001) presented an existential take on psychosis. Arguing that we have no definitive proof for biological explanations for these client presentations, Spinelli suggested abandoning traditional diagnosis in favor of understanding the meaning of the experiences of severely disturbed clients. He identified two types of clients in this regard: one who is frightened by her mental turmoil and one who adopts the experiences as truth. The latter client is more difficult to help than the former, according to Spinelli.

Lars speculates on Helen's recounting of her current experience. She clearly presents a sense of aimlessness, a feeling that her existence is "humdrum." These elements add up to meaninglessness. At present, Helen is not very authentic because she refuses to face up to her existential tasks and have the courage to live without self-deception. However, that she comes to counseling suggests that she is moving in the right direction—with some support, she will likely begin to confront her sense of despair and the reality of her finite existence. Helen does not seem to be very centered right now; she lives more according to the needs of others and neglects her own very difficult feelings. She seems a little vegetative, yet Lars sees movement starting to build.

NATURE OF THERAPY

Assessment

Existential therapists don't do much formal assessment; most would agree that to assess and diagnose doesn't capture the essence of individual existence. Furthermore, it creates distance between client and counselor, interfering with the authentic encounter necessary for effective therapy. The existential therapist will look for the client's assumptions and judgments about herself and the world and also her interest in undertaking the important task of examining one's life (Arnold-Baker & van Deurzen, 2008).

Lars does his best to get to know Helen, to enter her world, while maintaining his own authenticity. He notes that she is unsettled and questioning the meaning of her life, a good sign for the beginning of therapy.

Overview of the Therapeutic Atmosphere

ET is an experiential approach and is focused intently on the immediate subjective experience of client and therapist (Schulenberg, 2003). Because this approach is very philosophical, you might expect the existential counselor to act like your stereotypic philosopher: thoughtful, passive, turned inward. You would be wrong: Existential therapists are quite active in their relationships with clients (C. T. Fischer et al., 2000). Adams (2013) characterizes the ET counselor as directive because he can never disown his own assumptions, so to claim a nondirective stance would be acting in bad faith (p. 45). Rather, he says, the ET therapist is straightforward in his approach to clients and is transparent in his attempts to help them find their own directions.

As active as they are, existential therapists do not attempt to give clients solutions to their problems. In fact, they are more likely to challenge clients, encouraging them to have the courage to face the ultimate concerns (Cooper, 2003). As van Deurzen (2006) put it, "An attitude of openness is encouraged and clients are not mollycoddled, though treated with respect, care and understanding" (p. 283).

Generally, ET does not fit in a short-term model. Yalom typically sees clients for several years—and sometimes twice a week. However, he readily acknowledges that many therapists practice in conditions under which longer-term psychotherapy is not possible. There is, in fact, at least one time-limited model of ET in existence (Strasser & Strasser, 1997).

Lars begins the counseling relationship with Helen with a sure sense of who he is and a ready energy to devote to the process. He is unsure what is to come, but welcomes the challenge and has faith in Helen to be able to handle it.

Roles of Client and Counselor

The therapist in the ET tradition has been described as a consultant who has a very real, deep caring for the client (Bugental & Kleiner, 1993). The therapist also attempts to demystify the counseling process and relate authentically to the client. As part of relating authentically, the counselor must have attended to his own existential issues, for as van Deurzen (2010) pointed out, the counselor should not be "existentially lazy" (p. 256). The therapist who has accomplished this existential scrutiny will not hide behind authority or therapeutic neutrality and will

treat the client as an equal, or as Yalom and Josselson (2014, p. 287) wrote, as a "fellow traveler." In this role, the therapist is to be as authentic and genuine as possible. To accomplish this therapeutic stance, it is necessary for the existential therapist to have his own therapist (van Deurzen and Adams, 2011).

R. A. Walsh and McElwain (2001) emphasized that the client and counselor have a mutual investment and risk in the therapeutic encounter. Similarly, Spinelli (1997, 2007) saw therapy as a challenge for both therapist and client. He maintained that the therapist must be an active participant, not an observer of the process, and thereby risks having his values and beliefs shaken by experiences with clients. The client is challenged to clarify the nature of herself in all aspects. Spinelli (1997) described an attitude of "un-knowing" on the part of the therapist to facilitate the therapeutic relationship, as the "therapist's willingness to explore the world of the client in a fashion that seeks not only to remain accessible to, and respectful of, the client's unique way of being in the world, but also to be receptive to the challenges to the therapist's own biases and assumptions (be they personal or professional, or both) that the exploration may well provide" (p. 8).

The client must also be an active participant in the counseling process, struggling with choices and recognizing her freedom (Schulenberg, Hutzell, Nassif, & Rogina, 2008). When the client is reluctant to face the ultimate concerns, existential therapists call this *evasion* (van Deurzen, 2010) or *self-protection* (K. J. Schneider, 2011) rather than resistance. This reaction can be seen as stemming from the client not accepting the therapist's agenda or from an understandable desire to stay with the safe and familiar.

As Lars engages in the relationship with Helen, he relies on an attitude of "un-knowing" and the acknowledgment that what he brings to the relationship will be evident only if he is as authentic as he can possibly be. He is prepared to care deeply about Helen and to feel challenged by the paths of exploration she chooses and the likely sense of suffering and pain that will emerge.

GOALS

Perhaps the simplest statement of the goal of ET comes from Norcross (1987), who opined that "the purpose of psychotherapy is to set people free: free of symptoms and free to be aware and to experience one's possibilities" (p. 48). A more detailed description comes from van Deurzen (2012):

> The aim . . . is to clarify, reflect upon and understand life. Problems in living are confronted and life's possibilities and boundaries are explored. The existential approach does not set out to cure people in the tradition of the medical model. Clients are not considered to be ill but rather to be sick of life or clumsy at living. (p. 30)

Existential counselors want to help the client live an authentic life as much as possible, which involves accepting the very scary ultimate concerns of being—most importantly, the inevitability of our own deaths (Strasser & Strasser, 1997). They also want the client to accept responsibility—for the situation that brings them to therapy and for making it change (Adams, 2013). With the acceptance of our freedom and responsibility comes a greater sense of empathy for others and a fluid, creative way of looking at life, according to ET theorists (Todres, 2012). Ultimately, the client, who is typically feeling bored and apathetic or unhappy with life, needs to "come face to face with herself, in the ruthless honesty of inner silence" (van Deurzen, 2012, p. 204). Then she can decide what she really values—gives meaning to her life—and go for it.

Lars hopes that Helen, ultimately, can find her way out of her current "stuckness" into authentic experiencing. She must accept her own sense of freedom and the responsibility that is hers alone for what she does with this freedom. Lars believes that Helen will acknowledge her limited existence and the aloneness that will first catapult her into existential terror. However, Lars is certain that Helen will eventually find her way out of the abyss by examining her current existence and moving forward to develop new meaning in her life.

PROCESS OF THERAPY

A clear contract should be established as ET begins, including length of therapy, location, and fees (Arnold-Baker & van Deurzen, 2008). As with any approach to helping, the early sessions should be focused on building a strong, trusting therapeutic relationship. The actual working phase of therapy follows, in which the existential counselor assesses the client's material in terms of the four ways of being: *Umwelt*, *Mitwelt*, *Eigenwelt*, and *Überwelt* (Arnold-Baker & van Deurzen, 2008). With this knowledge (e.g., with which way of being the client is most comfortable), the counselor can then help the client examine her strengths and weaknesses and her beliefs and values and can gently point out where she is self-deceiving (Arnold-Baker & van Deurzen, 2008).

Fischer et al. (2000) pointed to three general themes that can be seen in all contemporary ET approaches: relationship, understanding, and flexibility (p. 248). The therapist must engage in the relationship and attend to its nuances. Understanding refers to the counselor's sincere attempt to enter into the client's world. The idea of the uniqueness of the individual leads to the conclusion that the therapist must be flexible in approaching the client and may need to change approach or orientation across or within sessions (R. A. Walsh & McElwain, 2001).

Although existential therapists always keep their versions of the ultimate concerns in mind, Yalom reminded us that these concerns are not in the forefront for all clients or for a particular client at all times. He warned us that "therapy should not be theory-driven but relationship-driven" (2003, p. xviii). However, M. Frank (2011) argued that the most important process in ET is for the client to become aware of her existential issues.

All existential therapists see the relationship as an existential encounter, which should be authentic and trusting. Bugental wrote about *presence*, or the quality of being fully engaged in the moment (Bugental & Bracke, 1992). For the best therapy, both therapist and client need to be fully present (K. J. Schneider, 2011).

Some proponents of ET take an interpersonal approach, seeing the client's pattern of interpersonal relationships as reflective of her stance toward self, others, and the world—in other words, her way of being in the world (Spinelli, 2007). This orientation would translate to a focus on the therapeutic relationship as an indicator of the client's selfhood. The relationship between therapist and client often becomes the center of therapy. Spinelli (2002) suggested that ET approaches are distinctly different from others in their focus on the here-and-now relationship of therapist and client—the experience of being "us," as he put it (p. 113).

K. J. Schneider and Krug (2010) identified three phases of the ET process. In phase one the client is anxious, and the therapist's goal is to develop a solid relationship with her and to help her start to experience the self. Phase two is associated with a sense of willingness on the part of the client, which results in deeper exploration of self-experiencing and responsibility. The final phase is one of creativity, in which the client realizes a stronger sense of meaning and purpose in life and engages her world, while at the same time remaining aware of the givens in her life.

Spinelli (1997) presented an interesting perspective on transference and countertransference. He maintained that labeling events in these terms allows the therapist to escape the essence of the real encounter by locating them in the past. Instead, these *resonances*, as he called them, should be viewed as evidence of the "values, beliefs and emotions that present themselves in the *current encounter between therapist and client*" (p. 37; emphasis in original).

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Video Example 6.3 Irvin Yalom describes the nature of psychotherapy.



https://www.youtube.com/watch?v=73wVVNrDl4I&list=PLAC6564852C9AA64B&index=2

Lars and Helen begin by negotiating a therapy contract. As their relationship begins, he attempts to enter her world as best he can, staying present in the moment and true to himself. Lars anticipates that his encounter with Helen will change both of them. Lars observes that Helen seems to be most comfortable in the Mitwelt, although she is beginning to consider the Eigenwelt. As he listens carefully to Helen, Lars anticipates that there are times that he will get off track, will be distracted, or will experience emotions that are connected with their encounter. When this happens, Lars will try to be authentic in dealing with these experiences.

THERAPEUTIC TECHNIQUES

Existential counselors are not big on techniques. In fact, Cooper (2008) commented that they "are often much better at saying what they *don't* do than what they *do* do" (p. 237; emphasis in original). Techniques are seen as potential barriers to an authentic relationship; they can get in the way of the counselor's understanding of the client on a meaningful level (Vontress, 2013). Other ET writers have accepted that, although for the most part existential counselors do not advocate any specific techniques, they do tend to draw from a wide array of interventions found in existing counseling approaches (Fischer et al., 2000); for instance, most existential counselors would agree that self-exploration, insight, and challenge are important elements of therapy. Yalom (1980; May & Yalom, 2005) would advocate that any intervention that helps the client gain awareness of the anxiety associated with the four ultimate concerns is fair game. I will present below a few techniques mentioned most often by ET advocates, with emphasis on how they might be used to address ET goals.

SOCRATIC DIALOGUE

Existential counselors engage their clients in self-examination, holding the belief that the client will find meaningful answers only through exploring her own experience and values (Tate, Williams, & Harden, 2013). In this dialogue, the therapist must be very careful not to offer solutions or advice, because to do so would be to assume an "expert" stance inconsistent with the practice of ET.

Lars and Helen discuss what is important in her life. Lars asks a bunch of questions of Helen, such as "What makes you happiest these days?" "Tell me about what seems most important to you of late." "Are these priorities the same as you have always held, or have things shifted for you?" In this discussion, Helen struggles with a feeling of emptiness, not really being able to identify what is important to her; she feels a deadness inside. Lars asks her to describe that deadness.

Bracketing

The existential counselor must learn to suspend his own beliefs and biases in favor of fully understanding the client's world (Cooper, 2008). This process is called *bracketing* and allows the therapist to adopt the attitude of "un-knowing" recommended by Spinelli (1997). However, modern ET advocates acknowledge that complete objectivity on the part of the counselor is impossible; the best we can do is to be aware of our assumptions so that they do not impede the client's exploration of her world (Cooper, 2008).

Lars works hard to clear his mind of his own beliefs and values when he encounters Helen. However, he is aware that this is not entirely possible, so he brackets his material, but remains aware that it is there without focusing on it.

Attention to Nonverbal Behavior

Because the emphasis in ET is on awareness of one's being, existential counselors are very interested in observing the client's nonverbal expression and calling her attention to it (Cooper, 2003).

Lars observes Helen for nonverbal signs of her current state. He notes that she clasps her hands across her body and asks her to notice this and try to describe what she is experiencing. Helen responds that she is feeling isolated and alone and the clasp of her hands is a way of soothing herself.

Self-Disclosure

It is quite common for ET practitioners to share their personal reactions with their clients; the therapist must be capable of being known to the client (K. J. Schneider, 2008). Stemming from the ET value that the counselor must be authentic and present, self-disclosure is seen as deepening the therapeutic encounter. The counselor can disclose in one of two ways: about the process of therapy (i.e., the client–counselor relationship) or about the therapist's own existential struggles (Colledge, 2002). Yalom and Josselson (2014) thought that disclosure should be most often about the therapeutic relationship in the moment, commenting that "it is the *examined* therapeutic relationship that heals" (p. 288, emphasis in original). Therapist self-disclosure can also help in clarifying and challenging the client's worldview (Spinelli, 2007). Great care must be taken when using these disclosures because they might overwhelm or confuse the client or turn the focus away from the client's process of exploration.

Lars is willing to open himself to Helen, should the moment arise. For instance, he might respond to the feeling that he is distant from Helen and express his real wish to more fully encounter her. Lars might also reveal some aspect of his own search for life meaning.

Paradoxical Intention

One of the best-known ET techniques, paradoxical intention, originated with Frankl (1984). Used mainly for what Frankl termed *neurotic fear* (as compared to the realistic fear of unbeing), it involves encouraging the client to "go with" a troublesome symptom or problem and experience it deliberately, while adding humor to the experience (Schulenberg et al., 2008). Facing and experiencing whatever it is we greatly fear allows us to engage the unique human capacity to laugh at

ourselves and thereby gain distance from our symptoms. C. T. Fischer (1991) added that practicing the symptom allows the client and the therapist to understand its meaning to the client.

Because Helen does not report a specific, traditional symptom, paradoxical intention may not be a good choice, thinks Lars. However, he does consider asking Helen to deliberately experience "humdrum" to more fully explore this sense of stuckness.

DEREFLECTION

Another strategy offered by Frankl, dereflection, consists of directing the client to turn her attention out to the world. It is meant to combat the tendency that Frankl saw in some distressed individuals to focus too intently on internal processes (Schulenberg et al., 2008).

Lars observes that Helen does not seem excessively self-focused at this time. Rather, she seems more intent on meeting the needs of others, and this is a long-time pattern for her. Lars concludes that using dereflection is not advisable, but he is always open to the possibility that it might be useful later on in therapy.

DREAM ANALYSIS

Yalom (1980) is a big fan of dream analysis. Rather than looking for unconscious conflicts between psychic entities as a psychoanalytic therapist would, however, the existential therapist is looking for manifestations of the client's issues around the four ultimate concerns. Another perspective on dream analysis comes from van Deurzen (2012), who advocates for an exploration of a dream for meanings at the four levels of existence—physical (e.g., what are the risks or threats to physical existence?), social (e.g., what is the social/cultural context of the dream?), personal (e.g., what are the dreamer's motivations?), and spiritual (e.g., what really matters to the client and what is in the way of obtaining it?) (p. 173). Determining the meanings in the dream is totally up to the client, even if the therapist suspects something other or more than the client finds. According to van Deurzen (2012), it is always better for the client to discover such meanings when she is closer to being ready to act on them.

Helen relates a dream to Lars about being swept away by a river. Her family watches from the banks, passively. The college professor is also on the banks, but seems to be upset and follows her progress closely. Together, Lars and Helen explore the meaning of this dream, finding that it symbolizes her feelings of powerlessness, the state of her relationships with her family, and her ultimate aloneness. The professor is the only hope, the dream seems to say. He may be the ultimate rescuer; however, it is likely that on a deeper level the professor-figure is a reflection of a part of Helen that wants to take action to find new sources of meaning in her life. Lars notes that the dream is very physical yet involves many social elements, too. Also of interest is that Helen doesn't seem, in the dream, to be terrified, but more intently observing what is happening. Lars thinks this is a good sign for therapy.

GUIDED FANTASY

Yalom (1980) described using imagery to increase death awareness (p. 175). The client is asked to meditate on her death in some way: for example, picture her funeral, write her obituary, or speculate on where, how, or when it will happen. This kind of imagery can also boost the client's awareness of what is meaningful and important, prompting the client to assume greater responsibility for her life.

Lars considers having Helen contemplate her death. She is at first very afraid of this exercise, but goes on to paint a vivid picture. She cries as she connects with the feelings of aloneness.

EVALUATION OF THE THEORY

ET is criticized on a number of counts. First, it is not really a cohesive theory of psychotherapy—it seems more a collection of components of existential philosophy on which to base a technically eclectic practice. The very diversity of viewpoints makes it difficult to form a coherent sense of ET. A second criticism is that writers in this area are often difficult to read. They tend to use abstract terms and sometimes convoluted language and rationales. For English-speaking readers, the borrowing of terms from German is often difficult. The philosophical nature of the approach and the emphasis on introspection have led to observations that the approach is most appropriate for highly educated clients (Vontress, 2013).

According to Cooper (2003), ET suffers from something akin to the paradox of relativism: If everything is individual and unique, how can we theorize about the givens of human existence? How can one advise authenticity and courage? If everything is subjective, isn't this a philosophy of "anything goes" (p. 31)?

Qualities of the Theory

Precision and Testability. You have probably divined by now that the ET approach is not very testable because of its philosophical nature and the variations in theoretical structures across theorists within this camp. However, a recent line of research in social psychology explores terror management theory, or the ways in which humans avoid evidence of their mortality. In Box 6.3, I provide a brief summary of this line of theory and research. Also, logotherapy has provided some testable constructs (e.g., meaning in life, paradoxical intention); research in this area is summarized under "Theory-Testing Research" and is supportive.

Box 6.3

Terror Management Theory: Existential Theory in an Experimental Paradigm

Despite claims by many that existential theory could not be studied in traditional scientific paradigms, in the early 1980s three graduate students decided to try. Sheldon Solomon, Jeff Greenberg, and Tom Pyszczynski, reviewing the current state of social psychology, concluded that it was quite elegant in describing *how* we function but lacking in explanation about *why*. Solomon et al. (2004) identified two critical questions that were neglected by mainstream psychology:

1. Why are people so intensely concerned with their self-esteem?
2. Why do people cling so tenaciously to their own cultural beliefs and have such a difficult time coexisting with others different from themselves? (p. 14)

They set out to study these issues, developing what they later named terror management theory (TMT). Their early research efforts got a less-than-warm reception from their social

(continued)

Box 6.3 *(continued)*

psychology colleagues, but they were not dissuaded. Based partially in evolutionary theory, Solomon et al. (2004) postulated that, because humans are self-aware, we are also aware of our own mortality. To compensate for the resulting terror, we developed culture. Culture gives us a sense of self-worth (we are valuable members of a meaningful venture), safety and security, symbolic immortality through preserving cultural artifacts and traditions (e.g., art and science), and protection for our children. Sometimes culture implies religion, which assures us of the "real" immortality of an afterlife.

The need for self-esteem, in this view, is universal (Solomon et al, 2004, p. 17). Self-esteem is connected to culture, for it is derived through membership in the meaningful culture and adherence to cultural rules. However, the existence of other cultural groups who have different values is inherently threatening: To acknowledge the validity of beliefs at odds with our own is to perceive that ours is not the true, protective cloak that shields us from mortality. Thus, two essential processes protect us from the terror of death: (a) belief in our cultural worldviews, which leads to (b) self-esteem attained through meeting our culture's standards.

Solomon et al. (2004) set out to test their theory, and a particularly interesting aspect of this research is that involving the *mortality salience* (MS) hypothesis: "If cultural worldviews and self-esteem provide beliefs about the nature of reality that function to assuage anxiety associated with the awareness of death, then asking people to ponder their own mortality should increase the need for the protection provided by such beliefs" (p. 20). MS interventions, for example, should produce positive affect for those similar to us (who hold the same beliefs) and denigration of those who are different. Typical MS interventions ask participants to write down feelings invoked by thoughts of their own deaths.

Terror management hypotheses have since been confirmed in a series of studies. For example, J. Greenberg et al. (1990) asked participants who were Christian to evaluate target individuals who were either Christian or Jewish after receiving or not receiving an MS intervention. They found that these Christian participants reported more positive reactions to the Christian target and more negative reactions to the Jewish target when they had received the MS intervention (they called these effects "worldview defenses"). No such differences were found in the control (no MS intervention) condition. Subsequent studies confirmed these attitudinal effects and found behavioral differences, too. Other research has demonstrated that MS interventions create activity directed at bolstering self-esteem and that relatively high self-esteem appears to reduce the need to enact worldview defenses.

Subsequent research examining the mechanisms underlying terror management processes has supported the theory (J. Hayes, Schimel, Arndt, & Faucher, 2010). Further investigations have examined other variables related to terror management. For example, Yaakobi (2015) found that the desire to work serves as a buffer from death anxiety induced by MS intervention, even when comparing cultures that differed in the extent to which they valued work. Reasoning that humor was also a way to deal with existential anxiety, Long and Greenwood (2013) found that participants primed with MS intervention composed funnier cartoon captions when compared to those written by individuals primed with thoughts about physical pain. So terror management is alive and well—if you believe the research (but you would have to be of a culture that values such scientific activity, according to the theory). You might want to give these ideas some thought the next time you are facing a client of a different worldview.

Empirical Support. ET folks are not too enthusiastic about traditional empirical research. Vontress (2013) opined that "existential therapy is essentially a philosophy for living. As such, it seems illegitimate to compare its outcome with those of psychologically based therapeutic models" (p. 155). Some opine that qualitative approaches to the study of ET make sense (e.g., Finlay, 2012), but these investigations seem few and far between. Further, the general lack of structure and clarity of ET as a theoretical orientation contributes to the difficulty. However, a significant amount of research has accumulated around some logotherapy constructs, as you will see when you read the theory-testing section below.

Research Support

Outcome Research. Formal outcome research on ET is rare. Lantz and his colleagues have reported on the outcomes of ET with several different client problems. For example, Lantz and Raiz (2004) presented a 5-year study of ET with 29 older adult couples. They found significant improvement during therapy on the Purpose in Life Test (Crumbaugh & Maholick, 1964) and on perceptions of the couples' relationships. Lantz and Gregoire (2000a) studied 27 couples dealing with breast cancer who were seen in ET over a 20-year period. This study revealed nine common themes in these couples' lives: mindfulness of being, loss of control, recollection and grief, guilt and abandonment, communication disruptions, why us?, anger at God, anger at medical personnel (due to perceived coldness and distance), and worries about future sexual performance. Eighteen of the couples provided three measurements on the Purpose in Life Test and a measure of relationship functioning. Overall, these couples showed improvement over the course of therapy and maintained these changes at follow-up. Similarly, positive outcomes were reported with couples in which one member was a veteran of the Vietnam War (Lantz & Gregoire, 2000b). In evaluating Lantz's research, however, it is important to note that these are not controlled outcome studies (with standardized intervention and control groups), so conclusions from these should be considered with care.

Julom and de Guzmán (2013) reported on a study of logotherapy with Filipino/a clients who were para- or quadriplegic as a result of spinal injury. Using measures of purpose of life, they identified 32 individuals who displayed high levels of meaninglessness and randomly assigned 16 of these clients to a logotherapy intervention and the rest to a control condition. Analyses indicated that both groups found increased meaning in life over time, but the logotherapy groups' increases were larger than the control groups'. However, very little information was provided regarding the intervention in this research, and it also seems likely that the control group was receiving services as well (possibly accounting for the observed improvement).

Theory-Testing Research. ET theorists generally advocate case study or qualitative approaches to research, although Yalom (1980) reviewed research from general psychology that he asserted supports ET. K. J. Schneider (2011) also noted that support for ET can be found in common factors research that looks at the therapeutic alliance, empathy, and genuineness. R. A. Walsh and McElwain (2001) came to similar conclusions after reviewing research that they saw as relevant to ET, although it is not explicitly grounded in existential principles. For example, they cited research based in constructivistic notions about the role of narrative in human lives that links storytelling and a sense of life meaning as evidence in support of ET.

Still, some direct tests of ET theory can be found. Graham et al. (2010) investigated a hypothesis they derived from ET theory about perfectionism—that it results from the struggle to find

meaning in life and to accept past experiences. Using a 4-week longitudinal design, they found that there was support for this hypothesis and that perfectionism was a predictor of depression. As you saw in Box 6.3, TMT explores some hypotheses developed from existential theory. J. Hayes et al. (2010) provided a recent review of TMT research, finding hundreds of studies over the last 20 years, and concluded that TMT is well supported.

A comprehensive annotated bibliography of research on logotherapy was presented by Batthyany and Guttmann (2006). It is impossible to summarize the results of this book-length review, but many of the studies were supportive. Joshi, Marszalek, Berkel, and Hinshaw (2013) reported on a study that specifically tested logotherapy constructs in a college-student sample. Their results, too complex to describe here, were partially supportive of logotherapy theory specifically and ET generally.

Studies have demonstrated that constructs within logotherapy, such as the extent to which individuals find meaning in life, can be accurately measured, which adds credence to ET ideas in general and logotherapy in particular (see Schulenberg et al., 2008, for a review). Perhaps the most active area of research involves meaning in life (Park, 2010); findings partially support predictions derived from ET. Meaning in life has been associated with a number of positive outcomes, including general psychological well-being and lower depression levels (Nikŭcević & Nicolaides, 2014). Brassai, Piko, and Steger (2011) demonstrated that life meaning played a protective role among Romanian adolescents; lack of meaning was associated with risky health behavior (e.g., unsafe sex, drug use) and poorer psychological outcomes (e.g., quality of life, well-being). Further, distinctions have been made between the *presence* of and *search* for meaning, suggesting that unfulfilled search can lead to poor outcomes (Dezutter et al., 2013). Steger, Kawabata, Shimai, and Otake (2008) looked at the relationships between search, presence, and well-being across cultures, comparing American and Japanese college students, reasoning that Japanese students would value search more positively than would American students as a result of collectivistic cultural norms. They found that among American students, low presence but high search students were unhappier than those who had high presence and either low or high search. That is, if Americans perceived life meaning, the degree to which they were searching did not affect them. No such differences were found in the Japanese sample; in fact the search for meaning was correlated with the presence of meaning in this sample.

Using longitudinal methods, Falman, Mercer, Gaskovski, Eastwood, and Eastwood (2009) showed that changes in life meaning and levels of boredom were related over time, but there was evidence that the relationship was two-way rather than one-way (i.e., boredom predicted meaning over time, but also meaning predicted boredom). However, in a second study they manipulated life meaning by having college students vividly recall a memory with high or low meaning and found predicted changes in boredom. The point of this research was to test the causal prediction of ET that lack of meaning causes boredom, not the opposite, so these results provide some support for ET theory.

J. M. Adler, Harmeling, and Walder-Biesanz (2013) demonstrated that the quality of clients' meaning narratives was associated with sudden gains in psychotherapy. Narratives that indicated that the client was actively seeking coherent meaning were associated with sudden gains in well-being. Looking from a bird's eye view, Oishi and Diener (2014) used data from the Gallup World Poll to demonstrate that suicide rates were lower in countries having higher reported meaning in life. Wealthier countries also had lower meaning in life than poorer countries, but this effect was explained by religiosity—poorer countries were found to be more religious than wealthier

countries. Oishi and Diener also tested other variables that might account for the relation between wealth and meaning, such as educational level and individualistic attitudes, finding that they were indeed related to wealth and meaning in expected ways (e.g., wealthier nations were more individualistic, and individualistic societies reported less meaning), but religiosity was still a strong predictor of meaning in life after accounting for these variables. These results would seem to contradict Frankl's assertion that meaning does not have to involve religion.

Fabry (2010) reviewed the literature on paradoxical intention, finding 19 studies of the effects of this intervention. In some cases these studies were not specifically theoretically grounded in logotherapy theory (e.g., Broomfield & Espie, 2003). All 19 studies produced data in support of the effectiveness of paradoxical intention, but when compared with other bona fide therapeutic interventions, paradoxical intention was not found to be more effective. To her credit, Landry did point out that there were methodological weaknesses in some of the studies reviewed, and only two were published more recently than the year 2000.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

ET is seen as very useful with a wide range of clients. Its emphasis on the universal concerns of human existence transcends culture, according to advocates (Vontress, 2013). Vontress also points out that a number of existential ideas are compatible with values of non-Western cultures, such as the philosophy associated with *Umwelt* that humans are inseparable from our physical environment and the notion that we are all connected (*Mitwelt*). Cooper (2008) acknowledged that cultural issues have not received much specific attention from ET theorists, but also suggested that because of its emphasis on uniqueness that leads to the challenge of "mainstream" ideas. ET may be particularly suitable for those who have been marginalized (p. 261). However, the emphasis on individual choice and responsibility in ET theory can be problematic in considering people from cultures other than the White, Western European variety. A particular problem might arise where the client is from one of the groups that have historically experienced oppression (e.g., LGBT, African-American, Native American)—she might find the emphasis on free will and choice to be counter to her views of the world. However, Frankl (1984) would contend that, even if there is no choice, meaning can be found in suffering.

Burlin and Guzzetta (1977) contended that the themes of ET are particularly relevant for women. For example, the ET value that "people are subjects, not objects" encourages women to discover value within themselves rather than through the culturally endorsed dimension of physical attractiveness (p. 262). Likewise, K. J. Schneider (2008) suggested that themes relevant in feminist therapy, such as power, gender, and sexuality, are consistent with ET's emphasis on courage, freedom, and responsibility and also with the exploration of limitations and constrictions found in ET.

Some ET theorists argue that labels such as homo- and heterosexual are the result of the operations of historical social power dynamics (you can refer to the discussion of Foucault's ideas in Chapter 15 to get a sense of this) and that their socially constructed nature implies an element of choice (see Crabtree, 2009, for a discussion). This stance would clash with the ideas of many lesbian, gay, bisexual, and transgender (LGBT) individuals who see sexual orientation as biologically determined (Medina, 2008). Crabtree (2009) suggested that writing sexuality off to social forces can lead to ignoring the prejudice and discrimination experienced by individuals who identify as LGBT. Medina (2008) encouraged counselors to transcend the causal debate and instead concentrate on the client's construction of sexuality and the meaning that she gives to it.

THE CASE STUDY

The case of Helen was relatively easily conceptualized from an ET perspective. She is at a stage in her life in which she is re-evaluating meaning, which fits perfectly with ET assumptions. Because she is from a social situation where she has the means and support to engage in such reflection, the application of ET theory was fairly straightforward.

Summary

ET theory is grounded in philosophy more than perhaps any other theory of counseling. Its advocates unite in the contention that humans are motivated to seek meaning in life. Yalom (1980) presented the four ultimate concerns of life: death, freedom, isolation, and meaning. Psychological health is seen in authentic living and in awareness and acceptance of our plight as human beings.

ET is seen as an encounter between two beings focused on the present. The relationship between therapist and client is central and is often the vehicle for interventions, such as when the therapist self-discloses to the client. Very few specific techniques are identified in this approach.

ET theory is criticized for being difficult to read and understand, and its diverse nature makes it difficult to test directly under traditional scientific paradigms. Case study or qualitative research is often used along with drawing supportive information from the more general studies of psychotherapy or psychological functioning. ET is a flexible approach, so it is often characterized as helpful to a wide range of clients. However, its emphasis on freedom and individual responsibility may not fit with the worldview of clients who are members of groups that have been oppressed.

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Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy*, Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 4.

CHAPTER 7

Gestalt Therapy



Fritz Perls

Jessica is a 30-year-old African-American woman who is a police officer. She is physically fit and verbal and appears open to counseling. Jessica has a 5-year-old son, Dale, from a previous marriage. Jessica and Dale have had no contact with Dale's father for several years.

Jessica seeks counseling because she is troubled in her current relationship with Randy, with whom she has been living for 2 years. Recently, the couple had a serious fight involving physical contact. Jessica had been trimming Randy's hair, and she moved his head too abruptly. Randy became angry and Jessica apologized. Randy remained agitated and got up, threatening to leave their apartment. Jessica, who feared that Randy would not return, took Randy's car keys. Randy reacted by locking the door, closing the blinds, grabbing Jessica by the neck, and shoving her against a wall. Randy then retreated to the bedroom. The couple did not speak about the incident afterward, and they have not discussed it since then. This altercation was the fourth episode of violence in Jessica's relationship with Randy.

Jessica is the oldest in a family of four children. Her parents divorced when Jessica was 12, and her mother remarried shortly afterward. She has two step-siblings as a result of this marriage, but she is not close to them. Jessica reports a "normal" childhood and some emotional turmoil as a teenager (in reaction to the divorce), but overall says the household in which she lived was relatively calm. Jessica characterizes her mother as distant and businesslike and reports that she has difficulty relating to her.

Jessica had a positive relationship with her biological father, who has not remarried, up until she decided to become a police officer. Her biological father reacted very negatively when Jessica told him, saying, "Cops are pigs. If you become a cop, I never want to see you again." Jessica pursued her wishes despite this reaction and has spoken with her father only three times in the last 8 years.

Jessica admits that she is afraid of Randy when he gets angry, but says that otherwise they have a good relationship. Jessica seems to take responsibility for anything that goes wrong in her relationship. Randy sees no real problem with the violent incidents in the past and does not want to come to counseling. According to Jessica, he is very much in charge of their relationship—specifying how and when things get done around their apartment. Jessica's son, Dale, and Randy generally get along but are not close.

Jessica wants to learn how to create a better relationship with Randy so that they do not get into as many fights. She sees herself as responsible for many of the problems in the relationship. Jessica thinks that if she tries harder to meet Randy's expectations things will get better.

BACKGROUND

Gestalt therapy (GT) is in some ways a difficult topic to approach. Historical descriptions of GT often center on the practice of the flamboyant and controversial Fritz Perls (1893–1970). Perls (1969b) is captured well by this statement in his autobiography, written when he was 76: "I believe that I am the best therapist for any type of neurosis in the States, maybe in the world. How is this for megalomania?" (p. 228).

Others have contributed to the theory and practice of GT, including Perls's wife, Laura, and the theory has evolved considerably from the approach he developed. Often, writers comment on "Perlism," which refers to Perls's distinctive style of doing therapy: showy, confrontive, and typically in a very public workshop format (Parlett & Hemming, 1996a). Insiders speak of "splits" within the GT community: "East and West Coast, New York and Cleveland Gestalt Therapy, Gestalt Therapy with the empty chair and Gestalt Therapy face to face, Gestalt Therapy and body work, Gestalt Therapy and psychoanalysis, Gestalt Therapy of the early Perls and Gestalt Therapy of the later, etc., etc." (N. Friedman, 2003, p. 60). Modern variants of GT are generally less confrontive and more attentive to the therapeutic relationship than the style practiced by Perls. In this chapter, I will attempt to convey the approach as it is practiced currently, but also describe the defining features of Perls's approach to GT.

Probably because Perls was a very colorful character and prone to providing showy public demonstrations of GT, the credit (or blame) for the theory is usually placed with him. He was a very controversial figure, a self-confessed "dirty old man" (F. Perls, 1969b), which prompted Clarkson and Mackewn (1993) to comment

> Who Perls was depends upon whom you speak with, and when. To some he was a hero, to others a bastard; to some cruel, to others tender; to some generous, to others the world's biggest taker; to some a genius, to others a near-illiterate non-intellectual; to some he seemed sociable and happy, to others lonely and poor at making genuine contact with the people around him; to some he was a beautiful sensuous man, to others an ugly toad, a dirty lecherous old man; to some a narcissistic exhibitionist, to others a shy, withdrawn introvert too proud to ask for love. (p. 30)

Perls was initially trained in classic psychoanalysis, and his first theoretical attempts replaced Freud's sexual drive with the hunger drive (Harman, 1990). In *Ego, Hunger, and Aggression* (1947), his first book, Perls attempted to integrate these ideas with traditional psychoanalytic theory. Aspects of the "oral metaphor" can be seen in later GT theory's emphasis on the assimilation (or digestion) of experience and the rejection of introjection, or swallowing whole. Perls's subsequent writings retained some of the flavor of psychoanalytic theory, but progressively diverged in both theory and technique.

A major influence on Perls's thought was Gestalt psychology, a branch of perceptual psychology that explored how humans create meaning out of perceptual stimuli. The influence of this approach can be seen in the ideas about the holistic nature of human experience and the primacy of figure–ground relationships (see the section on "Needs" later in this chapter). As GT theory evolved, however, the influence of the purely perceptual Gestalt theory diminished. Perls acknowledged that he was not wholly committed to classic Gestalt theory because he was uncomfortable with the traditional scientific approach used by these theorists. "The academic Gestaltists of course never accepted me," he wrote (1969b, p. 62).

GT theory was also shaped by Perls's background in theater, his stints in Reichian body therapy and Rolfing, and existentialist and Zen philosophy. Wilhelm Reich, who believed that psychic energy, including emotion, was stored in the body, was Perls's analyst from 1931 to 1933.

Born in 1893 to a progressive Jewish family, Perls grew up in a suburb of Berlin, Germany. He was the youngest of three children; his mother was devoted to her children, whereas his father was more distant emotionally and physically (traveling for business) and reportedly had numerous extramarital affairs (Clarkson & Mackewn, 1993). Fritz was closer to his mother than to his father until about age 10, when his relationships with both parents, along with his scholastic performance, deteriorated. Rebellious throughout his adolescence, he was expelled from school once but managed to find a second school that affirmed his independence, from which he graduated. Throughout his adolescence he pursued theater work, and his emphasis on nonverbal behavior in GT is said to stem from these experiences (Clarkson & Mackewn, 1993).

After serving in World War I, Perls received his medical degree in 1920. He began his practice of medicine as a neuropsychiatrist (Clarkson & Mackewn, 1993). At age 31, still living at home with his mother, Perls began psychoanalysis with Karen Horney. Although brief, this analysis started Perls on the road to becoming an orthodox analyst, despite a very negative experience with his second analyst, who said almost nothing during sessions and scraped his feet on the floor to signal the end of sessions (F. Perls, 1969b). In 1926 he moved to Frankfurt, Germany, and it was there that he became familiar with Gestalt psychology. After Perls completed his training analysis, he established himself as a psychoanalyst and practiced in Berlin from 1928 to 1933.

According to Clarkson and Mackewn (1993), the existentialist influences in GT came by way of Laura Posner Perls, who had studied with the well-known phenomenologists Buber and Husserl. Laura and Fritz met in 1926 and married in 1929. They had two children, Renate and Steve.

Fritz and Laura left Berlin in 1933 as Hitler was appointed chancellor of Germany (Clarkson & Mackewn, 1993). They ended up in South Africa, where they established the South African Institute for Psychoanalysis. During this period Perls returned to Europe for a conference, hoping to meet Sigmund Freud. He was disappointed when his work was poorly received and Freud paid him little attention. Shortly thereafter, the International Psychoanalytic Association decreed that analysts who had not served as training analysts in Europe could not be recognized as such in other parts of the world. This invalidation of Perls's work in South Africa was a powerful event in Perls's development.

Perls served as a physician in the South African Army during World War II and then moved to the United States in 1946; Laura and their children followed a year later. Settling in New York, the couple established a practice and eventually founded the Gestalt Institute of New York. The participants in the institute were diverse people with wide-ranging interests and strong personalities. During this time period, Perls first encountered Eastern religion and psychodrama, a form of psychotherapy invented by Jacob Moreno that required the client to act out life situations.

What many consider to be the foundational text of GT, *Gestalt Therapy: Excitement and Growth in Human Personality* (F. Perls, Hefferline, & Goodman, 1951), was a result of the vigorous and lively discussions among the early members of the Gestalt Institute. According to Parlett and Hemming (1996a), the book originated from a 50-page manuscript that Perls

asked Paul Goodman to transform into a book. Goodman, described as a "quirky, brilliant thinker" (p. 91), took the challenge and ran with it; some authors refer to the work as Goodman's (G. Wheeler, 1991). The exercises in awareness in the first half of the book were contributed by Ralph Hefferline, who used them with his university students. The book is often referred to as "Perls, Hefferline, and Goodman" (or PHG), and its merits are still the subject of debate. All acknowledge that the basic elements of the GT approach (e.g., holism, the phenomenological approach, experiments) were in the book, but it has been characterized both as dense and unreadable and as multilayered and deeply meaningful, like poetry (Parlett & Hemming, 1996a).

Fritz Perls was diagnosed with a heart condition in 1956 and moved by himself to Miami, Florida, at age 63. Tension had arisen in Fritz and Laura's relationship, and although they never divorced they never lived together again for any significant period (Clarkson & Mackewn, 1993). It was in Miami that Fritz became the therapist, and then lover, of Marty Fromm. This relationship, needless to say, was a controversial one, labeled "irresponsible and unethical" by Clarkson and Mackewn (1993, p. 23). Perls characterized his relationship with Fromm as the most important in his life. It ended when Fromm fell in love with a younger man (F. Perls, 1969b).

Perls moved to the West Coast in 1960 and became affiliated with the Esalen Institute in Big Sur, California, in 1964. He was in poor physical health at the time. Ida Rolf eventually treated Perls with her approach, which emphasized breaking down chronic tension through deep muscle massage. Perls responded favorably, perhaps further supporting his conviction that many psychological dynamics are translated into physical problems.

Esalen became famous in the 1960s as a center of the human potential movement. It was known for the freewheeling styles of teachers and participants, which included sexual encounters and drug use. At Esalen, Perls was exposed to many well-known individuals, including Rollo May, Virginia Satir, and Abraham Maslow (Clarkson & Mackewn, 1993). He began the workshop tradition for which he is well known at Esalen, where he demonstrated GT on stage in front of large crowds. *Gestalt Therapy Verbatim*, consisting largely of edited transcripts of Perls's workshops, was published in 1969 (F. Perls, 1969a). An interesting account of Perls's and others' antics at Esalen, which still operates, is found in W. T. Anderson's (2004) *The Upstart Spring*.

From Esalen, Perls moved on to start a Gestalt community at Cowichan Lake, Vancouver Island, Canada, in 1969. According to reports, Perls was happy there, leading training sessions and working on several books. Rather quickly, however, his health declined, and he died of a heart attack after surgery in March 1970.

M. V. Miller (1989), in his introduction to *Gestalt Therapy Verbatim*, pointed out that GT was a product of the 1960s, which he described as "outrageously playful, promiscuous, utopian, rebellious; the mood of the sixties was alternatively good-humored and angry, and somehow managed to be at once sophisticated and naïve" (p. 19). Over the years of his professional career, Perls's philosophy evolved from traditional conservative psychoanalysis to the freedom-loving, spectacular approach of GT, rebelling against authority and emphasizing a return to innocence. Perls himself and GT became icons of the hippie generation (Crocker, 1999), which rejected traditional norms in favor of experiments in living, the most prominent of which were drug use and "free" sex. You can read some vintage Fritz in the excerpt from *Gestalt Therapy Verbatim* in Box 7.1.

Box 7.1

Excerpt From *Gestalt Therapy Verbatim*

So we come to our basic conflict and the basic conflict is this: Every individual, every plant, every animal has only one inborn goal—to actualize itself as it is. A rose is a rose is a rose. A rose is not intent to actualize itself as a kangaroo. An elephant is not intent to actualize itself as a bird. In nature—except for the human being—constitution, and healthiness, potential, growth, is all one unified *something*.

The same applies to the multi-organism, or society, which consists of many people. A state, a society, consists of many thousands of cells which have to be organized either by external control or inner control, and each society tends to actualize itself as this or that specific society. The Russian society actualizes itself as what it is, the American society, the German society, the Congo tribes—they all actualize themselves, they change. And there is always a law in history: Any society that has outstretched itself and has lost its ability to survive, disappears. Cultures come—and go. And when society is in clash with the universe, once a society transgresses the laws of nature, it loses its survival value, too. So, as soon as we leave the basis of nature—the universe and *its* laws—and become artifacts either as individuals or as society, then we lose our *raison d'etre*. We lose the possibility of existence.

So where do we find ourselves? We find ourselves on the one hand as individuals who want to actualize themselves; we find ourselves also embedded in a society, in our case the progressive American society, and this society might make demands different from the individual demands. So there is the basic clash. Now this individual society is represented in our development by our parents, nurses, teachers, and so forth. Rather than to facilitate the development of authentic growth, they often intrude into the natural development.

They work with two tools to falsify our existence. One tool is the stick, which is then encountered again in therapy as the *catastrophic expectation*. The catastrophic expectation sounds like this: "If I take the risk, I will not be loved any more. I will be lonely. I'll die." That's the stick. And then there is the hypnosis. Right now, I am hypnotizing you. I am hypnotizing you into believing what I say. I don't give you the chance to digest, to assimilate, to taste what I say. You hear from my voice that I try to cast a spell on you, to slip my "wisdom" into your guts until you either assimilate it or puke, or feed it into your computer and say: "That's an interesting concept." Normally, as you know if you are students, you are only allowed to puke on the examination paper. You swallow all the information and you puke it up and you are free again and you have got a degree. Sometimes, though, I must say, in the process you might have learned something, either discovered something of value, or some experience about your teachers, or about your friends, but the basic dead information is not easy to assimilate.

Source: Excerpted from Perls, F. S. (1969). *Gestalt therapy verbatim*. Lafayette, CA: Real People Press.

Second- and third-generation students of GT, such as Erving Polster, Lynne Jacobs, and Gary Yontef, continue to practice and promote the approach. These later theorists have promoted a more moderate form of GT than the confrontive, stagey "Perlism" (Parlett & Hemming, 1996a, p. 95; J. C. Watson, Goldman, & Greenberg, 2011). Wagner-Moore (2004)

described "modern Gestalt therapy" as "a gentler, 'Rogerianized' version" (p. 183). However, one of the confusing things about GT theory is that, although there are core principles and a broad sense of method, there is little orthodox doctrine about how these are put into action (Parlett & Hemming, 1996a). A survey of 225 attendees at the American Association of Gestalt Therapy's second international conference in 1997 revealed that GT is largely defined by how it is practiced (i.e., spontaneous, authentic, creative, alive, a process as compared to content orientation) rather than by its theory (Bowman, 1998, p. 105). I suspect the same is true today.

M. V. Miller (1989) observed that "Gestalt therapy remains on the margins of the therapeutic establishment where it no longer generates much heat or controversy; most psychotherapists have heard of it, but relatively few know very much about it" (p. 20). Despite this rather grim assessment, there still seems to be significant activity around this theoretical orientation, particularly in Europe. Yontef and Jacobs (2014) reported that there is a GT institute in every major U.S. city and in many other countries around the world. In the United States and Canada, emotion-focused therapy (see Box 7.2 for a description), which combines elements of Gestalt and person-centered theories, is considered a respected theoretical development. Enough supportive research on this approach has accumulated for it to be referred to as evidence-based experiential psychotherapy (L. S. Greenberg, 2011).

Box 7.2

Gestalt Plus Person Centered Equals Emotion-Focused Therapy

Emotion-focused therapy (EFT) combines elements of the person-centered (PC), Gestalt (GT), and systemic approaches. Based on a humanistic, non-pathologizing philosophy, EFT specifies that emotions signify what we should pay attention to and at the same time prepare us to react. Emotions must be processed adaptively, and thus dysfunction results when individuals fail to process emotions (either because they avoid attending to them or transform an unwanted emotion into another more acceptable one), are unable to regulate emotions, or have difficulty creating meaning from them (L. S. Greenberg, 2011). The goal of EFT is to promote the experiencing of and reprocessing of emotions so that clients experience more freely and behave more adaptively. The EFT counselor first creates a warm, accepting therapeutic relationship and then uses active, directive techniques to help the client experience and transform maladaptive emotion. EFT theorists are clear that the therapeutic alliance is the same as that created in PC therapy; the therapist must be congruent, empathic, and sensitively present (L. S. Greenberg, 2011).

Techniques used in EFT are those seen in PC counseling, such as focusing on specific experiences, particularly emotions, and chair dialogues similar to those used in GT (which will be discussed later in this chapter) are used to further deepen experiencing (two chair and empty chair; Murdock & Wang, 2008). The PC-style interventions promote emotional exploration, and that leads to the transformation of the feelings so that clients can gain new meanings from them and behave more adaptively. Two-chair dialogue is intended to help clients more fully experience aspects of themselves that are in conflict or inhibiting experiencing.

There are many sources of current information on GT, including a number of organizations, websites, and journals, such as The Gestalt Therapy Page (http://gestalt.org) and the Gestalt Therapy Network (www.gestalttherapy.net). That the Association for the Advancement of Gestalt Therapy (www.aagt.org) hosted a biennial 2016 conference demonstrates that GT is still of interest among practicing therapists. A recent book, *Gestalt Therapy* (Wheeler & Alexsson, 2015), presents both historical and contemporary perspectives on GT.

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Video Example 7.1 Watch Gestalt therapist Shelley Stelmach with client Helen.



BASIC PHILOSOPHY

GT theorists begin with the notion that humans are growth oriented. A very basic value is holism (Yontef & Jacobs, 2014): Humans can't be separated from their environments, nor can they be divided into parts (such as body and mind). Physical and psychological functioning are inherently related; thoughts, feelings, and physical sensations are all a part of a unified being. GT theorists often use the term *organism* to convey the inseparable psychological and physical aspects of human nature; the process of being in touch with one's experience (defined in the broadest sense) is known as *organismic self-regulation* (Yontef & Jacobs, 2014).

GT is a humanistic/existential approach, and as such it emphasizes individual choice and responsibility (Clarkson, 2014). In fact, GT theorists sometimes use the term *response-ability* to reinforce this perspective (F. Perls, 1970a). Another important quality of GT is its phenomenological orientation—an emphasis on awareness as an end state rather than a means to some end, as in other approaches (Clarkson, 2014).

One can see the GT view of humans as neutral. Perls seemed to see humans as simply another form of biological life, yet the emphasis in the theory on growth and actualization would seem to support a positive view of human nature. According to GT theory, all organisms have an innate tendency to grow toward fulfillment and actualization (Clarkson, 2014). In GT, the focus is on growth and excitement, not dysfunction (Sheldon, 2013, p. viii).

An important aspect of the GT mentality is an emphasis on being creative, spontaneous, and taking risks (Wheeler & Axelsson, 2015). It is expected that healthy behavior will sometimes be in conflict with societal norms. Perls (1970a) wrote, "Society has undergone a process that has moved it so far from healthy functioning, natural functioning, that our needs and the needs of society and the needs of nature do not fit together any more. Again and again we come into such conflict until it becomes doubtful whether a healthy and fully sane and honest person can exist in our insane society" (p. 16).

Paralleling developments in many approaches (e.g., person-centered therapy, psychoanalysis), GT theorists of late have placed great emphasis on the inherent relatedness of the human condition, identifying a relational approach to GT (Jacobs & Hycner, 2009; Wheeler & Axelsson, 2015). These contemporary GT theorists focus more on the role of interdependence in human life; you will see this in current writers' re-emphasis on *field theory*, which originated with Kurt Lewin (1951). Although the concept of *field* is difficult to define precisely, it translates into (a) awareness of the subjective nature of therapy and the therapist's participation in the relationship (Parlett & Lee, 2005), (b) attention to and exploration of the experiential field of the client, or the ways in which

she organizes her experience (Joyce & Sills, 2010), and (c) an emphasis on context at all times. From the relational approach we learn to emphasize subjectivity over objectivity—there is no one true reality out there, because it is our perceptions of the world that really count (Frew, 2013).

Enrico is Jessica's Gestalt therapist. He begins his work with her from the premise that she is a growing organism living an existence embedded in the environment and tries to understand how she perceives her reality and how it is organized. Jessica has the potential to grow in creative ways, actualizing herself in relationship to the world around her. She has the capacity to accept responsibility for herself and make choices that are true to her actualization. Yet Enrico notes that allowing Jessica's true potential to surface may be contrary to some commonly accepted social rules.

HUMAN MOTIVATION

Human behavior is motivated by the drive to satisfy needs. Both biological and psychological needs are important. Although GT theory does not present a specific list of needs, biological needs are clearly important, and further reading of GT literature suggests that one very important need is connection to other human beings. The existential philosophical basis of GT adds the desire to create meaning to what motivates humans (Clarkson, 2014).

Another way to look at motivation from a GT perspective is to see humans as striving to regulate the organism so that it can grow. The goal of the process of self-regulation is harmony with the environment, maturity, or actualization. Self-regulation involves the process of determining what is good and bad for the organism, which should lead toward acceptance of the good and rejection of the bad. The tendency to self-regulate is innate, and humans adapt easily to the changing environment (Crocker, 1999).

Enrico sees Jessica as striving to meet her needs so that she can grow and mature. She gravitates toward experiences that maximize her growth, including wanting contact with other people. Jessica strives to adapt to her environment in a harmonious way.

CENTRAL CONSTRUCTS

CONTACT

Contact is the central feature of life, according to GT. It is defined as meeting the environment, which can be either external to the person or aspects of the self. Seeing, hearing, touching, moving, talking, smelling, and tasting are all ways of contacting the environment (M. Polster & Polster, 1990). Healthy contact results in *assimilation* of novel elements (i.e., things not already a part of the organism) and hence growth (F. Perls et al., 1951). Following contact, the organism withdraws for a period of rest to "digest" the results of the contact (Mann, 2010). Assimilation involves aggression and destruction, which are natural processes essential to making new experiences part of the organism, thereby creating growth (F. Perls et al., 1951). As a result, Gestalt therapists see aggression as a natural and healthy part of life rather than as an antisocial behavior.

Effective contact is essential to life because it is necessary for the satisfaction of needs. Probably the most important form of contact is that with other people. Contact can occur in a fully aware state, such as when we deliberately touch someone else, or in the sort of automatic mode that we use in most of our daily living. An example of the latter kind of contact is breathing, during which we make contact with the environment.

The individual makes contact with the environment at the *contact boundary* (Mann, 2010). An important aspect of the contact boundary is the differentiation between self and other.

Jessica is able to make basic contact with her environment. She is healthy, indicating that she obtains the basic substances she needs. Enrico observes that she has a number of relationships, indicating that she is able to establish some kind of contact with other human beings. Jessica appears to have a sense of self; Enrico has a hunch that this sense varies from relationship to relationship.

NEEDS

Life is a process of need satisfaction (J. C. Watson et al., 2011). GT theorists use the notion of Gestalt, a German word roughly meaning "whole" or "shape" (O'Leary, 2013) to describe this process. A Gestalt has a *figure*, or feature that stands out, and a *ground*, which is the rest of experience (i.e., the background). In perceptual terms, the figure is clear and compelling to our attention, and everything else becomes ground. Look at the picture shown in Figure 7.1. What you make of this picture depends on what features become figural to you. If you are able to shift your attention, you will see that two different perceptions of this drawing are possible (a young woman and an old woman). Figure 7.2 illustrates another basic aspect of the GT theory of perception—the fact that we strive to integrate pieces into a complete Gestalt. (Do you see the horse and rider?)

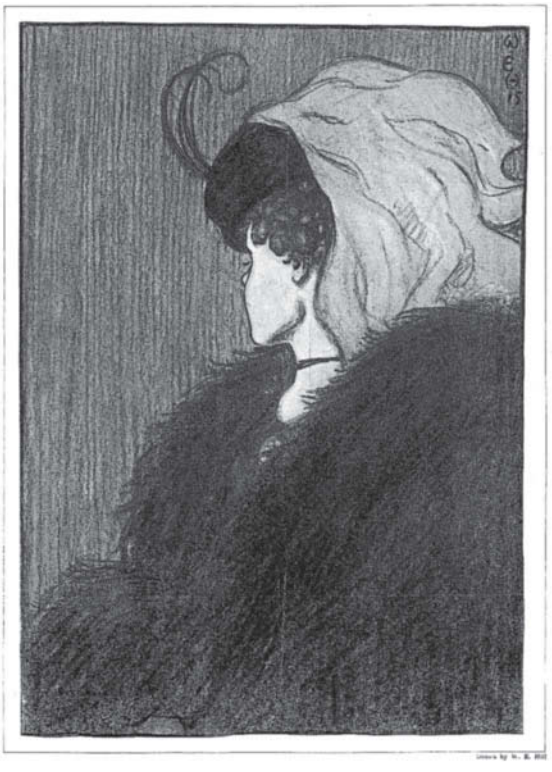


FIGURE 7.1. A Figure–Ground Exercise.

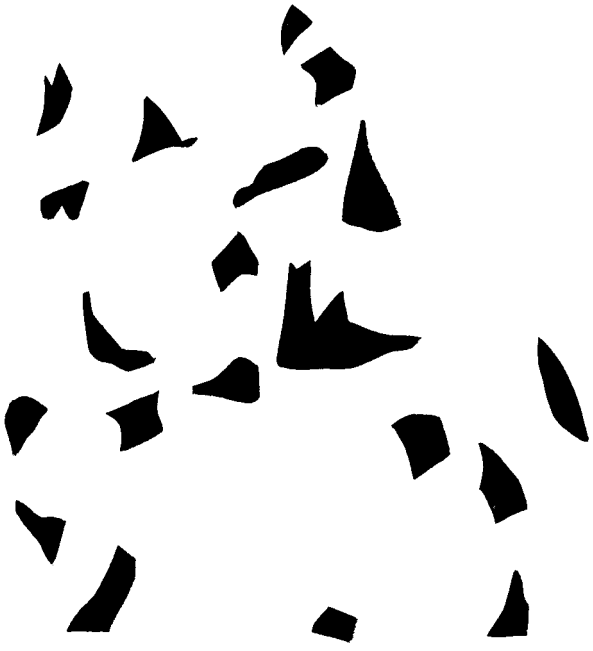


FIGURE 7.2. A Perceptual Integration Task.

In GT theory, a need is an incomplete Gestalt that emerges into the organism's awareness; it becomes figure, and the rest of experience becomes ground. Think about how difficult it would be to concentrate on this paragraph if you were very hungry. Your mind would probably keep drifting to images of pizza! Once a need has become figural, the person initiates behavior aimed at meeting the need. When the organism is successful at satisfying the need, the Gestalt is completed and it is said to be destroyed (Frew, 2013)—the need disappears, perceptually. At this point, the organism is in a state called the "fertile void" (Joyce & Sills, 2010, p. 39), a state of pure awareness. Another way to describe this part of the cycle is to say that the individual has reached *closure* (Frew, 2013). However, soon another incomplete Gestalt emerges. Whatever need is most urgent to the organism at a given time becomes figure (Yontef, 1995). It is important to note that *awareness* (of the need) is critical to this cycle.

The continual process of need emergence, satisfaction, and Gestalt destruction is the essence of life. Healthy growth requires this natural rhythm of figure–ground cycles. In fact, GT theorists like to draw pictures of the *cycle of experience or awareness*, and Clarkson (2014) acknowledged that everybody seems to have her own version of the cycle and name for it. It is in this spirit that I have created Figure 7.3.

Enrico makes some very basic observations in his early interactions with Jessica. He sees that Jessica is aware of the environment around her; he assumes that the degree to which she is aware varies from situation to situation. She appears to be meeting physiological needs adequately. Enrico tries to deduce current needs from Jessica's presentation and wonders if one thing that is figure *for her is a need to be loved. Her work and relationships with intimates other than Randy seem to be* ground *at present.*

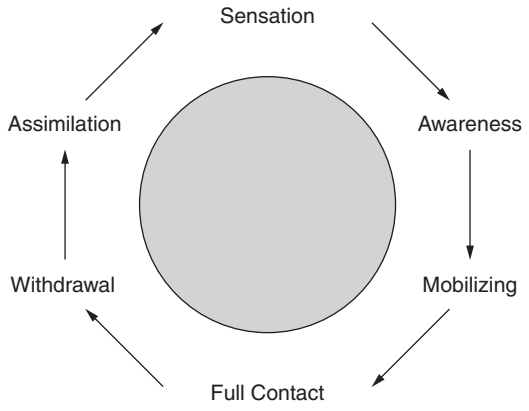


FIGURE 7.3. The Cycle of Awareness.

POLARITIES

GT emphasizes the holistic nature of human functioning, and this allows the recognition of the power of polarities. If something exists, the opposite must as well; for instance, light implies dark, and right creates left (F. Perls, 1969a). Other relevant polarities are life and death, good cop and bad cop, passive and aggressive, and masculine and feminine (Levitsky & Perls, 1970). Perls maintained that Freud partly described one of the most important polarities when he acknowledged the superego. However, Freud did not label the other end of the dimension, which Perls (1969a) called the *infraego*. More commonly, Perls called this polarity top dog and underdog. Contemporary GT theorists would add connection/separation to the list of important polarities (Yontef & Jacobs, 2014).

Polarities are a natural part of life, and we have within our psyche both ends of the polarities. However, sometimes we don't want to accept one end of the polarity, so we rigidify them into dichotomies and reject one end of the continuum (Yontef & Jacobs, 2014).

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Video Example 7.2 What polarity exists in Helen's description of the voice that chastises her and holds her back?



Enrico suspects that Jessica can recognize a number of polarities operating in her experience. Some particularly critical polarities seem to be bad–good and strong–weak. In her relationship with Randy, she seems to reject the strong part of the strong–weak polarity.

CONTACT DISTURBANCE

When the cycle of awareness is disrupted, problems are seen at the contact boundary. Perls et al. (1951) identified some basic ways that contact is interrupted; these processes are called *contact disturbances* or *boundary problems*. They are also sometimes called *resistances* (to awareness). Traditional GT practitioners deem these ways of operating dysfunctional if used chronically and inappropriately (F. Perls et al., 1951). For example, in discussing introjection, or the swallowing

whole of experience, Perls et al. (1951) declared, "On this point we differ with Freud. He held that some introjections are healthy . . . but in this he was obviously failing to make the distinction between introjection and assimilation" (p. 190). Most current GT theorists maintain that these processes should be seen as *modifications* of contact—simply the ways the individual meets the environment—and are not inherently good or bad (Clarkson, 2014). Frew (2013) pointed out that the original identification of these contact modifications as problematic was culture bound, and contemporary GT therapists would not consider them as interruptions or avoidances unless this quality emerged from dialogue with the client.

For Perls, though, the most primitive contact disturbance was *introjection*, or the taking in of experience or food without digesting it. Infants survive by introjection of food, and the introjection of the attitudes and values of parents is to some extent an unavoidable feature of early childhood (E. Polster & Polster, 1973). For the infant, the only alternative to introjection is vomiting or spitting out, by which the infant deprives itself of nourishment. Once the child develops teeth and can bite and chew, she is able to digest and assimilate both physically and psychologically (Clarkson, 2014). For example, we often operate, or should operate, on the basis of rules that are dictated by society—a sure sign of introjection (Mann, 2010). You *should* be nice, be quiet, and obey the rules! The problem, according to GT theory, is that we have not really considered whether these are our own values, or in the typical GT way of saying it, we have not chewed them up, digested them, and assimilated them. They are foreign, alien things that sit in our stomachs.

The counterpart to introjection is *projection*, in which an unwanted part of the self is expelled into the environment. According to Perls and colleagues, we are aware of the impulse but can't cope with it, so we conclude that it has to come from outside of us. A good example of projection is seen when we avoid the experience of our own hate for someone by believing that they hate *us*. Projection can be based on introjection because the "shouldn't" that prompts the projection is probably an introject (E. Polster & Polster, 1973). A less dysfunctional view of projection is that it is essential to empathy. Empathy involves identifying with another's experience, and one way to do that is to use one's own experience as a guide (Parlett & Hemming, 1996b).

Confluence is similar to introjection, except that it refers to a complete loss of self in which the individual cannot separate herself from the environment—most importantly, from other people (Mann, 2010). Yontef and Jacobs (2014) pointed out that confluence occurs when the individual is unable to withdraw when it is appropriate to do so. An individual in confluence with another person has trouble expressing her own beliefs and values. A good example of confluence might be a kid who becomes a gang member and adopts the identity (self) of the gang. As with all of the boundary disturbances, confluence can be healthy, particularly in intimate relationships.

In *retroflection*, the unacceptable impulse is turned toward the self, such as when John tenses his muscles to resist slapping someone (Mann, 2010). For this reason, Gestalt counselors are often interested in the physical expressions of their clients as clues to where awareness has been interrupted. Retroflection can be healthy because it is sometimes dangerous to express our impulses (such as by hitting someone); the extent to which the retroflection is adaptive depends on whether the individual has a rational reason for restraining the impulse (F. Perls et al., 1951). Awareness is the key to understanding healthy retroflection. Unaware, chronic retroflection is, according to Perls et al. (1951), equivalent to repression and is therefore neurotic.

Various writers have identified several other defenses or contact disruptions (Yontef, 1995). An individual can *isolate* herself, losing contact with both the environment and the self. Although withdrawal can be healthy at times (e.g., to avoid bad things), persistent isolation is dysfunctional

(Yontef & Jacobs, 2014). In *deflection*, the impulse is blunted or dampened, such as when Kathy smiles to soften the expression of her anger (Yontef, 1995). Deflection is also seen when we avoid or interrupt interaction with another person (O'Leary, 1992).

Jessica seems to be demonstrating several interruptions to contact. Enrico thinks that she has introjected cultural values that mandate that women can't be assertive and angry. She also appears to be very critical of herself, suggesting retroflected feelings that might have originally been directed at Randy. Allowing Randy to control the household may be evidence that she is in confluence with him.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Originally, Perls revised the developmental theory of psychoanalysis, shifting the focus from the sexual instincts to the hunger instinct (Clarkson, 2014). Infants progress from sucking to biting; development culminates with the ability to chew food thoroughly so that it can be digested and assimilated. Perls and his followers later de-emphasized this model, although elements of it can be seen in the descriptions of the process of need satisfaction as destructive and in the use of eating-related metaphors (e.g., introjection as swallowing whole).

GT has relatively little developmental or personality theory (M. V. Miller, 1989). M. V. Miller (1989) maintained that the anti-intellectual bias of GT (largely a product of the 1960s influences) is responsible for this indifference to the "why" of behavior. Perls (1969a) even said, "*Why* and *because* are dirty words in Gestalt therapy" (p. 44; emphasis in original).

Even though they lack an elaborate theory, GT theorists acknowledge the importance of childhood events. According to Perls (1970a), "Maturation is the development from environmental support to self-support" (p. 17). To grow healthfully, children need support from the environment as well as love and respect (Yontef, 1995). Events in childhood that are related to the frustration of need satisfaction can live on in adulthood and create trouble for the individual (see the later discussion on unfinished business). Perls noted that children need to learn to deal with frustration and overcome it, thereby increasing their independence. He said, "In the process of growing up, there are two choices. The child either grows up and learns to overcome frustration, or it is spoiled" (1969a, p. 32).

The self is simply the organism at the contact boundary, yet it is seen as an active transformer of experiences. The self is "the artist of life. It is only a small factor in the total organism/environment interaction, but it plays the crucial role of finding and making the meanings that we grow by" (F. Perls et al., 1951, p. 235).

Jessica has developed from needing complete environmental support to a level of self-support that allows her to function adequately as an adult in her community. However, Enrico suspects that some early childhood experiences of need frustration are still plaguing her.

HEALTH AND DYSFUNCTION

Healthy people are those who live in harmony with the environment, according to GT theory. The process of self-regulation guides the individual to be aware of shifting needs of the organism, which then organize behavior (Yontef & Jacobs, 2014). The organism simply follows its natural tendencies to self-regulate, taking in what is good for it, digesting it, and assimilating it (Clarkson, 2014).

The healthy individual recognizes her interconnection with the environment, so although she is self-supporting she strikes a balance between taking care of herself and attending to the needs of other people and her community (Mackewn, 1997). *Creative adjustment* is a term used by GT counselors to describe this balance between changing the environment to meet the needs of the organism and changing the organism to fit the environment (Yontef & Jacobs, 2014).

Healthy contact with the environment results in a "clear bright figure freely energized from an empty background" (F. Perls et al., 1951, p. 255). In Yontef and Jacobs's (2014) terms, "Good health has the characteristics of a good Gestalt. A *good Gestalt* describes a perceptual field organized with clarity and good form" (p. 312; emphasis in original). It is clear which need is most important, the person can attend to it, and the bright shiny need is satisfied. Once the need is satisfied, the Gestalt is closed and another figure emerges.

Health can also be described as living an authentic existence (Yontef, 1995). "Since unfinished business does not pile up, he is free to do and be quite fully and intensely whatever he is doing or being, and people around him often report a sense of his being much more *with* them when he is with them" (Enright, 1970, p. 120; emphasis in original). The healthy individual is spontaneous, emotionally responsive, and expressive and can make direct interpersonal contact with others and relate authentically. She takes responsibility for the choices she makes in life and can "love, work and play" (Wheeler & Axelsson, 2015, p. 43).

Dysfunction in GT counseling is called *dis-ease* to emphasize the view that the person is not in harmony with the environment (Clarkson, 2014, p. 52). Neurosis is seen as a "growth disorder" that results from the interruption of the cycle of awareness (F. Perls, 1969a). Wagner-Moore (2004) identified a rather narrow view of this process—that all disruptions are due to a failure to be aware of a need—and a second, broader view associated with the contemporary GT theorists. In this enlarged view, disruption of the cycle of awareness can also happen when the need or goal is in awareness and the person acts but fails to satisfy the need.

When the continuous process of Gestalt formation and destruction has failed in some way, the result is *unfinished business*, because the need that is not met hangs around to bother the person (O'Leary, 2013). Significant unmet needs drain the person's energy and psychological resources, interfering with the healthy processes of awareness and contact. The person does not clearly perceive her current needs and may appear confused or uncertain of what she wants. She may also display stereotypic or rigid behavior, signaling that her behavior is governed not by the organismic search for homeostasis but by the unfulfilled need (Clarkson, 2014). In practice, the unfinished business is often emotion that the individual blocks from experience and therefore doesn't express, such as anger or grief (O'Leary, 2013).

Gestalt counselors recognize that dysfunctional behavior is a creative adjustment made in an earlier difficult situation (usually childhood) that is no longer functional in the present (Yontef & Jacobs, 2014). Probably, these behaviors protected the organism from injury or pain or somehow allowed a limited form of need satisfaction in what was then an emergency. Unfortunately, the use of this *neurotic self-regulation* in the present prevents the person from responding spontaneously and creatively to the environment as it now is. Healthy organismic self-regulation is replaced by the will to control experience instead of accepting it (Yontef & Jacobs, 2014).

Perls (1969a) contended that modern society (defined as the kind existing in the United States and in Western European countries) contributes a great deal to the development of unhealthy functioning. Western culture encourages people to artificially separate mind and body (Clarkson & Mackewn, 1993). Social norms often punish aggressive behavior, which

according to GT theorists is a normal and helpful kind of human behavior. Other "shoulds" are introjected at early life stages, and these are not necessarily in alignment with healthy organismic self-regulation.

If we focus on our experience long enough, we will eventually come across something uncomfortable or unpleasant. We inherently want to avoid such experience, so we interrupt our awareness of the now (F. Perls, 1970a). Many times what we don't want to experience is our own cruelty or aggression, and we disown the experience rather than tolerating it in our awareness. Society doesn't help when it encourages us to reject these experiences. By interrupting our experience, according to Perls, we reveal ourselves as frightened children who, instead of assuming adult responsibilities, retreat into phony social roles: "These phony roles are meant to mobilize the environment for support instead of mobilizing one's own potential. We manipulate the environment by being helpless, by playing stupid, asking questions, wheedling, flattering" (F. Perls, 1970a, p. 18).

If the client can get past the phony roles, she might be able to observe the *impasse*, the point where she is stuck. She no longer has support from the environment, but does not have sufficient self-support to function adequately (F. Perls, 1969a). Mackewn (1997) characterized the impasse as the point where growth and resistance to growth are in a deadlock. Yontef and Jacobs (2014) described the experience of impasse as one of terror. We avoid prolonged contact with our impasses because they force us to "take existential responsibility for our own stuckness and our ability to choose to experience things differently and we have often not had sufficient environmental or self support to face these choices . . . we are paralysed by the fear of the unknown" (Mackewn, 1997, p. 171). If the client can stay in the impasse long enough, she will eventually start to experience authentically and will eventually attain self-support and improved awareness (Clarkson, 2014; O'Leary, 2013).

GT theorists don't spend much energy discussing what might be called traditional forms of dysfunction, such as depression, anxiety, and so forth. They recognize emotions as signals to the self about unmet needs or danger (Cole, 1998). An exception to this position is that anxiety is seen as resulting from two possible processes. The first process is cognitive. Anxiety is "futurizing—failing to remain centered in the present" (Yontef & Jacobs, 2014, p. 315). Perls (1969a), in his characteristically flamboyant way, called anxiety "stage fright." Anxiety can also be created through faulty breathing. When an individual becomes aroused, deep breathing is required. If the individual breathes shallowly and quickly, she is likely to experience symptoms that feel like an anxiety attack (e.g., hyperventilation; Yontef & Jacobs, 2014).

Jessica is not optimizing her integration with her environment. She has interrupted contact and appears to be carrying around some unfinished business, with associated behavior patterns. Enrico guesses that her early experiences with her withholding mother may have created an unfulfilled need for love for Jessica. She responded, he thinks, by burying her need because allowing it into awareness was painful. Jessica learned to deny her needs and feelings in intimate relationships through this early solution. Her experience with her father about becoming a police officer is another piece of unfinished business. Jessica felt close to her father, yet she has almost completely isolated herself from this relationship in recent years.

Jessica's relationship with Randy is problematic because she is denying aspects of her experience in it by using old patterns of defense. She is not experiencing some very vivid feelings that she has about how she and Randy relate, probably because she has introjected the societal rule that girls and women should be "nice." Further, her experiences with her mother and father—that uncompleted need for love and

acceptance—are active in her relationship with Randy. Instead of experiencing and expressing her feelings and needs, she retroflects her dissatisfaction to herself, becoming critical of her own behavior in the relationship. She also shows confluence with Randy in her failure to assert her own needs and wants.

NATURE OF THERAPY

ASSESSMENT

No formal assessment is used in GT, although Yontef (1995) noted that nothing in the theory absolutely forbids it. More generally, the Gestalt counselor is the assessment tool, using his powers of observation to assess how the client functions in her life. The Gestalt therapist sees assessment and treatment as an integrated process that attends to all aspects of the individual's experience (physiology, ethnicity, social context, family relationships, etc.). The Gestalt counselor looks most specifically at the individual's patterns of contact with the environment, her level of awareness, and the amount of environmental and personal support she has (Yontef, 1995). Enright (1970) observed that the Gestalt therapist tells the client to "sit down and start living, then note[s] where and how he fails" (p. 113).

Traditional diagnosis is also viewed with suspicion by hard-line GT advocates based on the humanistic idea that labeling people is dehumanizing (Clarkson, 2014). Others take the position that diagnostic terminology helps in communication with other professionals and can facilitate therapy (Joyce & Sills, 2010). The most common assessment/diagnostic question used in Gestalt counseling is "What do you experience right now?" (Yontef, 1995, p. 272). That is, the Gestalt therapist is most interested in assessing the client's current state of awareness.

Enrico greets Jessica and simply asks why she came in. He listens and observes her closely as she relates her story about the fight with Randy. As she talks, he notes her tone of voice and physical reactions. Jessica pauses in her narrative, and Enrico inquires, "What are you experiencing right now?" Jessica stiffens and looks surprised. She then tentatively begins to describe her feelings of anxiety about being in therapy, her fear of Randy, and a feeling of being alone.

OVERVIEW OF THE THERAPEUTIC ATMOSPHERE

The essence of Gestalt counseling is observed in the therapist's emphasis on the immediate experience of the client. A famous GT slogan is "I and Thou, Here and Now," which Perls borrowed from the philosopher Buber (Yontef & Jacobs, 2000). Yontef and Jacobs (2014) modified the phrase to "what and how, here and now" to emphasize the present-centered, experientially focused nature of GT (p. 317).

The dictate to remain in the present does *not* mean that the past or the future is never the subject of therapy; it means that these are examined as they are experienced in the present through remembering and planning (Clarkson, 2014). Laura Perls (1992), reacting to the misperception that GT does not deal with the past or future, wrote "The past is ever present in our total life experience, our memories, nostalgia, or resentment, and particularly in our habits and hang-ups, in all the unfinished business, the fixed gestalten. The future is present in our preparations and beginnings, in expectation and hope, or dread and despair" (p. 52).

Traditional Gestalt therapists are very suspicious of intellectual activities because they tend to lead to *talking about* rather than experiencing and acting. Another famous Perlism is "Lose your

mind and come to your senses" (F. Perls, 1970a, p. 38). Seeking intellectual understanding (asking the *why* question) is avoiding life. Gestalt counselors tend to believe that "in modern life we suffer from too many explanations. . . . Perls's Gestalt therapy gave up on explanations; it became impatient for something to happen. Happening, after all, is the best explanation" (M. V. Miller, 1989, p. 12). Emphasizing action, rather than talking, usually leads to the construction of experiments in awareness, in which the counselor asks the client to actively experience some disowned aspect of her life in the session (Wheeler & Axelsson, 2015).

Because experiencing the unfinished situation in the therapy session arouses anxiety, Perls characterized therapy as a "safe emergency" (F. Perls et al., 1951, p. 286). The re-experiencing of the rejected experience in the safe environment of counseling allows the completion of the Gestalt and thus the assimilation of the experience. An important consideration is the balance between support from the counselor (safety) and the therapeutic emergency (risk). The client is not allowed to stay in "safe but infertile territory," but neither is she exposed to experiences too threatening (M. Polster & Polster, 1990, p. 104).

The current approach to Gestalt counseling is more moderate than what Perls presented. Support of the client is considered very important, and Gestalt counselors tend to emphasize the building and exploration of the here-and-now relationship between therapist and client more than Perls did and are less rejecting of the intellectual elements of counseling (J. C. Watson et al., 2011). The Gestalt therapist strives to create an authentic relationship with the client, which is referred to as the therapist's *presence* (Brownell, 2010). According to Wagner-Moore (2004), the contemporary Gestalt therapist views the therapeutic relationship as a critical aspect of therapy and is less likely than Gestalt therapists of the 1970s to use the techniques stereotypically associated with the approach. Yontef and Jacobs (2014) added that good therapy involves a fluid back-and-forth shifting on the therapist's part from attending to the client's process to focusing on the relationship between therapist and client.

MyCounselingLab

Video Example 7.3 In this video from an interview with Helen's therapist, note the importance placed on relationship building to support the client and do the experiential work to come.



The Gestalt counselor is active, directing the client's attention to various aspects of her experience. A primary task of the therapist is observation in the interest of helping the client discover where she has interrupted her experience (J. C. Watson et al., 2011).

Gestalt counseling can be either short or long term (Yontef & Jacobs, 2014). Although Perls maintained that group psychotherapy using the "hot seat" method (discussed later) is superior to all other forms of counseling, contemporary Gestalt therapists disagree, practicing individual, couples, family, group, and organizational GT (Jacobs & Hycner, 2009). However, other contemporary GT advocates take stronger stands on the length and modality of therapy: Frew (2013) opined that GT is most effective as a long-term approach, and Sheldon (2013) argued that group therapy was the best method to use.

Enrico endeavors to help Jessica stay in the here and now without sacrificing his support of her. He makes observations about how he feels in relation to her in an honest, open way. He asks many how *and* what *questions and no* why *questions. Enrico encourages Jessica to reveal her present experience as*

she talks about her relationship with Randy. If she brings up her father, mother, or family, Enrico will encourage Jessica to explore her feelings about them as they are present in the here and now.

ROLES OF CLIENT AND COUNSELOR

As is the case with Albert Ellis and rational emotive behavior therapy (see Chapter 9), the role of the counselor in GT often gets confused with the person of Fritz Perls. In Perls's (1970a) version of GT, the role of the counselor is to frustrate the client's avoidance of self-support. The client is often confronted with her attempts to get the counselor to take care of her and her reluctance to be authentic. One of Perls's favorite labels was "phony" (Nelson-Jones, 2000). Clearly, confrontation was the hallmark of Perls's approach to GT (Yontef & Jacobs, 2014). N. Friedman (2003) commented that the therapist in this version is something of a stage director or coach and related that Laura Perls maintained that in interacting with clients in this way, Fritz Perls "turned away from the patient" (p. 63). Although this extreme approach is not used by many (if any) Gestalt counselors currently, the extent to which confrontation is used probably varies greatly among GT practitioners.

In more recent versions of GT, the abrasive style of Perls is softened. Gestalt counselors are expected to be authentic, present, and transparent in their relationships with their clients. This authenticity promotes a nonhierarchical alliance between counselor and client (Frew, 2013). In this dialogic or relational GT (Jacobs & Hycner, 2009), acknowledgment is made of the dependence, or really interdependence, of the client and counselor, and "support, healthy confluence, compassion, kindness, accepting the validity of the patient's wishes, are all part of a good therapeutic attitude" (Yontef, 2009, p. 44).

Gestalt therapists are admonished to stay in touch with their own experiences in counseling, using such awareness as a diagnostic tool. "Exclude nothing; dismiss nothing as irrelevant. What is your body doing involuntarily in the presence of this other person? Are your muscles tightening up or relating and opening? Does your attention wander or is your interest riveted? If you begin to daydream, *when* do you do so and *what* are you daydreaming?" (Mackewn, 1997, p. 47; emphasis in original). To maintain this level of awareness, a Gestalt therapist must have a significant emotional commitment, according to Clarkson (2014). Candidates should undergo personal psychotherapy, similar to the training analyses of psychoanalysts, only from a Gestalt counselor, of course. Parlett and Hemming (1996b) warned us that "Gestalt therapy is not an approach which can be applied by people who are themselves largely unaware of their own contact style or bodily experience" (p. 207). It is also considered important for the GT counselor to be in good physical health and practice growthful habits, such as getting the type and amount of rest, recreation, and diet that he knows is personally helpful (Clarkson, 2014).

The client in Gestalt counseling is expected to engage actively in the process of self-discovery. She is a student who is learning to test what is offered in therapy, to see if it fits (Yontef, 1995). The Gestalt therapist respects the client's expression of disagreement (or even anger) with the therapist because it demonstrates self-support. The last thing the Gestalt counselor wants is for the client to introject the values or opinions of the therapist.

Enrico is a moderate Gestalt counselor. His first goal is to connect with Jessica in an authentic relationship. Enrico observes Jessica as she talks about her experience and also pays attention to his responses to her (e.g., he has an image of her in her police uniform that quickly alternates with an image of a small child). Enrico also notices that his muscles are tensing and that he has impulses to rescue Jessica.

Jessica, eager for the therapist's help, openly discloses about her situation. She is willing to engage with Enrico. Jessica has a little difficulty expressing her own wants and preferences in counseling, but Enrico helps her stay with her experience until she is able to experience her needs.

Goals

The one big goal in GT is awareness. Perls (1969a) said, *"Awareness per se—by and of itself—can be curative"* (p. 16; emphasis in original). There are two kinds of awareness: awareness of a moment, process, or aspect of content, and awareness of one's own awareness (Mann, 2010). The point is that, although the Gestalt therapist wants the client to be aware of a current situation in therapy, he is also interested in the client understanding the process of awareness so that she can apply it to other situations. An added benefit of this kind of awareness is that it promotes taking responsibility for behaviors enacted (Yontef, 1995). Parlett and Hemming (1996b) described the goal of GT a little differently, saying that the process should "promote self-support sufficient for the person to live a life of freedom and choice (thus increasing his or her 'response-ability')" (p. 205; quotes in original).

Awareness also involves modification of the contact style if it is dysfunctional (Frew, 2013). Such modification will ultimately result in the growth of the individual, for increased awareness will result in better harmony with the environment and enhancement of the organism through assimilation of needed things. Thus, a goal of GT could be said to be growth. In fact, many Gestalt therapists maintain that people come to counseling not for remediation, but for the facilitative aspects of GT. M. Polster and Polster (1973) emphasized the growth orientation of Gestalt counseling when they wrote "therapy is too good to be limited to the sick" (p. 7).

Enrico hopes to help Jessica become aware of the unfinished business she is carrying around. Clearly there is some with both her mother and father. He'd like to help her recognize the ways she avoids contact with the environment and aspects of herself. Enrico has no predetermined ideas about what she should do about her situation or relationships; he'd like her to become aware so that she can decide for herself. Ideally, Jessica will come to value awareness and responsibility in her life, taking these tools out of therapy to use in future life experiences.

PROCESS OF THERAPY

Gestalt counseling has three central elements: relationship, awareness, and experiment (Clarkson, 2014). The first step is for the Gestalt counselor and client to establish an authentic *relationship*. This relationship is often the medium through which awareness is explored. For example, the client's desire to be dependent on the therapist can be brought up explicitly, with the client living and describing this experience in the session. *Awareness*, of course, is critical, because interruptions in the awareness process are what bring the client to counseling. *Experiments* are therapeutic activities created to further awareness; they are discussed later under a separate heading.

Levitsky and Perls (1970, pp. 140–144) described the rules of GT; the most critical of these are (a) staying in the now; (b) maintaining I and thou, or the emphasis on aware and authentic communication; (c) using "I," not "it," language, or taking responsibility for all statements; and (d) asking no questions—because they are seen as asking something of the counselor and therefore as aspects of the client's passivity or laziness. The client is urged to turn questions into statements. Clients in therapy groups are expected to follow the "no gossip" rule: One must

speak directly to any individuals present, not about them. O'Leary (2013) includes using I language under what she labels "language techniques," which also include things like changing *can't* into *won't*, eliminating qualifiers (e.g., *maybe*, *sort of*, *possibly*), and making demands (instead of being ambiguous or passive).

An aspect of GT that sets it apart from other approaches is its emphasis on physical or body sensation and functioning as a critical aspect of human existence. Unfinished business is often seen in the body of the client. Thus, Parlett and Hemming (1996b) suggested that in Gestalt counseling "the body is regarded as a source of wisdom, a provider of organismic truth" (p. 200).

Gestalt therapists refer to the "paradoxical theory of change" (Yontef & Fairfield, 2008, p. 91). By this term, they mean that the more you try to change, the more you stay the same. Change is, instead, accomplished by becoming aware of and accepting who you are. The Gestalt therapist needs to be aware of this dictate so that he will not align with aspects of the client that pressure the client for change. Perls et al. (1951) recommended that the Gestalt counselor adopt a stance of *creative indifference* toward his work. This somewhat confusing term does not mean that the counselor is truly indifferent to the client, only that he is not intensely invested in some particular outcome or process in therapy (Mackewn, 1997). Joyce and Sills (2010) noted that creative indifference comes out of the therapist's being in the fertile void, discussed earlier as the state following need satisfaction.

Contemporary Gestalt therapists are prone to referencing the "field," a somewhat vague construct that originated with Lewin's (1951) notion that behavior is a function of both person and environment. The idea of field is used to emphasize that the person should always be viewed in context, and that includes the therapist and the therapy situation, too. The therapist is an integral part of the therapy, not a detached observer. Further, according to Parlett (2005), the field has inherent structure, which should be examined in therapy. These ideas connect to the relational emphasis in current GT theory—the therapist and client both have input into the here-and-now situation, and to this they must attend (Jacobs & Hycner, 2009). Another important implication of the field perspective is that, similar to family systems therapists (see Chapter 13), Gestalt therapists are aware that any change in the field will affect the rest of it (Yontef, 2005).

Client resistance is not to be fought, eliminated, or overcome in Gestalt counseling. In fact, Frew (2013) declared that "there is no concept of resistance in Gestalt therapy" (p. 240). Instead, resistances are identified as the energy of the organism placed in service to protect the person from an experience that might be harmful (Yontef & Jacobs, 2014). Typically, these behaviors (i.e., the neurotic adaptations or contact modifications) stem from adaptive responses to past experience, as described earlier. Instead of wanting the client to overcome the resistance, the GT counselor wants the client to experience it, encourage it, and bring it to the center of awareness. In this way, resistances, which are ways of avoiding meaningful contact, can be used to resolve unfinished business (Joyce & Sills, 2010). Another way of putting this might be that the resistances are modifications of contact that are not to be judged dysfunctional but are to be explored (Clarkson, 2014).

Although Gestalt therapists will acknowledge transference and countertransference, they see these phenomena differently from the way traditional psychoanalysts would see them (Joyce & Sills, 2010). Transference is not seen as purely the client's distorted way of perceiving the world, although it is seen as a clue to how the client habitually structures experience. Gestalt therapists acknowledge that we do bring the past into current situations, particularly when we carry around unfinished business. However, GT theory distinguishes itself by instructing that the

therapist's input to the interaction be considered, too, and the Gestalt counselor needs to be ready to examine his contributions to the situation. The therapist must be open to being changed in the therapeutic encounter and ready to admit to being wrong (Yontef & Jacobs, 2014).

Clarkson (2014) identifies three kinds of countertransference. The first occurs when the counselor's unfinished business is activated while in a relationship with the client. The Gestalt counselor must be alert to this event and be able to set these responses aside (termed *bracketing*) to be dealt with in supervision or personal therapy (Mackewn, 1997, p. 95). However, the counselor's reactions can also be those experienced by others in the client's life or past, perhaps reactions to the client's transference behaviors. Third, Clarkson discussed a confluence-based response in which the counselor experiences the client's experience—the feelings, thoughts, or response tendencies that the client has or even the ones she may be avoiding (p. 128). It is most important that the counselor, in continuing recognition of the dialogic nature of GT work, be able to acknowledge his own input in the relationship and be able to distinguish between the types of countertransference.

Enrico focuses on the three elements of Gestalt counseling with Jessica. It is relatively easy to establish a relationship with her, but Enrico is sensitive, at first, to the relatively superficial level of their contact. As time goes on, the relationship becomes more authentic.

Awareness is always central for Enrico. He endeavors to be aware of his own experience in relation to Jessica, and everything he does in counseling is directed toward helping Jessica become aware of her experience. For example, when she is talking about her mother, Enrico notices that she assumes a rather flat tone of voice. Enrico asks Jessica if she is aware of how her voice has changed.

Enrico sees Jessica struggle with contact around her feelings for her mother and father. When he asks questions, attempting to get Jessica to experience these in the session, he notes that she becomes more closed physically and less responsive verbally. Attempting to explore the resistance, Enrico asks Jessica to become aware of how she is feeling, physically and emotionally. If she still shows a need to protect herself, Enrico accepts this as a sign of Jessica's strength and helps her verbalize this to him. He is not adamant about reciting the rules of therapy with Jessica, although he does encourage her to use "I" language.

Enrico notes no countertransference, although he is aware that this could happen. He has recently returned to GT to explore some of his own interruptions. He will be vigilant in looking for signs that his own issues are intruding on his interactions with Jessica. Noting that he experiences Jessica as wanting him to direct and support her, Enrico decides that this is his response to her typical way of operating based on her unfinished business. He finds ways to share his reactions with Jessica and they explore their experiences.

THERAPEUTIC TECHNIQUES

GT has often been perceived as synonymous with its techniques, particularly dialogue techniques and the "empty chair" (discussed later). Current Gestalt theorists and therapists reject this perspective, saying, "Most modern Gestaltists would adopt a therapeutic relationship characterized more by dialogue and an appreciation and exploration of the subtle exchanges, some explicit, others implicit, that arise between counsellor and client, rather than techniques involving invasion or deprivation" (Clarkson, 2014, p. 27). In reality, Gestalt counselors are technically eclectic; any technique that fosters awareness is considered acceptable.

As I noted earlier, toward the end of his career Perls began to work increasingly with groups and thought that individual therapy was becoming obsolete (F. Perls, 1970a). During the late 1960s, Perls did most of his work in large training workshops for professionals, in which he would invite members of the audience to participate as his clients. Essentially, he was really doing one-session individual counseling with the client in front of an audience. The client would assume the "hot seat," and Perls would create various exercises in awareness.

Contemporary Gestalt counseling generally doesn't employ structured techniques, instead favoring a present-focused phenomenological exploration of the client's awareness (Brownell, 2010; Jacobs & Hycner, 2009; Joyce & Sills, 2010). Spontaneously co-created one-of-a-kind experiments are a central feature of this approach. In the following, I describe some of the techniques used in traditional Gestalt counseling; you should keep in mind that most contemporary GT practitioners would likely be less structured in their approaches.

EXPERIMENTS

Experiments are activities that help the client increase awareness. The idea is to create a new experience for the client; because the outcome of the experiment is unpredictable, they are sometimes called *safe emergencies* (Brownell, 2009, 2010). Although the experiment is most often suggested by the therapist, the relationship should be such that the client will feel she can decline (Joyce & Sills, 2010). The spontaneity of the experiment is important—the "creative adventure" arises from the moment-to-moment experience of client and therapist (Roubal, 2009, p. 272). Although experiments are often described as one-of-a-kind experiences tailored for the specific client, many of the techniques described in this section are considered experiments in awareness; dialogues are probably the most notorious example.

Enrico expects that he and Jessica will devise experiments in awareness spontaneously as they work together. In his close attention to Jessica he notices that when she talks about her fight with Randy, she seems to shrink into her chair and crosses her arms across her chest. He asks her if she is aware of these sensations. Would she like to try an experiment? When Jessica agrees, he asks her if she can focus on these sensations in her body and describe them.

THERAPIST SELF-DISCLOSURE

Often, the Gestalt therapist, attending closely to his experience, will disclose his awareness to the client (Wheeler & Axelsson, 2015). "Sometimes the therapist is bored, confused, amused, angered, amazed, sexually aroused, frightened, cornered, interrupted, overwhelmed and on and on. All of these reactions say something about both the patient and the therapist and they comprise much of the vital data of the therapy experience" (E. Polster & Polster, 1973, p.18). The Gestalt counselor authentically discloses an experience, and then the client and counselor discuss it in the immediacy of the relationship. Wheeler and Axelsson (2015, p. 33) caution that this kind of disclosure is not "anything goes," but is always performed in the service of the client's goals.

Enrico decides to disclose his alternating images of Jessica as a child and police officer to her. She bursts into tears, saying that she feels like the child in the moment. Enrico replies that he feels like taking care of her.

DIALOGUES

In the interest of increasing awareness and addressing unfinished business, Gestalt counselors often ask the client to create a conversation, or dialogue, in the counseling session. These dialogues can be (a) among parts of the self, (b) with the therapist, or (c) with some other individual in the client's life, past or present (Hycner, 1987). Dialogues are also created between the "splits" or polarities in the client's personality (Levitsky & Perls, 1970).

Historically, one very well-known dialogue is top dog and underdog (Levitsky & Perls, 1970). In this experiment, the client plays two parts of herself: the critical, demanding top dog and the whiny, excuse-using underdog. These are the end points of a critical polarity inherent to humans and, according to Perls (1969a), we use the conflict between the top dog and underdog as a way of torturing ourselves. In top dog–underdog dialogue, the client alternates between playing the two poles. She bosses like the top dog and whines like the underdog. The goal of the dialogue is to have these two aspects of the self listen to each other. Ultimately, full expression of these aspects of the self will result in their integration (M. V. Miller, 1989). That is, the two aspects will no longer be "split off" from each other, but integrated as parts of the personality. Many modern Gestalt therapists would likely reject this version of dialogue as outdated, although some sources still acknowledge it (Clarkson, 2014).

A contemporary perspective on dialogue is found in emotion-focused therapy (EFT; see Box 7.2 for a brief description; Elliot, Watson, Goldman, & Greenberg, 2004; L. S. Greenberg, 2011). EFT theorists differentiate between two-chair and empty-chair dialogues. Two-chair dialogues are aimed at healing split aspects of the self, whereas empty-chair dialogues are interventions for unfinished business. Anything or anyone can be put in the empty chair, and the client talks to the entity. Often, the client is asked to play the part of the person or projection in the chair and switches seats as she does this enactment. Sometimes the Gestalt counselor plays the entity in the empty chair. This approach has many uses from the GT perspective, including creating a situation in which unfinished business can be completed with significant others, helping the client resolve internal conflicts, and allowing the client to experiment with behavior that is threatening and scary (Crocker, 1999).

MyCounselingLab

Video Example 7.4 Watch Helen's two-chair dialogue.



Enrico asks Jessica if she'd like to talk to her mother, guessing that Jessica has unfinished business with Mom about love and belonging. Hesitant at first, Jessica agrees to try the experiment.

Enrico: *Tell your mom what you're experiencing right now.*
Jessica: *I wish I could get close to you.*
E: *What are your feelings?*
J: *I am sad. I'm angry. I want to hurt you.*
E: *Say that again.*
J: *I'm ANGRY!!*

PLAYING THE PROJECTION

To increase the experience of disowned parts of the self, the Gestalt counselor might ask the client to play the role of the projection (Sapp, 1997). For instance, if the client sees someone as angry and hateful toward her, the therapist might ask her to act out an angry and hateful person.

The therapist could then ask the client if she could find these qualities in herself (Levitsky & Perls, 1970).

Because Jessica does not seem to be projecting, Enrico decides that playing the projection is not a technique he will use.

EXAGGERATION

If the client appears to be unaware of some (typically nonverbal) aspect of her experience, the Gestalt counselor guides her through the process of exaggerating the movement (Levitsky & Perls, 1970). Often, the original expression of the client is incomplete or stunted; the therapist helps her make the movement more authentic. The client might be wiggling her leg. The astute Gestalt counselor asks her to exaggerate the wiggle, attempting to get the client to increase her awareness of this expression and the beliefs, feelings, or history associated with it (Wheeler & Axelsson, 2015). This technique can also be used with client statements—the counselor hears the client glossing over something she says and asks her to repeat it, perhaps more forcefully.

When Jessica talks about her mother, Enrico notices that she hunches up her shoulders. He asks Jessica if she notices this. Jessica says, "Not really," so Enrico asks her to exaggerate the tension and describe what it is like. Jessica reports that she is protecting herself from psychological blows from her mother.

REVERSALS

Recognizing that observable behaviors are sometimes the opposite of underlying impulses (i.e., at the opposite end of a polarity), the Gestalt counselor directs the client to act the reverse (Levitsky & Perls, 1970). For instance, a shy client could be asked to play the extrovert.

Enrico has observed (from watching her dialogue with him in the empty chair) that Jessica is passive in her relationship with Randy, always trying to please him. He asks Jessica to put Randy back in the chair and play the bossy, bitchy, overbearing woman.

DREAM WORK

Perls (1970b) called the dream the "royal road to integration" (p. 204), seeing dreams as the most spontaneous form of human expression. Despite the allusion to Freud's position on dreams ("the royal road to the unconscious"), the way dreams are handled in GT is very different from the way they are addressed in traditional psychoanalysis.

In Perls's approach to GT dream work, the client takes on the role of the parts of the dream, giving each its own speech and experiences. Perls (1970b) insisted that the client "play" all of the objects and people in the dream, giving them voice and action, because this represents experiencing aspects of the self symbolized in the dream elements. Most likely, these aspects are ones that the client has disowned or that represent important people in the client's life (Staemmler, 2004). The therapist does not interpret the dream other than in the general sense of regarding it as existentially meaningful to the client—the client does the interpreting, if any occurs (E. Cain, 2013).

Joyce and Sills (2010) described a much broader approach to dream work. Although including the traditional play-the-part method, they also suggested that clients can benefit from

interventions such as (a) telling the dream in present tense, (b) creating different endings for their dreams, (c) nonverbally telling the story of the dream, and (d) devising dialogues between dream elements, among others.

Jessica dreams that she is a gardener. She has her hoe and her spade and her gardening gloves. She gleefully plants flowers and vegetables and watches them grow.

Enrico asks Jessica to play the parts in the dream. First, she is the hoe, turning up the soil. Then she is the spade, moving things around, carrying soil to where it belongs. The gloves protect. Flowers and plants struggle against soil and emerge into sunlight. Moving around Enrico's office, she gains physical awareness of all of these elements of the dream—and of herself.

Working with Polarities

Gestalt counselors are aware of what is included in the client's presentation, but are often more interested in what is missing (Parlett & Hemming, 1996b). Likely, the client has repressed, or "disowned," one aspect of the self, which tends to be one end point of a polarity. Examples of polarities identified in GT theory are messy–tidy, strong–weak, love–hate, dependent–responsible, and, of course, the famous (or infamous) top dog–underdog. The Gestalt therapist brings the polarities to the client's attention, often using less toxic language for them (Parlett & Hemming, 1996b). Clients can also be asked to play the polarity, similar to the way in which playing the projection is used. That is, the client is asked to take the role of each of the ends of the polarity identified as critical for her, possibly in a two-chair dialogue (Mann, 2010).

One of Jessica's key polarities appears to be strong–weak. She is a tough, strong police officer, yet a weak, dependent person in her relationship. Enrico decides to have Jessica play both of these polarities to help her increase her awareness of this split.

Awareness Training or Bodywork

In one sense, all Gestalt counseling is awareness training. In a more specific sense, Gestalt counselors work with their clients to become more aware of their physical sensations because these are often clues to aspects of experiences blocked out of awareness (Wheeler & Axelsson, 2015). The client might be asked to attend closely to any body sensation that the counselor thinks is important—breathing, tone of voice, physical gesture, and so on.

Enrico notices that Jessica clenches her fist when she talks about Randy. He asks that she attend to this motion and experience what the tensing is like. He might even ask her to "play" her fist.

EVALUATION OF THE THEORY

Responses to GT are numerous and rarely moderate! Crocker (1999) commented that GT has a reputation as "an intrinsically rude and confrontational method, lacking in both gentleness and a respect for clients, and practiced by people with questionable moral standards" (p. 7). GT has also been characterized as "wild, uncontrolled, undisciplined—in a word, dangerous" (E. W. L. Smith, 1991, p. 62). These criticisms seem to stem from two sources. First, the approach is highly identified with Perls and his confrontive, abrasive approach. GT in the classic form overemphasized the individualistic. Moreover, Perls acted unethically and was

sometimes abusive (Clarkson & Mackewn, 1993). Captivated by Perls's charismatic style, many insufficiently trained people put on their Gestalt therapist hats and created havoc (Parlett & Hemming, 1996a). A second reason that GT is thought to be wild and dangerous seems to be connected to its adoption of the rebellious, antiauthoritarian stance of the mid- to late 1960s. This reaction also seems to be the result of GT's emphasis on raw experiencing and lack of structure.

Contemporary approaches to GT would seem less susceptible to these critiques. Modern Gestalt therapists are careful to explain that "the experiment is not simply a facile technique to be applied indiscriminately" and to caution counselors to provide support in conjunction with challenge (M. Polster & Polster, 1990, p. 104).

The lack of supporting theory is also seen as a failing of GT; the approach is seen as little more than a collection of gimmicky techniques, the most notorious of which is the empty- or two-chair dialogue (M. V. Miller, 1989; Wagner-Moore, 2004). Miriam Polster (cited in Hycner, 1987) argued that the excessive reliance on technique is seen only among inexperienced or narrow-minded Gestalt counselors. Indeed, if you read contemporary GT sources (e.g., Clarkson, 2014; Wheeler & Axelsson, 2015), you are likely to see few structured techniques and a pronounced focus on the phenomenological exploration of the client's experience.

QUALITIES OF THE THEORY

Precision and Testability. Gestalt theory (the perception theory) was based on well-constructed laboratory research. The constructs of GT theory diverge from classic Gestalt theory, and some are very difficult to operationalize. They are difficult to define (e.g., contact) and observe, partly because they are so broad (e.g., awareness). At the same time, L. S. Greenberg (2011) and associates (see Elliot et al., 2004) have achieved some success in operationalizing particular GT techniques and processes, such as their attempts to capture client levels of experiencing (see Box 7.2 and the discussion of research in the following sections).

Empirical Validity. Although fewer studies on the outcome of Gestalt counseling have been conducted compared to other theoretical approaches, support for the effectiveness of the therapy is evident (Strumpfel, 2004). Less support exists for the theoretical structure on which Gestalt counseling rests, possibly because it is so difficult to operationalize. Again, the exception to this generalization is the research of L. S. Greenberg (2011) and associates on EFT.

RESEARCH SUPPORT

Outcome Research. Outcome research on GT exists, but not to the extent that it does for other theoretical approaches (e.g., cognitive or behavior therapy). In their early classic study of encounter groups, Leiberman, Yalom, and Miles (1973) examined the outcomes of group leaders. Two GT leaders were included in this study. These two leaders produced very different outcomes, although they were characterized similarly as active, energizing leaders. One leader produced the highest number of casualties (participants who were negatively affected by the group experience) among all of the leaders, whereas the second GT leader had no casualties. The second leader tended to produce mild to moderate change among members. Yontef (1995) maintained that the first leader did not follow the principles of GT; he was "abrasive, insensitive, and charismatic rather than dialogic and experimental" (p. 290).

Elliot, Greenberg, Watson, Timulak, and Freire (2013) reported on a meta-analysis of humanistic–experiential therapy (HET), finding large effect sizes when pre- to post-therapy comparisons were made. In studies that compared treatment to untreated control groups, the effect sizes were large in favor of treated clients (0.96 versus 0.19). No differences in effectiveness were found when studies comparing HETs to other approaches were analyzed. However, it should be noted that there were very few studies of GT in this analysis. When looking at the process of HETs, Elliot et al. reported that studies of chair dialogue based in an EFT model (see Box 7.2) demonstrated that the intervention had positive effects, but in the case of empty-chair dialogue for clients who had experienced child abuse there was a higher dropout rate than EFT models that did not use chair dialogue (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010).

Strumpfel and Goldman (2001) reviewed huge amounts of research on GT, including studies conducted in Europe, and documented impressive support for the approach. For example, they described an Austrian study that included 431 outpatients, citing improvement rates of over 70% (Schigl, 1998, cited in Strumpfel & Goldman, 2001). This was an effectiveness study modeled on the *Consumer Reports* study (Seligman, 1995; see Chapter 1), so it did not involve all the trappings of a randomized clinical trial.

Individual studies of GT outcome are of varied sophistication and quality. Leung, Leung, and Ng (2013) performed an uncontrolled study of 58 participants in four Gestalt-oriented growth workshops in Hong Kong (most were mental health professionals). Although they had no control group, they did use validated self-report measures. Basic pre- to post-workshop comparisons showed that participants' levels of anxiety and depression decreased significantly and their levels of hope significantly increased. W. R. Johnson and Smith (1997) studied snake-phobic university students, randomly assigning them to Gestalt empty-chair dialogue (ECD), systematic desensitization, or no treatment. On objective measures of phobia, both the ECD and the systematic desensitization groups improved in comparison to the control participants. O'Leary, Sheedy, O'Sullivan, and Thoresen (2003) conducted a randomized study comparing GT groups and a no-treatment (assessment-only) control group with older adults. Comparing these rather small groups (21 in the control group and 22 in the two GT treatment groups), they found that at the end of the treatment, those in the GT groups reported expressing more anger and having less control over it. At first glance, this might look like a scary finding, but recall that one indicator of health in a GT model is the ability to experience and express emotions freely. Thus, O'Leary et al. (2003) interpreted this finding as an indication that the clients in the therapy group were possibly living more in the present because the treatment had allowed them the opportunity to deal with unfinished business.

An interesting study tested the effects of Gestalt group therapy with hospitalized schizophrenics in Israel (Serok & Zemet, 1983). Pairs of patients (matched on age, sex, and education) were randomly assigned to 10 sessions of GT group treatment or a no-treatment control group. Using two indexes of reality testing derived from the Rorschach inkblot test, Serok and Zemet found that clients in Gestalt group therapy showed improved reality testing compared to those who received no treatment. Some researchers would question the psychometric validity of the Rorschach (an ambiguous set of stimuli for which scoring is difficult), and because the Rorschach was the only measure of reality testing used, Serok and Zemet's results could be called into question.

Elliot, Greenberg, and colleagues (Elliot et al., 2004; L. S. Greenberg, 2011) have established a respected research program that investigates EFT. Although not directly intended to test

GT outcomes and theory, these investigations are still relevant to our understanding of GT. L. S. Greenberg (2011) summarized their program of research, which looks at both process and outcomes in EFT. EFT is manualized, and a number of randomized clinical trials have shown positive results (e.g., Ellison, Greenberg, Goldman, & Angus, 2009; L. S. Greenberg, Goldman, & Angus, 2001; L. S. Greenberg & Watson, 1998; J. C. Watson, Gordon, Stermac, Steckley, & Kalogerakos, 2003). For example, J. C. Watson et al. (2003) compared EFT (actually called process-experiential therapy at the time) to cognitive-behavioral treatment for depression and found both treatments to result in reduced levels of depression and increases in the use of adaptive coping styles. Comparing client (person)-centered therapy (CCT) and EFT, Goldman, Greenberg, and Angus (2006) found that both treatments produced positive change, although EFT seemed to reduce symptoms more than CCT. Ellison et al. (2009) looked at long-term change in the same group of clients studied by Goldman et al. (2006), documenting evidence for the superiority of EFT compared to CCT. In other studies reviewed by Elliot et al. (2004), the results were similar, demonstrating significant empirical support for this variant of GT theory. However, to their credit, Elliot et al. (2004) did point out that this research is conducted almost entirely by advocates of EFT, warning that allegiance effects could play a part in the process (see Chapter 1).

Theory-Testing Research. Some of the EFT research directly assesses the effects of empty-chair dialogue (ECD) on client outcome, generally providing support for this intervention and thus indirect support for GT theory. L. S. Greenberg and his colleagues have conducted quite a bit of research on this approach, so I will sample only a few studies in the following section. Interested readers can consult Elliot et al. (2004) or L. S. Greenberg (2011) for further detail.

A number of older studies directly examined ECD. L. S. Greenberg and Foerster (1996) examined the performances of 22 clients who were rated as successful or unsuccessful in resolving unfinished business using ECD. In a detailed study of these ECDs, Greenberg and Foerster found that successful resolution was more likely to be accompanied by intense emotional expression, need expression, and positive expressions about the "other" in the dialogue (whether it was the self or someone else). These findings would seem to support the GT assumption that increased experiencing or awareness is necessary for the resolution of dysfunction (unfinished business). Paivio and Greenberg (1995) studied the effects of treatment containing ECD compared to a group educational experience that introduced information about unfinished business. Significant differences were found between the groups on symptom measures; most significantly, the ECD group reported more resolution of unfinished business than did the educational experience group. However, differences between the treatment groups weaken the interpretation of the results of this study (e.g., the number of sessions in the two conditions was not equal).

L. S. Greenberg and Malcolm (2002) analyzed the process and outcomes of ECD in resolving unfinished business. They found that clients who displayed indications of having resolved the unfinished business had better outcomes than those who did not. Field and Horowitz (1998) studied the use of ECD in resolving grief following the loss of a spouse. Participants completed a dialogue and then self-rated the amount of unresolved grief they had felt during the dialogue. The degree of resolution was related to symptoms 6 months and 14 months after the study. That is, participants who indicated less resolution showed higher levels of depression, avoidance of the grief, and intrusive memories than those who had more fully resolved their grief.

Other research bearing on GT has attempted to explore boundary or contact disturbances. For example, B. Mills (1997) attempted to develop a self-report scale to measure projection, introjection, retroflection, confluence, and deflection. Unfortunately, these efforts have not been very successful (Caffaro, 1991; B. Mills, 1997). A question that can be raised in this area is whether individuals can rate their own contact disturbance styles, as is assumed by these kinds of investigations. Still other investigators have attempted to create a method for rating the quality of contact in an interpersonal relationship, but the reliability and range of the ratings seriously hampered the usefulness of this attempt (Leonsky, Kaplan, & Kaplan, 1986).

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Many critics have pointed to the individualistic bias of GT. Saner (1989) opined that "most American Gestalt Therapy theorists and practitioners are unaware of being influenced by culture values or fixed gestalten best described as individualism or individualistic neurosis. My claim is that the contemporary form of Gestalt Therapy made-in-U.S.A. is not universally valid and needs theoretical and methodological revisions in order to be truly cross-culturally valid and meaningful" (p. 59). Similarly, Priester (2014) noted the very American and individualistic emphasis on self-disclosure, catharsis, personal responsibility, and present-time orientation. However, it would seem that more recent, relational approaches to GT would be less susceptible to this criticism. Clarkson (2014) noted that "currently, there is increasing recognition . . . that responsibility for the self inevitably includes responsibility for the others who share our world" (p. 32). Still, Frew (2013) noted that concepts such as organismic *self*-regulation may not make sense to individuals from collectivistic cultures.

The emphasis in GT on verbal, emotional, and behavioral expressiveness is counter to the values of many cultural groups (Sue & Sue, 2013). Traditional Hispanic/Latino and Asian individuals may see the control of emotions and behavior as signs of wisdom. Also, GT's emphasis on self-disclosure may be in opposition to these groups' values. At the same time, GT's disavowal of insight may be consistent for individuals who want action, such as individuals of lower socioeconomic status. The relative lack of focus on content and the ambiguous structure of GT, on the other hand, may be disconcerting to clients of diverse cultural backgrounds, such as Hispanic/Latino clients (Sue & Sue, 2013).

Frew (2013) maintained that GT is appropriate for clients of diverse backgrounds because of the emphasis on context—the GT counselor must understand each client embedded in their unique web of relationships. GT therapists strive to understand and validate the client's experience, accepting the client's experience as they present it. As Frew (2013) put it, "The Gestalt therapist enters the client's house through whatever door is provided" (p. 225); thus, this welcoming and validating stance on the part of the therapist would seem to be accommodating for clients from many backgrounds.

GT writers have paid attention to the issues of gay, lesbian, and bisexual individuals. F. Curtis (1994) and Singer (1994) presented chapters on GT with gay and lesbian couples. Singer provided a good description of issues specific to gay couples, while also acknowledging that GT counseling with a gay couple is not that different from GT counseling with a straight couple. Curtis discussed critical issues for lesbians, such as the strong heterosexist bias in most cultures, and applied GT constructs to issues likely to emerge with lesbian clients in counseling, such as shame.

Enns (1987) described a feminist perspective on GT. She maintained that GT is in many ways consistent with a feminist orientation because it emphasizes awareness and personal power. In this system, women can be encouraged to become aware of parts of themselves that are culturally discouraged (e.g., intense feelings of anger). GT can also support women as they go against existing norms in defining themselves separately from others. At the same time, the emphasis on responsibility and individuality found in GT can be problematic. Enns (1987) pointed out that "the singular focus of Gestalt Therapy replaces the old 'shoulds' with a new and potentially dangerous 'should': 'I must be fully autonomous, self-reliant and self-determining'" (p. 94; quotes in original). This kind of approach at best neglects the role of environmental factors and at worst characterizes the examination of these factors as intellectualizing or making excuses (p. 94).

Enns (1987) also highlighted GT's neglect of the fundamental interrelatedness of humans. Autonomy in the GT model looks very much like a male value, counter to the female valuing of relationships that is discussed by many feminist writers. At the same time, women traditionally equate their self-worth with gaining and maintaining the love and approval of others. GT's support for growth and personal responsibility may help female clients find their worth in themselves rather than in others' perceptions of them. Again, the more recent relational approaches to GT may address some of these criticisms.

Fernbacher (2005) argued that the emphasis on awareness in GT is facilitative in working with clients from diverse backgrounds, provided that the therapist is aware of his own process. She also pointed to the field theory construct of GT as promoting the understanding of the client and counselor as indivisible from their contexts (e.g., culture, society, political systems). However, Fernbacher also cautioned that the heavy reliance on nonverbal observation and intervention in GT calls for attention to differences across individuals to understand the meaning and impact of these expressions.

THE CASE STUDY

Jessica presents with troubled feelings about her relationship, for which she blames herself. This internalization fits well with a GT approach because it suggests that she is denying her personal dissatisfaction with the relationship. She has lost contact with her aggression and anger as well as her need for love. Jessica's history, especially her unfulfilling relationships with her parents, also seems to be amenable to a GT viewpoint.

Potential problems with a GT approach for Jessica would seem to involve her feelings of responsibility for the relationship with Randy. Women are taught by Western culture to take care of relationships, so insisting that she violate these cultural rules could create difficulty for her. That Jessica is African-American could also be a factor in employing a GT framework because the emphasis on individualism may be counter to the more collectivistic approach of African-American culture.

Summary

Gestalt counseling is an existential–humanistic approach to human functioning. Individuals are seen as functioning holistically and striving to meet needs, such as physical and emotional support. Needs are met through contact with the environment in an unending cycle of need emergence, activity by the individual aimed at satisfying the need, need satisfaction, and

disappearance of the need. Contact with the environment is sometimes scary or painful, so we sometimes avoid contact by introjecting, projecting, deflecting, retroflecting, or moving into confluence. When we avoid contact and needs go unmet, we create unfinished business, holes in the personality, and psychic splits. Our awareness of the environment (which includes the self) is disrupted and contributes to further dysfunction.

Gestalt counseling is conceptualized as an encounter between two individuals. No formal assessment or diagnosis is used. The counselor is to be authentic in the relationship and will self-disclose if it seems helpful. The goal of GT is to support the client so that she can freely experience herself and her environment. Numerous techniques are employed, and most Gestalt counseling involves some form of experiment in awareness.

GT has been faulted for its extreme emphasis on individual responsibility. This orientation may lead to problems in using this approach with individuals who are from cultures that are more relationship or group oriented. Outcome research supports GT as a viable approach to psychotherapy, and some research supports the link between increased experiencing and client progress.

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Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy,* Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 7.

CHAPTER 8

Behavior Therapy



B.F. Skinner

Shirley is a 79-year-old single White female. She has been married twice; both husbands are deceased. Shirley has no children and no surviving relatives. She does not work; she lives on Social Security and income from pensions.

Shirley was ordered to come to counseling by the municipal court because she has been caught shoplifting on multiple occasions. Mandated counseling was assigned as an alternative to traditional sentencing after she was recently arrested. Based on her description of the incident that brought her to counseling, it appears that Shirley was an ineffective thief. She did not check to see if she was watched; instead, she just grabbed some items and headed out the door of the department store.

Shirley was a last-born child, raised in Chicago. She describes a very unhappy relationship with her mother, whom she characterizes as unloving, harsh, and domineering. She describes a good relationship with her father, although she resented that he never stepped in to protect her from her mother. Shirley graduated from college with a degree in finance and was one of the few women working in business in the 1940s. She describes herself as very successful at her job managing investments, despite being in a male-dominated career. Her first husband was a military officer. After they married, Shirley left her job and moved with her husband through a number of assignments across the United States and Southeast Asia. Shirley's second husband owned an auto parts store. During this marriage, Shirley focused on her role as a homemaker and was involved in volunteer work in her community. Shirley portrays both of her marriages as very happy and rewarding.

Currently, Shirley reports being involved in community service with older adults, helping out at a senior citizens' center about once a week. She no longer drives a car, instead relying on the bus for transportation. Shirley lives alone in an apartment and reports that she has few social contacts outside of her volunteer work.

As she reluctantly discusses her shoplifting, Shirley says that she has recurrent obsessive thoughts about stealing when she is in a store. She describes a feeling of anxiety that does not subside until she has stolen something and left the store. Shirley immediately feels guilty about her actions. She says that she never steals anything particular; it does not matter what she takes. Shirley reports that she first began to steal things when she was in her 40s, after the death of her mother. Her first husband knew about the shoplifting, but she was better able to control it back then. Her second husband apparently never knew about it. Shirley has never experienced legal difficulties as a result of her stealing until recently.

Shirley is unhappy about being referred to counseling. She believes that she is the only one who can prevent her "compulsive stealing" as she terms it, and that therapy can do little to help her. Shirley is extremely embarrassed to see a counselor and expresses a good deal of shame about her behavior.

BACKGROUND

Behavior therapy (BT) is actually a cluster of models and techniques that involve several different perspectives on human learning. In this chapter, I will review the models and techniques of traditional BT, but will also include techniques based on what is generally called cognitive-behavior therapy. The term *cognitive-behavior therapy* (CBT) can be a confusing one; it is sometimes used to refer to a behavioral approach that includes the appreciation for and modification of cognitive influences on behavior. Other times it is used to refer to any of the cognitive approaches (such as rational emotive behavior therapy and cognitive therapy; see Chapters 9 and 10). Most therapists in the behavioral tradition today would acknowledge the influences of cognition, yet there are still a few hard-core advocates of BT who maintain that the target of change should be behavior—and only behavior (e.g., the classical applied behavior analysts; see the following sections). However, out there in the "real world" of practice, you will mostly see a pragmatic approach that blends aspects of the material in this chapter along with assumptions and interventions more closely resembling cognitive therapy and rational emotive behavior therapy.

What the BT approaches share is commitment to a scientific approach that is concerned with "the application of principles broadly derived from psychological research (across experimental, social, cognitive, and developmental psychology), rejecting a traditional intrapsychic or disease model of disordered behavior, and with an emphasis on the empirical evaluation of treatment effectiveness" (C. R. Glass & Arnkoff, 1992, p. 609). Others add that BT is characterized by a concern with current causes of behavior rather than those rooted in the individual's history (Spiegler, 2013a).

Because BT has such a long history, many influences, and many influencers, a comprehensive historical perspective is beyond the scope of this chapter. What follows are snapshots of important figures in BT; readers who would like a more complete review should consult Glass and Arnkoff (1992) or Fishman, Rego, and Muller (2011).

BT was developed very much in reaction to the psychoanalytic model, and therefore early BT emphasized observable behaviors rather than internal events or client history (Goldfried & Davison, 1994). As Franks and Barbrack (1990) put it, "Behavior therapy began in the late 1950s as an antimentalistic, somewhat blinkered alternative to the prevailing disease-oriented model of psychodynamic psychotherapy" (p. 551). The early behaviorists wanted only to deal with what they could see in their efforts to predict and control behavior—they had no use for things like thoughts and emotions as influencing actions. Contemporary forms of BT are more flexible in admitting cognitive and emotive factors in the explanation of human activity. Spiegler (2013a) noted that "today . . . most behavior therapists believe that dealing only with directly observable behaviors is too restrictive. After all, humans think, hold beliefs, have expectations, and imagine. Although cognitive processes cannot be observed directly, they clearly influence how people act and feel" (p. 264).

The most distant origins of BT are usually located with Russian scientist Ivan Pavlov and his experiments on classical conditioning. In studying the eating behavior of dogs, Pavlov discovered

that pairing food, which resulted in the dogs salivating, with a bell eventually resulted in the dogs salivating in response to the bell only. This model will be explained more fully in a later section.

Joseph Wolpe (1960) used this classical conditioning model as the basis for his approach to the understanding and treatment of anxiety, which he called *reciprocal inhibition* (more on this model later). Fishman and Franks (1997) noted that the important technique spawned by the theory of reciprocal inhibition, systematic desensitization, was the first real alternative to the psychoanalytic approaches in vogue in the 1940s and 1950s.

Most sources trace the beginnings of American behaviorism to John B. Watson and his 1913 *Psychological Review* article, "Psychology as a Behaviorist Views It." Watson, who had been influenced by Pavlov's work, was vehement about erasing "mentalism" from psychology, thereby eliminating the study of consciousness as a viable approach to understanding human behavior (Fishman et al., 2011). You can read some of Watson's writing on this issue in Box 8.1.

Box 8.1

John B. Watson on Behavior and the Concept of Mental Disease

For some years I have been attempting to understand the physician's concept of mental disease. Not long ago I had the pleasure of attending a medical meeting and of listening to a physician who has been very successful in his treatment of neurasthenia. Several cases of neurasthenia were described. Since none of the patients showed general organic disturbances of a serious kind and since all of the neurological tests showed normal functioning of the reflexes of the central nervous system, the physician concluded that the disease was "purely mental." He then began to describe the condition of such a patient's ego—the general content of consciousness, the inward reference of attention, and the peculiarities of the field of attention. At the end of his discourse two or three eminent physicians stated their satisfaction that the speaker had been willing to come out clearly and say that the disease was "*mental*." In other words, they expressed their approval of the fact that the speaker did not, in functional nervous cases, deem it necessary to find lesions in the central nervous system or even a toxic condition of the nervous system before admitting that the patient had a disease.

Being the only psychologist present, I did not like to admit that I did not understand the physician's use of the term "mental." (I do not wish by this assertion to stir up strife or bitter argument, but rather to confess ignorance on my own part and to seek for some common ground of discussion.) As a sequel to this meeting I began to attempt to formulate my own ideas as to the terminology I should use in describing a mental disease. I think that at the outset I should admit that I know a good deal more about terminology than I know about diseases of any kind. I am strengthened in this attempt to give my concept of mental diseases by the difficulty I have had in understanding the terminology (involving throughout and often transcending the current concept of consciousness) of the psychoanalytic movement.

I have been for some years an earnest student of Freud (and other psychoanalysts), but the further I go into their terminology [p. 590] the more sure I am that there is a simpler and a more common-sense way (and at the same time a more scientific way) of describing the

essential factors in their theory. I am convinced of the truth of Freud's work, but as I teach the Freudian movement to my classes I drop out the crude vitalistic and psychological terminology, and stick to what I believe to be the biological factors involved in his theories (Freud himself admits the possibility of this). The central truth that I think Freud has given us is that *youthful, outgrown, and partially discarded habit and instinctive systems of reaction can and possibly always do influence the functioning of our adult systems of reactions, and influence to a certain extent even the possibility of our forming the new habit systems which we must reasonably be expected to form*.

. . . I think the chief difficulty in completing the description in terms of the every-day language of habit formation lies in our failure to look upon *language* (the patient's here) as being only a system of motor habits. As a short cut—a system of economy—the human animal has formed a system of language habits (spoken words, inner speech, etc.). These language habits are built up from and always correspond more or less closely to the general system of bodily habits (I contrast here for convenience of expression *language habits* and *bodily habits*) such as the eye-hand, ear-hand, etc., systems of coordination and their complex integrations. This general correspondence between language and bodily habits is shown clearly in the football field, where we see the player making a complex series of movements and later hear him stating in words what systems of plays he employed; and in the case where we hear a man tell us what acts he is going to perform on a horizontal bar and later see him executing these acts. Words have grown up around motor acts and have no functional significance apart from their connection with motor acts. I have come recently to the view that speech should be looked upon as a vast system of *conditioned reflexes* . . . Words as words are learned largely by imitation, but words receive their standing as functional units in integrated habit systems by virtue of the fact that they become *substitutable for the stimulus which originally initiated an act*. A simple illustration will possibly serve to make clear my point. The cold air from an open window leads a child who has gone to bed to draw up the covers. The words of the nurse "cover up, dear" will lead to the same act. Of course in habit systems as complex as those in speech, words get further and further divorced from the original stimuli for which they were substituted (i.e., from the original integrations in which they first played a part.) The final test of all words, however, is the question whether they can stand adequately (be substituted) for acts. We often see an instructor despair of telling a student in words how to conduct an experiment. He then resorts to acts and goes through the experiment for the student. Our words thus stand as a kind of shorthand sketch of our repertoire of acts and motor attitudes.

Source: Watson, J. B. (1916). Behavior and the concept of mental disease. *Journal of Philosophy, Psychology, and Scientific Methods, 13,* 589–597.

Watson and his graduate student (and later, second wife) Rosalie Rayner applied Pavlov's ideas about conditioning to create conditioned fear in their famous report about Little Albert (see Box 8.2; J. B. Watson & Rayner, 1920/2000). Later, Watson's student Mary Cover Jones (1924/1960a) used these ideas to eliminate fear in a 3-year-old boy, Peter (see Box 8.5). It is also interesting that Jones (1924/1960b) acknowledged the usefulness of observational learning in her discussion of eliminating children's fears.

The second model of learning, the operant model, originated with the work of E. L. Thorndike, who studied the behavior of cats. He would put cats in a puzzle box and entice them to figure out how to get out of the box by placing food outside. Thorndike noticed that in repeated trials the cats became faster and faster at getting out of the box. From his observations, he formulated the law of effect, which proposed that behavior is learned through its consequences (Kazdin, 2001).

B. F. Skinner is probably the most famous name associated with the operant approach, which is sometimes called *radical behaviorism*. The focus of this approach is on the consequences of behavior. Skinner, who performed most of his research with laboratory animals (rats and pigeons), was aware of the potential applications of his science of behavior to developing intervention techniques for people, but he did not pursue this (Spiegler, 2016). In fact, Skinner and his colleagues were credited with the first use of the term *behavior therapy* in a report on using conditioning principles with hospitalized schizophrenics (Fishman et al., 2011). However, Skinner was more interested in broad applications of his work, such as in his novel *Walden Two* (1976), in which he describes a community based on behavioral principles. Others went on to apply the principles outlined by Skinner to working with psychological dysfunction, as was the case with Ayllon and Azrin, who developed the notion of token economies (Glass & Arnkoff, 1992). Token economies are systems of behavior change based on the awarding of a token, such as a coin, for performing desired behavior. Tokens can then be exchanged for other things desired by the participant, such as coveted food, toys, or recreational time.

A third force in BT came from the work of Albert Bandura, who recognized the power of observation in learning (Spiegler, 2016). Bandura (1969, 1974) developed social learning theory, which emphasizes the role of social events such as the observation of others in learning. The individual who demonstrates a behavior is called the model, and hence this approach is sometimes referred to as *modeling theory*.

Recognizing the power of observation was a revolution because it turned our attention to cognitive processes in learning. Bandura discovered that his participants could learn a behavior through observation and then, placed in the same situation, refuse to perform it. This finding led to the assumption that the learning is stored cognitively in some way (Kazdin, 2001). In current applications, modeling is typically combined with other behavioral techniques, such as when a counselor models a desired social skill as a prelude to teaching it to the client (Spiegler, 2013a). The label *social-cognitive theory* is often used to describe the current version of social learning theory (Wilson, 2011).

It is difficult to discuss the history of BT without pointing to the influence of Hans Eysenck and his controversial study of psychotherapy, which I reviewed in Chapter 1. *Psychotherapy* was the term that Eysenck, a classical conditioning behaviorist, used to refer to approaches other than behavioral, and he expended a great deal of energy attempting to discredit the former and promote the latter. A particularly rabble-rousing quote from Eysenck (1960) is the following: "Learning theory does not postulate any such causes, but regards neurotic symptoms as simple learned habits; there is no neurosis underlying the symptom, but merely the symptom itself. *Get rid of the symptom and you have eliminated the neurosis*" (p. 9; emphasis in original).

BT is currently a vital approach, and the prominent professional association of these counselors is the Association for Behavioral and Cognitive Therapies (ABCT; www.abct.org). It was formed in 1966, and until 2005 was known as the Association for Advancement of Behavioral Therapies (the name change should tell you something). The *Behavior Therapist* is the official journal of the ABCT.

Box 8.2

The Story of Little Albert

John B. Watson was a famous behaviorist. In 1920, he and his graduate student Rosalie Rayner decided to see if they could create human fear through conditioning principles that Watson had outlined in an earlier article (J. B. Watson & Morgan, 1917). They chose as their subject of study Little Albert, an 11-month-old infant whom they described as "stolid and unemotional" (J. B. Watson & Rayner, 1920/2000, p. 313).

Watson and Rayner presented to Albert a white rat. When Albert touched the rat, a loud noise was made by banging a steel bar with a hammer. Albert immediately showed signs of distress and on the second pairing began to cry. Seven subsequent pairings were conducted, and it was clear that the presentation of the rat produced a strong reaction because on the last trial Albert "*raised himself on all fours and began to crawl away so rapidly that he was caught with difficulty before reaching the edge of the table*" (J. B. Watson & Rayner, 1920/2000, p. 314; emphasis in original).

Watson and Rayner also tested whether the conditioned emotional response would transfer to other stimuli. They presented Albert with a rabbit, dog, sealskin coat, cotton wool, and Santa Claus mask. All of these presentations evoked responses from Albert, as did Watson's hair. Albert's reactions were similar 5 days later. Finally, the researchers looked at the effect of time on the conditioning, finding that 31 days later the fear reactions still persisted, without any further pairing of the noise and stimuli.

Unfortunately for Albert, he was mysteriously removed from the hospital a day after the tests of persistence were made. Watson and Rayner never had the chance to decondition him, although they speculated that either pairing feared objects with food or sexual stimulation or simply repeatedly presenting the feared stimuli until habituation occurred would cause the "fatigue" of the reflex.

True to his behaviorist ideology, Watson (and Rayner) took on the Freudian perspective in the report's discussion. "The Freudians twenty years from now, unless their hypotheses change, when they come to analyze Albert's fear of a sealskin coat—assuming that he comes to analysis at that age—will probably tease from him the recital of a dream which upon their analysis will show that Albert at three years of age attempted to play with the pubic hair of the mother and was scolded violently for it" (J. B. Watson & Rayner, 1920/2000, p. 317).

A subcategory of BT is applied behavior analysis, or ABA. ABA is the term generally used for an approach to working with autistic children that is based in the principles of operant learning (although to be fair, its proponents argue that ABA is useful in many more contexts than just with autistic kids). You might often hear this approach called the Lovass method, named for the psychologist who published groundbreaking research on intensive behavioral therapy with kids. Lovaas (1987) claimed that half of the children in his study achieved average intelligence assessments after the very intensive treatment (40 hours per week for over 2 years). Although there are criticisms of this method, it is still widely used and is considered very effective (Axelrod, McElrath, & Wine, 2012). An organization for the applied behavior analysts is the Association for Behavior Analysis International (www.abainternational.org).

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Video Example 8.1 Applied behavior analysis.



https://www.youtube.com/watch?v=SLBLnNxzftM

The first journal exclusively devoted to BT was *Behavior Research and Therapy*, originated by Eysenck and Rachman, and the first to promote operant principles was the *Journal of Applied Behavior Analysis*, which debuted in 1968 (Fishman et al., 2011). There are many journals devoted to BT, including *Behavior Research and Therapy* and *Behavior Modification*. Division 25 of the American Psychological Association is the Division of Behavior Analysis (www.apadivisions.org/division-25). In testimony to its historical roots, Division 25 sponsors a B. F. Skinner award for innovative research on a yearly basis.

S. C. Hayes, Luoma, Bond, Masuda, and Lillis (2006) identified a third wave of BT approaches that are cognitively oriented, but focus more on the context and function of thought than the specific content of it (as does, for example, classic cognitive therapy; see Chapter 10). That is, these approaches, particularly acceptance and commitment therapy (ACT), look at the situation in which thoughts occur and the effects of the thoughts in terms of behavior and beyond to life satisfaction. Chapter 16, "Mindfulness Approaches," reviews two of these: ACT and dialectical behavior therapy.

BASIC PHILOSOPHY

Because contemporary BT is more of a general orientation than a specific theoretical approach, the assumptions behind the orientation are helpful in understanding how it is currently practiced (Antony, 2014). Martell (2007) outlined eight basic principles of BT; these are listed in Box 8.3. I will present here a general overview of the philosophy of the approach, which will touch on these principles.

Box 8.3

The Principles of Behavioral Therapy

1. Behavior, whether public or private, is strengthened or weakened by its consequences.
2. Behaviors that are rewarded are increased; those that are punished will decrease.
3. The approach is functional rather than structural.
4. Neutral stimuli, paired with positive or negative environmental stimuli, can take on the properties of the environment in which they are presented and be conditioned to be positive or negative.
5. Behaviorism is antimentalist.
6. Behavior therapy is data driven and empirically based.
7. Changes clients make in therapy must generalize to their day-to-day lives.
8. Insight alone is not beneficial to a client.

Source: From Martell, C. R. (2007). Behavioral Therapy. In Rochlen, A. (Ed.), *Applying Counseling Theory: An On-line, Case Based Approach*, pp. 143–156. Upper Saddle River, NJ: Prentice Hall. Used with permission.

Behaviorists tend to take a neutral view of human nature. Although they recognize genetic influences, ultimately they believe behavior is determined by the environment, so to rate humans as inherently "good" or "bad" is useless (Skinner, 1971).

Behavior therapists tend to emphasize, as you might expect, behavioral descriptions of people rather than trait descriptions (Spiegler, 2016). They are more likely to describe how someone talks (e.g., she speaks very quickly) than to characterize someone using trait descriptions (she's snotty). At the extremes, behavioral therapists would rather discuss behavior disorders or problems in living than traditional diagnostic categories because the latter are imprecise and involve trait language. However, a review of BT resources will demonstrate that traditional diagnostic categories are often used for organizational purposes.

Early behaviorists, such as Ullmann and Krasner (1965), pointed out that traditional approaches to behavior change were based on what they called the "medical model" (p. 2). In this approach, also called the disease model, a person experiencing psychological difficulties is viewed as sick or diseased, and the sickness results from some underlying causal factor or mechanism inside the individual (such as repressed conflicts). What needs to be changed, then, is the underlying cause, not the symptom. If you don't treat the cause, you get more symptoms—perhaps different ones, but symptoms just the same; this process is called *symptom substitution*. Taking a medical approach to psychological dysfunction leads to a "doctor knows best" attitude because the real causes of behavior can't be seen. Diagnosis becomes central in the medical model, which should then guide treatment.

In stark contrast to the medical model, BT adopts the psychological or learning model of dysfunctional behavior, which focuses on overt behavior—and in the case of CBT, cognition, too. In this model, the symptom is the focus of attention rather than the assumed underlying causal factor(s). Behavior is seen as simply behavior, which gets defined as pathological because it deviates from social norms (Bandura, 1969). BT counselors see themselves as *scientists* who rely on the results of experimental studies of learning to help their clients. They do not search for deep, hidden causes of behavior; it is not necessary to know the origins of a problem to solve it (Wilson, 2011). In fact, some of these folks do not like to use the term *behavior therapy*, instead preferring alternatives such as *behavior modification* or the *environmental analysis of behavior* (Sherman, 1973).

Historically, a controversy within the ranks of behavior therapists has centered on the roles of cognition and emotion in human behavior. These arguments allow the identification of several varieties of BT, ranging from radical behaviorism to cognitive-behavior modification. Radical behaviorism, rooted in the ideas of Watson and Skinner, would totally exclude cognitive or otherwise inferred processes from *causal* explanations of behavior (Goldfried & Davison, 1994). That is, although these theorists recognize that thoughts and feelings exist, they can be controlled or modified using the same manipulation of antecedents and consequences as any other behavior (Rummel, Garrison-Diehn, Catlin, & Fisher, 2012). A more moderate position is the one presented by Martell (2007): "behaviorists do not accept that there is a mind apart from the body" (p. 147). At the extreme, these theorists adhere to an "outer model of psychopathology" and accuse cognitively oriented behavior therapists of adopting the medical model because they pay attention to events inside people that cannot be observed directly (Reitman, 1997, p. 342).

At the other end of the spectrum fall the cognitive-behavior therapists and social learning theorists, who allow for the influence of internal events such as cognition and imagery in understanding and changing behavior. Most behavior therapists today probably fall into the

cognitive-behavioral camp; in fact, as early as 1982 a study of the members of ABCT showed that a majority of them used cognitive techniques (Gochman, Allgood, & Geer, 1982), and Craighead (1990) reported that 69% of respondents to an ABCT membership survey characterized themselves as cognitive-behavioral in orientation. Last and Hersen (1994) noted that "the importance of cognitions in mediating maladaptive behavioral and emotional responses is now accepted by most *practicing* behavior therapists" (p. 8; emphasis added). To clearly describe behavioral principles, my presentation of BT will rely mostly on classic discussions of the theory; readers should keep in mind that current practices are pragmatic and integrative (Martell, 2007).

JaNelle is the behavior therapist who accepts Shirley as her client. She is a moderate behavior therapist who, at times, attends to cognitive processes. Approaching Shirley with a neutral attitude, JaNelle assumes that Shirley's behavior is mostly environmentally determined. She is aware that some therapists (and indeed some behavior therapists) would associate Shirley's behavior with a Diagnostic and Statistical Manual of Mental Disorders *(Fifth Edition; DSM-V) diagnosis of obsessive-compulsive disorder. JaNelle prefers to simply describe the behavior and look for the elements that support it. JaNelle is also interested in the cognitions that Shirley has at the times when the problem behavior occurs.*

HUMAN MOTIVATION

Behaviorists see humans as motivated to adapt to the environment. Adaptation in this view means survival; thus, our behavior serves to obtain things that help us survive—things that then become valuable to us, or reinforcing—and to move us away from behaviors or experiences that don't promote survival—experiences that then become aversive. According to Skinner (1971), "The process of operant conditioning presumably evolved when those organisms which were more sensitively affected by the consequences of their behavior were better able to adjust to the environment and survive" (p. 114). On a more general level, Wolpe (1990) defined adaptive behavior as that which "actually results in satisfying the individual's needs, brings him or her relief from pain, discomfort, or danger, or avoids undue expenditure of energy" (p. 8).

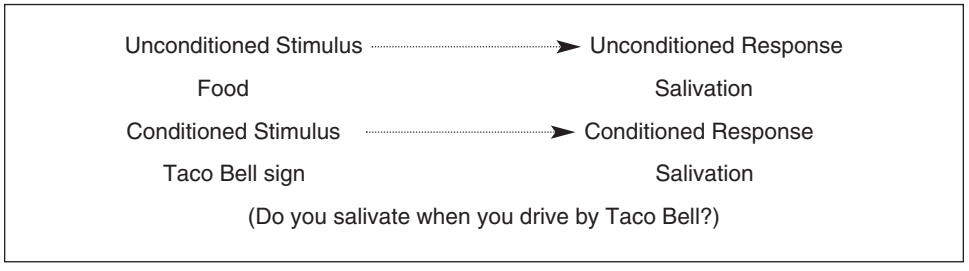
JaNelle sees Shirley's behavior simply as the most recent way she has adapted to the environment. Shirley seeks positive stimulation and avoids aversive situations. In this way, Shirley is seeking the resources she needs to survive and moving away from experiences that might be harmful. Unfortunately, Shirley's behavior has become maladaptive for her because it places her in opposition to society. Getting resources (i.e., items from the store) is adaptive in some ways, but social rules have determined that Shirley's behavior is dysfunctional.

CENTRAL CONSTRUCTS

To understand contemporary BT, it is helpful to know the three major models of learning: *classical*, or Pavlovian; *operant*, or Skinnerian; and *observational*, or modeling. The first two approaches generate a distinct set of techniques, whereas the theory of observational learning is generally applied as a way to enhance operant and classical interventions through adding attention to cognitive and social influences on behavior (Bandura, 1969). Although the distinctions among the models can be fuzzy, and the connections between the models and techniques are not as simple as one would like, I present the models because a basic understanding of learning principles is useful in many situations.

Classical Conditioning

Classical conditioning is thought to be an involuntary, reflexive process (Ullmann & Krasner, 1965). In this model, a relation between a stimulus and response that is presumably "wired in" for evolutionary reasons gets associated with a new stimulus, which can then elicit the response. For Pavlov, this sequence had to do with a bell, food, and dog saliva. We could diagram this relation in humans as follows:



This classical conditioning model is the basis of Wolpe's approach to changing dysfunctional behavior, which he called *reciprocal inhibition* (Wolpe, 1960, 1990). Wolpe reasoned that anxiety is a dysfunctional behavior when it occurs in circumstances in which there is no objective threat to the person (Wolpe, 1960). The idea is that anxiety (the unconditioned stimulus, or UCS) gets conditioned to some stimulus that is normally not anxiety provoking (the conditioned stimulus, or CS). In other instances, anxiety is a natural and adaptive response, or the "autonomic response pattern or patterns that are characteristically part of the given organism's response to noxious stimulation" (Wolpe, 1960, p. 88).

A little green garden snake, for example, is not really an occasion for a major anxiety attack because it is not harmful to me (provided that I have correctly identified it). So why do I jump and scream when I see one of these little critters? Using a classical conditioning model, we would see the snake as a CS, having been paired with some other natural event that was indeed threatening or noxious, the UCS. That other event (and we often don't know what it is) is what originally evoked the anxiety. The snake now evokes anxiety because of its earlier association with the UCS.

The association between a conditioned stimulus and a conditioned response can be weakened or eliminated by repeated presentation of the CS in the absence of the UCS, a process called *extinction* (Wolpe, 1990). For example, Pavlov could repeatedly ring his bell and never present food to the dog. Eventually, the dog will stop responding with salivation when the bell rings because it hasn't gotten any food in a long time—the salivation response is extinguished. Some BT techniques are based on the principle of extinction, such as when an individual is made to sit in a room with a garden snake until her anxiety goes away, a procedure called exposure therapy.

Because Shirley's problem behavior involves anxiety, JaNelle considers the possibility that classical conditioning is involved. Somehow, anxiety has been associated with being in a store for Shirley, and it disappears when she steals something and leaves the store. JaNelle wonders if Shirley has somehow associated being in a store with a truly threatening situation that would logically lead to anxiety. Perhaps she experienced a life-threatening event in a store in the distant past. In terms of intervention, it does not matter

how or when the original conditioning occurred, except that JaNelle needs to be sure that the anxiety is conditioned to the store, not something else. For example, the problem could be more general. Shirley might experience anxiety every time she leaves her home. JaNelle knows that she needs to explore this issue with Shirley as well as the abrupt cessation of the anxiety that she experiences upon leaving the store.

OPERANT CONDITIONING

Developed most elegantly by B. F. Skinner, the operant learning model starts with the idea that behavior is maintained by its consequences. The term *operant* is used because it emphasizes that behavior operates on the environment to produce consequences that, ideally, contribute to the person's adaptation (Nye, 1996; Skinner, 1953); it contrasts with *respondent* (classically conditioned) learning, in which the behavior considered is seen as sort of automatic.

In the operant model, behavior is said to be *contingent upon* its consequences (Skinner, 1971). *Reinforcement* is the formal term for consequences that maintain a given behavior. That is, reinforcers are consequences that *increase* the probability that a behavior will occur. Whether a particular event is reinforcing is a function of an "individual's biological endowment, learning history, and current situation" (Milan, 1990, p. 71). To take a simple example, some people like salty foods, and others like sweet foods. The reinforcement value of potato chips is higher for me compared to that of chocolate.

Two kinds of reinforcers can be distinguished—positive and negative (Skinner, 1953). *Positive reinforcers* increase the likelihood of a behavior occurring because something good is presented following the appearance of the desired behavior. *Negative reinforcers* increase the probability of behavior through the removal of aversive stimuli. Keep in mind here that the terms *positive* and *negative* are not used in the ways we typically use them. In BT language, *positive* refers to the *addition* of something that causes behavior to increase, whereas *negative* refers to the *removal* of something, *resulting in an increase* in behavior (Nye, 1996). In other words, *do not* confuse negative reinforcement with punishment. When Mom pats little Johnny on the head after he does a cartwheel, she has employed positive reinforcement; you are likely to observe more cartwheels. When Dad gives Laura a cookie to stop her tantrum, Dad's cookie-giving behavior is *negatively* reinforced; it terminated an aversive stimulus (the tantrum). You will likely see Dad give cookies when future tantrums appear. Note that Laura's tantrum behavior is positively reinforced, assuming that she likes cookies and has not just eaten a truckload of them. Box 8.4 gives another example of positive and negative reinforcement.

Box 8.4

Behavior Modification in Humans and Felines

I have a cat. His name is Skat, but he is also known as the Cat from Hell. Skat the Cat is, like most cats, used to going where he wants to when he wants to. Skat is equally comfortable roaming the neighborhood or sleeping on my feet.

Sometimes Skat the Cat wants inside when he is, in fact, outside. He is not very patient, and one way of demonstrating this is through screen-scratching behavior. Clearly, someone at

some point must have let him in the house following screen-scratching behavior, thereby positively reinforcing his screen-scratching behavior (it was not me, of course). As a good student of behavior modification, I would never positively reinforce screen-scratching behavior, yet because some visitor(s) have, this behavior is on an intermittent schedule of reinforcement with a *very* long interval. The intermittent schedule thus accounts for Skat's persistence in the behavior—he has been known to keep it up for hours . . . despite it being 3 a.m.

What is my response to Skat's behavior? I consider screen-scratching behavior an aversive stimulus, so my first impulse is to yell at him. This behavior on my part, as you might guess, is extinguished very quickly because it produces no change in the noxious stimulus. I could opt for an extinction approach (i.e., never opening the door), but because he is apparently on a long-interval intermittent schedule, it would take a very long time and many screen replacements to extinguish his behavior. Chasing him away is even more aversive to me because I must get out of bed in the middle of the night to do so. Also, Skat might just find my chasing him a positive reinforcer! "Hey look! I got Mom out of bed and all upset! This is fun! Maybe I can get her to do it again!"

One night I had a glass of water at hand and, perhaps vaguely remembering some observed relationship between Skat's behavior and the experience of getting wet, decided to throw the water thorough the screen. Bingo! Skat was gone . . . and my water-throwing behavior was *negatively* reinforced. The noxious stimulus of screen scratching was terminated as a result of my water-throwing behavior. The next time he appeared at the screen, guess what I did? (I threw the water, of course.)

But what of Skat's behavior? Because screen scratching was immediately followed by a consequence that decreased the probability of that behavior, we conclude that he experienced punishment. Now we know that punishment merely suppresses behavior and could have some other problematic consequences, such as avoidance, but Skat likes inside and food too much to avoid me altogether. Instead, he substituted another behavior for screen scratching, a very loud meow. Choosing the lesser of two evils, I now immediately let him inside when he yowls (thus positively reinforcing the yowling behavior). Every now and then he delicately puts a few claws on the screen to show me that he has not forgotten his power and then yowls. Mostly, though, we are satisfied with the contingencies we have established.

Reinforcers come in all shapes and forms. The most basic reinforcers are food and sex because they relate to the evolutionary goals of survival and reproduction (Nye, 1996). Skinner (1953) called these *primary* reinforcers. Many things are reinforcers because they have been historically linked with survival. Skinner (1971) gave the example of a person moving out of the hot sun into the shade. The behavior of moving is reinforced by the reduction in temperature that follows, which is presumably good for the organism's survival.

Unfortunately for neophyte behavior modifiers, though, what is reinforcing to one person may not be to another. The power of a given reinforcer can also vary across time. Many things affect whether a given consequence is reinforcing; for example, food is not reinforcing just after a big gourmet meal. Too much of a good thing is called *satiation*; the power of a reinforcer is decreased in these circumstances (Skinner, 1953). To get around the problem of all things not being reinforcing across people or time, BT theorists have referred to the notion of *establishing operations* (Lejuez, Hopko, Levine, Gholkar, & Collins, 2006). Establishing operations are defined

as "environmental events, operations, or stimulus conditions that affect an organism's behavior by altering the reinforcing or punishing effectiveness of other environmental events and the frequency of occurrence of that part of the organism's repertoire" (Lejuez et al., 2006, p. 457).

Many things become positively reinforcing because they are associated with gaining desired outcomes; they are not the desired consequence itself. These *conditioned reinforcers* become reinforcing because they tend to occur at about the same time that reinforcement occurs (almost in a classical conditioning sense; Reynolds, 1968; Skinner, 1953). Some stimuli occur in the presence of many kinds of reinforcers, and these stimuli become *generalized reinforcers*. Money is a good example of a generalized conditioned reinforcer. The paper or metal substance is not in itself positively reinforcing, but it becomes so because it is associated with getting reinforcing things (food, clothes, or other things that support survival). Attention from others is a conditioned reinforcement, presumably because babies have to get someone's attention to get things that meet survival needs, such as food or clothing (Ullmann & Krasner, 1965). Manipulating the environment is a generalized reinforcement because many kinds of reinforcers occur only following such behavior (Skinner, 1953).

Sometimes a stimulus in the environment signals that a given contingency is operative. This is called a *discriminative stimulus*, and you can think of it as a traffic light of sorts. When the light is green, a behavior such as walking across the street will result in reinforcement (getting to where one wants to go, a conditioned reinforcer). When the light is red, it is a signal that behavior will not be reinforced (i.e., you could get hit by a car and smushed, which would be considered punishment, I think). As we all know, however, a traffic light is not truly a discriminative stimulus because, if you are careful, you can still walk across the street on a red light and receive the reinforcer of getting to the other side. Perhaps a better example would be a light on a drawbridge. If you go against the red light, you will not be reinforced; instead, you will probably be punished unless you are a very good swimmer!

When behavior becomes controlled by discriminative stimuli, it is said to be under stimulus control. Discriminative stimuli can become conditioned reinforcers, as in the case of money. The acquisition of money becomes reinforcing because it signals that the behavior of giving money to others gets us desired things (food, swimming pools, shoes; Ullmann & Krasner, 1965).

Once a discriminative stimulus is established, *generalization* can occur, and the reinforced behavior will appear in situations in which a stimulus similar to the discriminative stimulus is present. For example, if Laura receives cookies from Dad when she throws a temper tantrum, Dad becomes a discriminative stimulus for tantrum behavior. Laura also may begin to show tantrum behavior in the presence of other male adults or in the presence of adults in general.

Extinction is said to occur when the reinforcement maintaining behavior is removed and a response becomes less frequent and finally disappears (Skinner, 1953). The behavior is extinguished because the contingencies supporting it are no longer in effect. An important thing to know about extinction, however, is that early in the process "emotional behaviors," such as anger or frustration, may occur (Skinner, 1953, p. 69). Also, the target behavior may intensify (i.e., increase in frequency or strength) under extinction conditions (Sherman, 1973). For example, Sam exhibits loving behavior toward Sally, calling her daily on the phone and visiting her in the evenings. She reinforces him by cooking his dinner and allowing sexual contact. However, Sally suddenly decides that she no longer desires relationship behaviors with Sam and discontinues reinforcing his loving behaviors. At first, his phone-calling behavior intensifies; he calls her

hourly and drives by her house every night. He probably displays some emotional behavior, such as anger or sadness. If Sally continues to ignore Sam, his behaviors of calling and driving by will eventually decrease and then disappear.

Reinforcements can be given after every response (called *continuous* reinforcement) or after some responses and not others (*intermittent* reinforcement). Resistance of the target behavior to extinction varies depending on the schedule of reinforcement (Skinner, 1953). Behavior reinforced intermittently is extremely resistant to extinction, whereas continuous schedules produce much less resistance. In the laboratory, behavior can be maintained in pigeons on a 1-in-10,000 response schedule (Skinner, 1953). My cat's screen-scratching behavior is clearly on an intermittent schedule, with long intervals between reinforcements (see Box 8.4).

Punishment is the opposite of reinforcement; a punisher is anything that reduces the probability of a behavior occurring. For example, if I lock myself out of my house in the middle of January, I am strongly punished for this behavior because it results in (for me) an extremely aversive event (exposure to cold weather). It is unlikely that I will repeat this behavior, for sure.

Operant behavior is behavior that the organism freely emits. However, a desired behavior can be created by a process called *shaping*, in which responses that gradually more closely resemble the desired behavior are reinforced in a progression.

JaNelle wonders if operant learning could account for Shirley's stealing behavior. From that perspective, stealing behavior would be reinforced by something. Normally, JaNelle might guess that the stealing behavior is reinforced by what Shirley acquires as a result. However, Shirley has indicated that she does not steal any particular object, which suggests that the objects themselves are not reinforcing. JaNelle guesses that the cessation of anxiety is highly negatively reinforcing to Shirley, so that leaving the store becomes a highly reinforced behavior. It is possible that on an earlier occasion Shirley experienced anxiety while in a store and resorted to a previously learned behavior of picking something up in a wild, almost random attempt to decrease her anxiety. She then fled the store. In a chaining process, the anxiety reduction reinforced the behavior of leaving the store, which then became a conditioned reinforcer that reinforced the stealing behavior.

Observational Learning

The idea that people can learn by viewing the behavior of others was developed by Bandura (1969, 1974). Also called *social learning theory* (Bandura, 1969), this approach incorporates the cognitive aspects of learning because what is learned through observation and later performed must be retained somehow, presumably in the brain. Observational learning plays a large part in the acquisition of new behaviors; it is much more efficient to learn a behavior vicariously than to randomly emit behaviors to be shaped by the environment (Bandura, 1969).

Consider learning to bowl. You've never bowled before, and your buddies drag you to the bowling alley. Trying to be a good sport, you put on your bowling shoes and take to the lanes. Almost automatically the first thing you do is watch someone else bowl. If one of your buddies is a teacher-type, she may take you through the process of a turn by showing you step by step how to wind up, move forward, and release the ball. Your buddy is the model. You learn the fundamentals without ever picking up the ball. Of course, you may need some practice to bowl a perfect game. Bandura (1969) pointed out that role playing interventions often involve modeling because the client first observes the behavior on the part of the counselor before performing it.

Both dysfunctional and functional behavior can be learned through modeling. For example, a phobia can be acquired by watching someone else experience an anxiety-provoking event (Bandura, 1969; Wolpe, 1990). This phenomenon is called *vicarious* conditioning.

Modeling theory combines readily with operant theory because the consequences of the modeled behavior *for the model* influence the observer's behavior as well (Bandura, 1969). If, for example, Mary sees other children praised for speaking up in class, she will be more likely to speak herself (if she values the teacher's positive reinforcement). Likewise, punished behavior can be learned observationally and displayed when the punishment contingencies are not known to be in effect.

JaNelle wonders if modeling plays a role in Shirley's behavior. Certainly, aspects of the stealing behavior could have been learned through modeling, but the observation that Shirley is not a successful thief would suggest otherwise. Had Shirley observed a good thief, she might have learned to be inconspicuous in her behavior and to hide the stolen object!

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Traditional behaviorists are not interested in personality theory or developmental stages, although they do allow that *personality* is an abstract term that describes consistency in behavior across situations (Zinbarg & Griffith, 2008). They don't see the term as very useful. If the client's history is important, it is viewed through the construct of a *learning history*. Reynolds (1968) maintained that understanding reinforcement contingencies operative in an individual's past makes it possible to implement different contingencies in the present and thus to change behavior.

Contemporary behaviorists recognize that we have some characteristics that seem to be stable across situations (such as sociability; Antony, 2014). Although these tendencies may influence what we do, it is more important for behavior therapists to emphasize what can be modified in behavior.

JaNelle is not very interested in Shirley's childhood. She is, however, interested in the history of the stealing behavior and asks Shirley to recount how it first started. Shirley remembers being in a store shortly after her mother's death and getting panicky. She grabbed the first thing she saw (a really nice fountain pen) and left the store immediately. Afterward, she felt very guilty and ashamed, as well as fearful of returning to the store because they might catch her.

HEALTH AND DYSFUNCTION

In the behavioral tradition, psychological health is seen as adaptive behavior, taking social and cultural context into consideration (Antony & Roemer, 2011a). Adaptive behavior is that which promotes the survival of the person. Although BT advocates acknowledge that genetics and biology have roles in behavior, they would assert that almost all behavior has learned components (Spiegler, 2016).

Psychological dysfunction is maladaptive behavior, and it arises from the same processes as adaptive behavior—namely, it is learned (K. Jordan, 2008). The "so-called symptom is the problem" (Sherman, 1973, p. 18). In addition, maladaptive behavior can result from not learning—that is, deficits in skills (K. Jordan, 2008). Whether a behavior is considered dysfunctional is

dependent on whether it is adaptive or maladaptive for a given situation. Behavior is not considered to be equivalent to mental illness or psychopathology, as it is in the medical model.

A classical conditioning perspective portrays psychological dysfunction as resulting from faulty conditioning of anxiety (or fear; the terms are used interchangeably) to behaviors (Wolpe, 1990). Essentially, fear is an unconditioned response that gets associated with a previously neutral conditioned stimulus. Although he did acknowledge that some behavior (e.g., nail biting, extreme stinginess, and nocturnal enuresis) is unrelated to anxiety (1990, p. 9), for Wolpe the majority of neurotic behavior is, in essence, simply habit learned in anxiety-provoking settings. Wolpe (1990) saw schizophrenia, antisocial personality disorder, and drug addictions as primarily biological in nature, although conditioning procedures could be used to alter some behavior patterns in these presentations.

Wolpe defined neuroses as "persistent maladaptive learned habits in which the foremost feature is anxiety" (1990, p. 23). These habits can be established in a variety of ways. First, neurosis can be based on simple classical conditioning, in which anxiety is aroused by a threatening situation and some stimulus in the situation is associated with the anxiety. This association can be established in one trial if the situation is traumatic enough. For example, the anxiety in a battle situation can become conditioned to the sound of gunfire or sirens. The individual knows that the *sounds* of gunfire or sirens are not immediately threatening but becomes anxious nonetheless when she hears them in a nonbattle situation.

Fear can also be vicariously conditioned, according to Wolpe (1990). Observing someone else's extreme fear response to a stimulus might result in the observer acquiring a classically conditioned fear of that stimulus. If Damon, as a child, observed his mother reacting very fearfully to the sight of a Doberman pinscher, he might develop the same neurotic fear.

In a similar process, neurotic fears can be brought about by misinformation (Wolpe, 1990). The old fear of masturbation causing blindness is a good example of this neurotic mechanism.

Although the classical conditioning approach appears to focus heavily on anxiety and the maladaptive behavior associated with it, Wolpe (1992) maintained that many forms of depression are based in anxiety as well. In fact, he estimated that 60% of depressions are neurotic, which in his view means anxiety based.

JaNelle considers the possibility that Shirley's anxiety in stores is classically conditioned somehow. When she asks Shirley about the history of her anxiety in stores, Shirley relates that she doesn't remember anything in particular triggering the anxiety. She just started to get panicky while in a store one day. Although it is interesting that Shirley mentions that the attacks started shortly after the death of her mother, JaNelle does not consider this information particularly useful.

From an operant perspective, dysfunctional behavior is maintained by contingencies of reinforcement. Spiegler (2016) suggested two broad classifications of maladaptive behavior: behavioral excesses and deficits. Excesses are behaviors that are performed too strongly or too often (p. 55); I'd add to this group behaviors that are inappropriate or ineffective for a given situation. Behavioral deficits refer to situations in which individuals have failed to learn behaviors called for by the situation. From this perspective, excess behaviors are viewed as maladaptive responses maintained by existing environmental reinforcers. Deficit problems involve a lack of desirable behaviors—the individual just never learned them. A deficit in behavior can also result when the contingencies in a situation punish or simply do not reinforce the behavior.

A social learning perspective fits with the operant perspective because dysfunctional behavior can be learned, maintained, and suppressed by observations of models. If the individual is not exposed to the right models, she will not learn certain behaviors deemed important to a given cultural group, for example. If a child is never exposed to a dinner in which multiple forks are used, for instance, she will not know what to do when faced with a formal place setting.

Even though BT advocates don't like formal diagnosis, they will still theorize about general diagnostic presentations. For example, operant theorists view depression as stemming from problems in the person's range of actions, or what is called the *behavioral repertory*. Ferster (1983) conceptualized depression as resulting from an overuse of passive behaviors and a decreased incidence of adaptive, active behavior. Consequently, the depressed person receives little positive reinforcement from her environment (Ferster, 1983). Escape behavior is reinforced when the individual avoids the stress and anxiety of uncomfortable situations, such as when the passive, depressed individual avoids unpleasant events at work by staying home in bed. This conception of depression has led to the treatment strategy known as behavioral activation (BA; Dimidjian, Barerra, Martell, Muñoz, & Lewinsohn, 2011). The idea behind BA is to get the client moving so that positive reinforcement is obtained while blocking attempts to escape aversive experiences.

Still other behaviorists point out that depression can result when an individual perceives no control over the world or, more accurately, when she perceives that there are no contingencies between her behaviors and outcomes. This "helplessness" view of depression suggests that the critical factor in affective states is "the person's perception of his ability to control the world" (Goldfried & Davison, 1994, p. 234; see also Seligman, 1975).

Social skills deficits, from an operant perspective, could be the result of faulty learning (i.e., the individual was reinforced for behaviors deemed socially inappropriate) or a simple lack of behaviors (i.e., the individual never learned social behaviors). Some social behaviors might have been punished.

JaNelle thinks that Shirley's stealing behavior may be reinforced by the cessation of anxiety; that is, the stealing is negatively reinforced. When she enters a store, Shirley becomes anxious and then steals something so that she has to exit the store, thereby escaping the anxiety.

NATURE OF THERAPY

ASSESSMENT

Assessment is very important in BT. It is seen as a scientific process that focuses on "what the client *does* rather than the traits the client *has*" (Glass & Arnkoff, 1992, p. 599; emphasis in original). Both formal and informal assessments are used, but behaviorists are most emphatic that they are *not* doing personality assessment or looking for underlying causes of symptoms. Kuehnel and Liberman (1986) pointed out that a behavioral assessment should include client strengths as well as deficits. BT counselors also look for sources of reinforcement that can be used to facilitate behaviors.

Formal diagnosis (e.g., from the DSM-V) is not consistent with the BT model because it is based on the trait-oriented medical model and is thus far from a functional analysis of an individual's behavior. However, BT counselors are likely to use formal diagnoses for pragmatic reasons, such as when required by third-party payers or when working within a medical treatment setting (Spiegler, 2016).

In BT, assessment is closely linked to intervention, and it focuses on the individual's current behavior, with specific attention paid to antecedents and consequences, broadly speaking (Zinbarg & Griffith, 2008). Some BT counselors would add organismic variables such as cognitions and physiological factors (Goldfried & Davison, 1994). A *baseline*, or frequency count of the target behavior over time, is typically established so that change in behavior can be clearly documented (Zinbarg & Griffith, 2008).

Assessment in BT can be seen as a *functional analysis*, and the acronym ABC reminds us of the elements of the analysis (Antony, 2014). *A* would stand for antecedent, *B* for behavior, and *C* for consequences. The actual assessment phase is followed by the creation of hypotheses about the conditions maintaining the behavior of interest, or the *target behavior*, which is identified through the assessment process. Baseline patterns established in earlier phases of assessment may suggest hypotheses about what is controlling the behavior (Kazdin, 2001, p. 104). The process of establishing target behaviors is a collaborative one, and multiple target behaviors may be identified.

A variety of methods can be used to assess behavior in BT counseling; indeed Antony (2014) suggests that because clients' behavior will vary across situations, multiple methods and multiple informants should be used in assessments completed in multiple situations.

The most theoretically pure form of assessment is direct observation of the client by independent, trained raters across various life situations (Goldfried & Davison, 1994). Clearly, this is an expensive and cumbersome form of assessment, and it is rarely used except perhaps in institutional settings. Even in institutional settings, samples are used (e.g., a 10-minute observation taken eight times per day). Instead, BT counselors more often use their own observations (e.g., in-session role play or imagery techniques), those of the client's significant others, or simply the client's self-report.

The simplest and most cost-effective assessment method is the informal assessment, which involves interviewing the client (K. Jordan, 2008). More structure can be added by using existing structured interview guidelines, such as the Anxiety Disorders Interview Schedule (DiNardo, Brown, & Barlow, 1994). Some behaviors, such as social skills, can be assessed through role play scenarios. The therapist can then either simply observe or record the presence or absence of targeted behaviors.

Behavior therapists often ask clients to log the frequency of a behavior between counseling sessions, a technique called *self-monitoring*. There are three potential problems with self-monitoring. First, there is the question of whether the client can accurately and honestly monitor her behavior. Second, monitoring may disrupt normal routines, causing the client to become aggravated. Third, behavior has been known to change when monitored—most notably, unwanted behavior tends to decrease (Spiegler, 2016).

Formal assessment in BT often involves the use of standardized instruments or symptom checklists. Wolpe (1990), for instance, was adamant that the use of the Willoughby Neuroticism Questionnaire and the Fear Survey Schedule is essential in BT. He said, "Failure to use these instruments is a serious deprivation of data, parallel to a physician's nonuse of the electrocardiogram in suspected heart disease" (1990, p. xi).

Behavioral checklists and surveys are often used in cognitive-behavioral forms of BT (Spiegler, 2016). Clients might be asked to complete the Beck Depression Inventory (Beck, Ward, Mendelson, & Erbaugh, 1961), the Reinforcement Survey Schedule (Cautela & Kastenbaum, 1967), or the Test Anxiety Behavior Scale (Suinn, 1969). Many other such inventories exist.

JaNelle begins with a simple interview approach with Shirley. She asks a lot of questions about Shirley's current situation, including her living situation, social activities, and financial supports. Shirley reports that, although she enjoys her community service, she wishes she had more friends with whom to spend off-hours. JaNelle thinks that an assessment of Shirley's social skills, with some focus on assertive behavior, is warranted. To start, JaNelle closely observes as she and Shirley interact. She notes that Shirley seems a little shy at times, avoiding eye contact and speaking very softly.

Gently, JaNelle asks Shirley about the incident that got her to counseling. Initially reluctant, Shirley responds to JaNelle's approach and tells JaNelle about the recent incident. She admits that this behavior happens about on a weekly basis. JaNelle asks many specific questions about these incidents, attempting to gain a step-by-step picture of Shirley's behavior. She considers a live observation of Shirley's stealing behavior, but then decides to have her role play the behavior in the counseling session.

Overview of the Therapeutic Atmosphere

Behavior therapists assume that behavior is predictable from antecedents, organismic variables, and consequences, so "clinical interaction constitutes a form of experiment" (Goldfried & Davison, 1994, p. 4). This emphasis on the scientific approach in BT has led, at times, to significant disagreement about the nature of, or necessity for, the counseling relationship in BT. At one extreme, Eysenck (1960) dismissed the transference-based relationship of psychoanalysis, saying, "Behavior therapy has no need of this adjunct, nor does it admit that the evidence for its existence is remotely adequate at the present time. . . . In certain cases, of course, personal relationships may be required in order to provide a necessary step on the generalization gradient; but this is not always true" (p. 19).

In contrast, others emphasize that the therapeutic relationship is essential to BT. For example, Wolpe (1985) maintained that "trust, positive regard, and serious acceptance of the patient are part and parcel of behavior therapy practice" (p. 127). As Goldfried and Davison (1994) put it, "A tough-minded approach to conceptualizing human problems in no way precludes a warm, genuine, or empathic interaction with clients" (p. 7). Last and Hersen (1994) added that it would be asking a great deal of a client to do all of the self-monitoring and practicing required in BT in the absence of a good therapeutic relationship.

Most contemporary behavior therapists see a good relationship as important in producing good client outcome (Antony, 2014). For one thing, the BT counselor has the potential to reinforce the client for desired behavior (Goldfried & Davison, 1994). In what might be seen as a surprising development, those who have recently proposed adaptations to the BT approach have emphasized the therapeutic relationship as a powerful factor in therapy; these behaviorists maintain that the counselor must form a close and genuine attachment with the client (using positive reinforcement to strengthen the alliance; Antony & Roemer, 2011a).

Because Shirley does not really believe that she belongs in counseling, JaNelle knows that it is essential that she establish a solid relationship with her. JaNelle tries to be supportive, genuine, and caring in her interactions with Shirley.

Roles of Client and Counselor

The counseling relationship in BT is collaborative, and the client is seen as a co-therapist (Spiegler, 2016). The counselor is a model for the client (Goldfried & Davison, 1994) and takes the role of

a consultant who is teaching the client the skills necessary to be her own behavior therapist. As you might guess, the therapist is very active and directive.

The client in BT is just that, a client rather than a patient (Sweet, 1984). The client is expected to contribute actively to the BT assessment and goal setting and to complete her homework faithfully. She is a learner of the knowledge presented by the teacher/counselor.

JaNelle approaches Shirley as a collaborator, acknowledging that Shirley has not voluntarily come to counseling. She offers herself as a consultant to Shirley, suggesting that she has some ideas that might help Shirley better her life conditions. If Shirley accepts this offer, JaNelle will expect Shirley to be a partner in BT counseling, participating in goal setting and homework assignments.

Goals

The goal in BT is simple: reduce or eliminate maladaptive behavior and teach or increase the incidence of adaptive responses. Picking behaviors to modify sounds easier than it really is. Traditionally, BT has targeted very specific behaviors such as smoking, weight gain or loss, and specific phobias. These behaviors are easily observable and quantifiable. However, clients often present much more complicated pictures and often do not present their concerns in terms of specific, observable behaviors. For example, many clients come to counseling saying that they want to get rid of their depression or that they are unhappy with their relationships.

Spiegler (2016, p. 57) presented the "*dead person rule:* never ask a client to do something a dead person can do." Only dead people can avoid behaving altogether, so it is generally better to prescribe behavior than to try to delete it. For example, it would be better for Robert to ask Steve to pick up his clothes after his shower than to admonish "Don't leave your clothes on the bathroom floor."

The recognition within the ranks of BT counselors that client problems are usually not as simple as we would wish has led to further considerations about selecting behavioral goals (Marsh, 1985; J. K. Thompson & Williams, 1985). Target behaviors in modern BT include cognitions and emotions, and it is important that the targets involve some "*significant* aspect of the client's overall functioning" (Marsh, 1985, p. 66; emphasis in original). In other words, the BT counselor should be aware that the traditional, specific targets of BT may not coincide with the desired outcomes of the client.

J. K. Thompson and Williams (1985) presented an even more radical view in observing that "behavioral therapists, simply because of the ease of their available technology, often treat rather than think" (p. 48). They argued that behavior therapists need to accept that some client problems are existential in nature, requiring a different perspective, one that admits the possibility of "*long-term therapy* and focusing on the therapeutic *relationship*" (p. 49; emphasis in original).

Shirley and JaNelle set two goals for counseling: decrease the anxiety that seems to be connected to Shirley's stealing behavior and increase her social skills, particularly assertive behavior. They also agree that some problem solving around Shirley's desire to have more social contact in her life would be helpful.

The specific goals they establish are as follows: (a) Shirley will be able to enter a department store and purchase an item (or just browse) without stealing anything. (b) Shirley will learn new social behaviors, including increased eye contact and voice volume. (c) Shirley will increase her social contacts (outside of her volunteer work) to at least three times per week.

PROCESS OF THERAPY

BT practitioners see therapy as composed of two distinct phases: assessment and intervention (Wolpe, 1990). After the therapist has performed a functional analysis of the client's behavior and specified a target behavior or behaviors, it is time to intervene. At an early point in this process, the client is oriented to BT, which usually consists of giving her a brief explanation of how the BT counselor views problems and interventions (Wolpe, 1990). Goldfried and Davison (1994) were very clear that the client's expectations about therapy are important to assess and address because misconceptions can get in the way of treatment. Clients may expect detailed explorations of childhood events, dream analysis, or free association. The BT counselor should be empathic about the client's reasons for these assumptions, but should not necessarily accede to them (Goldfried & Davison, 1994). The counselor can listen to client history empathically, while also inserting comments to help the client redefine the problem in behavioral terms. In essence, the behavior therapist teaches the client the behavioral model.

BT counselors see the first session of counseling as critical. It has four goals: "(1) establishing rapport with the client, (2) understanding the client's problem and selecting a target behavior, (3) gathering data about maintaining conditions, and (4) educating the client about the behavioral approach to treatment and issues of confidentiality" (Spiegler & Guevremont, 2003, p, 83). At the end of this session, the client and counselor may create a written therapeutic contract (Goldfried & Davison, 1994). The contract typically contains information about fees, cancellations, frequency of sessions, and other procedural details. It also outlines the expectations for the client's and counselor's behavior both within and outside of the counseling sessions (such as the expectation that the client will complete homework between sessions).

When clients behave in ways that suggest resistance to BT, the fault is laid squarely at the feet of the BT counselor. In discussing this issue, Goldfried and Davison (1994) maintained that "*the client is never wrong*. If one truly accepts the assumption that behavior is lawful—whether it be deviant or nondeviant—then *any* difficulties occurring during the course of therapy should more appropriately be traced to the therapist's inadequate or incomplete evaluation of the case" (p. 17; emphasis in original). What other therapists (particularly of a psychoanalytic persuasion) would call transference and countertransference, the behavior therapist calls stimulus generalization (Beach, 2005). In the case of "transference," for example, the person of the therapist is similar to a stimulus person in another realm or time of the client's life, and she responds to the therapist in the same way that she responded to the previous person.

JaNelle works to establish a good working relationship with Shirley. She describes the basics of BT to Shirley and explains that Shirley's anxiety and stealing behavior are learned and can be unlearned if Shirley is willing to work on it. Shirley, the reluctant client, is not very happy about the ordeal of therapy, but she grudgingly agrees that getting rid of her stealing behavior might be a good thing. JaNelle empathizes with Shirley's unhappiness about being compelled to undergo therapy. After Shirley and JaNelle agree on goals for counseling, JaNelle gives Shirley a written contract that states these goals, the duties of both parties, and the expected outcomes of counseling.

THERAPEUTIC TECHNIQUES

A variety of techniques are used in BT counseling. The majority of these techniques focus on overt behavior, but some, to some extent, focus on internal events like cognition (Wolpe, 1990). Some of these techniques are implemented by the counselor, and others are taught to the client so that she can use them on her own. Many of the techniques presented have cognitive aspects.

Relaxation Training

In addition to being the basis for several other techniques in BT (e.g., systematic desensitization), progressive relaxation training is thought to be therapeutic by itself (K. E. Ferguson & Sgambati, 2009; Goldfried & Davison, 1994). Goldfried and Davison (1994) described two types of relaxation training. One approach, typically called *progressive relaxation*, alternates between tensing and relaxing specific groups of muscles, one at a time. For example, the counselor might begin by having the client tense her right hand, then relax it, and then study the difference. After several repetitions of this sequence, the therapist might direct the client to tense her arm, and so forth, progressing through all of the various major muscle groups in the body. It is important that clients practice their relaxation training, so in the past they were given audiotaped instructions to use at home between sessions. Nowadays, mobile phones, iPods, and podcasts might be used for this purpose.

The second approach to relaxation training, relaxation by letting go (Goldfried & Davison, 1994), is really an advanced form of the tensing–relaxing procedure. After clients have learned how to do the first version, they either spontaneously or are encouraged to simply relax progressive muscle groupings without the tensing part.

JaNelle teaches Shirley progressive relaxation training, beginning by giving her an introduction to the process and why it is helpful. She then guides Shirley through a complete relaxation session. Shirley takes home an audiotape so that she can practice.

Exposure Therapy

Used widely for phobias and other fears and for compulsive behavior, exposure therapy, also sometimes called *flooding*, requires that the client encounter the anxiety-provoking stimulus and not respond as she typically does (e.g., with escape or compulsive behaviors; Hazlett-Stevens & Craske, 2009; Levis, 2009). Mary Cover Jones's work with Peter, described in Box 8.5, is an example of this technique. Exposure can be done imaginally or in vivo, and sometimes the therapist even accompanies the client in these situations to make sure the response is prevented. In other instances, a significant other is recruited to help with the procedure. For these reasons, the technique may be referred to as exposure with *response prevention* (Antony & Roemer, 2011b). For example, I once had a client who had a light switch compulsion. On his own, he discovered the technique of "just not doing it." Even though he was anxious, he would refrain from touching the light switches in his home. He was doing self-directed exposure and response prevention. This technique was very successful for him; his light-switching behavior was virtually eliminated.

Box 8.5

Mary Cover Jones: A Pioneer in Eliminating Fear in Children

Mary Cover Jones was a graduate student who worked with John B. Watson, the American founder of BT. In two articles, she described her work, which was based on Watson and Rayner's (1920/2000) study of fear in infants (the Little Albert study; see Box 8.2). In an article published in the *Journal of Experimental Psychology*, Jones (1924/1960a) related her efforts to eliminate fear in children, fear that had presumably been classically conditioned.

(continued)

Box 8.5 *(continued)*

Jones selected 70 children from a group in an institution that we might call day care. These children were in this institution temporarily because they could not be cared for in their homes (e.g., a parent was ill, a mother worked). Jones (1924/1960a) selected kids who showed "a marked degree of fear under conditions normally evoking positive (pleasant) or mildly negative (unpleasant) responses" (p. 39). The children's fears included such things as being left alone, loud sounds, and the sudden presentation of animals (rats, rabbits, snakes).

Jones tested a number of techniques in a case study format. For example, she found that "verbal appeal," which consisted of talking about the feared object in a pleasant way, did not work. "Social repression," in which the feared object was presented to a child in the presence of other children, was equally ineffective. Presaging Bandura's (1969) ideas, Jones did find that social imitation showed promise as an intervention for fear. However, Jones maintained that the best method of eliminating fear was direct conditioning, which she detailed in a separate article, "A Laboratory Study of Fear: The Case of Peter" (1924/1960b).

Peter was a 2-year-old boy who demonstrated fears very similar to Little Albert's—of a rat, fur coat, rabbit, cotton wool, and other white furry objects. After presenting a white rat to Peter (whereupon he screamed and fell over), Jones (1924/1960b, p. 46) observed the following reactions in a subsequent testing period:

Playroom and crib	Selected toys, got into crib without protest
White ball rolled in	Picked it up and held it
Fur rug hung over crib	Cried until it was removed
Fur coat hung over crib	Cried until it was removed
Cotton	Whimpered, withdrew, cried
Hat with feathers	Cried
Blue woolly sweater	Looked, turned away, no fear
White toy rabbit of rough cloth	No interest, no fear
Wooden doll	No interest, no fear

Jones used two kinds of conditioning with Peter and reported that his fear was completely eliminated and that he even showed signs of affection toward a rabbit at the end of the study. In the first stage of conditioning, Peter was exposed to the rabbit in the presence of other children who were not afraid of it. Gradually, situations were introduced that required Peter to be closer to the rabbit. In a second stage of the procedure, a rabbit in a cage was brought as close as possible to Peter while he was eating, without disturbing his eating. Presumably, the rabbit was brought closer and closer every day.

Jones reported extinction of the fear behavior not only toward the rabbit, but also in response to the white cotton, fur coat, and the other objects to which he initially reacted. Peter also seemed to be less fearful of new animals or unfamiliar situations. Although his fears appeared to be gone, Jones reported that Peter returned to a rather diminished and discouraging home environment, in which his mother used fear to control his behavior ("Come inside Peter, someone might steal you!" Jones, 1924/1960b, p. 51). Unfortunately, we have no further information about the fate of Peter.

A variety of theoretical conceptualizations have been offered for the underlying mechanisms supporting this technique. Although theoretically based in extinction, Massad and Hulsey (2006) warned that the prudent behavior therapist should know that exposure does not eliminate underlying conditioning in associations established by trauma; it merely weakens them. Other theorists argue that exposure builds new associations alongside the old, which inhibit the expression of the anxiety-ridden ones (Zalta & Foa, 2012). Recent conceptualizations also emphasize that learning to tolerate anxiety during exposure is more important than reducing it (Abramowitz, 2013).

Exposure is a tricky technique to use. Several critical considerations in the success of it are (a) an accurate assessment and conceptualization by the therapist, (b) proper client preparation, and (c) a strong therapeutic relationship (Zoellner, Abramowitz, Moore, & Slagle, 2009). The counselor must also be ready to deal with the real distress experienced by the client because, theoretically, terminating the exposure too soon may result in the failure of the technique or even an increase in the anxiety (Marshall & Gauthier, 1983). Flooding involves exposure to the client's worst fear for extended periods of time, and Zalta and Foa (2012) reported that it is not often used currently because clients prefer gradual exposure. In addition, flooding was found to be no more effective than gradual exposure. For gradual exposure, a fear hierarchy, described in the following section on systematic desensitization, is developed to guide the exposure.

Sometimes skills training is added to exposure interventions (Marshall & Gauthier, 1983). For example, imaginal or in vivo exposure can be used with a client who is fearful of public speaking, but it might also be a good idea to teach the client some public-speaking skills. In cognitive-behavioral approaches, therapists teach clients coping cognitions to use while in the midst of the flooding experiences. The client first rehearses these statements, uses these statements out loud, and then fades to private rehearsal of the thoughts (Meichenbaum, 1977).

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Video Example 8.2 Exposure therapy



https://www.youtube.com/watch?v=wE5F-FjbTRk

JaNelle thinks that in vivo exposure and response prevention is a potentially useful technique for Shirley. Shirley will have to enter a store, experience her anxiety, and refrain from stealing anything. JaNelle begins by taking a "field trip" with Shirley. She and Shirley enter numerous stores, and JaNelle makes sure that Shirley does not take anything.

Systematic Desensitization

This technique evolved from Wolpe's (1990) idea that, if a response that is incompatible with anxiety (or other undesirable behavior) can be produced in the presence of a stimulus classically conditioned to fear, the fear will become disassociated with the stimulus. He called this process *reciprocal inhibition* because one response (anxiety) is inhibited by a presumably opposite one. Nowadays systematic desensitization is seen as simply another form of exposure therapy. Most commonly, step-by-step graduated exposure to the feared stimulus is paired with deep muscle relaxation (Spiegler, 2016). However, other responses, such as pleasant imagery, humor, and sexual arousal, have been used in this procedure, along with drugs (tranquilizers) and carbon dioxide inhalation.

The first steps in systematic desensitization are (a) teaching the client progressive relaxation procedures and (b) constructing an anxiety hierarchy to be used in the procedure (Head & Gross, 2009). Progressive relaxation, as described earlier, consists of teaching the client to alternatively contract and relax muscle groups in the body, progressing from one part of the body to another.

The anxiety (or fear) hierarchy is a list of situations that evoke fear in the client, ranked from least to most threatening, on a 1-to-100 scale. Goldfried and Davison (1994) recommended that jumps between items be 10 points or less; if a gap is more than 10, at least one additional item should be constructed to bridge the gap. Hierarchies are usually composed of 12 to 24 items.

Once these tasks have been accomplished, the actual desensitization procedure begins. The client is relaxed and is instructed to imagine the item or scene lowest on her fear hierarchy. She is taught to give some kind of a signal, usually by raising one finger, when the image creates anxiety. The image is visualized for 5–7 seconds, after which the counselor helps the client get back to the relaxed state (Head & Gross, 2009). The idea is to keep the level of anxiety relatively low so that it is counteracted by the relaxation (Sherman, 1973). The item is then presented again until the client can visualize the scene without anxiety (Head & Gross, 2009). When the client is successful, she is asked to visualize the next item on the hierarchy. Wolpe (1960) maintained that two to four items could be presented per counseling session and that it usually took between 10 and 30 sessions to get to the highest items on the hierarchy without disturbance.

JaNelle decides that systematic desensitization would be ideal for Shirley's anxiety episodes connected with her stealing behavior. She explains the procedure to Shirley, and they work on Shirley's anxiety hierarchy. As expected, Shirley's most feared image is of being in a store by herself. This scene she rates as a 100. The remainder of Shirley's hierarchy is shown in Figure 8.1.

JaNelle begins the procedure in the next session, asking Shirley to relax and taking her through a progressive relaxation sequence. She then asks Shirley to imagine being in her apartment and thinking about going to a store. Immediately, Shirley's finger shoots up, and JaNelle asks her to again relax and to "wipe the picture out of your mind." JaNelle presents the image repeatedly until Shirley no longer indicates anxiety, and then they progress to the next item in the hierarchy.

100 Standing in a store by herself
95 Walking through the door of the store
90 Getting off the bus near the store
80 Riding the bus to the store
75 Getting on the bus to go to the store
65 Walking to the bus stop
55 Leaving her apartment to go to the store
50 Looking at an item she has stolen
40 Telling someone she is going to the store
30 Thinking about going to a store

FIGURE 8.1. Shirley's Hierarchy of Anxiety.

Aversive Techniques

Aversive techniques are considered a last resort in BT (Wolpe, 1990). These techniques, based in a classical conditioning model, are sometimes called *aversive counterconditioning* and consist of pairing some noxious stimulus with an unwanted emotional reaction. The most commonly used aversive stimuli are electric shock and nausea-inducing drugs.

As you might guess, these techniques have been the subject of controversy. One "problem" to which these techniques were applied was homosexuality. In the 1960s, there was a flurry of interest in changing sexual orientation, and many times this was approached by showing clients same-sex erotic stimuli (e.g., photographs) while administering shock. The shock was terminated when heterosexual erotic materials were presented (Haldeman, 1994). Of course, the ethics of such treatment were eventually questioned, even when used with men who voluntarily sought such treatment. The ethical issues, arguments about whether these techniques really produced aversion, and lack of support for their effectiveness resulted in their abandonment in the 1970s (Haldeman, 1994; LoPiccolo, 1990).

Aversive techniques have also been employed to treat alcohol dependence (Antony & Roemer, 2011b). Mostly, these approaches have used nausea-inducing drugs, although shock has also been used. Concerns about the usefulness of these interventions beyond traditional interventions for problem drinking have also been raised (Wilson, 1987). The point is made that relapse is common when the aversive consequences are no longer in place (Antony & Roemer, 2011b).

One problem that seems to justify aversive techniques is self-injurious behavior, often seen in developmentally disabled individuals. These individuals frequently place their lives in danger by banging their heads or performing other dangerous behaviors. A pad is attached to the client's arm or leg, and shock is delivered upon the occurrence of an unwanted behavior. A detailed review of the necessity for such procedures, often by government regulatory committees, is typically required to begin such a program (e.g., Nord, Wieseler, & Hanson, 1991).

JaNelle does not think that aversive techniques are advised in Shirley's case. After all, they are techniques of last resort, and Shirley's problem seems to be more about anxiety than anything else, so aversive techniques might be counterproductive because they might increase her anxiety.

Shaping

The process of teaching a new behavior is called *shaping*. First, the BT counselor gets the client to respond in some way, usually by using verbal prompts. Modeling can also be used in this stage. The therapist can demonstrate the behavior, or the client can watch a videotape. After the initial response is established, the therapist will reinforce only responses that move a step closer to the desired response (K. F. Ferguson & Christiansen, 2009).

Shaping could be used to address Shirley's social skills deficits, JaNelle thinks. She plans to model eye contact and appropriate voice tone for Shirley and then praise her when she attempts these behaviors. At first, Shirley's attempts will be tentative, but JaNelle will reinforce them and coach Shirley to improve them. She will then reinforce Shirley's improved behaviors.

Reinforcement

The BT counselor can use positive and negative reinforcement to increase the occurrence of a desired behavior. For instance, praising the client for completing an assigned homework activity

would tend to increase the probability of homework getting done. Negative reinforcement is probably used less often because it is difficult to find a situation in which a negative stimulus could be discontinued upon the appearance of a desired behavior. An important source of reinforcement in BT is the counselor's verbal responses to the client, which Beach (2005) called *verbal conditioning*. He opined that the therapist must be alert in the counseling situation to the kind of verbal behavior she is reinforcing—for instance, differentially reinforcing verbalizations about problems (by "uh hming" every time the client speaks of these and not responding to nonproblematic or successful behavior) might make the client's situation worse (Beach, 2005).

Often clients are taught to self-reinforce. If the client, for example, went to the gym and worked out, she would reward herself with a hot bath or a low-fat ice cream sundae. Another example of self-reinforcement is seen in stress inoculation training (Meichenbaum, 1977). Clients are taught to use coping cognitions in stressful situations and then to self-reinforce their successful use through covert verbal statements ("Hey, I did a great job getting through that!").

JaNelle thinks that positive reinforcement would be a good technique to use with Shirley. She praises Shirley for coming to counseling and reinforces Shirley's discussions of her life with attention and head nods. JaNelle will use positive reinforcement to teach Shirley assertive skills and will reinforce her for completing homework assignments. She will also use positive reinforcement when Shirley survives an in vivo experience in a store.

DIFFERENTIAL REINFORCEMENT

This technique, sometimes called *differential reinforcement of other* behavior (DRO), consists of reinforcing one behavior (a desired one) and subjecting an undesired behavior to extinction at the same time (Wallace & Najdowski, 2009). Any behavior other than the target response can be reinforced during a specified time interval, or a response incompatible with the undesirable behavior can be reinforced (Nemeroll & Karoly, 1991). For instance, if Mother wants Hillary to watch less TV, she could reinforce Hillary for reading a book or playing outside of the home or almost any behavior other than watching TV.

JaNelle is not quite sure about how to use DRO with Shirley. She supposes that she could go to a store with Shirley and reinforce her for walking through the store without stopping. She could also reinforce her for talking to a salesperson.

EXTINCTION

Extinction involves removing a reinforcement that is maintaining a behavior. A very common example is when parental attention is reinforcing a child's tantrum behavior. The parent simply does not respond to the tantrum. When using extinction procedures in isolation, it is important to be sure one can tolerate the possible intensification in the target behavior that might result when the intervention is first implemented (Sherman, 1973). For the parent tolerating a tantrum, this can be a very stressful experience, as you can guess!

For Shirley, applying extinction to her stealing behavior would mean virtually the same thing as in vivo exposure because JaNelle thinks that the stealing is partly maintained by the anxiety reduction Shirley experiences. However, operant extinction would require that Shirley perform a very difficult behavior—picking up an item in the store and not leaving the store.

Punishment

Punishment, remember, is when the consequences of an event are linked to a decrease in or disappearance of the behavior. For the purposes of intervention, two kinds of punishment can be identified (Milan, 1990; Skinner, 1953). First, and most familiar to us, an aversive event can be applied following the undesirable behavior, which is sometimes called punishment by *contingent stimulation* (Milan, 1990). Spanking a child falls under this category.

A second kind of punishment results when a desirable set of conditions is terminated when an unwanted behavior occurs. For instance, Dad can turn off Liza's favorite television show if she is slapping her little brother. Because this kind of punishment can be seen as the termination of a positive reinforcer, it is referred to as *punishment by contingent withdrawal* (Milan, 1990). A similar procedure is *response cost*, in which an individual is required to surrender something reinforcing, such as when you pay a fine at the bank for bouncing a check.

Time-out from reinforcement is another form of punishment, in which positive reinforcers are removed for a specified period of time. A familiar example of this procedure is seen in classrooms, when a child displaying disruptive behavior is removed to a time-out room. The critical element is that all sources of reinforcement are unavailable to the child. Usually, the access to reinforcers is removed only for a short period of time (e.g., a minute or two) because longer intervals do not increase the effectiveness of the time-out intervention (Kazdin, 2001). However, we should note that time-out could also be conceptualized as an extinction procedure: We are simply removing the reinforcer that maintains a behavior.

Punishment as a behavior change technique has drawbacks. First, because punishment only suppresses behavior, such behavior is likely to reappear when the contingencies are no longer in effect (Skinner, 1971). Also, humans are motivated to escape or avoid aversive conditions, so punishment can create these behaviors—the best way to avoid punishment is to avoid the punisher. Punishment can also result in aversive emotional states, such as shame, anger, frustration, anxiety, or depression (Milan, 1990). Individuals may resort to dysfunctional behaviors to avoid these aversive states, such as refusing to think about the punished behaviors or engaging in risky behaviors such as drinking alcohol or doing drugs to blunt these feelings (Milan, 1990). Finally, these negative feelings may become associated with the agents of punishment, such as parents, school, or law enforcement officials (Kazdin, 2001). Consider also that using punishment models the use of aggressive behavior. For these reasons, punishment should be a last resort and used very carefully (Antony & Roemer, 2011b).

If punishment must be used, it should be immediate to the undesired behavior (Meindl & Casey, 2012). A consistent, continuous schedule is more effective than intermittent punishment (Kazdin, 2001).

JaNelle doubts that punishment would work for Shirley's stealing behavior unless Shirley would agree to self-punish. In a sense, she already does that by making herself feel guilty and ashamed after she steals, and this has not been effective in deterring her behavior. Getting arrested can be seen as a punishment, but not one that is likely to happen every time, making it an ineffective punisher.

Assertiveness Training

In Wolpe's view, assertive behaviors are called for when the client is experiencing dysfunctional anxiety in interpersonal situations. Assertive behavior is defined as "socially appropriate verbal and motor expression of any emotion other than anxiety" (Wolpe, 1990, p. 135). Wolpe thought

that anxiety got (classically) conditioned to social responding, and through reciprocal inhibition, assertive responding should compete with the anxiety and weaken the conditioning. Assertiveness training involves teaching the client to express the resentment that she experiences in interpersonal relationships because anger, for example, is thought to inhibit the expression of anxiety (Wolpe, 1960).

Other BT theorists would probably take an operant (i.e., skills deficit) view in using this technique (Duckworth, 2009b). After assertive behavior is defined for the client, the assertive behavior is modeled for the client, or she could be verbally prompted to perform the behavior. The behavior therapist then shapes the client's behavior, reinforcing better and better assertiveness responses. Primarily, the behavior therapist could use praise as the reinforcer unless she is working with a child, in which case other kinds of reinforcers might work (such as candy).

Assertiveness training is perfect for Shirley. JaNelle will teach her to make eye contact, speak with more volume, and ask for things she wants. For example, JaNelle will help Shirley practice asking a fellow volunteer to go out to a movie or dinner with her.

STIMULUS CONTROL

Many behaviors are under the control of one or more stimuli. As noted earlier, these stimuli are termed *discriminative stimuli*. The most commonly used examples of these types of behavior are cigarette smoking and eating. People who smoke tend to have specific triggers for smoking behavior, such as finishing a big meal. If you eat popcorn in bed at night, just getting in bed may cause you to feel an urge to eat. In fact, it is thought that overweight individuals often eat in response to cues in the environment rather than in response to hunger.

Once the discriminative stimuli associated with a behavior have been clearly specified (and there are usually more than one), the environment can be manipulated to produce, increase, or reduce the behavior (Poling & Gaynor, 2009). Typically, the behavior therapist teaches the client how this process works and helps the client identify discriminative stimuli or the lack thereof (Kazdin, 2001). The client is then charged with putting the program into place. Sometimes the BT counselor would even help the client make the desired changes in the environment.

If a stimulus is controlling an unwanted behavior, the client is usually urged to avoid the stimulus at first. A gradual approach to the stimulus is then developed so that the client can resist performing the behavior (Kazdin, 2001). In other cases, the client might need to associate a behavior with one or more stimuli to get it under control. For example, if Julie has a problem with eating too much too often, it might be helpful for her to limit eating to full meals at a set table. She would not be allowed to eat while watching television or in any other location.

JaNelle decides that Shirley's stealing behavior is cued by the stimulus of a department store. Shirley reports that she rarely steals at the grocery store or in other kinds of stores. JaNelle decides that to extinguish the association between the store and stealing, Shirley will avoid the department store for a while. She is assigned the task of going to the grocery store once a day for a week. The first day she is to walk into the store and immediately walk out. The second day she is to walk down one aisle and then out of the store. After each of these forays, she is to positively reinforce herself in some way. A gradual progression in the amount of time she spends in the grocery store is prescribed until she reports no anxiety or impulses to steal. JaNelle then transfers this program to the department store.

Covert Conditioning

Covert conditioning procedures employ imagery in the service of changing behavior. The term *covert* is used because the client imagines experiencing, rather than really experiencing, the behavior to be changed, along with the consequences of maintaining it (Cautela, 1994). In addition, the manipulation of consequences to change the imagined behavior is covert.

Cautela (1994, p. 3) identified a number of covert conditioning procedures that can be used (e.g., sensitization, extinction, covert positive reinforcement, covert negative reinforcement, response cost); most of these are simply applications of BT techniques using imagery.

The *self-control triad* or procedure is a more complex intervention consisting of three steps. First, the client mentally shouts "stop" when a target behavior occurs. She then takes a deep breath, exhales, and relaxes (step 2). Step 3 is to imagine a pleasant scene, which is seen as aiding the relaxation and also as providing self-reinforcement (Kearney, 1994).

A general outline of covert conditioning is as follows (Cautela, 1994): The client's ability to image is checked; if necessary, imagery exercises are assigned. The client is then asked to imagine the target behavior as she actually experiences, not as if she were viewing a video of herself performing it (Kearney, 2006). In the case of covert positive reinforcement, for instance, the client is asked to imagine successful behavior. Once this scene is clear to the client (she indicates by some signal, such as raising a finger), the counselor instructs the client to imagine a pleasant scene (the reinforcer). This sequence is repeated a number of times in the session, and it is also assigned as homework, using a specially prepared recording of instructions.

Covert conditioning could be used to extinguish Shirley's anxiety associated with department stores through using covert desensitization. JaNelle would guide Shirley through an imaginary sequence of going into the store, staying there while the anxiety becomes intense, and then leaving the store without taking anything. Reinforcement could also be added; after Shirley imagines a successful trip to the store, she would imagine a pleasant scene.

Modeling

Modeling is a flexible technique that often is combined with other kinds of interventions. The most basic form of modeling is simple observation, in which the client watches a model perform a target behavior (Spiegler, 2016). The model will typically progress through harder and harder tasks. For example, if a client is afraid of heights, she might observe a model standing on a step stool and so on until the model is looking over the balcony rail of a 20-story hotel.

Another version of modeling is *participant modeling*, also known as *guided participation* (Spiegler, 2016). In this approach, the client actually practices the target behavior after the model (usually the therapist) has demonstrated it. The model coaches the client through successively more difficult behaviors.

JaNelle uses modeling to help Shirley learn new social skills. She demonstrates appropriate vocal tone and eye contact and then asks Shirley to practice these in the counseling session. Together, JaNelle and Shirley identify situations in which Shirley might have behavioral deficits and then generate new responses for Shirley. JaNelle first models these behaviors, and then Shirley tries them out for herself.

JaNelle considers using modeling as an initial step in desensitizing Shirley to department stores. She could videotape a model entering a store, choosing an item to buy, purchasing it, and

then leaving the store. Shirley could watch the videotape between counseling sessions until she could do so without experiencing anxiety.

BEHAVIORAL SELF-CONTROL

Not really a specific technique, behavioral self-control refers to teaching the client to apply behavioral techniques to herself. Kanfer and Karoly (1972) pointed out that in using this approach, the client must really commit to the process and her designated goals. They specified factors that promote "intention statement making" (p. 411; e.g., these statements are more likely when the client is experiencing the negative effects of behavior or when positive reinforcement is available) and those that decrease the likelihood of these statements (e.g., when the person is likely to receive punishment for making the statements or the probability of punishment is high for failure).

Almost any of the behavioral techniques described earlier can be used in a behavioral self-control model. You might remember the television ad campaign in which the celebrity model (Larry Hagman) snapped a rubber band around his wrist when he experienced the urge for a cigarette. This is an example of an aversive self-control procedure (based in either aversive counterconditioning or punishment). Another example of a way in which the behavioral self-control approach is used is teaching the client stimulus control procedures.

MyCounselingLab

Video Example 8.3 Watch the first two minutes of this video. What behavior therapy technique is being used?



https://www.youtube.com/watch?v=XOeZqFaoeF0

EVALUATION OF THE THEORY

BT has evoked a great deal of controversy over the years, comparable to that associated with psychoanalytic theory. Behavior therapists have been accused of being cold-hearted because of their scientific approach and language (Goldfried & Davison, 1994). The emphasis on prediction and control of behavior has led to accusations that BT denies the rights and freedom of clients (Franks & Barbrack, 1990) and that it ignores the importance of emotion in human behavior. As Sweet (1984) put it, "Behavior Therapy is viewed as the cold and mechanical application of techniques, previously tested on sub-human species, and often delivered in a dangerous and impersonal fashion" (p. 254).

Behavioral approaches are seen as simplistic and most applicable to discrete and narrowly defined problems, such as phobias. The first applications of BT were with extremely dysfunctional clients (e.g., mentally challenged or psychotic clients), so its utility for a wider range of clients was questioned (Franks & Barbrack, 1990).

BT is criticized for its emphasis on observable behavior at the expense of thought and feeling. However, as we have seen, most behavior therapists today attend to cognition and other inferred events as important aspects of human behavior (Fishman et al., 2011). Neglect of the client's past is also cited as a weakness of behavioral approaches, to which the behaviorists would retort that reinforcement (learning) histories are very important in understanding the client's current presentation.

Behavior therapists are also said to ignore the role of interpersonal relationships in the generation and maintenance of psychological dysfunction (Marshall & Gauthier, 1983). For example, Marshall and Gauthier (1983) suggested that failures in BT procedures could result when improvement results in decreased dependence of the client on family members or other significant others.

Currently, BT, or probably more accurately CBT, is considered a mainstream, evidence-based form of therapy. Because its techniques are so structured and easy to understand, it lends itself to easily disseminated forms of treatment, even interactive, computer-based treatment (see www.stoppulling.com for an example of a treatment for trichotillomania, or hair pulling).

Qualities of the Theory

Precision and Testability. BT theorists maintain that theirs is the most scientific approach because it is rooted in "established principles and paradigms of learning" (Wolpe, 1997, p. 633). Certainly, it is very precise to count behaviors following the institution of a reinforcer and observe changes from baseline rates of behavior. If one is studying nodding behavior, clearly this behavior can be operationalized fairly easily. The complex behaviors involved in client presentations and in the counseling process, however, are not as easily specified and targeted.

Arguments abound about the exact definition of some BT terms, such as *reinforcement*. Some critics assert that the definition of reinforcement is circular: What is a reinforcement? Something that makes behavior increase. Why did that behavior increase? Because it was reinforced. The classical conditioning model has also been criticized, particularly by advocates of social learning theory (Bandura, 1969). They maintain that the effects of classical conditioning procedures are simply that the person builds a mental image that affects her behaviors rather than establishing a relatively permanent conditioned reflex. Still other authors note that attempts to tie BT techniques to the principles of learning from experimental laboratory study are fruitless and that these very principles (e.g., reinforcement) are questionable as explanations for *learning* even though they can at times predict *performance* (Breger & McGaugh, 1965/1973; Jacobson, 1997).

Empirical Support. Overall, BT has received support from outcome research. It is important to note, though, that many studies test cognitive-behavior therapy (in a multitude of forms) rather than pure BT (if such a thing really exists). As I noted earlier, the validity of the theoretical bases of BT is much less clear.

Research Support

Outcome Research. The literature on the efficacy of BT is enormous (Antony & Roemer, 2011b; Emmelkamp, 2013). Numerous outcome studies have supported the efficacy of BT, although the evidence to support the claims for the superiority of the approach over others is not as robust. I shall review a few meta-analyses and then several studies that provide examples of research testing BT. However, because of the sheer amount of research relevant to BT, it is impossible to provide a comprehensive summary.

Early meta-analyses demonstrated the utility of BT across diagnostic categories, beginning with M. L. Smith and Glass (1977), who suggested a slight superiority for behavioral and cognitive-behavioral approaches over the other approaches in the analyses. However, these effects tend to disappear when methodological variables are controlled (M. L. Smith, Glass, & Miller, 1980).

These methodological issues involve the reactivity of the measures used—how responsive the outcome measures are to the demands of the experimental situation (Lambert & Ogles, 2004). Behaviorally oriented studies generally use measures that are more susceptible to these influences. Also, when allegiance effects (i.e., the theoretical allegiance of the study's authors) are controlled, differences between approaches tend to disappear (Wampold, 2001). Overall, then, we can be pretty certain that BT is effective, but probably not superior to other therapeutic approaches (which of course is the typical conclusion for all of the major approaches to counseling; Lambert, 2013).

Butler, Chapman, Forman, and Beck (2006) reviewed 16 meta-analyses on outcome studies of cognitive-behavioral therapy. They found that CBT was effective over a wide range of dysfunction and that BT was as effective as CBT in the treatment of adults who were depressed or displaying signs of obsession and compulsion. As you will see from the following material, global meta-analyses (i.e., assessing outcomes across client problems) are less common currently than are those assessing studies of specific disorders.

Meta-analysis seems to have established that a number of behavioral interventions are effective in treating anxiety problems. At the most basic level, relaxation training alone has been shown to reduce a wide variety of types of anxiety (e.g., clients undergoing medical procedures, social anxiety; Manzoni, Pagnini, Castelnuovo, & Moniari, 2008). The evidence seems clear that exposure in vivo is effective for the various anxiety disorders (e.g., phobia, panic disorder, agoraphobia; Emmelkamp, 2013). An alternate form of exposure therapy, virtual reality exposure, appears to be as effective for anxiety problems as in vivo or imaginal exposure (Opriş et al., 2012). Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, and Marín-Martínez (2008) meta-analyzed studies of exposure and response prevention (ERP) and cognitive therapy for obsessive-compulsive disorder, finding that both were effective but opining that ERP should be preferred because it was less costly. However, ERP does seem to have higher levels of client dropout compared to other approaches, likely due to the inherently negative experience of tolerating anxiety without the compulsive response. An interesting study of this phenomenon was performed by Lee and Rees (2011), who interviewed eight clients who had completed ERP. These clients readily reported the distressing nature of the intervention, but also indicated that the support and encouragement of the therapist and others helped them get through it. Lee and Rees's findings would seem to fit with those of Gloster et al. (2011), who in a large randomized controlled trial (RCT) for clients with panic disorder with agoraphobia found that therapist-guided exposure produced better results than when the client performed exposure trials alone.

McGuire et al. (2014) analyzed eight RCTs of BT for Tourette's syndrome and found that BT produced medium to large effects. Most of the comparison groups in the studies they analyzed, however, were waiting list or "nondirective" conditions (p. 109), so the relative efficacy of BT with regard to other approaches was not established. Reichow (2012) reviewed five meta-analyses of early intensive behavioral intervention for autism spectrum disorder. Four of the five found the interventions to have moderate to strong effects; Reichow argued that the one analysis that did not misinterpreted one of the studies included in a way that minimized the strength of the treatments. Studies of behavioral treatment for another childhood disorder, attention-deficit/hyperactivity disorder, were the target of a meta-analysis performed by Fabiano et al. (2009). They found large to very large effect sizes, indicating that a wide range of behavioral intervention was effective for clients in the various studies included, who were mostly male and around the ages of 7 to 8.

A meta-analysis of studies of substance use disorders (e.g., drugs, alcohol, and tobacco) demonstrated that contingency management procedures (the general term for manipulating reinforcers and punishers) produced positive results (Prendergast, Podus, Finney, Greenwell, & Roll, 2006). Kurtz and Mueser (2008) meta-analyzed 22 studies of social skills training for schizophrenia, demonstrating that this intervention led to improvement in social and living skills as well as to decreases in negative symptoms. Similarly, G. Zimmerman, Favrod, Trieu, and Pomini (2004) used a meta-analytic technique and determined that CBT interventions were useful as adjuncts to psychotropic medications in reducing hallucinations and delusions among clients diagnosed as schizophrenic. Other studies have found BT strategies to be effective treatments for eating disorders, chronic pain, insomnia, and tension headaches, to name just a few, prompting Antony and Roemer (2011b) to opine, "In fact, there are few problems for which behavioral therapies have not been found to bring at least some relief" (p. 107).

For those who argue that meta-analysis is comparing apples and oranges, exemplar studies can be informative. As early as 1975, the Temple study (Sloane, Staples, Criston, Yorkston, & Whipple, 1975), described in Chapter 1, reported no differences in efficacy between BT and psychoanalytically oriented therapy, but both produced more improvement than a wait-list control group. The National Institute of Mental Health Collaborative Treatment of Depression study compared CBT (Beck's approach; see Chapter 10), interpersonal psychotherapy, placebo–clinical management, and psychopharmacological treatment with clinical management and found no differences in outcomes across the four conditions (Elkin et al., 1989).

Rothbaum et al. (2006) described an interesting study comparing the use of virtual reality exposure (VE), traditional in vivo exposure, and a control treatment for fear of flying. They found that VE and traditional exposure produced similar good results—76% of the clients in these treatments agreed to go on a post-treatment flight compared to 20% of control participants. Other examples of the success of exposure therapy can be readily found in the literature, and a fairly recent meta-analysis of VE for anxiety disorders found that a large effect size favored VE over control conditions and that VE was equivalent to, or a little better than, in vivo exposure (Powers & Emmelkamp, 2008). Of great current interest is acceptance-based therapy (see Chapter 16 for an example, acceptance and commitment therapy); Hayes-Skelton, Roemer, and Orsillo (2013) tested the utility of acceptance-based behavior therapy in an RCT for clients who were diagnosed with generalized anxiety disorder. They used relaxation training as a control condition, but found very few differences in the outcomes of the two groups of clients. Both interventions were effective in reducing anxiety both at the end of treatment and at follow-up.

Theory-Testing Research. Discussing the role of theory in BT is difficult because BT is not a theory per se; it is more a collection of techniques said to be based on theories of learning. BT scientists had little use for the "hows" of their technologies, prompting Tryon (2005) to opine "the cognitive revolution in psychology occurred partly because functional statements made by behaviorists lacked causal mediating explanatory mechanisms. The search for causal mediators and moderators is evidence that behavioral scientists value explanation in addition to novel prediction" (p. 69). Still, most investigations of BT have focused on the effects of a given technique on the incidence of a target behavior. Very few attempt to test the assumed mechanisms underlying the technique. Although outcome research could be cited as indirect support for the model of learning underlying the technique, it is clearly indirect at best.

When attention is turned to explanatory mechanisms, the theoretical formulations of BT are questionable. For example, several causal models for the effects of systematic desensitization and other forms of exposure have been proposed. However, none has gained strong empirical support. Here is an example: Wolpe (1990) thought that pairing an incompatible state (e.g., relaxation) with the undesirable one (e.g., anxiety) would cause deconditioning (i.e., reciprocal inhibition). Because research seems to show that relaxation is not necessary, Wolpe's causal scheme is undermined (Emmelkamp, 1990). However, the meta-analysis of relaxation treatment reported earlier (Manzoni et al., 2008) found that relaxation was effective with a wide range of presentations in which anxiety was central. Regardless, exposure to the feared object or situation is currently considered to be the curative factor for anxiety disorders, but there is little agreement about how it actually works (Abramowitz, 2013; Emmelkamp, 2013; Tryon, 2005). However, the fact that exposure and response prevention seem to help when fear avoidance responses are present would seem to support a hypothesis that these behaviors are maintained by avoidance conditioning. Similar concerns are raised by the observation that behavioral and cognitive intervention are equally effective in treating depression, and the two treatments, said to have different underlying mechanisms, produce similar changes in both cognitive and behavioral indicators (Emmelkamp, 2013).

Some BT researchers would point to single-subject intensive case studies as providing evidence for the theoretical underpinnings of BT. Historically, these designs have been used quite often in BT studies (Fishman et al., 2011). A baseline is established on a target behavior, an intervention is made (e.g., instituting reinforcement or extinction), and then the intervention is withdrawn. Changes in behavior with the presentation and withdrawal of the intervention are thought to be evidence of the validity of behavioral techniques. Again, these types of studies can demonstrate relationships between interventions and performance of a given behavior, but they provide little evidence for the theoretical foundations of BT.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Several characteristics of BT make it an attractive approach to use with clients from diverse backgrounds. First, the structure inherent in BT, as well as the therapist's directiveness, would appeal to clients from Asian backgrounds, as would the relative de-emphasis on expression of emotion (Shen, Alden, Söchting, & Tsang, 2006; Sue & Sue, 2013). In contrast, Spiegler (2013b) cautioned that the directness of BT can be problematic for clients from some cultures, such as those from Japanese and Native American cultures.

African-American clients might respond positively to the collaborative nature of the therapeutic relationship once they have established that the counselor is trustworthy. However, clients from Asian or Hispanic/Latino backgrounds may expect a more formal approach from the counselor because of the emphasis on hierarchy found in these cultures. The concrete and immediate nature of the BT approach would fit well for American Indians and Alaskan Natives because they tend to be present-oriented (Sue & Sue, 2013). On the other hand, the future orientation implicit in the BT emphasis on goal setting could create discomfort. Some evidence for the applicability of BT with Alaskan Natives was provided by Patten et al. (2013), who described a tobacco cessation intervention developed specifically for adolescents. This intervention, which involved group activities and testimonials from tribal elders, was based primarily on social-cognitive theory (Bandura, 2004), which is an elaboration of cognitive and behavioral theories.

Patten et al. reported that cultural adaptations seemed to be successful, and self-report data indicated that the program was successful in creating short-term abstinence.

Spiegler (2016) discussed issues of diversity relative to BT and maintained that its emphasis on the role of the environment in problematic behavior is particularly suitable to clients who are of diverse backgrounds because cultural differences can be taken into account. Chambless (1986) had earlier made this point and noted that the emphasis on environmental factors should result in less blaming of the client for problems. Further, Chambless opined that African-American clients would be likely to respond positively to BT's active, directive, and problem-focused approach (p. 7). Another plus for clients from diverse backgrounds is that interventions are specifically designed for individual clients and can be tailored to fit the client's background and current circumstances (Spiegler, 2016).

Some aspects of BT are compatible with feminist values. Initially, feminists reacted positively to the behavioral principle that learning is a function of environmental factors, seeing this as a departure from traditional approaches that blame the individual for his or her problems (Kantrowitz & Ballou, 1992; Worell & Remer, 2003). BT emphasizes self-help and encourages client self-direction, which are consistent with feminist philosophy (Hunter & Kelso, 1985). BT's emphasis on skills development and goal of giving the client more control over the environment are also consistent with feminist ideology.

At the same time, the behaviorists can be criticized for ignoring the sociopolitical context of their clients' lives. Kantrowitz and Ballou (1992) argued that defining health as behavior that is adaptive is problematic. Who decides what is adaptive? They maintained that the norms of the dominant social group (i.e., White males) define adaptiveness, which is an unfair, biased standard, particularly for women and other historically oppressed groups. The broader issue underlying the controversy about definitions of health is probably control—that is, is it OK for a behavior therapist to "engineer" changes in clients' behavior without taking serious note of social or cultural forces that are very powerful (Ivey, D'Andrea, & Ivey, 2012)? Clients who are facing prejudice and discrimination would likely feel misunderstood if these issues were not addressed as part of the counseling process. Further, BT's emphasis on a rational, scientific approach to human behavior is a reflection of White, male, European values, which may be very different than those of women and members of other ethnic or cultural groups (Kantrowitz & Ballou, 1992).

Collins and McNair (1986) pointed out that, although BT emphasizes the environmental determinants of behavior, interventions most often target individual behavior. This bias can be seen as supporting the oppressive forces in society that affect women and individuals from non-White cultures, those of lower socioeconomic status, and those of diverse sexual orientations and ableness. They specifically pointed to the use of skills-training interventions with women and argued that treating the woman, rather than the culture, reinforces traditional sex-role behavior, such as when parent training focuses primarily on the roles of mothers and children. Further, Collins and McNair suggested that the more active coping strategies of minority women could be deemed maladaptive by therapists who endorse traditional sex-role stereotypes. However, others have argued that recent versions of behaviorism are much more attuned to environmental aspects of client presentations than were earlier versions (Spiegler, 2016). CBT, particularly, seems adaptable to clients from many other cultures (Horrell, 2008); much of the research on this issue reviewed in Chapter 10 ("Cognitive Therapy") would probably be applicable to BT as it is currently practiced.

In the late 1960s, behavior therapists as a profession supported the use of conditioning procedures to change the sexual orientations of homosexuals (Glass & Arnkoff, 1992). However, in 1974 the president of the Association for the Advancement of Behavior Therapy, Gerald Davison, declared in his presidential address that it was unethical to continue these attempts (Davison, 1976). According to Glass and Arnkoff (1992), Davidson's plea was one of several that prompted the elimination of homosexuality as a diagnostic category in the DSM-IV.

THE CASE STUDY

The story of Shirley is, in many ways, an ideal fit for the BT approach. Her primary problem behavior, the shoplifting, is fairly specific, and BT approaches are easily applied. It is less clear that BT approaches will directly affect Shirley's loneliness, although it does seem to make some sense that increasing Shirley's social contacts would help to some degree with this problem. However, if Shirley's loneliness is associated with feelings that are not addressed by increased social contacts, such as mourning, this approach might be less useful.

Summary

Behavior therapy rests on a psychological model that emphasizes the learned nature of behaviors, whether they are adaptive or maladaptive. Three general models of learning are identified (classical, operant, and social learning), although the validity of these models and their direct connections to some techniques can be questioned. A variety of techniques is associated with BT, and most have been found to be effective.

BT has been the target of criticism and controversy. The traditional approach to BT emphasizes behaviors and their environmental rather than personal determinants. This emphasis, less common today, may lead to less attention to emotional and cognitive factors in behavior.

In some ways, BT seems to be an approach that is applicable to a range of clients—if carefully applied. Some client groups may respond favorably to the problem-focused, direct techniques used in BT. However, BT's lack of attention to societal norms that influence behavior in ways that discriminate against some groups is a potential pitfall associated with this approach.

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Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy*, Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 3.

CHAPTER 9

Rational Emotive Behavior Therapy



Albert Ellis

Alan is a 27-year-old White male. He works in a warehouse managing workers who move stock. Alan is married to Teresa, an Asian woman who is 30 years old. The only child of devout Catholic parents, Alan is a committed Catholic, as is Teresa. Teresa and Alan are active in their church, and most of their social activity is church related. Alan's parents live in another city two hours away, and Teresa's live on the West Coast. The couple has no children.

Alan comes to counseling because he is anxiety ridden and showing some repetitive, anxiety-driven behavior. He reports that when he leaves a room in his home, he has to return several times to be certain that he has turned off the lights. Sometimes he flips the light switch; other times he just looks at it. Alan is also troubled by the worry that he has run over someone with his car on his way home from work and frequently gets back in his car and retraces his route to make sure he has not. Most troubling to Alan is disturbing mental imagery of a religious nature that he believes he cannot control. Alan is hesitant to describe these images, but he says they involve the Virgin Mary and sexual content.

Alan reports that he has had variants of these symptoms for at least 5 years. He recalls being almost immobilized by his fears shortly before he and Teresa married. Alan went to counseling at that time and found some relief from his symptoms, but says that his anxiety was still bothersome. Since that time, Alan has experienced brief periods of compulsive behavior, but of the least disturbing kind, such as checking the light switches. He became more concerned when the religious images began about a month ago, along with the worries about hitting someone with his car.

When he comes to counseling, Alan appears uncomfortable and nervous. He speaks quickly and softly and seems motivated, but is at a loss about what to do about his symptoms.

BACKGROUND

The colorful and flamboyant Albert Ellis (1913–2007) thought up rational emotive behavior therapy (REBT). Ellis, a sex therapist who retrained as a psychoanalyst, freely admitted that he developed his theory out of his frustration with the passive, slow methods of psychoanalysis (Ellis, 1994b). He also acknowledged that REBT is a product of the "personal anti-neurosis campaign" of his youth (Ellis, 1997a, p. 76; see Box 9.1). I shall begin this chapter with a quote that will give you a good flavor of Ellis:

> Why did I (really) become a psychotherapist? In a word, because I primarily wanted to help myself become a much less anxious and happier individual. Oh, yes, I wanted to help other people, too, and I wanted to help the world be a better place, with healthier and happier people who fought like hell to create better, better conditions. But I *really* and *primarily* wanted to help me, me, me! (2004, p. 73; emphasis in original)

Box 9.1

Rational Emotive Behavior Therapist, Heal Thyself!

Young Al Ellis had a fear of girls. When he was 19, he decided to do something about it. He had already conquered his fear of public speaking—in his own words, "Shit, I said to myself. If in vivo desensitization is good enough for little children, it's good enough for me. I'll try it with my terror of public speaking. If I fail, I fail. If I die of discomfort, I die! Too damned bad!" (Ellis, 1997a, p. 71). With this experiment, the technique now known as shame attacking was born—and was found to be successful.

Ellis then decided to apply this technique to his girl phobia. He lived, at the time, near the Bronx Botanical Gardens and frequented this beautiful park often, but flirted with girls only in fantasy. Telling himself "do, don't stew" (1997a, p. 72), Ellis gave himself the homework assignment to go to the gardens every day in July, find women sitting alone on benches, sit down beside them, and talk—for 1 whole minute! Ellis carried out his assignment with 130 women that month, and to his great surprise, not one screamed, threw up, or called the police. Ever the scientist, Ellis reported that "30 of them waltzed away. They rejected me before I even got going! But, I said to myself, strongly, 'that's okay. That leaves me a sample of an even hundred—good for research purposes!'" (1997a, p. 72).

Of the first hundred, Ellis managed to make one date, but then she didn't show up. Ellis persisted and reported that of the second hundred women he talked to, he got three dates. He claimed that this first expedition into REBT was entirely successful, so that forevermore he could talk to women any place, any time.

REBT was first known as rational therapy, but in 1961 Ellis renamed his theory rational emotive therapy to emphasize the emotional elements of the approach (Ellis, 1994b). The *B* was added in 1991 to acknowledge the behavioral element that Ellis maintained had always been crucial to rational emotive therapy but had not been widely recognized. Using the term *rational*, Ellis said, was a mistake because *rational* implies an absolute criterion, and no such criterion exists (Ellis, 1999e). He opined that a better name would be cognitive-emotive behavior therapy, except that cognitive therapy and cognitive-behavioral therapy got there first.

Albert Ellis was born in Pittsburgh, Pennsylvania, in 1913, the oldest of three children. He was raised in New York City. Ellis's early childhood experience was characterized by benign neglect; his father was a salesperson who traveled a good deal, and his mother adopted a laissez-faire approach to parenting (Ellis, 2010). His parents divorced when Ellis was 12. After that, his father was rarely seen and did not support the family financially.

Ellis experienced a number of physical maladies in his early years that required periods of hospitalization and reduced activity during convalescent periods at home (Yankura & Dryden,

1994a). At age 12 Ellis launched his writing career, and around age 16 he began devouring books and articles about philosophy and psychology, which set the stage for the development of his theory.

As a child and young adult, Ellis was shy and socially avoidant. Ellis's voracious reading habits served him well when at the age of 19 he decided to overcome his fear of public speaking (Ellis, 1997a). He had read the early works of several behaviorists who advocated in vivo desensitization (Mary Cover Jones and John Watson; see Chapter 8) and assigned himself the task of giving many public speeches. Ellis (1997a) found, to his surprise, that he actually began to enjoy public speaking. Subsequently, he applied this desensitization technique to his anxiety about relating to women (see Box 9.1).

After receiving his bachelor's degree in business administration, Ellis worked at a succession of jobs, planning to support himself with these while becoming a professional writer. He wrote voluminously during this time, but had little success getting published. At the same time, he was extensively reading and studying many resources on sex to produce his manuscript *The Case for Sexual Promiscuity* (Yankura & Dryden, 1994a). He became somewhat of an authority on sex among his friends and associates and even started a small consulting practice (Blau, 1998). At the age of 28, Ellis entered Columbia University, training as a marriage, family, and sex therapist and eventually earning his master's and Ph.D. degrees in clinical psychology.

Working in his first job, Ellis increasingly became aware of the weaknesses of the authoritative, advice-giving approach he was taught in graduate school. Ellis embarked on a course of traditional psychoanalytic study, complete with a training analysis and supervised practice. He learned to use the psychoanalytic couch, dream analysis, and transference neurosis in his work. Anticipating that this "depth" therapy would create more profound change in his clients, Ellis was disappointed to find that the results did not meet his expectations. His clients simply did not change in the profound ways promised by psychoanalytic theory. Becoming skeptical about the efficacy of traditional psychoanalysis, Ellis began experimenting with variants of psychoanalytic theory, such as those proposed by Harry Stack Sullivan, Karen Horney, and Otto Rank. Ellis found these approaches much more to his liking because, although they used psychoanalytic theory, they dispensed with the slow, laborious methods such as free association and dream analysis.

Although these variants of psychoanalysis seemed to create client change more quickly than standard psychoanalysis, Ellis still found himself dissatisfied with the results of his therapy. He began to experiment with a fusion of psychoanalysis and behavior therapy and became convinced that insight alone was not enough to "cure" his clients—behavioral change was needed, too (Ellis, 1994b). In 1954, Ellis began to integrate his knowledge of behaviorism, philosophy, and psychology, and by January 1955 he began practicing rational therapy (RT; Ellis, 1992a). He presented his first paper on RT at the American Psychological Association (APA) annual convention in 1956. In 1959 he founded the Institute for Rational-Emotive Therapy (Ellis, 1992a), and in 1962 he published his landmark book, *Reason and Emotion in Psychotherapy* (revised in 1994).

These events marked the beginning of Ellis's long and controversial career. He was known for his no-nonsense style and his free use of profanity in professional contexts. His early career took place in a psychological community largely dominated by psychoanalysis and conservative attitudes about sex; Ellis's ideas ran counter to both of these cultures. In fact, Ellis's first idea for his doctoral dissertation about love among college women was not approved because the faculty

thought it was too controversial (Yankura & Dryden, 1994a). The profession of psychology was not very accepting of his rational emotive therapy either; Ellis reported that "its strong cognitive component horrified almost everyone except the Adlerians" (1992a, p. 9). Eventually, however, Ellis's persistence paid off, and his contributions have been recognized by several professional organizations (American Counseling Association, American Humanist Association). In 1985, he was given the APA's award for distinguished professional contribution to knowledge. Today REBT is international in its influence and is generally considered one of the major approaches to psychotherapy.

A close study of REBT theory will reveal similarities to the ideas of the intellectual descendants of Sigmund Freud. Ellis acknowledged the influence of Alfred Adler, Karen Horney, Harry Stack Sullivan, and Otto Rank on his work, along with the existential philosophers (Heidegger, Kierkegaard, Buber, Sartre, and others). He also recognized the contributions of Will Schutz and Fritz Perls and the 1960s encounter movement (Ellis, 1994b). Ellis (1997a) was also unflinchingly critical of other theorists, writing, "I could fairly easily see that Socrates was something of a sophist. That Plato was often a silly idealist. That Kant courageously threw out God and then cravenly brought him in the back door. That Freud was an arrant overgeneralizer. That Jung was a brilliant but sloppily mystical thinker. That Wilhelm Reich was pretty psychotic. That Carl Rogers was a nice fellow, but an FFB—a fearful fucking baby" (p. 70).

Ellis was one of the most prolific psychologists of the twentieth century. He published over 800 articles and more than 70 books. You can read Ellis's response to an early critique of his theory in Box 9.2.

Box 9.2

An Early Defense of Rational Emotive Therapy from Albert Ellis

Dr. Robert J. Smith (1964), in a recent article, has raised some interesting objections to rational-emotive psychotherapy. The kind of thoughtful presentation that Dr. Smith has made in his article is quite valuable, in that it vigorously challenges the originator of a theoretical view to face certain difficulties inherent in his system and to present experimental data that would validate his views. Let me now, thanks to Dr. Smith, put on my own thinking cap and see if rational-emotive therapy (R-E T) cannot meet and benefit from some of the points he makes.

Dr. Smith first notes that R-E T in severing itself from historical rationalism raises the question: how is a criterion for rationality determined (e.g., the therapist as being rational when the client or patient is not).

The answer seems to be—if we are perfectly honest—that practically all contemporary systems of psychotherapy contend that the patient is "irrational" (that is, "neurotic," "sick," "disturbed") and that this contention is largely a definitional value system, since a nontherapist (a Nietzschean, for example) could counter that either (a) the patient is *not* irrational, because he *should* be anxious or hostile and "enjoy" these feelings, or that (b) he is truly irrational, but that it is good for him to be so (since certain human values are enhanced by irrationality). Only by somewhat arbitrary definition, therefore, is the patient held to be irrational—by the rational, Freudian, Rogerian, or other type of therapist.

Fortunately enough, however, the patient almost invariably comes to therapy because he thinks he is getting poor results in living and he agrees with the therapist that he is therefore self-defeating, unreasonable, or irrational. He presumably wants to change his ways and become less disturbed and more rational; and this is what the therapist will presumably help him do. In rational-emotive therapy, therefore, rationality is not exactly, as Dr. Smith notes, "what the body of expert RT practitioners jointly accept as such," but also what the body of most therapists and patients accept as such.

How to have your therapeutic cake and eat it?—or to define emotional disturbance in the patient's own terms and try to help him actualize himself and still guide him, at least at times, away from a "self" that he largely defines in regard to fairly rigid and too-limiting cultural norms? R-E T solves this problem, not entirely elegantly, with what Smith calls a "naive eclecticism." While accepting the fact that the patient is largely irrational because he defeats his own ends (e.g., makes himself anxious when he would like to be self-confident and secure), it also points out to him that he is never likely to get the goals he desires until he unconditionally and unqualifiedly accepts himself whether or not he fails at certain achievements and whether or not he is universally approved by others.

R-E T contends, in other words, that once certain goals, such as being unanxious and self-confident are (by somewhat arbitrary definition) assumed to be "good" and "rational," then a scientific and factually validatable method of reaching these goals *can* be established and taught to patients; and one of its "findings" is that feelings of security and worth, to be permanent and deep seated, can *not* be anchored to arbitrary, culture-centered norms, but that, instead, the truly self-accepting individual likes himself when he seeks his *own* unique satisfactions and is not *too* concerned (though for practical reasons, he has to be *somewhat* concerned) about the conformity of pressures of his culture.

Source: Ellis, A. (1965). An answer to some objections to rational-emotive psychotherapy. *Psychotherapy: Theory, Research and Practice, 2*, 108–111. Copyright © 1965 American Psychological Association. Reproduced with permission.

For many years, on Friday nights Ellis conducted a demonstration of REBT at the Albert Ellis Institute. Admission was $5, and two lucky audience members were chosen to serve as the demonstration clients for Ellis. Even in his 80s he maintained an 80-hour workweek schedule, conducting individual and group REBT and REBT supervision, lecturing, and, of course, writing.

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Audio Example 9.1 Listen to this audio recording from 4:15 through 13:07 to hear Albert Ellis discuss how to deal with difficult people.



https://www.youtube.com/watch?v=_rwkU8BfVgk

Albert Ellis passed away in July 2007. His autobiography *All Out!* was published in 2010. Ellis's work will be continued at the Albert Ellis Institute, founded by Ellis in 1955 (http://rebt.org). *Rational Living*, the first REBT journal, was first published by the institute in 1966; in 1988 it

became the *Journal of Rational-Emotive & Cognitive-Behavior Therapy* (Neenan & Dryden, 1996). There are a number of prolific REBT theorists and therapists, many of whom were mentored by Albert Ellis. Among these you will find Raymond DiGiuseppe, Kristene Doyle, Windy Dryden, and Wouter Backx, the authors of the third edition of *A Practitioner's Guide to Rational Emotive Behavior Therapy* (2014). Due to a disagreement in philosophy with the Albert Ellis Institute, the REBT Network (www.rebtnetwork.org) was created in 2006 and Ellis REBT in 2012 (www.ellisrebt.co.uk), both largely the product of the energy of Debbie Joffe Ellis, Ellis's wife, to carry on his vision. A recent addition to the REBT bookshelf, *Albert Ellis Revisited* (Carlson & Knaus, 2014) is a collection of Ellis's original writings with commentary by contemporary scientists and practitioners.

BASIC PHILOSOPHY

REBT can be summarized in one sentence by Ellis's paraphrase of Epictetus, the stoic philosopher: "It's never the events that happen that make us disturbed, but our view of them" (2005, p. 259). This assumption lies at the heart of REBT theory: that people can control their own thoughts, feelings, and behaviors. When his clients said someone "made" them feel a certain way, Ellis was known to reply, "That's really impossible. No one can make you feel almost anything—except with a baseball bat" (2002, p. 110).

Ellis saw his theory as constructivist—by this, he emphasized the individual's creation of his reality and the fact that the individual's perception of reality, not some externally validated reality, is the deciding factor in determining behavior (Ellis, 1998a). In his later writings, Ellis (Ellis & Ellis, 2011) was inclined to say that philosophically REBT has much in common with Tibetan Buddhism in its emphasis on the connection between healthy mental processes and happiness.

Ellis is best characterized as a soft determinist (Ziegler, 2000). Individuals have some choice in their lives, but inherited or innate potentials also exert substantial influence. In fact, Ellis (1979c) once wrote that he thought that about 80% of the variability in human behavior is attributable to biological factors, leaving only 20% to environmental influence (p. 17). If so much of behavior is biologically determined, one might wonder if it makes any sense at all to attempt behavior change. Ellis would reply that innate characteristics can be changed—it is just very difficult, requiring much use of the REBT tactic of PYA (push your ass; Ellis, 1998b).

REBT theory is fairly neutral in terms of human nature. Humans are neither essentially evil nor actualizing; in fact, REBT advocates would probably acknowledge that there is a little of God and the devil in all of us. Ellis (1994b) identified two powerful human tendencies: the tendency to take wishes or desires and make them into absolute MUSTS and the tendency to work to achieve a better life (pp. 14–15). Thus, human beings are biologically programmed to be both irrational and rational, self-actualizing and self-defeating (Ellis & Ellis, 2014).

In REBT, people are seen as responsible for their behavior; they can easily determine if that behavior is "bad" or "good," self- and society-serving or self- and society-defeating. The standard for good and bad is a consensual one based on community standards (Ellis, 1994b). A centerpiece of REBT theory is that the behavior should never be equated with the person—one's *behavior* can be said to be bad, but not the person behaving (Ellis, 2005). Ellis opined that people are always in process, ever changing, so that makes it impossible to evaluate their worth at any one point in time (Ellis, 1994b).

Raphael is Alan's REBT counselor. He greets Alan and asks him what brings him in. Raphael is thinking that Alan is, like himself, only human, likely to have both strengths and weaknesses. Alan will probably show some signs of irrationality. At other times, Raphael will discern very forward-moving, productive aspects of Alan. What Raphael keeps most in mind is that the world is as Alan currently views it.

HUMAN MOTIVATION

REBT counselors assume that people have the overall goals of "surviving and being reasonably happy (a) when alone, (b) socially, with other people, (c) intimately relating to a few selected people, (d) gathering information and education, (e) working productively, and (f) having recreational interests, such as art, music, literature, philosophy, entertainment, and sports" (Ellis, 1994b, p. 18). Ellis believed that humans should be long-range hedonists, implying that the basic human motivation is to obtain pleasure and avoid pain but with an eye toward the future in terms of the effects of behavioral choices.

Raphael sees Alan as a person in search of survival and happiness. Raphael notes that Alan is currently involved in behavior directed toward satisfying intrinsic human goals. He seeks (and has established) social and intimate relationships in that he has a partner, Teresa, and friends at work as well as at his church. He and Teresa play on the church softball team. Alan mostly works productively, but lately his anxiety is getting in the way. He also finds that his anxiety leads to socially avoidant behavior, and he has been spending more time at home.

CENTRAL CONSTRUCTS

ABCs

REBT is as simple as ABC. The *A* stands for the antecedent event or activating experience, or something that happens to us that we find relevant. Sometimes the *A* refers to adversity (Ellis & Ellis, 2011). The *A*, in fact, can be almost anything. *A*s can be thoughts, fantasies, emotions, or other people; it is whatever the person is upset about (Wolfe, 2007). Dryden (2013) argued that most often, the *A* will involve an inference about the activating event, meaning that it is not just that I fell down the stairs at the theater but that I fell down the stairs and everyone was looking at me and thinking "what a klutz."

The *C* is the consequence, or what we normally think of as the result of the *A*. *C*s can be emotional events (sadness, happiness, anxiety, depression) or behaviors (persistence at a task, avoidance, compulsive behavior). *C*s can take the form of healthy emotions (such as sadness or happiness) or unhealthy emotions (depression, anxiety, or rage; Ellis, 1999d).

If you have had the good fortune to be exposed to Ellis, Epictetus, or some other rational emotive behavior therapist, you know that what makes the difference in experiencing healthy or unhealthy emotions is what you think about the *A* event. *A* is not directly connected to *C*, but instead is filtered through *B*, our belief about *A* (DiGiuseppe et al., 2014).

An important but conceptually difficult aspect of REBT is that, even though the ABC model seems very straightforward (i.e., *A* activates *B,* then *B* causes *C*, or $A \times B = C$; Ellis, 1999c), Ellis (1994b) is clear that emotions, beliefs, and behaviors interact. That is, feelings usually involve cognitive components and vice versa. Behaviors are intertwined with thinking

and feeling. Let's assume that I believe very strongly that the world must be fair and just. When someone cuts in front of me in line at the grocery store (an *A*), I am likely to perceive this slight as much more catastrophic than someone who does not hold the same belief. The *A* becomes much more negatively valenced based on my *B* system. Another example of the interrelatedness of human experience is that extremely powerful or unusual *A*s (e.g., a hurricane) can cause *C*s (Ellis & Dryden, 1997).

Raphael begins to identify some of the As, Bs, and Cs of Alan's presentation. The Cs are what brings him to counseling, so Raphael starts by looking at them: anxiety, unwanted repetitive checking behavior (of light switches and his path home from work), and disturbing imagery. The As of Alan's situation seem less clear. Alan reports that prior to his repetitive behavior, he has thoughts and images associated with danger that seem to trigger it—simple sentences like "Something bad might happen if I leave the lights on" or "I might have run someone over." The C of experiencing religious imagery is also an A event because it is connected to the Cs of anxiety, shame, and guilt. It is less clear where the images themselves come from.

BELIEFS

Beliefs are simple, declarative sentences we say to ourselves or images and symbols that have special meaning to us. Collectively, our beliefs form our life philosophies, which then "run—and ruin! most of our lives" (Ellis, 1994b, p. 46).

There are two kinds of beliefs, according to REBT theory: rational beliefs (rBs) and irrational beliefs (iBs). On a descriptive level, rational beliefs are "logical and/or have empirical support, and/or are pragmatic" (Ellis, David, & Lynn, 2010, p. 3). As you can see from the "and/ors" in the previous sentence, to be rational beliefs must meet one of the three criteria. They generally lead to mild to moderate emotions (DiGiuseppe et al., 2014). Dryden (2013) identified four kinds of rational beliefs: "nondogmatic preferences . . . non-awfulizing beliefs, discomfort tolerance beliefs, and acceptance beliefs" (p. 4). These will make much more sense to you after you read the following information on irrational beliefs.

Irrational beliefs are rigid, demanding musts or shoulds (Bernard, Ellis, & Terjesen, 2006). They are usually illogical and unrealistic, but not always. Early versions of the theory listed various specific irrational beliefs (e.g., "It is absolutely necessary that I be loved and approved of by everybody around me"), but generally Ellis said that the core irrational belief was demandingness, which leads us to *must*erbate (yes; this is Ellis's term; Ellis, 1994b): the world *must* be fair, I *must* be perfect, others *must* be nice and love me. The tendency to think irrationally is inherent (biologically based) as is the tendency to think rationally (Ellis, 1979a).

When people rely on irrational thinking a lot, they can fall into other kinds of irrational thinking that are thought to be derivatives of the musts—that is, one doesn't engage in these unless there is a demand in play. These irrational beliefs are (a) awfulizing, or seeing things as much more than bad; (b) I-can't-stand-it-itis, or low frustration tolerance (LFT), the belief that bad things should never happen and I can't stand it if they do; or (c) damnation, or rating ourselves, others, or the world as absolutely, totally horrible (Ellis & Ellis, 2014). DiGuiseppe et al. (2014) substituted the term *frustration intolerance* for LFT to recognize that many clients really are experiencing a lot of frustration and just don't have enough tolerance (i.e., the problem is not necessarily that they have *low* frustration tolerance).

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Video Example 9.1 Watch this video from 7:10 to 8:48. What irrational beliefs is Gloria holding?



https://www.youtube.com/watch?v=odnoF8V3g6g

We are not always aware of our iBs because they can operate on both conscious and unconscious levels (Ellis et al., 2010). Humans are in the habit of hanging onto their iBs, repeating them again and again to themselves. Eventually, they are transformed into basic (irrational) philosophies that feel like the truth sent from on high (Ellis, 1994b). These dysfunctional basic philosophies are then reinforced in a number of ways. They lead to strong negative emotions, which makes them feel true. They use circular reasoning (If I fail, I am bad. I failed, therefore I'm bad).

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Video Example 9.2 Watch this video from 10:31 to 12:51 to see Albert Ellis explore Gloria's irrational beliefs.



https://www.youtube.com/watch?v=odnoF8V3g6g

Raphael thinks that Alan's iBs are fairly easy to guess, although Alan might not consciously think about them. Raphael thinks that Alan seems to have some kind of extreme belief around the light switches: "If I don't turn off all light switches, some disaster will happen and that would be awful!" Similarly, he might be thinking, "I absolutely must not *ever hit anyone with my car. If I did that, it would be* terrible *and I would be an absolutely* rotten *person!" Although Raphael is wondering what the imagery is about, he suspects that Alan is also telling himself that he should* never *have images such as these, and the fact that he does makes him an* unworthy worm, *a* definite no-goodnik! *Underlying these specific beliefs is Alan's adoption of the three musts, and most particularly the first: I* must *be perfect. Because he has such difficult symptoms that sometimes seem to cause other people to treat him badly, Alan probably harbors the other two musts as well: others* must *treat me well, and the world* must *be an easy place to live or I just can't stand it. Clearly, Alan is awfulizing, is rating himself as worthless, and is beset by low frustration tolerance. He sees himself as all bad because of the symptoms he experiences.*

GOALS

According to REBT, people have goals that they carry with them, and the most important *A*s happen when those goals are thwarted. We all have the general goals to survive and be happy, but these are translated into more-specific subgoals that we share with other people (e.g., the desire for a successful career) or that may be idiosyncratic. One common goal is to be loved (Ellis, 1995a). When we receive information that indicates that someone important is unhappy with us, the goal of being loved is blocked and we experience an antecedent event. Other specific goals mentioned by Ellis are to be comfortable and successful (Ellis, 1995a). "We naturally want love, power, freedom and fun—for they often add to our enjoying of life and help us survive" (Ellis, 1999c, p. 8).

Alan's goal of being reasonably happy is threatened by his compulsive behavior. He has to interrupt his normal life rhythms to check the light switches, and he can never relax at home because he must go back and check to see if he has hit anyone with his car. The anxiety and depression he experiences also interfere with his goal to be comfortable and successful. He is having difficulty at work because of his anxious, compulsive behavior, Raphael discovers. His coworkers sometimes react to his apparent discomfort and anxiety, and he sometimes checks and rechecks small details of their work. Raphael suspects that Alan's goals to be accepted by others and loved by his wife are also frustrated to some extent because his sometimes odd, anxious behavior puts others off, and Teresa is getting quite frustrated with his "checking" behavior (the light switches and his route home from work). He is most concerned about the strife in his relationship with Teresa. (Raphael wonders, as an aside, if Teresa is experiencing some I-can't-stand-it-itis about Alan's behaviors.) Raphael also knows that Alan's religion is very important to him and guesses that the imagery Alan reports creates a perception that Alan can't possibly achieve his goal of being worthwhile in the eyes of God and his church.

HUMAN WORTH RATINGS AND USA

In REBT, global human worth ratings—that is, seeing yourself or someone else as an all-good or all-bad person—are a no-no. The person and the behavior must be separated—one can behave badly, but that does not make one a bad person (a rotten person or a worm; Ellis, 1999a). Ellis (2005) opined, "So you accurately tell yourself, 'I did that desirable or undesirable act. It certainly did not do itself! I did it with my little hatchet; and I will—because of my talents and fallibilities—do many more desirable and undesirable behaviors. But I *am* not my acts—just a *person* who behaves well and badly'" (p. 15; emphasis in original).

Instead of making global judgments of worth, individuals should work toward unconditional self-acceptance, or USA (Ellis & Ellis, 2014). USA can be achieved in one of two ways. One option is to fight your natural tendencies to self-evaluate and instead choose to see yourself as a good person just because you are alive and human (Ellis, 1999b). The problem with viewing yourself as inherently good is that it is definitional—anyone could come along and disagree with your definition of yourself and say that you are a worm. You have no way of proving that your assertion is right. Also, "you, alas, are a fallible and often screwed-up human" (Ellis, 1999b, p. 54), so you would be constantly confronted with your own imperfection. The better option to global goodness is to refuse to make such evaluations of the self at all. Simply evaluate your behavior, thoughts, and feelings as good or bad according to the standard of rationality (i.e., whether they help you achieve your goals; Ellis, 1999a).

This REBT rule applies to our self-ratings as well as to our appraisals of others. Ellis maintained that it is best to practice UOA, or unconditional other-acceptance, too (Ellis & Ellis, 2014). Because others are human, they will also most certainly treat you badly and may even believe that you *deserve* to be treated that way! UOA, then, involves applying the same standards to others that you apply to yourself—hate the behavior, not the person. Similarly, Ellis argued that unconditional life-acceptance (ULA) is necessary to achieve a state of minimal disturbance (Ellis & Ellis, 2014).

Alan is rating himself as a worthless human being, particularly because of the uncomfortable religious images he experiences that he feels he cannot control. He does not unconditionally accept himself. Because he has experienced the anxiety and repetitive behavior for a long time, he tells Raphael that he believes

that there is something wrong with him—he is a 100% bad person. He also sees most other people as uncaring and mean because they would not accept him and his dysfunctional behavior.

Secondary Disturbances

It's bad enough that we create our own unwanted negative feelings and behaviors (*C*s). What's worse is that, according to REBT, we go even further and believe that we "*must not* think crookedly, *must not* have disturbed feelings, *must not* have dysfunctional behaviors" (Ellis, 1999a, p. 81). When we have an upsetting ABC experience, we treat the *C*s as activating experiences themselves (*A*2s) and then get all wound up with *B*s about them. Ellis called these kinds of upsets secondary disturbances because they come in response to the first ABC sequence, which we have mishandled by relying on an iB in response to *A*1. Then we create more trouble by adding an iB in response to *A*2 (or the original *C*). When we tell ourselves that we *must not* have lousy thinking, or get anxious, or whatever, we are creating a secondary disturbance or symptom stress (DiGiuseppe et al., 2014).

For example, if my mother yells at me (*A*1), I can respond with the rB "Well, I'd rather she didn't do that, but it does not make me or her a rotten person." This sequence might result in some annoyance or mild discomfort on my part, a healthy negative emotion. Alternately, I might respond with the iB "She *must not* yell at me—I can't stand it and she is a rotten person!" In this second case, the *C* would probably be anger, and even some angry behavior (such as shouting back at Mom). If I shout, then I have created an *A*2 because I immediately respond with the iB "I must be perfect at all times, absolutely never lose my cool or be mean to anyone or I am a *worm*!" I have then constructed the secondary disturbance, *C*2—that is, shame, guilt, or depression.

Ellis (1999a) noted that clients can even create *tertiary disturbances* that have to do with musting about doing well in therapy and expecting that the counselor will help perfectly, significantly, and quickly! These tertiary disturbances need to be discovered and disputed while, or even before, the counseling addresses the primary or secondary ones.

*Raphael thinks that Alan is evidencing significant secondary disturbances. When he gets anxious and performs his compulsive behavior (*C*1 and also* A*2), he tells himself that he must not be like this (iB2) and that he absolutely should not ever act in such silly, immature ways (iB2). Further, life should not be so difficult—he just can't stand how hard it is to live (iB2). These Bs are likely creating feelings of rage and depression (*C*2s).*

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

REBT does not present a personality theory or offer a detailed developmental discussion. As noted earlier, REBT postulates that humans are a product of both inherited influences and environmental teaching, but constitutional factors are considered the more powerful ones (Neenan & Dryden, 2011). Ellis did not discuss any developmental progression; at one point, he called Freud's psychosexual stages figments of his (Freud's) obsessive need for perfection.

Biological influences include things such as individual differences in the tendency to think irrationally or react emotionally and, conversely, to grow and actualize. Tendencies toward behavior (such as compulsive behaviors) can also be innately determined (Ellis, 1997b).

The most important environmental influences are other people. We absorb rules, standards of behavior, and goals from those around us, including parents, siblings, teachers, peers, and religious or political groups. "You, like almost all people, are a born 'musturbator' and will almost inevitably take parental, societal and personal rules and foolishly make them into imperatives. So most—not all—of your profound musturbation is self-constructed, self-repeated, self-learned" (Ellis, 1995a, p. 4; quotes in original). Of course, we don't have to internalize these rules, but it is our human nature to do so.

When her parents, for example, tell Julie that she should be getting better grades, they really mean, according to Ellis (1995a), that it would be *preferable* if she got all As. Like most parents, they then proceed with business as usual and still love Julie even if she gets all Cs. Because she is born with a twisted little human mind, Julie takes the preferential "you should" and turns it into an absolute demand that runs something like this: "I absolutely *must* get all As and be perfect. It will be positively *horrible* if I don't, and I will be a *worthless, rotten worm*."

Much of this construction of musts and shoulds happens when we are children and have immature (bad, rigid, crooked) thinking processes (Ellis, 1995a). We then carry these irrational ideas into adulthood, constantly reindoctrinating ourselves without really realizing what we are doing.

Raphael and Alan don't spend a lot of time discussing Alan's childhood or how he got to be how he is today. Raphael knows that, although some of Alan's behaviors and beliefs probably originated early in his life, some things about Alan may be the result of biological influences.

HEALTH AND DYSFUNCTION

In the REBT view, healthy people are those who rely mostly on rational beliefs in their daily lives. Healthy folks tend to use flexible, preferential thinking rather than absolutistic musts and shoulds (Dryden, 2013). Unconditional self-acceptance is characteristic of healthy individuals because they take responsibility for their psychological functioning and choose to accept that they are imperfect beings. They will still have the inclination to awfulize, should, musturbate, and do all of those other things associated with the human tendency to be irrational, but mostly they will defeat these tendencies (Ellis, 1995a). High frustration tolerance (HFT) is an important aspect of psychological health, but it must not be confused with always accepting situations we don't like. Instead, HFT means that one often tolerates disliked situations in the short term, while working to change them to reach desired goals (Harrington, 2011).

Healthy people have healthy basic philosophies that value flexibility and open-mindedness and oppose bigotry (Ellis, 1994b). Relativistic thinking and desiring (as opposed to absolutely needing) is a core characteristic of psychological health. Self-interest is a primary value because healthy people realize that "if they do not primarily take care of themselves, who else will?" (Ellis, 1985, p. 108). However, they balance self-interest with social interest because most of them also want to live happily in a social group. If they act in ways counter to the group's good, they are not likely to create an environment in which they can live happily.

Acceptance (USA, UOA, ULA) is an important characteristic of the healthy person, in the sense of accepting one's and others' human fallibility, given that life is complicated and sometimes influenced by factors outside of one's control. However, acceptance does not mean resignation; healthy people actively change their worlds when they can (Dryden, 2011). In fact, Ellis (1999c) argued that the REBT counselor's job is not only to help clients deal with iBs around social injustice, but also to encourage them to work to change these unhealthy *A*s.

Healthy people endorse the philosophy of REBT. The values in the REBT philosophy include long-range hedonism, self-interest, social interest, self-direction, tolerance of others, acceptance of life's ambiguity and uncertainty, flexibility and openness to change, and the value of scientific thinking (Ellis, 2005). Commitment to something outside of one's self is important, whether that commitment is to people, things, or ideas. REBT also emphasizes risk taking, nonperfectionism, and nonutopianism (Ellis, 1985, p. 110).

Dysfunction from an REBT perspective is, most simply, operating in the world on the basis of irrational beliefs or, more globally, on the basis of an irrational philosophical system. Ellis (2003) wrote, "I have stubbornly insisted that human disturbance is contributed to by environmental pressures, including our childhood upbringing, but that its most important and vital source originates in our innate tendency to indulge in crooked thinking" (p. 205).

People who experience life difficulties have taken their preferences and elevated them to absolute demands. "Anxious, depressed, and enraged people have many dysfunctional ideas or irrational beliefs by which they largely create their neurotic disturbances; and as the theory of REBT holds, these beliefs almost always seem to consist of or be derived from unrealistically, illogically, and rigidly raising their nondisturbing wishes and preferences into godlike absolutist musts, shoulds, demands, and commands" (Ellis, 1999d, p. 477). They awfulize, engage in damnation, and have textbook cases of I-can't-stand-it-itis.

Demandingness is the core of psychological dysfunction, from which all other problems flow. Awfulizing, frustration intolerance, and global condemnation of human worth flow from the original must: it is badder than bad that my demand isn't met, I just can't stand it, and I am a worm/you are a worm/the world is one big worm.

When the client's issue involves self-esteem, the person is said to be experiencing *ego disturbance*; all other forms of dysfunction are referred to as *discomfort disturbance* (Neenan & Dryden, 2011). Dryden (2009) offered a more detailed description of various forms of dysfunction, describing the philosophies, beliefs, and consequences associated with them (e.g., anxiety, shame, depression). For example, in non-ego anxiety, the individual will have a "threat to non-ego aspect of personal domain . . . (a) rigid demand . . . and (b) LFT belief" (Dryden, 2009, p. 6). In contrast, the elements of ego anxiety are some kind of threat to the ego, a rigid demand, and a self-depreciation (self-downing) belief.

Ellis acknowledged that severe psychological dysfunction, such as personality disorders, profound depression, obsessive-compulsive disorder, or psychosis, likely stems from the joint influence of traumatizing early experience and innate, organic deficits (Ellis, 2002). Individuals who display these syndromes are probably inherently more emotionally reactive and behaviorally disorganized than "nice normal neurotics" (Ellis, 1997b, p. 198). They may experience more frustration and criticism in life because of their sometimes odd behavior (Ellis, 1994a). Even worse, individuals with severe dysfunction tend to create severe secondary disturbances about their very real deficits. They easily develop severe LFT, insisting that "my symptoms *must* not be so upsetting and handicapping." They self-down about having such deficits (Ellis, 1994a). These problems tend to make individuals with these kinds of dysfunction VDCs (very difficult customers; Ellis, 1994a, 1997b).

Raphael thinks that some of Alan's thoughts and behaviors stem from biological tendencies, such as the propensity toward anxiety and compulsive behaviors. Alan might even be seen as having obsessive-compulsive disorder. Raphael has identified the irrational beliefs that Alan connects

with light switches, running people over with his car, and the scary sexual religious imagery. Raphael can also see how Alan responds to events in his life with thought processes that are self-defeating. He is self-downing and has low frustration tolerance. With the recent resurgence of his compulsive behavior, Alan seems to be holding beliefs such as "I must not be flawed like this! I can't stand it that I am not perfect in every way! Further, when I am like this, everyone disapproves of me. I'll never be loved and accepted by everyone, and that is really intolerable! I can't stand this anxiety or the rejection of others! I am a rotten, flawed human, and I will never lose these symptoms, and therefore I can never have a happy life or the love of those important to me. This is just too hard!" Clearly, Alan is showing both ego and discomfort disturbance; he downs himself for his anxiety, compulsive behavior, and images. He believes that he can't stand the pain and trouble in his life.

NATURE OF THERAPY

ASSESSMENT

Older sources maintain that REBT rejects the traditional (medical) model of assessment, in which clients are subjected to a comprehensive assessment procedure prior to therapy (DiGiuseppe, 1995a). However, some recent advocates are more prone to formal assessment. For example, clients starting counseling at the Albert Ellis Institute complete a rather elaborate set of self-report instruments before their first session (DiGiuseppe et al., 2014). A large number of self-report instruments have been developed to assess beliefs; a good discussion of these can be found in Macavei and McMahon (2010). The goal of assessment is to formulate an REBT case conceptualization (Dryden, David, & Ellis, 2010).

REBT therapists may also use several structured techniques that are directed at assessing clients' belief structures. These more formal techniques, sometimes called *vivid REBT*, are discussed later.

Informal assessment involves simply asking what brings the client to therapy. The counselor then listens for *A*s, *B*s, and *C*s as well as other characteristics deemed relevant to REBT treatment, such as cognitive flexibility, problem-solving skill, and indicators of secondary emotional disturbance (DiGiuseppe, 1995a). The *C* is usually explored first because it is what gets the client to counseling. After the client and counselor agree on the most important *C*, it is time to get to *A.* Finally, the counselor assesses *B.* Advocates of REBT do acknowledge that it is sometimes difficult to determine what iBs the client is holding because iBs are often not immediately available to conscious reflection (Ellis, 1994b). When the client is simply asked what he is thinking (in conjunction with an *A* or a *C*), he will usually report automatic thoughts or inferences about *A* (DiGiuseppe et al., 2014) rather than the core iBs.

Although the counselor can proceed to dispute these thoughts, this is not the most efficient route. Instead, the REBT therapist uses *inference chaining* to get to the core beliefs (DiGiuseppe et al., 2014). In this procedure, the counselor asks the client to assume that the thought or inference is true and then asks, "Then what?" or says, "That would mean . . ." The client's response is then followed by further questioning, until the process reveals the iB.

For example, Larry does not like to dance in public, but his girlfriend, Pam, wants to go out and boogie. Their relationship is deteriorating because of this argument, and Larry asks his counselor for help. The following might be a typical assessment dialogue:

Larry: *I just can't go out dancing.* [an *A*]
Louise: *Why?*
Larry: *Because I'd be petrified.* [a *C*]
Louise: *What would you be petrified about?*
Larry: *That other people would watch me dance.* [an inference]
Louise: *If that happens, then what?*
Larry: *They'd see what a terrible dancer I am.* [an inference]
Louise: *And if other people saw that you were a terrible dancer?*
Larry: *They'd laugh at me.* [an inference]
Louise: *And if they laughed?*
Larry: *That would be absolutely awful.* [an iB]
Louise: *What would be awful about the laughing?*
Larry: *I'd feel really stupid.* [suggestion of an iB—a demand]

In this example, the counselor has clearly gotten to a part of the problem—Larry is awfulizing about looking bad in public. However, she has not yet really helped Larry to see the core underlying demand, which is probably "I absolutely must be perfect" (i.e., "I must never appear stupid or imperfect") or "Others must always approve of me." Further questioning would reveal this more significant philosophical idea. As this example illustrates, clients also have iBs about inferences (e.g., the inference that others seeing Larry dance would laugh is connected with the idea that it would be awful) that contribute to emotional upset; these should be assessed along with the ultimate, core iB (Dryden, 1995b). This example also illustrates that the inferences clients make can be faulty—who knows if folks watching Larry would laugh? They might instead applaud and cheer!

Some clients have difficulty labeling emotional experience or relating emotions to *A* events, making the traditional dialogic methods of assessment ineffective. Dryden (1995c) recommended the use of vivid methods in these cases. Vivid assessment can take a number of forms. First, the counselor can try using language that is much more emotional and colorful than normal. Guided imagery about *A* events might help the client experience more fully his emotions and cognitions. The client can be asked to bring photographs or mementos that relate to the problem situation to his sessions. Finally, Dryden (1995c) described the *interpersonal nightmare technique*, in which the client is asked to write a brief script, as if for a play, about his most feared event. The script can be audiotaped and then played for the client in the counseling session, and the counselor and client can examine the beliefs revealed.

Dryden (1995c) also described riskier techniques that involve either re-creating the problem situation in the counseling session (rational emotive problem solving, or REPS; Kanus & Wessler, 1976) or performing in vivo assessment. In REPS, for example, the therapist might criticize the client, re-creating the behavior of a critical other. As Dryden noted, this technique can be very difficult for the client, and the counselor must be careful to fully assess the client's reaction to it. If the client finds the approach negative, the counselor should immediately explain his rationale for using it.

In vivo assessment involves a field trip. Client and counselor actually take the assessment process out of the office and into the setting most relevant to the problem. A client with an animal phobia, for instance, might be taken to a zoo or an animal shelter. Again, the counselor must be very careful to monitor the effects of this technique on the client.

Raphael decides not to use formal, standardized testing with Alan. Instead, he proceeds by asking Alan what is bringing him in and then looks for the A*s,* B*s, and* C*s. Raphael has guessed quite a few of Alan's irrational beliefs. The* A*s of the situation are less clear. Some perception of threat seems to set off Alan's irrational beliefs about checking light switches and driving in his car. The* A*s could be thoughts, the sight of light switches, or images of hitting someone with his car. Another explanation could be that Alan is simply biologically predisposed to anxiety, which then sets off his belief system, so that the anxiety is acting like a secondary* C*. The* C*s for Alan include anxiety, repetitive behavior, depression, shame, guilt, and probably some anger, although Alan is not expressing that directly.*

Raphael might use some imagery assessment around Alan's repetitive behavior to see what he is thinking before and during this behavior. This approach would provide clues to the specific content of Alan's beliefs. Inference chaining might be useful around the light-switching behavior, creating a dialogue such as the following:

R: *So you get the notion to go back and check to see if the switch is off, that you might have left it on?* [the *A*]
A: *Yes.*
R: *Why do you think you have to check to see?*
A: *Because I become unsure if I did it.*
R: *What if you didn't turn off the switch?*
A: *Something bad would happen*. [an inference]
R: *What kind of bad?*
A: *I don't know. Just something bad. Maybe the house would burn down.* [an inference]
R: *And if it did?*
A: *It would be awful, terrible, and it would be my fault.* [an iB resulting in *C*—anxiety, compulsive behavior]

It would be risky, but Raphael could use the interpersonal nightmare technique to explore Alan's fears about hitting someone with his car. This kind of assessment could also be done in vivo, but if Raphael chooses this approach, he would probably blend it with the use of some coping statements (discussed later) to help Alan through the experience.

Overview of the Therapeutic Atmosphere

REBT counseling is distinctive in its active, directive nature. Ellis (1992b) wrote, "If the therapist is namby-pamby, is Boy Scout-ish or Girl Scout-ish, as lots of therapists are, I doubt whether the therapist will be too helpful. Unless you use your own personality traits and have a good deal of push and drive to help your many unpushing clients, you will not greatly help those who are pushing very hotly in the wrong direction" (p. 95).

The authoritative stance of the counselor in REBT is combined with unconditional acceptance of the client (Wolfe, 2007). Ellis (1995a) added that "unlike Rogerians, moreover, they actively, forcefully teach their clients to *accept themselves* unconditionally" (p. 16; emphasis in original). The counselor is encouraging and supportive of the client and projects confidence that the client can change his ways (Ellis & Ellis, 2014). The REBT counselor often uses humor with clients because one of the major reasons they are clients is that they take themselves, their problems, and the world too seriously (Neenan & Dryden, 2011). However, Dryden and Neenan (2006) cautioned that the REBT therapist needs to be interpersonally flexible, willing to be formal or informal, self-disclosing or not, and humorous or unfunny depending on what most promotes the therapeutic relationship.

As in most current approaches, the therapeutic alliance is considered important in REBT work (DiGiuseppe et al., 2014). The REBT counselor uses active listening and empathic

responding, conveying unconditional acceptance of the client. Although Ellis recognized the value of the therapeutic relationship, he also cautioned that, depending on the relationship, too much emphasis on it can lead to clients *feeling* better, not *getting* better (i.e., changing their behaviors; Ellis, 1996). Also, he warned that a very close relationship can be damaging for clients who tend to be dependent. The REBT counselor avoids letting the client get into lengthy descriptions of *A*s because he is not very interested in history, seeing it as "sidetracking" (Ellis, 1979b, p. 95). Likewise, allowing the client to wallow in *C*s is considered nonproductive. The real deal is to guide the client back to the source of the *C*s, the iBs.

Although Ellis claimed that REBT is more efficient than other therapeutic approaches, whether it is a brief approach is questionable. Ellis was fond of saying that "poor Sigmund Freud was born and reared with a propensity for *in*efficiency, while I seem to have been born and reared with a gene for efficiency" (1996, p. 4; emphasis in original). Despite this humorous claim, no evidence has been presented indicating the average number of sessions of REBT clients. Ellis (1996) maintained that most "normal neurotic" clients are helped within 20 sessions.

Raphael is an energetic, active counselor who demonstrates respect and acceptance of Alan. He approaches the relationship in a straightforward, honest way and expects Alan to do the same. Raphael responds empathically to Alan's presentation and conveys understanding of Alan's discomfort about his bothersome and scary symptoms.

Roles of Client and Counselor

An interesting quandary arises when attempting to describe the role of the counselor in REBT: It seems that even more than with other approaches, it is easy to confuse the role of the therapist with the personality of Albert Ellis (Garfield, 1995). Ellis's distinctive confrontive and directive style threatens to become the "manual" for how to do REBT, and Ellis believed that a softer, more indirect approach is probably ineffective. "If therapists are honest, direct, and active they are likely to achieve better results with most clients more of the time. But not with all!" (Ellis, 1994b, p. 54). Ellis and Ellis (2014) indicated that, typically, REBT therapists are a little stern and unlikely to exude warmth and love, but at the same time are empathic and unconditionally accepting.

You don't have to mimic Albert Ellis to be an REBT therapist. As long as you know the theory, you can implement it with a softer style. Wolfe (2007) went so far to say that "you definitely don't have to use an exhortative voice tone or four-letter words in order to be a good REBT practitioner" (p. 188).

REBT counselors "often employ a rapid-fire active-directive-persuasive-philosophical methodology" (Ellis & Ellis, 2014, p. 214). The therapist serves in a teacher role to help the client learn the ABC model. Many (if not most) REBT counselors adopt an informal style in relating to their clients (Dryden, DiGiuseppe, & Neenan, 2010).

The REBT client is a student of the counselor, but needs to be a very involved and energetic one. Clients have to work hard in REBT. Although Ellis believed that we can change our ways of thinking, emoting, and behaving, "*only hard work and practice* will correct irrational beliefs—and keep them corrected" (Ellis & Ellis, 2014, p. 154; emphasis in original).

Raphael approaches Alan as a friendly teacher, an expert on the ABCs. Alan responds well to this structured approach and works hard as the REBT student.

GOALS

REBT has two major goals: (a) to eliminate irrational thinking and thereby the associated dysfunctional emotions and behaviors and (b) to teach the client REBT philosophy.

At the simplest level, the goal of REBT is to help clients change irrational beliefs into rational beliefs. "REBT holds that showing disturbed people that they are profound musturbators is most probably the most important thing a therapist can do to help them" (Ellis, 1999a, p. 80). Ellis maintained that you can change your *A*s, *B*s, or *C*s. However, he warned that *A*s are sometimes difficult to change because we have little control over them. Sometimes it is impossible to change a *C* unless we change our *B* first (Ellis, 1994b, p. 22).

Beliefs therefore are the target of many REBT interventions. However, the REBT therapist also wants the client to learn unconditional self-acceptance, high frustration tolerance, and unconditional acceptance of others and the world (Ellis & Ellis, 2011). Further, the REBT counselor strives to help clients change their dysfunctional basic philosophies. Ellis (1994b) wrote, "Moreover, if you radically modify some of your basic musturbatory attitudes, and thus make a *profound philosophical change*, REBT hypothesizes that you can thereby change *many* of your self-defeating feelings and behaviors as well as your negative, antiempirical automatic thoughts, keep them healthfully changed, and actually make yourself less disturb*able*" (p. 23; emphasis in original). Ideally, the REBT client adopts the philosophy of the healthy person described earlier.

To change their philosophies, clients need to accomplish three major objectives: "(1) Acknowledge that they mainly are responsible for their own disturbed thoughts, feelings, and actions, and stop copping out by blaming their parents, their culture, or their environment. (2) Clearly see how they are thinking, feeling, and behaving when they needlessly upset themselves. (3) Work hard, forcefully, and persistently to change their neurotic cognitions, emotions, and performances" (Ellis, 1985, pp. 110–111).

Finally, clients in REBT are expected not just to feel better, but to get better, too. The REBT client must have insight into the ABCs of life, but also must work to behave differently (Ellis & Ellis, 2011).

Raphael's goals for Alan could be stated in several ways. First, he hopes to help Alan combat his specific iBs and change them into more rational beliefs. It would be particularly important to work with the secondary disturbance Alan harbors because without addressing this aspect of Alan's distress a new philosophy is unobtainable. Alan really needs to change how he thinks about life because it is possible that he will always experience some kinds of symptoms (anxiety, a tendency to obsess). He will need to develop a philosophy that emphasizes the need to accept himself (with his symptoms), work hard to defeat his irrational tendencies, accept others, and accept the ambiguity of human existence.

Raphael also wants behavior change for Alan. In the best case, Alan will be able to fight off his urges to engage in the repetitive behaviors.

PROCESS OF THERAPY

REBT actually follows an ABCDE model. *D* stands for dispute. The client's faulty beliefs and philosophies must be disputed so that he will give them up. When the client surrenders his iBs, then he will experience a new effect, or *E*. The *E* element also stands for effective new philosophy if therapy is really successful (Ellis & Ellis, 2011). Interestingly, noting the need to reinforce

newly learned rBs, Bernard (2009) suggested to Ellis (in an interview) that an *F* should be added to the equation, to stand for "forcefully agreeing with the rational belief and applying it" (p. 70). Ellis agreed.

There are two kinds of REBT: general, or *inelegant*, and preferential, or *elegant*. Inelegant REBT consists of using cognitive-behavioral interventions common to other forms of cognitive therapy to help the client learn healthy, rational behaviors (Ellis & Ellis, 2011). Inelegant REBT often focuses on the client's inferences that result from iBs; for instance, the therapist might confront the validity of the client's statement that everyone would laugh at him if he danced poorly.

Elegant, or preferential, REBT, in contrast, is aimed at the shoulds, musts, and I-can't-stand-its of the client. The therapist helps the client adopt a more functional basic philosophy, the REBT philosophy (Ellis & Ellis, 2011). In elegant REBT, therapists teach clients about the difference between preferences and musts, and the goal is to "arrange, for the rest of their lives, that they rarely (not never) change their preferences to grandiose demands and thereby make themselves significantly less upsettable" (Ellis, 1995b, p. 71). Clients, in essence, learn to be their own REBT therapists. One outcome of elegant REBT is that clients make a serious commitment to something outside of themselves, such as family, work, or a political cause (Ellis, 1991).

Wolfe (2007) maintained that the first task of the therapist is usually to help the client reduce his emotional disturbance. She sounds a little un-REBT-like when she writes that the second phase of therapy should address self-actualization. However, what she means by self-actualization essentially involves setting short- and long-term goals that involve cognitive, emotive, and behavioral changes, all of which are consistent with the REBT philosophy.

Client resistance is seen as stemming from several influences. Sometimes clients resist because they believe that the therapist is mistaken (Ellis, 2002). However, another way to look at resistance is that it is simply difficult to change. For instance, Ellis (2002) suggested that some clients may hold beliefs such as "It's not only hard for me to change, but it's *too* hard! It absolutely *should not be* that hard! How awful! I guess I'd better give up trying to do so!" (p. 27; emphasis in original). Ellis called clients who resist REBT (and other therapies, too) difficult customers (DCs; Ellis, 1987). The most important source of resistance is the innate tendency of humans to think irrationally, to be short-range hedonists "obsessed with the pleasures of the moment rather than of the future" (Ellis, 1987, p. 365).

Other sources of client resistance include the client's embarrassment about the problems he is experiencing, his unwillingness to give up secondary gains resulting from symptoms, his belief that he must punish himself, and his perfectionism/grandiosity (Ellis, 2002). Transference-like phenomena—such as client–therapist mismatching, traditional client transference in the psychoanalytic sense, and genuine attraction between client and therapist—can also feed resistance. Finally, clients are also known to resist out of rebellion and reactance or hopelessness or in response to a judgmental, moralistic therapist.

Not surprisingly, Wolfe (2007) indicated that countertransference is a direct function of therapist cognition. She recommended disputing irrational beliefs ("I can't stand it when my client drones on and on"), even resorting to using the REBT self-help form, shown in Box 9.5 later in this chapter. Ellis (2001) presented a similar view, but also pointed out that countertransference can have both rational (i.e., helpful) and irrational aspects. The desire and motivation of the

counselor to help the client, for example, can be beneficial in therapy. In contrast, Ellis (2001) described a case in which his own low frustration tolerance (and attraction to the client) got in the way of therapy. DiGiuseppe et al. (2014) opined that countertransference will result if the counselor is carrying around the same iB as the client. The result will be that the counselor has difficultly forcefully disputing the iB. The remedy, of course, is that the therapist should do self REBT. If you really want to be a good REBT counselor, you should carefully read Ellis's (2003) article, "How to Deal with Your Most Difficult Client—You," in which he described particular irrational beliefs to which therapists are susceptible. For instance, do you believe that you absolutely must be successful with most of your clients most of the time? If so, you have some disputing to do.

Raphael knows that he needs to dispute Alan's irrational thinking and to help Alan learn to do this as well. The D *will lead to* E, *a new effect (less anxiety, shame, and anger) as well as a new effective philosophy. At first, the focus of counseling will be on Alan's symptoms, and the duo will work to modify the iBs that lead to the dysfunctional emotions and compulsive behaviors. An elegant solution will involve Raphael helping Alan adopt a philosophy of self-tolerance, long-range hedonism, self-interest, social interest, self-direction, tolerance of others, acceptance of life's ambiguity and uncertainty, flexibility and openness to change, and the value of scientific thinking. Raphael will encourage Alan's commitment to his partner and church.*

If Alan seems reluctant to accept the task of therapy, Raphael will look for the sources of this resistance. Raphael will examine his own behavior, but also test the hypothesis that Alan is embarrassed about his situation or that he feels hopeless or that he can't change. Low frustration tolerance could also be creating Alan's unwillingness to work, or he might be punishing himself for his awful thoughts that are in violation of his religious values.

THERAPEUTIC TECHNIQUES

The major technique used in REBT is *D*, or disputing. Albert Ellis typically began using disputation very quickly. However, other REBT counselors would argue that teaching comes before disputing. Neenan and Dryden (2011) advised that the principle of informed consent requires that the first task of the therapist is teaching the client about REBT—most importantly, the link between thoughts and feelings. Resources exist that can be given to the client to read, such as Dryden's (2012) book, written specifically for clients, *Dealing with Emotional Problems Using Rational-Emotive Cognitive Behavior Therapy*. For some clients, it is also useful to directly teach the ABCDE model. The therapist patiently teaches the client how to identify *A*s, search out *B*s (most likely iBs), and then link these to *C*s. Ultimately, the client learns to dispute his iBs to reach *E*, the new effective philosophy. He probably also has to practice some *F*s, too: forcefully accepting and applying new rBs (Bernard, 2009). Neenan and Dryden (2011) emphasized that the client should be taught how to generalize what he learns in counseling so that it can be applied to new situations without resorting to the company of an REBT therapist.

There are many REBT techniques, and REBT therapists are not shy about borrowing from other approaches, too—particularly general cognitive-behavioral interventions. In the following sections I review a selection of techniques that are particularly characteristic of REBT.

Disputing

Cognitive disputes often begin with asking the client to assume that the *A* is true (Dryden, David, & Ellis, 2010). For instance, Larry's therapist would say, "So let's assume that, if you dance in public, others will laugh at you." Even if the *A* is very illogical, the counselor should avoid challenging it in the interest of getting to the beliefs beyond the *A*.

Ellis and Ellis (2011) identified three basic forms of disputing: realistic, logical, and pragmatic (pp. 24–25). *Realistic* disputing focuses on the "truth or factual reality" of beliefs (p. 24). For example, Lisa might be asked, "What evidence is there to support your belief that because Steve dumped you, you are a failure, a rotten person?"

The underlying rationale behind beliefs is the target of *logical* disputing. Kathy's therapist might ask her, "Does it follow logically that, if you fail one test in one class, you will always fail tests?" An example cited by Beal, Kopec, and DiGiuseppe (1996) is amusing: "I would very much like to win the Kentucky Lottery. If I did, I might win 10 million dollars. Wow, I would never have to work again. Now, because I very much *want* to win the lottery, does it follow logically that I *must* win the lottery?" (p. 217; emphasis in original).

Pragmatic disputing is seen when the therapist and client examine the outcomes of holding a given belief. The client is asked what will happen if he continues to hold the belief. Jorge's counselor asks him, "Well, as long as you think that every time you screw something up you are a *really rotten* worm, what feelings are you likely to have, and how often? Because we know you're human and you *will* screw up!"

Ellis and MacLaren (2005) added *philosophical* disputes, which focus on life satisfaction. Sometimes the client is so immersed in problems that he loses sight of the bigger issues in existence. To a client who believes that she is fat and ugly, the therapist might say, "I realize that you are very unhappy with your weight. Do you suppose that there might be other things in your life that are meaningful and important?"

DiGiuseppe et al. (2014) caution therapists about disputing awfulizing when clients have experienced very traumatic events. Challenging the badness of these events can result in alliance problems. Instead, the therapist can consider addressing demandingess or LFT.

Raphael uses all of the disputing methods with Alan. He asks Alan what evidence exists that, if the house burns down, it is his fault and he is worthless. Where is it written that, if he can't stop flipping light switches, he is a reprehensible worm?

Logical disputes include the following: Does it logically follow that, if Alan has these disturbing images, he is a totally worthless person? If a friend had these beliefs, would Alan find them reasonable? Yes, it might be preferable to banish those disturbing images, but does that mean he absolutely has to or he can't live a meaningful life? Pragmatic disputes include the following: What do you do to yourself by continuing to believe that it would be absolutely the end of the world and your existence if you did hit someone with your car on the way home from work? Where is it going to get you if you continue to believe that you must always be perfect? A philosophical disputing question might be this: Does this behavior have to be the center of your life, or are there other important things?

Bibliotherapy

Clients in REBT are often assigned readings, and very often these are Ellis's writings in various forms. One of Ellis's books was written specifically for the general public rather than clients or therapists, *How to Make Yourself Happy and Remarkably Less Disturbable* (1999b; see Box 9.3).

Box 9.3

Positive Thinking the REBT Way: The Five Self-Starting Beliefs

In his 1999 book, *How to Make Yourself Happy and Remarkably Less Disturbable*, Albert Ellis argued, as he has many times, that you *can* change if you want to. It just takes work, practice, and the right attitude. Always the proponent of self-help, Ellis recommended the following beliefs as the keys to happiness:

1. Because I am mainly a self-disturber, I can definitely stop disturbing myself.
2. I definitely can reduce my irrational thinking that sparks my emotional and behavioral problems.
3. Although I am distinctly fallible and easily disturbable, I also have the ability to think, feel, and act differently and thus to reduce my disturbances.
4. My emotional upsets include thoughts, feelings, and actions that I can observe and change.
5. Reducing my upsetness almost always requires persistent work and effort.

Source: Information from Ellis, A. (1999). *How to Make Yourself Happy and Remarkably Less Disturbable* (p.30–38). © 1999 by the Albert Ellis Institute. Reproduced for Pearson Education, Inc. by permission of Impact Publishers®.

Alan likes to read, so Raphael loans him a copy of How to Make Yourself Happy. *He encourages Alan to go to the website of the Albert Ellis Institute and look at the materials there. On a weekly basis, Raphael asks Alan what he has learned from his studies.*

PROSELYTIZING

Albert Ellis wants you to become a disciple! Clients are often told to go out and spread the word, to try to help friends and relatives work on their iBs (Ellis, 2002; Neenan & Dryden, 2011). The idea behind this approach is that sometimes identifying and analyzing someone else's problem is easier than identifying and analyzing your own. Of course, you must warn your client that others may not have uniformly positive responses. I guess then you have created an in vivo desensitization exercise (discussed later).

Raphael encourages Alan to try to help his wife or friends in his social group at church with their difficulties if the opportunity arises. For instance, if it is not a really "hot" topic, Alan might address Teresa's idea that she can't stand his (Alan's) repetitive behavior.

RECORDINGS

Clients are often given recordings of their therapy sessions to study between appointments (Ellis & MacLaren, 2005). Several things are helpful about this approach. Clients don't usually remember all that happened during their sessions, so tape review can reveal aspects they've forgotten. Reviewing tapes also gives clients the chance to really listen to how they think, and they might become more objective about their situations as a result.

Ellis (2011) recommended that once the client has identified a key iB he should record it, along with two or three disputes (of course, recorded *strongly*). The client should listen to the recording and share it with others. Multiple recordings are probably necessary to get better and better at disputing.

Alan routinely takes his counseling recordings home for review. He says that it helps him practice his changed thinking and philosophy. Sometimes Alan even plays these recordings for Teresa. Alan also records his favorite irrational belief (I am a worthless lout because I have these troublesome thoughts!) and several disputes. He listens to this recording faithfully every night.

Reframing

Reframing involves helping clients see things a little differently. For example, clients can be encouraged to view *A*s as challenges rather than pains in the you-know-what (Ellis & MacLaren, 2005). Self-criticism can be reframed as self-help, but, of course, this requires that the client be much less dogmatic about it.

Raphael encourages Alan to understand his "checking" behavior as an effort to keep himself and Teresa safe. Of course, this is a drastic way of doing so, but the reframe may help both Alan and Teresa relax a little about the symptom.

Stop and Monitor

Because some clients have great difficulty noticing their cognitions, it is sometimes helpful to have them place cues in the environment. Every time the client notices the cue, he is to stop and observe his thoughts at that moment (DiGuiseppe et al., 2014). Cues can be anything—a string around a finger or a yellow sticky on a computer monitor.

Alan decides to wear a ring on his right hand that he has not worn in years. Every time he glances at the ring, he observes and records his thoughts. He can then analyze them for faulty beliefs. When they can, Raphael and Alan also use the thought log in their sessions to track the sequences leading up to Alan's repetitive behavior or the disturbing imagery.

Rational Coping Statements

As clients dispute their iBs they create *E*s, effective new philosophies. Part of the *E*s are rational coping statements, which are sentences the client constructs that he should review and practice as part of working to change his ways (Ellis, 1995b). An example of a rational coping statement might be "I never absolutely need what I want. I only, only prefer it and can live reasonably happily even if I am deprived of it" (Ellis, 1995a, p. 19). Ellis (2002) cautioned that these mantras should be kept realistic, checked against what happens in the world, and revised as necessary.

Raphael teaches Alan rational coping statements to use. He asks Alan to restrain his repetitive behavior and talk himself through his discomfort, saying something like "If I forgot to turn off the light switch, something could happen. It is unlikely, but if something had happened, I can deal with it. It won't be absolutely terrible or awful, and I won't be a terrible and awful person." Similar statements could be developed about driving home from work and the troubling images. Alan could practice these statements first using imaginal techniques and then in vivo.

RATIONAL EMOTIVE IMAGERY

Rational emotive imagery (REI; Maultsby & Ellis, 1974) is an important emotional disputation technique. In REI, the client is asked to close his eyes and conjure up the terrible, awful, dysfunctional emotion that has been targeted in collaboration with the counselor. When the client has fully achieved the emotional experience, he signals the counselor, who then instructs the client to change the feeling into a healthy negative emotion. After the client has achieved this transformation, he is asked to gradually return to the therapy situation. He is asked how he feels now and how he managed to change from unhealthy to healthy feelings. A bonus in this technique is that the client can learn to distinguish between healthy and unhealthy emotions if the therapist allows the client to pick the second emotion (the therapist just insists on a healthy emotion and lets the client choose it).

Raphael and Alan start with the light switch behavior. Alan closes his eyes and tries to feel the anxiety that would result if he did not check the switches after leaving a room. When he indicates that he is fully experiencing this emotion, Raphael asks him to change it to a healthier emotion. Alan has great difficulty doing this. At first, he does not know what emotion to turn to. Raphael suggests concern. After Alan has made the emotional transformation, Raphael asks him to open his eyes. They talk about what Alan did to change his feeling of anxiety to concern, and Alan reports that he changed his thoughts; for example, he changed the thought "Something terrible *is going to happen, and it will be* all my fault. *Because I did not keep the terrible thing from happening, I am imperfect and a* terrible, horrible *person" to "Something terrible could happen. If it does, it does not mean that I am worthless because I did not prevent it. I would like to prevent terrible things from happening, but I don't absolutely have to, and sometimes I can't. This failure does not make me a rotten person." He also reported thinking that the connection between light switches and awful events was probably not based in reality.*

FLAMBOYANT THERAPIST ACTIONS

This intervention can be verbal or nonverbal. Ellis used this one often, in a verbal mode, either by swearing (and thereby modeling that he is not affected by what others think of him) or by using terms such as *rotten person*, *worm*, and *no-goodnik*. Nonverbal flamboyance is even more dramatic. The therapist could proceed to stand on his head in session and then ask the client to evaluate the behavior. When the client indicates that this stunt is a little weird (or stupid), the therapist can then respond with "Well, does that make me a weird or stupid person?"

Raphael, in the midst of a discussion with Alan about his embarrassing need to check light switches, jumps to his feet and proceeds to turn in circles until he is so dizzy he can hardly stand. All the while he is singing, "Take me out to the ballgame." Alan, at first, is shocked and then begins to laugh at Raphael. When Raphael, out of breath and dizzy, is able to talk again, he and Alan discuss what happened, with Raphael modeling rational thinking and emphasizing that maybe his behavior is silly, but that doesn't make him a stupid or worthless person.

HUMOR

REBT counselors believe in having some fun . . . gently (DiGiuseppe, 1995b). One must never make fun of the client, only of his silly behavior or thinking. Ellis devised some REBT tunes just for this purpose (Ellis & MacLaren, 2005; see Box 9.4).

Box 9.4

Sing Along with Albert Ellis

Perfect Rationality
(Tune: "Funiculi, Funicula" by Luigi Denza)

Some think the world must have a right direction,
And so do I—and so do I!
Some think that, with the slightest imperfection
They can't get by—and so do I!
For I, I have to prove I'm superhuman,
And better far than people are!
To show I have miraculous acumen—
And always rate among the Great!
Perfect, perfect rationality
Is, of course, the only thing for me!
How can I ever think of being
If I must live fallibly?
Rationality must be a perfect thing for me!

Love Me, Love Me, Only Me!
(Tune: "Yankee Doodle Dandy")

Love me, love me, only me
Or I'll die without you!
Make your love a guarantee
So I can never doubt you!
Love me, love me totally—really, really try dear;
But if you demand love, too
I'll hate you till I die, dear!
Love me, love me all the time
Thoroughly and wholly!
Life turns into slushy slime
Less you love me solely!
Love me with great tenderness
With no ifs or buts, dear.
If you love me somewhat less,
I'll hate your goddamned guts, dear!

You for Me and Me for Me
(Tune: "Tea for Two" by Vincent Youmans)

Picture you upon my knee
Just you for me, and me for me!
And then you'll see
How happy I will be, dear!

(continued)

Box 9.4 *(continued)*

Though you beseech me
You never will reach me—
For I am autistic
As any real mystic!
And only relate to
Myself with a great to-do, dear!
If you dare to try to care
You'll see my caring soon will wear,
For I can't pair and make our sharing fair!
If you want a family,
We'll both agree you'll baby me—
Then you'll see how happy I will be!

I Wish I Were Not Crazy!
(Tune: "Dixie" by Dan Emmett)

Oh, I wish I were really put together—
Smooth and fine as patent leather!
Oh, how great to be rated innately sedate!
But I'm afraid that I was fated
To be rather aberrated—
Oh, how sad to be mad as my Mom and my Dad!
Oh, I wish I were not crazy! Hooray! Hooray!
I wish my mind were less inclined
To be the kind that's hazy!
I could, of course, agree to be less crazy—
But I, alas, am just too goddamned lazy!

Source: From Ellis, A. & MacLaren, C. (1998). *Rational Emotive Behavior Therapy: A Therapist's Guide* (p. 70). Atascadero, CA: Impact. © 1998, 2005 by The Albert Ellis Institute. Reproduced for Pearson Education, Inc. by permission of Impact Publishers®.

Raphael will have to be careful using humor with Alan because he is clearly very sensitive about his troubles. Raphael could gently jest with Alan about the light switch issue. (How many times does he do it? Is it a particular switch or one of a certain color? Would he like to work on the switch in Raphael's office?) However, Raphael would have to be certain that he and Alan have a solid relationship before trying anything like this.

ROLE PLAYING

Role playing is used in several ways in REBT. Wolfe (2007) indicated that role playing can be used to problem solve around the practical problems that bring clients to therapy (e.g., how to assertively express one's feelings). Role playing can also be used to assess irrational beliefs by asking the client to enact the situations that elicit dysfunctional consequences. *Rational role*

reversal is useful after the client has learned something about disputing iBs. The client takes the counselor role and disputes the therapist's iBs. For best effect, the therapist should play a naïve client, presenting a problem that is close to the client's (Dryden, 1995c). If it seems as though the client might respond well, the therapist can humorously overdo the whiny thing: "Oh poor little miserable me. Everyone should be nice to me because I am such a wimp!"

Raphael could play the client and have Alan dispute his iBs about checking light switches and being frightened about driving. He could also present as a client feeling guilty about having "bad" thoughts in some context.

Rational-Irrational Dialogues

Dryden (1995a) described several techniques under this heading, all of which involve interchanges based on iBs and rBs. In the zigzag approach, the client lists a rational belief and then attacks the rB with an irrational belief. A rational defense is then formulated, which is attacked with an irrational belief. This process continues until the client has exhausted his irrational attacks. This technique is called zigzag because it is typically done on paper with the client filling in blocks like the ones shown in Figure 9.1. The same kind of dialogue can be done with two-chair role playing. One chair is the rational chair, the other the irrational, and the client moves back and forth between them.

Raphel considers having Alan create a zigzag analysis of his beliefs around light switches.

Reinforcements and Penalties

REBT therapists often assign reinforcements that are self-administered when the client completes a "work" task (Ellis & MacLaren, 2005). Likewise, penalties are things the client doesn't like doing, and they are activated if the client doesn't complete his task.

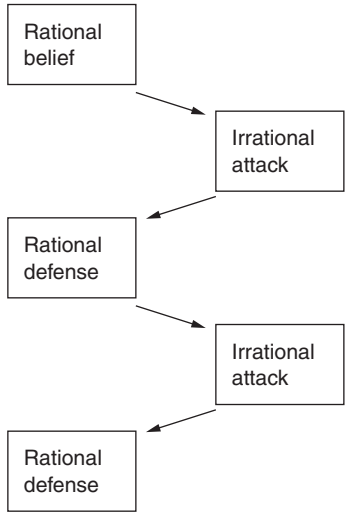


FIGURE 9.1. Zigzag Dialogue Form.
Source: Based on Dryden, W. (1995). *Brief Rational Emotive Behavior Therapy* (p. 152). New York: John Wiley & Sons, Limited.

For example, if Jenny completes her shame-attacking assignment of dancing for 3 minutes in the middle of a large department store, she can then go eat at fast food heaven (Jenny loves french fries). If she fails to do her homework, she has to spend an hour cleaning her basement (a task that she hates).

Raphael tells Alan that, if he goes without touching a light switch one evening, the next day he gets to play computer solitaire for 20 minutes. If he checks the light switches, no solitaire the next day at all.

Skill Training

Sometimes even if clients have all the right beliefs, they still have skill deficits that hinder their pursuit of their goals. REBT therapists would not hesitate to teach their clients assertive behavior or other social or interpersonal skills (Ellis, 2005). In fact, this technique would fit well in the second stage of therapy, in which the client and therapist might be working on life enhancement.

Because Alan sometimes feels awkward in social situations, Raphael decides to teach him some interpersonal communication skills. They role-play common social situations and devise responses for Alan. These listening and response skills should also help in his relationship with Teresa.

In Vivo Desensitization

Borrowed from behavior therapy, in vivo desensitization is simply asking the client to experience the feared situation. Typically, forceful cognitive coping and dispute statements are employed (Dryden & Yankura, 1993). Harrington (2011) called this approach "staying in there" (p. 14), noting that leaving a distressing situation reinforces LFT. Repetition is important—the client must encounter the stressor repeatedly (somewhat like Ellis and his 130 encounters with women). This technique is often used with phobias, and it could also be used in an imaginal approach if the in vivo version is too threatening. The client would simply visit the feared situation in fantasy and rehearse disputes and coping statements verbally.

Alan is the perfect candidate for in vivo desensitization. Raphael asks him to simply deny the urge to turn off light switches. He explains that Alan will experience anxiety, but that he can talk himself through it using his rational coping statements. Raphael also requests that Alan not retrace his route home from work, using the same rationale and strategies.

Acting on Rational Beliefs

This technique is similar to the "as if" technique used in individual psychology. Reasoning that we often spend a lot of time on iBs, it makes sense to have the client act on the basis of rBs developed in conjunction with the counselor (Ellis & MacLaren, 2005).

Alan is to act as though he truly believes that, if he is not perfect, that is simply too bad, not a total catastrophe. If the house burns down, that is tough luck. Alan is to proceed with his life as if he believed that he would not be totally worthless if he did not prevent this event from happening. The next time he experiences a disturbing image, Alan is to behave as if it doesn't make him a no-good, evil person, simply one who has some faults.

Homework

REBT counselors almost always give clients homework (DiGiuseppe et al., 2014). Tasks are devised that fit the client's problems and may include techniques described here, such as shame-attacking exercises and bibliotherapy. The REBT counselor is careful to collaborate with the client in developing homework so that the client can see how it will help (Dryden, DiGiuseppe, & Neenan, 2010). A frequently used homework assignment is the REBT self-help form, shown in Box 9.5 (from Ellis & MacLaren, 2005). The client is instructed to complete the form daily, and then the counselor and client review the results in the next counseling session. For practice, you might fill this in with Alan's ABCDEs.

Box 9.5

REBT Self-Help Form

A (ACTIVATING EVENTS OR ADVERSITIES)

- Briefly summarize the situation you are disturbed about (what would a camera see?).
- An *A* can be *internal* or *external*, *real* or *imagined*.
- An *A* can be an event in the *past*, *present*, or *future*.

D (DISPUTING IBs) **IBs (IRRATIONAL BELIEFS)**

(continued)

Box 9.5 *(continued)*

To identify IBs, look for:

- Dogmatic Demands (musts, absolutes, shoulds)
- Awfulizing (It's awful, terrible, horrible)
- Low Frustration Tolerance (I can't stand it)
- Self/Other Rating (I'm/he/she is bad, worthless)

To dispute, ask yourself:

- Where is holding this belief getting me? Is it *helpful* or *self-defeating*?
- Where is the evidence to support the existence of my irrational belief? Is it *consistent with social reality*?
- Is my belief *logical*? Does it follow from my preferences?
- Is it really *awful* (as bad as it could be)?
- Can I really not *stand* it?

C (CONSEQUENCES)

Major unhealthy negative **emotions:**

Major self-defeating **behaviors:**

Unhealthy negative emotions include:

- Anxiety
- Shame
- Depression
- Hurt
- Rage
- Jealousy
- Low Frustration Tolerance
- Guilt, Embarrassment

E (EFFECTIVE NEW PHILOSOPHIES)

E (EFFECTIVE EMOTIONS AND BEHAVIORS)

New healthy
negative emotions:

New constructive
behaviors:

To think more rationally, strive for:	Healthy negative emotions include:
• Nondogmatic Preferences (wishes, wants, desires)	• Disappointment
• Evaluating Badness (it's bad, unfortunate)	• Concern
• High Frustration Tolerance (I don't like it, but I can stand it)	• Annoyance
• Not Globally Rating Self or Others (I—and others—are fallible human beings)	• Sadness
	• Regret
	• Frustration

Source: From Ellis, A. & MacLaren, C. (1998). *Rational Emotive Behavior Therapy: A Therapist's Guide* (p. 70). Atascadero, CA: Impact. © 1998, 2005 by The Albert Ellis Institute. Reproduced for Pearson Education, Inc. by permission of Impact Publishers®.

Raphael would give Alan homework such as monitoring his thoughts, particularly during difficult situations. He might use the REBT self-help form with Alan to get him to chart and dispute his iBs. In fact, almost anything directed at Alan's beliefs could be used for homework.

Shame Attacking

Shame attacking is a well-known REBT technique (DiGiuseppe et al., 2014). The client is instructed to go out and do something dreadfully embarrassing. We can think of lots of examples, such as standing backward in an elevator or singing "My Way" while standing in line in a burger joint. It is best, however, if the shame-attacking behavior directly relates to the client's situation. The rationale for this technique is that the client will discover that he won't die of embarrassment, that it is not *absolutely 100% worse than bad* if others think he is weird. Rational coping statements can also (and maybe had better) be combined with this task.

MyCounselingLab

Video Example 9.3 Watch this video from 18:41 to 20:07. What technique is Albert Ellis using in this segment?



https://www.youtube.com/watch?v=odnoF8V3g6g

Raphael devises a shame-attacking exercise for Alan. He instructs Alan to stop at every stop sign on his way home, stick his head out the car window, and yell, "Did I run over anything yet?" If Alan can see the humor in this task, it might be quite successful. Raphael must be careful in assigning it, though, so he devises a few less risky shame-attacking exercises first. He and Teresa could take turns switching lights on and off in their living room for a designated period of time. Maybe he could progress to being able to tell a close friend about the light switch behavior, and even demonstrate it.

EVALUATION OF THE THEORY

REBT has evoked a great deal of controversy over the years. Some of this controversy is probably attributable to the personality of Albert Ellis—but, of course, he wouldn't have been upset if you did not like him or agree with his opinions! Ellis's use of salty language and liberal attitudes

about sex may have offended some, and if therapists adopt his style in toto, they'd better be ready for these kinds of criticisms (Garfield, 1995, p. 114).

On the most general level, REBT has been accused of being too intellectual, making it less useful for clients below certain levels of education and intelligence (Ellis, 1990; Garfield, 1989). Ellis himself specified that clients should be over the age of 8 and of average or above-average intelligence, adding that REBT is more effective with clients who have one prominent symptom (Ellis, 1985; Ellis & Ellis, 2011). The emphasis on cognition in REBT, in the views of some, inappropriately deemphasizes the role of client history, emotion, and the client–counselor relationship (Ellis, 1990).

Weinrach (1996) discussed several shortcomings of REBT theory. He believed that the theory has neglected to attend to cultural differences that affect definitions of rationality and the conduct of counseling. He pointed out that sometimes what is labeled rational could be counter to values from cultures other than that of the Westernized European American (e.g., when the avoidance of the disapproval of parents or other family members seems to drive emotions and is deemed irrational). Weinrach lamented that some REBT counselors have inadequate interpersonal skills, being more "tough minded than tender-minded" (Weinrach, 1996, p. 68). Neenan and Dryden (2000) added that REBT is often criticized because REBT therapists talk too much and, worse, put words in clients' mouths (p. 48).

Several REBT constructs or principles have been the target of commentary. The concept of long-range hedonism has been seen as problematic by numerous authors. At the least, they contend, this philosophy can lead to ignoring the interrelatedness of human existence; at its worst, it could promote very effective sociopathy (Weinrach, 1996; Wessler, 1996; Woolfolk & Sass, 1989). In response, REBT advocates would insist that they encourage *enlightened* self-interest, which means sometimes putting the needs of others before one's own (Neenan & Dryden, 2011, p. 95; my emphasis). Lazarus (2014) takes issue with the idea of UAO, arguing that there has to be some point at which UAO would be abandoned on the basis of another's behavior. He wrote "to claim that Hitler was not evil strikes me as asinine. And who, apart from extreme Islamic followers, would care to offer Osama bin Laden their love and endeavor to do good things for him?" (p. 271).

Ellis energetically defended his theory against all critics at any opportunity. He acknowledged the need for attention to cultural issues in REBT, but maintained that the theory is flexible enough to apply across cultures. Long-term hedonism is not a harmful philosophy; it requires social interest and cooperation because to survive and be happy, people typically choose to live in social groups (Ellis, 1989).

The strengths of REBT lie in its simple, clear-cut theory and method (Mahoney, Lyddon, & Alford, 1989). These qualities are probably appreciated by clients and therapists alike. REBT also sanctions a wide variety of techniques, so its flexibility allows the counselor to meet many different kinds of client presentations. Although there are no data to support the brevity of REBT, Ellis maintained that it takes less time than other forms of cognitive-behavioral therapy.

QUALITIES OF THE THEORY

Precision and Testability. Although on the surface REBT offers some fairly simple and precise predictions (e.g., irrational beliefs should lead to psychological dysfunction), many have identified problems with the testability of REBT theory.

Although there are recognized manuals for REBT (Ellis, 1994b; Walen, DiGiuseppe, & Dryden, 1992), some writers have opined that it is difficult to define what really happens in REBT (Haaga &

Davison, 1989). Haaga and Davison (1993) pointed out that it is difficult to define *irrational belief*, a key term in REBT. In his many writings, Ellis gave numerous definitions of the iB, creating much confusion about the construct. The term *irrational* is not used as it typically is (i.e., to mean illogical or unreasonable, although some iBs can be so deemed; Oei, Hansen, & Miller, 1993). In some writings, Ellis defined irrational beliefs as those that lead to unproductive outcomes (Ellis, 1994b; Wessler, 1996). Oei et al. (1993) pointed out that this definition is circular. In other versions, iB descriptions feature such adjectives as exaggerated, awfulizing, demanding, and judging and are said to lead to "debilitating and unhealthy negative emotions" (Ellis & Ellis, 2011, p. 20).

Ziegler (1999) and Wessler (1996) pointed out that a big challenge to REBT theory is the formulation of clear-cut hypotheses about its central constructs—antecedent events, cognition, emotion, and other consequences. The problem here is that over the years Ellis was refining his theory, he became more and more emphatic that *A*s, *B*s, and *C*s overlap significantly and are mutually influential. Because thoughts, feelings, and behaviors blend together, it is difficult to precisely measure any one of the primary constructs of the theory (F. W. Bond & Dryden, 1996; T. W. Smith, 1989). For instance, two of the major measures of irrational belief used in research, the Rational Behavior Inventory and the Irrational Beliefs Test (IBT), seem to measure beliefs and emotions simultaneously (Zurawski & Smith, 1987). However, newer measures seem to have corrected this problem (Macavei & McMahon, 2010).

Empirical Validity. Many studies report positive findings for REBT. However, the value of these findings is often suspect because of questions regarding the operationalization of variables (most particularly iBs; Zurawski & Smith, 1987). However, it is fairly well established that REBT is generally efficacious (David, Szentagotai, Eva, & Macavei, 2005; Oei et al., 1993), even if the exact mechanisms that lead to change are not specifiable.

Research Support

Outcome Research. Many studies have addressed the outcomes of REBT. For the most part, the findings have been supportive, but methodological problems often complicate the interpretation of results, particularly in older research. Using a standard summary review format, McGovern and Silverman (1986) concluded, for example, that their review of research published between 1977 and 1982 provided significant support for REBT theory. A similar review by Silverman, McCarthy, and McGovern (1992) found that 49 out of 89 studies they reviewed favored REBT over other approaches and that many not included in the favorable 49 showed no differences between REBT and comparison approaches.

In a recent, well-designed randomized clinical trial (RCT), Szentagotai, David, Lupu, and Cosman (2008) compared REBT, cognitive therapy, and pharmacotherapy for the treatment of major depression, finding no differences among treatments; all produced changes in general, global outcome measures. Sava, Yates, Lupu, Szentagotai, and David (2009) compared cognitive therapy, REBT, and drug treatment for major depression, finding no differences in their effectiveness on measures of depression and quality of life. Moreover, the psychotherapies were more cost effective than the drug treatment. REBT appears to be effective with adolescents who experience depression, too. In an RCT, Iftene, Predescu, Stefan and David (2015) demonstrated that REBT alone, pharmocotherapy alone, and group REBT plus pharmacotherapy were equally effective among Romanian adolescents.

Several meta-analyses have been completed on studies of REBT. Gonzáles et al. (2004) analyzed 19 studies of REBT with children and adolescents, finding a moderate effect size (0.50).

Extrapolating, this value means that the average treatment client scored better than 69% of the control group. Two other earlier reviews found similar results: REBT had strong effects in comparison to control conditions, but not when compared to general cognitive-behavioral therapy or behavior therapy (Engles, Garnefski, & Diekstra, 1993; Lyons & Woods, 1991). These findings prompted David et al. (2005) to conclude that REBT is probably as effective as other approaches for a wide range of client presentations.

Finally, an interesting outcome project was described by Ellis and Joffe (2002), in which the opinions of the participants from Ellis's Friday night sessions were summarized (see the "Background" section for a description of these sessions). After collecting data for a few years (with a 40% response rate), Ellis and Joffe randomly selected the responses of 100 volunteers and found that, whereas no clients reported that these sessions were not helpful, 19% responded that they were somewhat helpful and 78% thought that they were very helpful. Although this study has all kinds of obvious flaws and bias, I find it to be an aspect of Ellis history that is difficult to leave out.

Theory-Testing Research. Most of the research that bears on REBT theory has focused on the important REBT proposition that cognitive processes lead to emotional distress. Many of these studies have used nonexperimental methods; most simply measure the relationship between some theoretically important measure (unconditional self-acceptance, irrational beliefs, frustration tolerance) and some measure of psychological distress. I will briefly review a few of these.

Davies (2006) reported on a study of the relations between unconditional self-acceptance and irrational beliefs. Using both the IBT and a short version of the Attitudes and Belief Scale (DiGiuseppe, Leaf, Exner, & Robin, 1988, cited in David et al., 2005), Davies found support for REBT theory. Chamberlain and Haaga (2001) found that, after controlling for initial levels of self-esteem, USA was related to low propensity for depression. Further, participants higher in USA were more objective in evaluating their performances (on a speech) than individuals lower in USA and were less likely to denigrate individuals who evaluated their speeches poorly. Macavei (2005) compared the beliefs of depressed, mildly depressed, and nondistressed groups and found that the groups differed in expected ways on various dimensions of irrationality. These results were seen as supporting REBT theory, but questions about instrumentation and statistical analyses compromise the degree to which we can be certain about this conclusion. In contrast, J. Jones and Trower (2004) tested competing hypotheses about anger from REBT and cognitive therapy, finding more evidence to support cognitive theory than REBT. DiLorenzo, David, and Montgomery (2007) tested the relationships between beliefs and distress in college students and found that demandingness, awfulizing, LFT, and self-downing were positively correlated with distress, supporting REBT theory. These researchers also tested three models whereby beliefs connect to distress, most importantly Ellis's assertion that demandingness leads to the other categories of iBs (awfulizing, LFT, and negative self-evaluation). Support was found for Ellis's model over the other two. It is significant that the same pattern was documented by Hyland, Shevlin, Adamson, and Boduszek (2014) in a study of post-traumatic stress symptoms among military and law enforcement personnel.

Harrington (2006) developed a multidimensional measure of frustration intolerance, the Frustration Discomfort Scale (FDS), which contains subscales for emotional intolerance, discomfort intolerance, entitlement, and achievement. He then assessed the relationship between scores on this scale and depression, anxiety, and anger in a clinical sample. As would

be predicted by REBT theory, frustration intolerance was positively related to psychological distress, even after statistically controlling for negative affect and self-esteem. Subscales on the FDS were uniquely related to the various measures of dysfunction: Anxiety was most related to emotional intolerance, discomfort intolerance to depressed mood, and entitlement to anger.

The trouble with all of these studies is their nonexperimental nature. Because no manipulations are used, cognitive processes could be causing the psychological distress, as predicted by theory, or the other way around. Another possibility is that the measures are tapping the same global process or that an unknown third variable is responsible for the relationships found. Across these studies, there is wide variation in attempts to capture the last possibility by using measures of other constructs. Szentagotai et al. (2008), in their study of cognitive therapy and REBT for depression (summarized earlier), attempted to provide a more precise test of these theories by using measures that should capture the specific cognitive processes operating in these two theories as well as general outcome measures (e.g., well-known scales that measure depression). Somewhat disappointingly, they found that both treatments affected all of the cognition measures. However, in favor of REBT, they also found that on long-term follow-up, decreased demandingness was associated with less depression and fewer relapses.

However, there are other issues with studies that simply correlate irrational beliefs and distress, according to Szentagotai and Kallay (2006). First, this method leaves out the *A* (activating event), an essential component of the theory. Second, these authors pointed out that low levels of irrational belief do not necessarily correspond to high levels of rational belief.

Other tests of REBT theory have attempted to experimentally manipulate beliefs. For example, Cramer and Buckland (1995) had participants read and repeat rational or irrational statements and then assessed state anxiety and levels of irrational beliefs. They found that participants in the rational beliefs condition reported lower levels of anxiety than those in the irrational beliefs condition; scores on the Irrational Beliefs Scale (Malouff & Schutte, 1986) followed the same pattern. One problem with studies that use experimental manipulations is possible demand characteristics—that is, cues that allow participants to figure out what the experimenter expects. Typically, participants obey these messages. Although Cramer and Buckland attempted to control for this problem, it is not clear that they were successful. Similarly, Harris, Davies, and Dryden (2006) randomly assigned participants to one of three conditions (rational belief, irrational belief, or irrelevant belief) and then subjected them to a stressful situation. They found that participants in the irrational beliefs condition showed more anxiety and concern than did the other groups and also showed marked increases in blood pressure from pre- to post-test. A difficulty, however, with this research is that it appears that the groups were possibly different on blood pressure readings at pretest, making conclusions based on pre- and post-test changes suspect. Following up on his earlier study of irrational beliefs and self-acceptance (Davies, 2006) described earlier, Davies (2008) primed participants with either beliefs (rational or irrational) or self-acceptance beliefs (conditional versus unconditional) in an experimental design. His results showed that priming with irrational or rational beliefs related to self-acceptance in the predicted ways. More interestingly, he also tested the effects of priming with self-acceptance, which did not lead to changes in beliefs, suggesting that these two measures really are tapping different processes, weakening earlier criticisms of REBT research.

T. W. Smith, Houston, and Zurawski (1984) assessed participants' endorsements of irrational beliefs (via the IBT), then exposed them to stressful or nonstressful interviews and afterward

measured their psychological and physiological distress. Results suggested that only cognitive variables (preoccupation with cognitive processes, denigration of self or one's performance) were related to endorsement of iBs and, further, that a measure of fear of negative evaluation was more powerful than iBs in predicting emotional distress. These findings led T. W. Smith et al. (1984) to suggest that "it could be argued that this model is a useful metaphor but an inaccurate theory. Emotionally distressed persons may behave *as if* they endorsed various irrational beliefs" (p. 200; emphasis in original).

MacInnes (2004) reviewed a set of 20 studies of REBT (dated 1987–2000) and declared that the evidence did not support a causal relation between iBs and psychological dysfunction. David et al. (2005) came to the opposite conclusion, arguing that there was significant evidence in support of REBT theory and outcome. These disparate conclusions are likely due to a number of factors, including research published between the earlier reviews and David et al.'s. My assessment of the sophistication of REBT research is that recent studies are major improvements over previous ones, so they should be given more weight in evaluating the status of REBT.

Given the conflicting results found in tests of REBT theory, it is probably safest to remain unconvinced of the validity of the REBT predictions about beliefs and emotions. Although suggestive evidence does in some cases exist for the theoretical hypotheses of REBT, it is not clear whether the causal model is supported or that changes in beliefs observed in outcome research are specific to REBT (e.g., Szentagotai et al., 2008).

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Ellis claimed that he was the "first prominent psychologist to advocate gay liberation" (1992a, p. 10). He did, in fact, write the preface to a classic book on homosexuality (D. W. Corey's *The Homosexual in America*, published in 1951) at a time when this subject was very taboo. Ellis's history of sexual liberalism, as well as REBT's emphasis on tolerance of self and others, would lead him and his advocates to argue that REBT does not perpetuate bias based on sexual orientation.

Writing on the issue of multiculturalism, Ellis (2002) acknowledged that "therapists, like all humans, easily succumb to narrow-mindedness and intolerance" (p. 203). Still, he continued by adding that the emphasis on USA and UOA in REBT practice promotes openness to cultural difference.

On a theoretical level, the importance placed on personal responsibility and the assumption that problems reside within the person (in the form of iBs) in REBT can lead to an underemphasis on the role of social or cultural factors in people's lives. Groups that are the targets of negative stereotypes and oppression, such as women, ethnic minorities, and gay, lesbian, bisexual, or transgender (LGBT) individuals are greatly affected by these biased attitudes and prejudicial behaviors, and to tell them to change the ways they think about these influences could be detrimental to their functioning, if not discriminatory. REBT's assumption that the world is not fair (inherent in the third musturbatory attitude) could be seen as acceptance of prejudicial attitudes and discrimination in behavior. Ellis, of course, would maintain that REBT teaches clients to see the situation as bad, not 100% awful, and that it is very appropriate to encourage clients to change the *A*s through working for social justice (Ellis, 1999c). Ellis (2005) said it this way: "Clients can unconditionally accept themselves and other individuals and can achieve high

frustration tolerance when faced with life adversities . . . and most multicultural issues involve bias and intolerance—which REBT particularly works against" (p. 195).

Robin and DiGiuseppe (1997) maintained that REBT is an appropriate intervention for clients from all cultures. Citing REBT's empirical base, they argued that REBT does not need to rely on constructs that are essentially untested, such as those found in more construct-laden theory (e.g., psychoanalysis), which are liable to be culturally biased. They further argued that REBT's stoic philosophical values of tolerance and acceptance are compatible across such diverse cultures as Western European, Asian, and Native American. Acknowledging that the empiricist perspective of REBT is not consistent with some foundational cultural values (e.g., those that emphasize spirituality), Robin and DiGiuseppe asserted that it is still helpful and culturally respectful to point out the *B–C* connection and allow clients the choice of whether to use the information. They recommended that when working with clients from non-Western cultures the counselor should do two things: (a) tell the client about his expectations for therapy and (b) find out what the client's expectations are.

REBT is active, directive, and short term, which is consistent with the expectations of clients from many non-Western cultures (Sue & Sue, 2013; Wolfe, 2007). Sapp, McNeely, and Torres (2007), noting that the active–directive intervention is preferred by African-American clients, argued that REBT would be helpful to this group if modified to account for contextual influences on clients' presentations (e.g., contemporary influences of slavery or segregation, prejudice, and discrimination). In fact, these *A*s may be some of the traumatic ones for which DiGiuseppe et al. (2014) warned counselors not to challenge awfulness; counselors should challenge, in these cases, the ability of the client to tolerate the awful *A*.

Chen (1995) contended that the values underlying REBT (the emphasis on logical thinking, the cognitive control of emotion, the counselor as teacher, and the active–directive nature of therapy) are congruent with those of the Chinese culture, so REBT may be better than other theories for use with this cultural group. Disputing methods, however, probably need to be modified because the confrontive approach could create negative reactions in Chinese clients, who, although comfortable with the student role, become distressed about not knowing the answer to the teacher's questions. Instead, Chen recommended using didactic disputing, in which therapists provide clients with more alternatives. Also, emotive techniques should be used cautiously because of the normative Chinese reluctance to express feeling. Still, Ellis (2005) recognized that indirect methods are more effective with some clients and pointed to the use of stories, fables, and parables as examples of suitable interventions in these situations.

As with most of the other major theoretical approaches, REBT focuses on the individual. Healthy people are independent and autonomous. These values may clash with those from cultures that are more collectivistic (e.g., some Asian and Hispanic/Latino/Latina groups) and those for whom spirituality is very significant and the importance of individuality is downplayed (Sue & Sue, 2013). If the counselor does not recognize these biases, clients who are collectivistic can be labeled dependent, immature, and fused with family or others (Sue, Ivey, & Pedersen, 1996).

REBT, again because it mostly locates problems and the responsibility for change within the person (i.e., in cognitions), can be accused of being sexist as well. Women are devalued by our cultural norms, and to buy into these and to tell women to "deal with it and stop whining" is to ignore very real factors that influence women's mental health. However, Wolfe (1986) argued that the goals of REBT are consistent with feminist ideals for a number of reasons. REBT

targets and disputes the shoulds, musts, and "love-slobbism" that are the basis of sex-role stereotypes (Wolfe, 1986, p. 401). An emphasis on personal responsibility and autonomy in determining the goals of therapy and the encouragement of assertiveness are also supportive of feminist values. Wolfe (1986) maintained, in addition, that REBT encourages women (and others) to fight for *A* changes, or changes in the societal conditions that keep women and other groups down (p. 401).

Early in his writings Ellis referred to religious or spiritual beliefs as irrational because they couldn't be proven. However, he later modulated his views, maintaining that it was absolutistic, dogmatically held religious beliefs that were problematic (Ellis, 2000). W. B. Johnson, Ridley, and Nielsen (2000) observed the changes in Ellis's views and described a perspective on religiously sensitive REBT that allows the therapist to distinguish between constructive and destructive religious beliefs. To do this work, therapists should have explored their own religious beliefs and their professional backgrounds in terms of competence in dealing with religious issues in therapy.

THE CASE STUDY

In many ways, the case of Alan is ripe for the application of REBT. Anxiety is central in REBT theory, and the cognitive-behavioral slant of the approach seems helpful in working with Alan's behavioral disturbances. Alan shows symptoms of obsessive-compulsive disorder (OCD), about which Ellis theorized (1994a, 1997b). Alan's ABCs seem to be fairly easy to identify, although changing some of them (e.g., the images) might be tough. A puzzle presented by this case is the origin of the religious/sexual images. Other approaches might attempt to locate the source of these troubling mental pictures, but the REBT therapist would more likely see them as connected to biological deficits inherent in OCD.

Summary

REBT starts with the premise that life events (*A*s) don't cause emotions (*C*s). Beliefs about the events (irrational *B*s or rational *B*s) are what link the *A*s and *C*s. Humans are innately predisposed to think both rationally and irrationally, and these tendencies can extend to color an individual's life philosophy. That is, healthy people tend to think in terms of preferences, whereas dysfunctional people think in terms of demands. Healthy people have rational life philosophies that include tolerance for self and others, acceptance of uncertainty, rational self- and community interest, and an understanding of how one makes oneself disturbed. Dysfunctional people harbor many irrational beliefs that include musts, low frustration tolerance, and self-downing thoughts. They think in terms of absolutes and are conditional in their acceptance of self and others.

REBT follows an ABCDE model. After the ABCs are identified, the REBT counselor disputes (*D*) the irrational beliefs to help the client achieve a new effect or an effective new philosophy (*E*). Cognitive, behavioral, and emotive techniques are applied in a teaching model. The therapist, typically active and directive, is unconditionally accepting of the client. He teaches the client the ABC model without focusing too much on the *A*s or *C*s.

REBT has been criticized for being too intellectual and ignoring emotions and significant events in a client's past. The emphasis on rationality, independence, and self-determination may

be inconsistent with the experiences of clients from cultures other than those of Western European origins, those who are not heterosexual, or women. The idea that the world is not fair and we can't expect it to be may convey a tolerance of discrimination and oppression.

Research evidence supports the effectiveness of REBT. Studies attempting to test the theoretical assumptions of REBT offer mixed results.

MyCounselingLab

Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy,* Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 18.

CHAPTER 10

Cognitive Therapy



Aaron Beck

Steve is a 38-year-old White male. He lives in a residential treatment facility for recovering substance abusers and participates in a work–therapy program sponsored by a local hospital.

Steve is the only child of an upper-middle-class family. He characterizes his family life as "swell," like "Beaver Cleaver." Steve reports that his father was a great provider, but that their relationship was distant. His relationship with his mother was similar.

When he was in third grade Steve was sent to a private military academy. In seventh grade he switched to public school, but was subsequently expelled for "acting up" (he wore a bikini to school one day). After he was expelled, Steve re-entered the military academy, from which he eventually graduated.

When Steve was 11 his parents separated and then divorced. Steve lived with his mother, who remarried when he was 17. He remembers that his mother was very sad about the divorce, but that she "put up a strong front," assuring him that "things would be all right."

After graduating from the military academy, Steve entered the navy where he served for 4 years. After his discharge, he was working in an auto body shop when he discovered blood in his urine. He reports that his father sent him to the Mayo Clinic, where he was found to have a lesion on his left renal tube. Steve reports that his first episode of depression occurred at this time and that his first episode of mania occurred shortly thereafter. After seeing a psychiatrist, he was diagnosed with bipolar disorder and treated with lithium.

In 1990, Steve was engaged to be married. Around that time he was involved in an automobile accident that resulted in the death of the driver of the other vehicle. Steve reports that he does not remember the accident because he was intoxicated (alcohol), but that the police determined that the accident was the other driver's fault. Nonetheless, he was charged with manslaughter, placed on probation, and ordered to pay $10,000 in restitution. During this period, Steve's father was supportive, but his grandparents told him that his mother had announced to friends and family that she had "disowned" Steve.

After these events, Steve's fiancée presented him with the ultimatum that if he drank again she would leave him. He reports that he stopped drinking easily. A year later Steve's fiancée left him, and he resumed drinking. About 4 months later, Steve admitted himself voluntarily to the local Department of Veterans Affairs Alcohol and Drug Abuse Treatment Unit. Steve has subsequently relapsed and returned to treatment twice. He is currently medicated with antabuse and lithium.

Steve is in counseling as part of his participation in the work–therapy program. He says that he is too immature and that he sacrifices self- and others' respect when he "acts out." Steve reports that he basically accepts himself as he is, but that sometimes he imagines his parents' point of view—their son is an "alcoholic and a manic-depressive"—and this frightens and saddens him. He sometimes gets depressed about his situation. Steve tells his counselor that he wants to get back on his feet, get a good job, and become self-supporting.

BACKGROUND

The proper title cognitive therapy (CT) is typically reserved for the theoretical structure developed by Aaron T. Beck beginning in the late 1960s. Before I proceed to further background, I will remind you that in practice the distinctions among behavior therapy (Chapter 8), rational emotive behavior therapy (REBT; Chapter 9), and cognitive therapy (Chapter 10) can get really blurry, at least if you are someone other than Albert Ellis, Aaron Beck, or his daughter Judith. In fact, the term *cognitive-behavioral therapy* is often used as a general label for a number of systems that attend to the roles of cognition in dysfunction and intervention, including CT, REBT, problem-solving therapy (D'Zurilla & Nezu, 2007), self-instructional training (Meichenbaum & Jaremko, 1983), dialectical behavior therapy (Linehan, 1993a), coping skills approaches, acceptance and commitment therapy (S. C. Hayes, Strosahl, & Wilson, 2012) and others (K. S. Dobson, 2012). In the real world, many therapists use a combination of techniques from all these approaches. Cognitive-behavioral therapy is enormously popular and is widely recognized to have solid empirical support. If you follow the writings of the Becks (particularly those of Judith Beck), you will see that there is a very clear, pure version of CT, which is what I present in this chapter.

MyCounselingLab

Video Example 10.1 Watch a cognitive therapy session with cognitive therapist Dr. Jennifer D. Lundgren and client Helen.



The originator of CT, Aaron Beck, was the son of Russian immigrants. According to Weishaar (1993), Lizzie Temkin, his mother, wanted to be a physician, but this was unheard of in the early 1900s. Lizzie married Harry Beck, a commercial printer with socialist leanings, and Aaron Beck (born in 1921) was the youngest of their five children. The family was Jewish and very devoted to their religion.

Two of Beck's siblings died as children, leading to significant depression in his mother that abated only with Aaron's birth. As a result, Beck was overprotected by his mother (Weishaar, 1993). Beck almost died during his seventh year from sepsis that resulted from an infected broken bone. According to Weishaar (1993), this prolonged illness, hospitalization, and surgery resulted in Beck developing anxieties and phobias. He also had difficulties because of missed school and was held back a year in the first grade. He thought that he was dumb and that others thought so, too. These beliefs challenged Aaron to work hard, and he became an excellent student, graduating first in his high school class. During this period he acquired his nickname, Tim (for Temkin, his middle name), which is used by his close friends and wife (Weishaar, 1993).

Beck put himself through college at Brown, delivering papers and working as a door-to-door salesperson (Weishaar, 1993). He majored in English and political science, and a consult with a career counselor suggested that he should be a YMCA counselor! Warned about quota systems

enforced against Jews, Beck still applied to medical school at Yale and received his MD in 1946. According to Weishaar, Beck admitted that his anxiety was one reason he chose medical school—he wanted to defeat his blood-injury phobia. He acknowledged other fears as well, such as those of abandonment, public speaking, and heights (Weishaar, 1993, p. 13).

After flirting with a career in neurology, Beck turned his attention to psychiatry and was classically trained as a psychoanalyst. Early in his career he was engaged in the science of psychotherapy, attempting to test Freud's hypothesis that depression is anger turned inward. Instead, he found that depressed individuals were immersed in visions of loss and self-blame (Hollon & DiGiuseppe, 2011). A subsequent series of studies investigating the construct of masochism in depression more clearly revealed that a distinguishing characteristic of depression seemed to be pessimism and negativity rather than masochism (Clark & Beck, 1999). At about the same time, Beck's clinical work was informing his theoretical development. He began to notice that his clients had thoughts during free association that they did not report (Beck, 1997a). Most of these thoughts had to do with the analytic relationship (e.g., worries about what the therapist thought of the client), and they were closely associated with the client's current emotional state. Beck began to study these thoughts (later labeled *automatic thoughts*), along with what he called the internal communication system, and cognitive therapy was launched (Beck, 1997b).

Beck acknowledges the contributions of other psychologists to his system but maintains that he learned very little from existing theories of psychotherapy. Among the influences Beck recognizes are the philosopher Immanuel Kant and cognitive theorists Magda Arnold, George Kelley, and Albert Bandura. He characterizes Albert Ellis as a pioneer whose ideas provided support for his (Beck's) break from traditional psychoanalytic theory (Beck, 1991). Beck even uses the famous Epictetus quote usually associated with Ellis's REBT in his well-known 1976 book, *Cognitive Therapy and the Emotional Disorders* ("Men are not moved by things but the views which they take of them," Epictetus, quoted in Beck, 1976, p. 47).

Beck is a prolific writer and researcher, having published hundreds of journal articles and many books. Both the medical and the psychological communities have recognized his work. In 1989 Beck was awarded the American Psychological Association's Distinguished Scientific Award for the Applications of Psychology. He has also received the Association for the Advancement of Behavior Therapy Lifetime Achievement Award (1998) and the American Psychological Society James McKeen Cattell Fellow Award in Applied Psychology (1993). Beck is currently professor emeritus of psychiatry at the School of Medicine at the University of Pennsylvania.

Beck founded the Beck Institute for Cognitive Behavior Therapy in 1994; you can view its website at www.beckinstitute.org. Another website of interest is that of the International Association for Cognitive Psychotherapy (found at www.the-iacp.com), which publishes the *Journal of Cognitive Therapy*.

Beck's daughter Judith is a psychologist and cognitive therapist.[1] She is currently president of the Beck Institute (Aaron Beck is president emeritus). Judith's books *Cognitive Therapy: Basics and Beyond* (2011) and *Cognitive Therapy for Challenging Problems* (2005) present structured, easy-to-follow guidelines for the conduct of CT. If you want to try the CT approach to that diet you've been putting off, you could acquire Judith Beck's 2008 book, *The Beck Diet Solution*. Those interested in school counseling might want to look up *Cognitive Therapy for Adolescents in School Settings* (Creed, Reisweber, & Beck, 2011). Read a selection from *Cognitive Therapy: Basics and Beyond* in Box 10.1.

[1]To minimize confusion, where I reference Aaron T. Beck or his work, no initials are used.

Box 10.1

Judith Beck on Automatic Thoughts

Automatic thoughts are a stream of thinking that coexists with a more manifest stream of thought (Beck, 1964). These thoughts are not peculiar to people with psychological distress; they are an experience common to us all. Most of the time we are barely aware of these thoughts, though with just a little training we can easily bring these thoughts into consciousness. When we become aware of our thoughts, we may automatically do a reality check if we are not suffering from psychological dysfunction.

A reader of this text, for example, while focusing on the content of this chapter, may have the automatic thought, "I don't understand this," and feel slightly anxious. He may, however, spontaneously (i.e., without conscious awareness) respond to the thought in a productive way: "I *do* understand *some* of it; let me just reread this section again."

This kind of automatic reality testing and responding to negative thoughts is a common experience. People who are in distress, however, may not engage in this kind of critical examination. Cognitive therapy teaches them tools to evaluate their thoughts in a conscious, structured way, especially when they are upset.

Sally, for example, when she is reading an economics chapter, has the same thought as the reader above. "I don't understand this." Her thinking becomes even more extreme, however: "And I'll *never* understand it." She accepts these thoughts as correct and feels quite sad. After learning tools of cognitive therapy, however, she is able to use her negative emotion as a cue to look for, identify, and evaluate her thoughts and thereby develop a more adaptive response: "Wait a minute, it's not necessarily true that I'll never understand this. I am having some trouble now. But if I reread it or come back to it when I'm fresher, I may understand it more. Anyway, understanding it isn't crucial to my survival, and I can ask someone else to explain it to me if need be."

Although automatic thoughts seem to pop up spontaneously, they become fairly predictable once the patient's underlying beliefs are identified. You are concerned with identifying those thoughts that are dysfunctional—that is, those that distort reality, that are emotionally distressing and/or interfere with the patient's ability to reach her goals. Dysfunctional automatic thoughts are almost always negative unless the patient is manic or hypomanic, has a narcissistic personality disorder, or is a substance abuser.

Automatic thoughts are usually quite brief, and patients are often more aware of the *emotion* they feel as a result of the thoughts than of the thoughts themselves. Sitting in session, for example, patients may be somewhat aware of feeling anxious, sad, irritated, or embarrassed but unaware of their automatic thoughts until their therapist questions them.

The emotions patients feel are logically connected to the content of their automatic thought. For example, a patient thinks, "I'm such a dope. I don't really understand what everyone [at a meeting] is saying," and feels sad. Another time he thinks, "She [my wife] doesn't appreciate me" and feels angry. When he has the thoughts, "What if my loan doesn't go through? What will I do next?" the patient feels anxious.

Automatic thoughts are often in "shorthand" form but can be easily spelled out when you ask for the *meaning* of the thought. For example, when a patient had the thought "Oh, no!" the meaning was "[My boss] is going to give me too much work." "Damn!" for another patient was the expression of the idea, "I was stupid to leave my cell phone at home."

(continued)

Box 10.1 *(continued)*

Automatic thoughts may be in verbal form, visual form (images), or both. In addition to his verbal automatic thought ("Oh, no!") the patient had an image of himself, alone at his desk late at night, toiling over taxes (see Chapter 16 for a description of automatic thoughts in imaginal form).

Automatic thoughts can be evaluated according to their *validity* and their *utility*. The most common type of automatic thought is distorted in some way and occurs despite objective evidence to the contrary. A second type of automatic thought is accurate, but the *conclusion* the patient draws may be distorted. For example, "I didn't do what I promised [my roommate/friend]" is a valid thought, but the conclusion "Therefore, I'm a bad person," is not.

A third type of automatic thought is also accurate but decidedly dysfunctional. For example, Sally was studying for an exam and thought, "It's going to take me hours to finish this. I'll be up until 3:00 a.m." This thought was undoubtedly accurate, but it increased her anxiety and decreased her concentration and motivation. A reasonable response to this thought would address its *utility*. "It's true it will take a long time to finish this, but I can do it; I've done it before. Dwelling on how long it will take makes me feel miserable, and I won't concentrate as well. It'll probably take even longer to finish. It would be better to concentrate on finishing one part at a time and giving myself credit for having finished it." Evaluating the validity and/or utility of automatic thoughts and adaptively responding to them generally produces a positive shift in affect.

To summarize, automatic thoughts coexist with a more manifest stream of thoughts, arise spontaneously, and are not based on reflection or deliberation. People are usually more aware of the associated emotion but, with a little training, they can become aware of their thinking. The thoughts relevant to personal problems are associated with *specific* emotions, depending on their content and meaning. They are often brief and fleeting, in shorthand form, and may occur in verbal and/or imaginal form. People usually accept their automatic thoughts as true, without reflection or evaluation. Identifying, evaluating, and responding to automatic thoughts (in a more adaptive way) usually produces a positive shift in affect.

Source: Excerpted from Beck, J. S. (2011). *Cognitive Therapy: Basics and Beyond* (pp. 137–140). New York: Guilford Press. Reproduced with permission of Guilford Press.

BASIC PHILOSOPHY

CT theory generally takes a neutral position on the properties of human nature. When the overall qualities of human existence are discussed at all, it is from an evolutionary perspective, which portrays humans simply as organisms adapting to the environment.

Alford and Beck (1997a) characterized CT theory as constructivist because it stipulates that a critical aspect of human existence is the creation of meaning from experiences. Unlike radical constructivist approaches (those that recognize no single objective reality), however, CT assumes both an external, objective reality and a personal, subjective, phenomenological one (K. S. Dobson, 2012).

Beck would like to see his theory as the great integrator—that is, the "one" psychological theory that can explain all others (Alford & Beck, 1997a). One point in his favor is that the roots of the theory lie in both behavioral and psychoanalytic approaches. The behavioral roots of CT theory are evident in the techniques used in intervention and in earlier versions of the theory that placed little emphasis on processes out of awareness (such as modal processes; these are discussed in a following section). Beck (1991) wrote:

> The cognitive model was in part derivative from and in part a reaction against classical psychoanalysis. The derivative components consisted of the emphasis on meanings, the role of symbols and the generalization of reaction patterns across diverse situations. . . . The "reaction against" consisted of eschewing the predominately motivational model, the notion of an unconscious cauldron of taboo drives defended against by repression and other mechanisms of defense, and the critical importance attached to the psychosexual stages of development. (p. 192)

Recently, CT theorists have begun to discuss the childhood origins of core beliefs, seeming to parallel psychoanalytic notions of the origins of dysfunction (Padesky, 2004). Also, current versions of CT theory pay much attention to cognitive processes that are not fully in awareness (e.g., automatic thoughts, or ATs, and cognitive schemas; these are discussed later) and are in this way reminiscent of Freud's ideas about the unconscious determinants of behavior.

A final point to note about CT theory is that it is mostly a theory of psychological dysfunction. Because it originated as a theory of depression (Beck, Rush, Shaw, & Emery, 1979) and also because it has been intimately tied to therapeutic practice, CT theory tends to focus on the dynamics of psychological maladjustment rather than on healthy functioning.

Mia is Steve's counselor, and she follows a CT approach. Assuming that Steve is a human like any other, she begins her work with him without any preconceived notions about his goodness or badness; he is simply a person striving to make sense of his environment. His behavior, in Mia's view, is in response to his current perceptions of his environment, which are tied to his early learning. She seeks to understand the way he thinks about things and how his cognitive process is related to his current situation.

HUMAN MOTIVATION

CT theory is probably best characterized as an adaptive theory. Beck draws on evolutionary theory to locate the motivation for human behavior in three major evolutionary goals: survival, resource conservation and expansion, and reproduction (Beck, 2015, p. 19). Cognitive processes evolved to enhance adaptation to the environment—and hence survival. Humans struggle to comprehend the world and assign meaning to life events so that they can develop effective adaptive strategies: "Cognition is implicated in controlling or directing behavior so as to maximize positive consequences (both short-term and long-term)" (Alford & Beck, 1997a, p. 64). The basic needs of humans are thought to be preservation, reproduction, dominance, and sociability (Clark & Beck, 1999, p. 67).

Mia assumes that Steve's situation is a result of many influences, but at the most basic level he is struggling to adapt to his environment. He seeks positive consequences (survival, social contact, dominance or control of his situation, and intimate relationships). Mia looks at Steve's ways of construing the world to understand how his meanings relate to his behavior and feelings.

CENTRAL CONSTRUCTS

The Cognitive Model

Simply put, the cognitive model, which is the foundation of CT, proposes that our emotions and behavior are the product of our *perceptions* of situations—"the way you think affects the way you feel" (Clark & Beck, 2010, p. 31). Although CT theorists recognize that the relationship between cognition and emotion is bidirectional (i.e., emotions can affect thoughts), the attention in CT is squarely on what is seen as the *causal* relationship between thought and emotion (Hofmann, Asmundson, & Beck, 2013). Cognition, in this model, means both the process and the content of thinking, or how you think and what you think (Kovacs & Beck, 1978). Three levels of cognitive processing are seen in humans: the automatic or preconscious, the conscious, and the metacognitive (Alford & Beck, 1997a). The automatic level consists of thoughts and other cognitive organizations that are based in survival processes (see the later discussion of modes) that are largely out of awareness. The conscious level is what we normally think of as thinking, and the metacognitive level refers to our ability to think about our thought processes.

Of primary importance to Mia is how Steve thinks about things. She is also interested in the content of his thinking and is aware that some of his thoughts might not be very accessible to him at present. Steve's emotions and behaviors are clues to his thought processes.

Schemas

Schemas are cognitive structures that organize the barrage of information with which we are constantly confronted (DeRubeis, Webb, Tang, & Beck, 2010). They help us create meaning out of what otherwise would be a bewildering array of stimuli, both internal and external. Schemas are the most basic unit of psychological function. Beck compares them to electrons in that they are theoretically critical elements that can be observed only indirectly (Alford & Beck, 1997b, p. 282). A formal definition of schemas is provided by Clark and Beck (1999): "Schemas are relatively enduring internal structures of stored generic or prototypical features of stimuli, ideas, or experience that are used to organize new information in a meaningful way thereby determining how phenomena are perceived and conceptualized" (p. 79).

Schemas can be dormant or active, but we are mostly unaware of them (K. S. Dobson, 2012). To intuitively understand schematic processing, simply think of the word *librarian*. I am pretty certain that you almost instantly came up with a set of images or words associated with the label (female, glasses, hair in a bun). Further, if I told you someone was a librarian, you'd be expecting the person to display those qualities. Your "librarian" schema is activated and is influencing how you respond to information.

Schemas influence the selection, encoding, and retrieval of information in the cognitive system. They contain general knowledge, core beliefs, and emotional elements relevant to a particular domain of experience (Reinecke & Freeman, 2003). If your librarian schema is activated, you are likely to observe features of someone that are consistent with your librarian schema, and you may have great difficulty recalling features that are inconsistent with the schema. You might also feel some emotion stemming from your past experience with librarians.

TABLE 10.1
EXAMPLES OF ADAPTIVE AND MALADAPTIVE SCHEMAS

Adaptive	*Maladaptive*
No matter what happens, I can manage somehow.	I must be perfect to be accepted.
If I work at something, I can master it.	If I choose to do something, I must succeed.
I'm a survivor.	I'm a fake.
Others can trust me.	Without a woman, I'm nothing.
I'm lovable.	I'm stupid.
People respect me.	People can't be trusted.
I like challenge.	The world is frightening.

Source: Information from Wright, J. H. & Beck, A. T. (1996). Cognitive Therapy. In R. E. Hales, & S. C. Yudofsky, (Eds.), *The American Psychiatric Press Synopsis of Psychiatry* (p. 1015). Washington, DC: American Psychiatric Press. Used with permission of author.

(Did you get in trouble for talking in the library when you were a kid?) Some schemas are more easily activated than are others because they are broader, have more elements, and apply to more situations (i.e., are more complex; Clark & Beck, 1999). Adaptive and maladaptive schemas can be distinguished, as shown in Table 10.1. Clark and Beck (1999) added the most specific form of schema: the *simple schema*. Simple schemas deal with physical objects or very distinct, simple ideas, such as dogs, books, computers, and so forth. To give you a better idea of how schemas work, Box 10.2 illustrates an important schema dynamic: stereotype threat.

Box 10.2

The Power of Schemas

As you have read, schemas are the most basic unit of thinking and are developed either through personal experience with the world or through vicarious learning (watching what others do). Schemas are formed very early in life, even as early as infancy. When we experience new events, we store away information about those events for future use. For example, when Alexandra pets the family cat, she discovers that the cat is soft and warm and purrs. The next time Alexandra encounters a cat out in the environment, her "cat schema," which contains information about cats being soft, warm, and purring, will automatically be activated.

Although schemas are the basic unit of thinking, they can be quite complex. Each schema we hold is based on one or more core beliefs about the world. So as you can imagine, if we hold faulty core beliefs about something, we are also going to activate faulty schemas that affect behavior. If Alexandra had been scratched by her family cat, she might then hold a core belief that all cats want to hurt her, which then would activate a negative cat schema that includes scratching and danger each time she sees a cat. As you can see, schemas can be very powerful and can be accurate or inaccurate based on the experience the individual has in the world.

(continued)

Box 10.2 *(continued)*

Another example of the power of schemas is a dynamic called *stereotype threat*. Stereotype threat can be defined as anxiety aroused by the prospective risk of believing and confirming a negative stereotype about yourself because you belong to a group that has been negatively stereotyped. The threat then interferes with performance on tasks relevant to the stereotypic behavior. Although there are many examples of stereotypes that society has come to accept and advocate, a troubling one in particular is that females (innately) have poorer math skills than males. A study done by Keller (2002) showed that when males and females were given a math test, they performed relatively equally. However, when students were informed before the test of the stereotype that males typically scored higher than females, the females performed more poorly than the males.

Similar results were found when Steele and Aronson (1995) examined racial stereotypes regarding the performance of White and African-American students on intelligence tests. In this study, it was found that, if African-American students were primed with a racial stereotype about test performance before taking the test, they did more poorly than White students on the test. However, if African-American students were not reminded of the racial stereotype before taking the test, no differences in performance were observed.

Another example of stereotype threat that has been documented in the literature by Koenig and Eagly (2005) addresses the common stereotype that women are more socially sensitive than men. In this experiment, men who were warned that the test they were taking tapped this social skill and that women were generally superior in this domain scored lower compared to men who were told that the test measured information processing.

After reading this information, can you figure out the most influential schemas you have and how they might affect you?

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Mia's CT perspective tells her that Steve is surely harboring some maladaptive schemas. These schemas are influencing how he sees the world, including what he pays attention to and how he behaves and feels. Mia thinks that Steve probably operates, at times, from schemas such as "I'm a fake and a failure," but also from some manic schemas that are grandiose ("I am strong and powerful and can get away with a lot. I should take advantage of this. I can drink and act up and why not?").

BELIEFS

Beliefs are important components of schema and, as critical targets of CT, are discussed extensively. Judith Beck (2011) distinguished between two kinds of cognitions that are important in CT: (a) core beliefs and (b) assumptions, rules, and attitudes. Our schemas contain our *core beliefs*, which are the most basic beliefs we hold and are thought to be the hardest to modify. They tend to be overgeneralized and absolute and are usually self-referent (Clark & Beck, 1999). Assumptions, rules, and attitudes, also known as *intermediate beliefs*, are situated between core beliefs and ATs (J. S. Beck, 2011). These beliefs include "should" and "must" beliefs as

well as conditional beliefs that are influential in creating meaning from experience. An example of a conditional belief is "If I don't get an A in my Theories of Counseling course, then I am dumb." The intermediate beliefs also include rules or coping strategies used by individuals in reaction to other beliefs (Beck, 2015). These coping strategies are largely automatic and can be clearly distinguished from other forms of problem solving or coping responses. For example, an individual could hold the core belief "I am a failure," which is connected to the rule "I must get all As." A coping strategy would be "I will achieve perfection in all of my coursework so that I get As."

As she begins her work with Steve, Mia looks carefully for evidence of his core beliefs and associated attitudes, rules, and assumptions. Because he does not appear to be psychotic, his simple schemas are intact. She thinks that some core beliefs may be "I'm a goof-off and therefore nobody loves me" and paradoxically "I am cool and can do what I want." Steve may bounce back and forth between these beliefs and associated schematic processing.

Steve's intermediate beliefs are linked to his core beliefs and schemas. Mia discovers that Steve thinks that he should please people so that they will love him and that this will make him worthwhile. When his manic schemas are activated, he probably thinks that the world must be good to him and allow him anything he wants. If it doesn't, he gets angry.

Automatic Thoughts

ATs are a normal feature of our cognitive process (J. S. Beck, 2011). They are swift, evaluative statements or images that exist alongside our more conscious thoughts. ATs tend to occur in shorthand, rather than in full sentence form, and often seem to just pop up out of nowhere (hence their name). Depending on their content, these thoughts can be functional or distressing, but in either case they tend to be reasonable to the thinker (Beck, 1976). Usually, we are not particularly aware of our ATs; we are more likely to be aware of the emotion associated with them. In reality, ATs are the result of our core and intermediate beliefs. They are thought to be easier to change than intermediate or core beliefs (J. S. Beck, 2011).

Judith Beck (2011) identified three general types of AT. First are the distorted thoughts that are contrary to available objective evidence ("I never do *anything* right!"). Most ATs are of this type. A second type of ATs can be accurate, but the conclusion drawn is distorted ("I upset my boyfriend. Now he'll never love me again!"). A third type of ATs is accurate, but dysfunctional (J. Beck, 2011, p. 139). This kind of thought either contributes to a reluctance to approach a task or increases anxiety so that focus and concentration are disrupted. For example, I could have this AT: "It's going to take a *long time* to finish writing this book!" This thought is true, but it may decrease my motivation to write, or it may distract me from my current writing activity because it definitely increases my anxiety.

MyCounselingLab

Video Example 10.2 Listen to Dr. Lundgren talk about Helen's automatic thoughts.



Mia is interested in the ATs that might influence Steve's behavior. Probably he has some negative ATs, such as "I'm worthless," "Life is too hard," "I must not disappoint others," "I am not loved," and so forth. His drinking behavior is probably accompanied by thoughts such as "What the hell," "I can handle it," "No use in trying to quit," and "I can't stand it without a drink." If he is in a manic swing, his ATs are things like "I am great," "Others can't touch me," and "People had better be nice to me."

MODES

To more fully capture the complexity of human behavior, Beck proposed the concept of modes, which are defined as "networks of cognitive, affective, motivational, and behavioral schemas that compose personality and interpret ongoing situations" (Beck & Weishaar, 2014, p. 232). Modal information processing is largely automatic and global—particularly in the primal modes described shortly. Modes are either active or dormant; when activated, modes tend to dominate behavior in a rather automatic way.

The *conscious control system* can override modal processing (Beck, 1996). This system is responsible for metacognition and intentional behavior, such as that based on personal goals and values. Logical reasoning and long-term planning are also products of the conscious control system.

CT proposes three major mode categories: primal, constructive, and minor. *Primal* modes are the most basic kinds of operation and function to meet the evolutionary goals of survival, procreation, and sociability (Beck & Clark, 1997). Because they are so basic to survival, they operate rapidly and automatically. Thinking in the primal modes is distorted and rigid (Beck & Weishaar, 2014). According to what I identify as one of the earliest formulations of modal theory (Clark & Beck, 1999), the four primal modes are threat, loss or deprivation, victim, and self-enhancement. Each mode contains a cluster of schemas: cognitive-conceptual, affective, physiological, motivational, and behavioral. A description of these modes is shown in Table 10.2.The first three modes (threat, loss, and victim) have evolved to protect the organism against threats to survival. The self-enhancement mode works in a manner opposite to the first three modes to enhance the survival and adaptation of the person. Although Clark and Beck (1999) identified four primal modes, later sources seem to suggest others. For example, in their revised treatise on anxiety disorders, Beck and Emery (2005) stated that modes are "designed to consummate certain adaptational principles relevant to survival, maintenance, breeding, self-enhancement, and so on. Thus, we have a depressive mode, a narcissistic mode, a hostility mode, a fear (or danger) mode, an erotic mode, and so on" (p. 59).

Beck (1996) argued that primary modes are not inherently dysfunctional because they serve to enhance human survival. For example, it is very adaptive to mobilize the organism to fight or flee in the face of threat. Unfortunately for us, our environment has changed a bit from that in which the primary modes evolved, causing a "mismatch" at times in which modal behavior is not necessarily the best strategy to deal with the complex situations we encounter (Beck, 1996). Even what we think of as positive modes (self-enhancement) can become exaggerated, as in mania (or bipolar disorder), and are therefore dysfunctional.

The second class of modes is termed the *constructive* modes (Clark & Beck, 1999). These modes are developed primarily through life experience and serve to increase the life resources available

TABLE 10.2
THE FOUR PRIMAL MODES

Mode	*Characteristics*
Threat	Perception of threat
	Feelings of anxiety or anger
	Physiological arousal
Loss	Perception of possible or actual loss of vital resources
	Feelings of dysphoria (depression) or sadness
	Fatigue or physiological deactivation
Victim	Perception of injustice or offense against the self and self-interests
	Feelings of anger
	Physiological activation
Self-enhancement	Perception of achieved or anticipated personal gain
	Feelings of happiness
	Physiological activation

Source: Information from Clark, D. A. & Beck, A. T. (1999). *Scientific Foundations of Cognitive Theory and Therapy of Depression* (pp. 89–91). Copyright © 1999 by John Wiley & Sons, Inc. This material is used by permission of John Wiley & Sons, Inc.

to the individual (Clark & Beck, 2010). They are associated with positive emotions and adaptive characteristics and include (a) the capacity for intimacy, (b) personal mastery, (c) creativity, and (d) independence. As you can observe from Table 10.2, one of the primal modes, the self-enhancement mode, is constructive as well.

The *minor* modes are the third category of thinking and tend to be under more conscious control than the other modes. They tend to be narrowly focused on situations and include everyday activities such as reading, writing, social interaction, and athletic or recreational activities (Clark & Beck, 1999).

Mia listens very carefully to Steve. She thinks that he operates out of several of the primal modes that periodically dominate his cognition and behavior. First, his feelings about his parents and perhaps some of his drinking behavior seem to flow from a loss mode because he sometimes drinks because he is depressed or upset. He is unhappy with his irresponsible behavior, indicating a poor self-concept associated with the loss mode as well as weak constructive modes. At other times, Steve shows overactivation of the self-enhancement mode in his manic behavior. During these episodes, he is likely to be hyperactive, show irrational positive emotion, and have an inflated view of himself and his capacities. Steve's drinking can also occur when he is functioning in a manic fashion because the grandiose schemas associated with this mode include thoughts of invincibility. When he fails or the world does not treat him as he wishes, his victim mode is activated. At these times, he can become angry and aggressive.

It is evident to Mia that Steve is sometimes able to use his conscious control system to override his activated primal modes. The operation of this system is what gets him to treatment after he has relapsed into substance use. It is also what helps him evaluate his acting-out behavior and set goals for the future.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

In discussing human development, CT theorists conceptualize human functioning as the product of learning and genetics. Drawing on literature in developmental psychology, Beck (2015) begins with the notion that certain personality tendencies, such as sensitivity to rejection by others and dependency, can be genetic in origin.

As children, we strive to make sense of our environments (including ourselves and others) and organize this information into schemas (J. S. Beck, 2005). The tendency to create meaning through the use of schemas is thought to be innate. Based on the positive and negative experiences we have, we develop corresponding views of ourselves and the world. A kid who gets a lot of glowing feedback will develop a positive set of schemas about himself and the world and will therefore be less likely to develop faulty cognitive processes.

The earliest versions of CT theory did not elaborate a theory of personality. However, Beck later theorized about two general dispositions, autonomy and sociotropy (Beck, 1997b; Beck & Weishaar, 2014). Individuals who are high in sociotropy find their self-worth in relations with others. Autonomous individuals emphasize mastery and independence and build self-esteem through achievement and control (Clark & Beck, 1999). Different kinds of life experiences, then, will differentially affect individuals who are oriented toward one dimension or the other. For example, an interpersonal conflict would have much different ramifications for a sociotropic individual than for an autonomous one. Beck and his associates, however, acknowledged that pure types are relatively rare: Most people display tendencies of both sociotropy and autonomy (Beck & Weishaar, 2014).

Under normal circumstances, we tend to operate via simple schematic processing and with our conscious control system (Beck, 1996). We cruise along, using minor modes to attend to everyday activities. These schemas are activated and have some cognitive, affective (usually mild), and behavioral effects, but these effects dissipate quickly. Occasionally (or often, if you are dysfunctional), information is present that matches an *orienting schema* that is linked to a primal mode. When a match is made, the primal mode is activated; the cognitive, affective, behavioral, and physiological systems or schemas are energized; and primary modal processing is seen (Beck, 1996). The kinds of behavior, affect, and cognition observed will depend on whether the primary mode activated is one of the constructive modes or one of the defensive or protective modes.

I will pause here to note that not all contemporary discussions of CT include the modes and modal processing. Some writers simply discuss schematic processing (K. S. Dobson, 2012) or the various kinds of beliefs (J. S. Beck, 2011).

Steve appears to be more sociotropic than autonomous in his orientation. Mia thinks that his early experiences in his family resulted in the formation of schemas emphasizing the value of the love of others. He likely grew up wanting close relationships with his parents, but never achieved these. He may also have experienced the loss of these relationships because of his parents' conditional acceptance of his behavior. Steve's cognition and behavior suggest that as he matured, the loss primal mode may have been very alive, and so even now this mode and accompanying schemas are sensitive and easily activated. Also, it appears that early on his self-enhancement primal mode was hyperactive, as evidenced by his acting-out behavior at school.

HEALTH AND DYSFUNCTION

Although CT theorists don't spend a lot of time discussing healthy psychological functioning, it appears that the CT version of health would include information processing that allows the individual to meet his goals of survival, reproduction, acquisition of resources, and sociability. We can infer that healthy folks don't rely on a lot of primary mode processing and don't show a lot of distorted thinking. The constructive modes of processing are more in evidence, and the individual is able to use the conscious control system to moderate schematic processing. The healthy person probably has fairly good problem-solving skills, too. Although some authors opine that health in a CT model would include an "accurate view of oneself and the world" (Kellogg & Young, 2008, p. 49), other CT writers avoid this position: "Contrary to common belief among clinicians, the cognitive approach to depression and psychopathology does *not* assume that a well-adjusted individual is one who thinks logically and solves problems rationally" (Kovacs & Beck, 1978, p. 528; emphasis in original). Presumably, people can function with illogical beliefs and irrational thoughts as long as they are not creating problems in living. For example, one of my clients, Alex, believed that he was a flexible person. It was my observation that his cognitive and behavioral flexibility was limited. Alex had also received feedback from others to this effect. Fortunately, Alex did not see flexibility as crucial to his self-worth, so this inaccurate (i.e., not consensually validated) belief was not dysfunctional for him.

In viewing dysfunction, Beck and his collaborators emphasized an integrated view. For instance, Beck and Weishaar (2014) contended that "psychological distress is ultimately caused by many innate, biological, developmental and environmental factors interacting with one another, and so there is no single 'cause' of psychopathology" (p. 240; quotes in original). However, the focus in most of CT theory is, predictably, cognition. J. S. Beck (2004) wrote, "The cognitivist assumes that the individual's primary problem has to do with his construction of reality. The remedy lies in modifying the cognitive set. The psychological modification then produces biochemical changes that in turn can influence cognitions further" (p. 200). Beck did allow that pharmacological interventions can cause cognitive-neurochemical change. Writing specifically about depression, J. E. Young, Beck, and Weinberger (1993) put it this way: "The pharmacotherapist intervenes at the biochemical level; the cognitive therapist intervenes at the cognitive, affective, and behavioral levels. Our experience suggests that when we change depressive cognitions, we simultaneously change the characteristic mood, behavior, and (we presume) biochemistry of depression. The exact mechanism of change, however, remains a target of considerable investigation and debate" (p. 241).

Very early in his theoretical journey, Beck (1976) identified a number of cognitive problems that are characteristic of depressed individuals (see Figure 10.1). These *cognitive distortions* remain important theoretical constructs in CT theory. Each of the problems outlined in Figure 10.1 is followed by an example of Steve's cognitive distortions. Because much of Beck's early thinking was oriented to depression, another useful concept is the *cognitive triad*, which refers to the depressive person's negative views of the self, the world, and the future (Kovacs & Beck, 1978).

Distorted thinking results from faulty schemas and their associated core beliefs. Young et al. (1993) described the "deepest" type of schemas, the early maladaptive schemas (p. 242). These cognitive structures develop very early in life as a result of interactions with the surrounding

Cognitive Distortions

1. All or nothing thinking (black-and-white, polarized, or dichotomous thinking). Life is seen in rigid categories; no shades of gray are allowed. *Steve believes that he must be perfect in the eyes of important others to maintain self-respect.*
2. Catastrophizing (fortune telling). The future is viewed as a disaster; other kinds of outcomes are not considered as even remote possibilities. *Steve is sure that the future holds nothing but gloom; he will never get a job he likes nor regain his relationship with his mother.*
3. Disqualifying or discounting the positive. Good stuff just does not count! *Steve downplays his previous successes. He does not acknowledge that, despite his slips, he has been able to get himself to treatment and is currently doing well in the work–therapy program.*
4. Emotional reasoning. Because of the emotional investment in an idea, it is seen as true, regardless of discrepant information. *Steve is deeply hurt by his mother's disowning him and feels certain that she is right: He is worthless.*
5. Labeling. A global rating is made (of self or others). *Although Steve says he accepts himself, his reports that he worries about the opinion of his parents suggest that he may not be as self-accepting as he says he is. He may be rating himself negatively, which would be consistent with his early experience.*
6. Magnification/minimization. Negative information is highlighted; positive information is ignored or minimized. This kind of thinking is the opposite of wearing rose-colored glasses. *If Steve makes a mistake at work, he worries terribly that he'll be perceived as a bad worker and get fired. He does not attend to the things he does well at work.*
7. Mental filter (selective abstraction). One negative detail is attended to, resulting in a conclusion that does not consider other factors in a situation. *Steve's supervisor was curt with him, and Steve concludes that his supervisor is angry or unhappy with him. He does not consider that his supervisor has many other demands on her, and that she was brisk with other workers as well.*
8. Mind reading. Need this one be described? *Steve believes he knows exactly what his mother and father think of him.*
9. Overgeneralization. The conclusion (usually negative) becomes larger than is justified by an event. *Because Steve has not succeeded in staying "dry" previously, he concludes that he will never be able to achieve his goal of sobriety.*
10. Personalization. Another person's behavior is attributed to oneself without considering alternative explanations. *Steve's supervisor announces a new rule at work—anyone who gets angry must leave for one hour. Steve assumes that the rule was made in response to his outbursts and feels depressed.*
11. Should and must statements. Rigid rules for life that, if not met, create a catastrophe. *Steve believes that he must be perfect so that others will love him. Others must not show disapproval of him.*
12. Tunnel vision. A narrow focus on the negatives. *Steve sees his life in terms of his immature behavior, substance abuse, and cycles of mania and depression. He fails to recognize his strength in getting help and trying to turn his life around. He also ignores his successes in his current working environment.*

FIGURE 10.1. Cognitive Distortions.

Source: Information from Beck, J. S. (2011). *Cognitive Therapy: Basics and Beyond* (2nd ed., pp. 181–182). New York: Guilford Press. Adapted with permission.

environment—most notably those with significant others. After the schema is created, it can be activated by environmental or internal events, and information processing becomes selective—information that is consistent with the schema is admitted to awareness, whereas inconsistent information is distorted or rejected. In this way, the maladaptive schema is maintained.

These schemas are resistant to change, connected to significant emotional responses, and, if examined by the client, perceived as absolute truths (Young et al., 1993). A client would simply say, "That's just the way I am!" An example of such a schema might be called the rotten person schema. This person would be totally convinced that he can't do anything right and that others hate him. J. S. Beck (2005) identified three broad categories of negative core self-beliefs that would be seen in a rotten person schema: helplessness, unlovability, and worthlessness.

Beck and colleagues, over the years, identified specific ways of thinking and perceiving that are characteristic of various psychological dysfunctions. Beck (2005) called this idea the *cognitive specificity principle*. In anxiety disorders, for example, individuals have a strong sense of vulnerability: They are hypervigilant, focused on signs of danger or threat (Clark & Beck, 2010). ATs of threat and harm come easily and often, coming out of a powerful "danger" schema (K. S. Dobson, 2012). Other examples of dysfunction-specific beliefs are seen in drug-abusing clients who harbor "need" beliefs such as "I can't stand the boredom without my drug" (Beck, 1993). Individuals who display bipolar disorder are thought to have both depressive beliefs and beliefs such as "I have exceptional powers and should use them" (Beck, 1993).

The idea of cognitive specificity allows the extension of CT theory to various kinds of psychological dysfunction. Much attention has been paid to anxiety disorders, including panic disorder (Clark & Beck, 2010). Other conceptualizations have focused on eating disorders (Svaldi & Tuschen-Caffier, 2014), substance abuse (Beck, Wright, Newman, & Liese, 1993), suicide (Wenzel, Brown, & Beck, 2009), and even schizophrenia (Beck & Rector, 2005; Beck, Rector, Stolar, & Grant, 2009).

A revision of CT proposed by Beck (Beck, 1996; Clark & Beck, 1999) locates the source of psychological dysfunction in overactive primal modes. We are all born with the protoschemas for primal modes. Through experience, the primal modes are constructed and endowed with energy (or "charged"; Beck, 1996, p. 8). A series of experiences relevant to a specific mode will result in the mode being fully activated and operative. As Beck (1996) explains it, "A particular mode is generally silent or latent at first, but through successive relevant experiences can receive incremental charges until it reaches the threshold for full activation. In some psychopathological conditions—for example, recurrent depression—the mode is chronically but subliminally charged so that it can become fully activated after a comparatively minor stressful event (the kindling phenomenon)" (p. 8).

According to Beck (1996), the various categories of psychological dysfunction can be understood in terms of the specific primal mode involved and the characteristic "goal" of the mode (p. 8). For example, in depression the loss threatens the organism's livelihood, and the behavioral inactivation so common to depression represents a means of preserving the organism. Further, depression is typically accompanied by a weak constructive mode, so the individual probably has poor self-concept and a decreased ability to think constructively (Beck, 1996). Table 10.3 shows Beck's (1996) conceptualization of the psychological disorders and associated modal functioning. Note that Beck included hostility among these because he believed that it is needed to account for excessive violence and homicide.

TABLE 10.3
MODES AND DIAGNOSTIC CATEGORIES: PRIMAL SYSTEMS

Disorder	*Cognitive Features*	*Affective Features*	*Behavioral Impulse*	*Physiological Activation*
Specific phobia	Specific danger	Anxiety	Escape or avoid	Autonomic nervous system
General fear	Generalized danger	Anxiety	Escape, avoid, inhibit	Autonomic nervous system
Hostility	Threatened, wronged	Anger	Punish	Autonomic nervous system
Depression	Loss	Sad	Regress	Parasympathetic activation

Source: Information from Beck, A. T. (1996). Beyond Belief: A Theory of Modes, Personality, and Psychopathology. In P. M. Salkovskis (Ed.), *Frontiers of Cognitive Therapy* (p. 232). New York: Guilford Press.

Recently, CT theorists have become interested in the struggle to work with clients diagnosed as having personality disorders. Although she doesn't invoke modal theory, J. S. Beck (2005) noted that "cognitive therapists view the development . . . as the result of an interaction between individuals' genetic predispositions toward certain personality traits and their early experiences. A histrionic patient, for example, may have been born with a flair for the dramatic" (p. 41). Beck (2015) contributed a complex and detailed view of personality disorders, including cognitive profiles of a wide selection of personality disorders. Describing these is beyond the scope of this chapter, but interested readers can consult the third edition of *Cognitive Therapy of Personality Disorders* (Beck, Davis, & Freeman, 2015).

Mia thinks that Steve's most active schema is the depressogenic schema. He shows the negative triad in his dim view of himself, his perception that others don't like or approve of him, and his perception that the world is difficult and the future is uncertain or negative. Mia guesses that, although Steve's loss mode is somewhat active at present, it is not fully charged because he evidences mild to intermittent and moderate, rather than severe, depression. Because of Steve's apparent sociotropic orientation, Mia will be on the lookout for interpersonal situations that could set off more extreme modal processing.

Steve's loss primal mode was probably sensitized by his early experiences with his parents. They were distant in their interactions with him, and he interpreted the distance as rejection based on his inadequacy and bad behavior. The victim mode might be relevant to Steve's situation as well because he sometimes sees himself as the scapegoat of an unfair world (e.g., in the automobile accident). Steve may also have been born with genetic tendencies toward passive, depressive types of behavior.

When Steve's loss mode is activated, he withdraws and drinks to escape. He shows evidence of cognitive distortion in this situation ("It's no use; I can't do anything right; why bother to try to stop drinking when the world is so awful?"), low motivation, and behavioral inactivation. If Steve's victim mode is also activated by his perception of some injustice, he may feel threatened and angry, too. At these times, he may seem energized by the anger.

Occasionally, Steve enters a manic phase that results from activation of the self-enhancement mode. At these times, he may drink because he believes himself invincible. He acts out because he

has an exaggerated sense of his power. If his victim mode becomes activated at the same time, he may physically attack the person or entity perceived to be threatening him. When the manic mode is active, he probably has ATs such as "What the hell," "One drink is fine," and "Everyone loves me."

NATURE OF THERAPY

Assessment

Both formal and informal assessments are used in CT. Newman and Beck (1990) strongly encouraged a formal comprehensive diagnostic evaluation for three reasons: (a) to fully understand the psychological picture of the client, (b) to determine if any organic syndrome is involved, and (c) to assess the need for medication or hospitalization. Generally, both standardized instruments and a diagnostic interview are used (D. Dobson & Dobson, 2009). Ultimately, the goal of the assessment is a structured cognitive case conceptualization (J. S. Beck, 2011). Often, a special session (i.e., intake) is used for assessment prior to the official start of counseling. The initial evaluation generally results in a formal DSM-V diagnosis (American Psychiatric Association, 2013).

Formal assessment in CT often involves using standardized self-report inventories such as the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), the Automatic Thoughts Questionnaire (ATQ; Hollon & Kendall, 1980), and the Dysfunctional Attitude Scale (DAS; A. N. Weissman & Beck, 1978), which measures schema-related core beliefs and assumptions. Numerous other instruments have been constructed for cognitive assessment; an excellent review of these and their psychometric properties is presented by Dunkley, Blankstein, and Segal (2009). These instruments are often used intermittently throughout counseling to assess progress (Persons, 2008).

CT counselors are most interested in assessing their clients' thoughts, and they do this continually throughout therapy. The simplest way to make this assessment is to ask the client, "What was going through your mind?"—either in referring to a mood change in session or in helping the client reconstruct situations outside of therapy. As I noted earlier, the DAS or ATQ can also be used for this purpose.

Cognitive assessment leads to a formal treatment plan. In the first session of CT, the client is asked to establish goals; the therapist helps the client make these specific and concrete. The CT counselor then takes each problem or goal and analyzes it from a CT perspective. J. S. Beck's (2011) recent writings emphasize the creation of a formal cognitive conceptualization for each client, using a specific format; Figure 10.2 later in the chapter shows an example. The CT counselor must be careful to get a complete understanding of the client's perspective, along with the specifics of his presentation, so that the resulting conceptualization is acceptable to both client and counselor (K. S. Dobson, 2012).

Mia gives Steve the BDI to assess his current level of dysphoria. She finds that he is moderately depressed. She also spends time in the first session (as well as in later sessions) helping Steve identify his cognitions—first his ATs and later his core beliefs. She considers using the DAS to assess his core beliefs and assumptions.

Overview of the Therapeutic Atmosphere

CT is characterized by a collaborative relationship between client and counselor (K. S. Dobson, 2012). Cognitive therapists recognize the importance of the therapeutic relationship, sounding much like person-centered theorists in their emphasis on warmth, genuineness, trust, and respect (Kellogg & Young, 2008). However, cognitive therapists see the therapeutic relationship as necessary, but not sufficient for good therapy outcome (K. S. Dobson, 2012, p. 39).

The CT relationship is seen as different from other counseling relationships because it emphasizes a scientific approach (Beck, 1997a); the relationship is said to be based on *collaborative empiricism* (Beck & Weishaar, 2014). Client and counselor are co-investigators in the scientific study of the client's difficulties. The client's schemas, beliefs, and ATs are treated as hypotheses to be tested by the two scientists. Evidence is gathered and experiments are designed and conducted to test the hypotheses.

Alford and Beck (1997c) discussed the role of interpersonal support in CT. They maintained that the therapist must create "responsible dependency" in the client; the client is not to become passive in the relationship (p. 107). Support in CT means support of the client's efforts to learn and implement the CT model in his life. The therapist makes genuine efforts to understand the client and accepts the client in the sense that all client cognitions, feelings, and behaviors are openly examined for their advantages and disadvantages (Alford & Beck, 1997c). However, the cognitive therapist does not accept certain client actions and goals when they are considered antisocial (e.g., illegal acts, abuse of others).

Beck (1976) called CT a common sense therapy that simply helps the client apply problem-solving techniques that he has used in the past to correct the current faulty thought processes. CT is typically a short-term intervention, ranging from 10 to 20 sessions. For more severe problems (e.g., personality disorders), CT can be longer, but it is still considered a comparatively brief approach to these dysfunctions. Booster sessions are often scheduled after formal termination to help prevent relapse (J. S. Beck, 2011).

Mia approaches Steve in a friendly, warm way. She is accepting of him and responds empathically to his description of his troubles, hopes, and dreams. Mia attempts to build a relationship based on the idea that she and Steve will look at how he views the world, testing out the conclusions he draws, and determining their relationship to his feelings and behavior. Mia expects that, if Steve becomes engaged in their scientific counseling project, he will be in therapy for about 6 months. However, the length of Steve's counseling will likely depend on what goals he sets.

Roles of Client and Counselor

In CT, the counselor is an expert who teaches the client about cognitive theory (D. Dobson & Dobson, 2009). The expert orientation, combined with the emphasis on assessment and diagnosis, results in a relationship that somewhat resembles that of doctor–patient. Judith Beck (2011) characterized the cognitive therapist as caring, collaborative, and competent. The counselor typically is very active, particularly early in the therapy process. Cognitive therapists ask their clients a lot of questions and are very likely to assign tasks related to the clients' identified problems. Craske (2010) pointed out that the therapist serves as a source of reinforcement for the client, promoting constructive behavior change, and also acts as a model.

Initially, the client is a student who is expected to work hard to learn about CT. He is expected to devote energy to examining his thoughts and generating testable hypotheses about them (Hofmann et al., 2013). At the same time, the client is a collaborator in the counseling process whose direct input is always solicited in setting session agendas and selecting homework assignments (J. S. Beck, 2011). The client is the expert on his own experience. As therapy progresses, the client is expected to take more and more responsibility for what happens in counseling sessions, developing CT explanations for his feelings and behaviors, setting the session agenda, and developing homework tasks. In essence, the client becomes an expert on how CT theory applies to him (Alford & Beck, 1997c).

Mia takes a straightforward, educative approach with Steve. She explains the cognitive model to him in the first session, attempting to get him to understand and accept the system and engage collaboratively with her in the process of CT. She gives Steve a pad of paper and a pen and encourages him to take notes about the model. Mia is very aware that it will be important to establish a good working relationship with Steve because he is a sociotropic type who is sensitive to the evaluations of others. She is supportive and praises his efforts to learn and apply the model.

If Steve responds well to Mia's invitation to participate, he will become a good student of CT. Steve will work in tandem with Mia to identify his cognitive processes and understand how they relate to his feelings and behavior. He will follow Mia's instructions in his sessions and complete his homework assignments. The two will engage in collaborative empiricism, testing Steve's ideas in a CT model.

Goals

The goals of CT are to identify and change faulty information processing and to modify beliefs that support psychological dysfunction to ones that are more adaptive (Beck & Weishaar, 2014). Lest you think CT is about positive thinking (wearing the "rose-colored glasses"), Hofmann et al. (2013) will correct you, saying "cognitive techniques do not ask patients to think positively but rather more realistically" (p. 201). Typically, a good deal of CT focuses on the client's ATs (J. S. Beck, 2011). Through addressing ATs, basic beliefs or schemas are sometimes accessed, but significant change in these deeper structures may require longer-term therapy than is typical in CT. A broader goal of CT is to teach clients problem-solving strategies that they can use across situations.

Altering faulty core beliefs and the associated schematic change, although difficult, should prevent relapses (Young et al., 1993). The idea is to get the individual to operate based on reflective, constructive processes through the use of the conscious control system, or metacognition, rather than primitive schemas (Beck & Clark, 1997). The dysfunctional modes need to be deactivated and the more adaptive modes need to be built (Beck & Weishaar, 2014). Modifying the content of the modes is achieved through addressing core beliefs and schemas and is thought to lead to more adaptive behavior.

Steve is harboring some faulty beliefs that need to be modified. Mia helps him first identify his ATs and then replace them with more functional beliefs. For instance, the AT that "no one loves me" needs to be replaced with something less drastic.

Mia is sure that Steve's self-enhancement primal mode needs to be strengthened. This process will be tricky because Mia is aware that sometimes Steve's functioning based in this mode gets exaggerated (when he is manic). Steve will need to learn to use his conscious control system to discriminate between

these two states. Mia decides that Steve needs to find ways to deactivate or de-energize his primal loss and victim modes and to use his conscious control system to interrupt this modal processing when it occurs. Mia targets Steve's problematic ATs and intermediate beliefs as a way to start this process. Later in therapy, he can begin to examine his core beliefs, schemas, and primal mode content and process.

PROCESS OF THERAPY

CT can be seen as moving through three general stages (K. S. Dobson, 2012). In early sessions, behavioral activation is important. Once the client has some energy, the focus becomes specific ATs and their relationship to emotion and behavior. Finally (and some clients never get to this stage), the work turns to the more complex level of schematic processing. Of course, for clients experiencing problems other than depression, the behavioral activation phase may not be applicable.

In the first session of therapy, three goals are considered critical: establishing the working relationship, setting goals, and socializing the client (D. Dobson & Dobson, 2009). Young et al. (1993) added that rapport is enhanced and the client's suffering reduced if the therapist can create some quick symptom relief in the first meeting. Judith Beck agreed, writing that "one of the best ways to strengthen the therapeutic alliance is to help patients solve their problems and improve their mood" (2005, p. 67).

Socialization involves directly teaching the cognitive model. A second important part of the educative process is teaching the client about the structure of counseling sessions. Each CT session can be partitioned into three general phases, with specific tasks associated with each (J. S. Beck, 2011, pp. 100–101): The first phase involves (a) checking the client's mood, (b) setting the agenda, (c) an update of the client's situation, (d) reviewing homework, and (e) prioritizing the agenda items. In the second phase, (a) the client and counselor work on problems, (b) the counselor teaches cognitive and behavioral skills, and (c) new homework is devised. The final stage consists of (a) reviewing the new homework, (b) summarizing the session, and (c) eliciting client feedback. The summary and feedback segments include the therapist's summary of the session, but also provides the opportunity for the client to evaluate the session. The CT counselor asks the client to appraise the session and identify anything that the counselor said that felt wrong (J. S. Beck, 2011). Wenzel (2012) adds that clients should evaluate what they learned in the session as part of the feedback phase, so the counselor should ask questions like, "What is the most important thing that you will take away from today's session?"

Guided discovery describes the process of CT (Beck & Weishaar, 2014). The therapist has an idea (based on her cognitive conceptualization) about where she thinks the client needs to end up and through her questioning helps the client get there (Scott & Freeman, 2010). Persons and Tompkins (1997) put it another way: "The goal here is for the patient to discover the answers she needs, guided by the therapist" (p. 328). Along the way, the therapist checks with the client often to see if they are in agreement on the goals and activities of the counseling (Persons, 2008).

As counseling progresses, the counselor takes less responsibility and the client takes more for what happens in sessions. The therapist begins to take on an advisory role as the client conducts therapy (Young et al., 1993). Ultimately, the aim of the cognitive therapist is to help the client become his own counselor (K. S. Dobson, 2012). Clients are even encouraged to conduct their own "self-therapy" sessions, following proper CT structure, after therapy terminates (J. S. Beck, 2011).

Although CT therapists recognize the existence of transference, the goal in CT is to keep these reactions to a minimum through the use of collaborative empiricism (Wright & Beck, 1996). If client transference does appear, it is treated like any other hypothesis—client and therapist explore the cognitive process around it and the evidence that supports or refutes it.

CT theorists are well aware of problems in collaboration that can lead to resistance or noncompliance (Dienes, Torres-Harding, Reinecke, Freeman, & Sauer, 2011). Possible reasons for noncompliance include therapist errors (e.g., failure to validate the client's experience, poor socialization of the client), lack of collaborative skills on the part of the client or counselor, client factors (stress, beliefs about change), a match between client's and therapist's dysfunctional beliefs (e.g., the therapist and client both believe the situation to be hopeless), mistiming of interventions, or unclear or unrealistic therapy goals. Davis and Beck (2015) emphasized that it is important for the therapist to be attuned to the client's reactions in therapy and to correspondingly modify her style to match the proclivities of the client. For example, many clients like counselor self-disclosure, but there are some who may wonder "Why is this therapist wasting my time telling me about her problems?"

In her book *Cognitive Therapy for Challenging Problems* (2005), Judith Beck discussed difficulties in the therapeutic alliance, recognizing that these can result when the therapist makes errors or when the client's beliefs affect the alliance. When the problem is found to be the client's belief system, the therapist needs to determine whether it is a specific belief about the therapist or one about people and the world in general. For example, the client might harbor the core belief of helplessness, feel vulnerable, and avoid bonding with the therapist, or he might be overly protective and defensive. The therapist can then intervene with standard CT techniques.

Judith Beck also discussed therapists' dysfunctional reactions to clients and identified a number of ways in which these can be addressed, such as attending to the competence of the therapist, assessing one's expectations for clients (Are they too high or low?), giving feedback and setting limits, and practicing good self-care. In extreme cases, the client may be referred to a different therapist (J. S. Beck, 2005). The therapist must attend to her cognitive processes (e.g., ATs, beliefs) and emotional reactions to the client and the counseling process to avoid errors that could impede therapeutic progress (Davis & Beck, 2015). A more detailed view of countertransference was offered by Cartwright (2011), who distinguished between objective and subjective types, suggesting that cognitive therapists were most focused on subjective countertransference, which is defined as the counselor's responses to the client that are based on her personal issues (p. 115). She suggested that CT practitioners attend to objective countertransference as well, which refers to reactions experienced by the therapist that would be experienced by nearly anyone interacting with the client—that is, reactions similar to those of other individuals in the client's life.

Mia and Steve begin their work with Steve learning the relationships among thoughts, feelings, and behaviors (the cognitive model). Mia asks Steve what he wants to get out of counseling, and he replies that he wants to get his life together and get a good job. Mia explores what "getting his life together" means. Steve lists the following: (a) staying sober, (b) acting in more mature ways, (c) being less depressed and lethargic (which is also connected with his drinking), (d) establishing a better relationship with his parents, (e) feeling better about himself (despite his initial presentation of self-acceptance), and (f) getting a job.

Mia struggles to get Steve to be specific about his difficulties. She asks him what constitutes "acting-out" and "immature" behavior. He gives several examples: He yells at coworkers when he is frustrated. He has walked off the job when unhappy with how things were going (e.g., when his supervisor is dissatisfied with his performance). He pouts when he does not get his way in group discussions at the residence facility where he lives.

Although his current level of depression is not as severe as it has been in the past, Steve would like to work on ways to deal with possible intensifications of depression in the future. He and Mia decide that setting some goals about depression would be appropriate.

Mia and Steve establish the following treatment plan:

1. *Develop strategies to help Steve stay abstinent from drinking. Identify situations that trigger drinking (those that activate the loss mode, primarily). Evaluate dysfunctional beliefs and ATs associated with drinking.*
2. *Help Steve identify and evaluate beliefs and thoughts about himself and his relationships with others, including his parents. Work on ways to improve these relationships.*
3. *Problem solve about "acting-out" behavior. Identify beliefs and ATs associated with situations in which he feels criticized (i.e., the victim mode is operative). Construct alternative strategies to use in these situations.*
4. *Examine Steve's depression. Identify and evaluate the cognitive structure and processes that are active when he is depressed (the depressogenic schema and associated beliefs and ATs).*
5. *Develop job-search behaviors and implement them. Examine cognitions and emotions associated with these behaviors.*

Mia's cognitive case conceptualization, shown in Figure 10.2, guides her work with Steve. She helps him with his struggles, asking questions that orient his explorations (guided discovery). Mia gently encourages Steve to take responsibility for choosing topics to put on the agenda and to take the lead in applying the cognitive model. In each session, they follow the steps of the CT model: (a) Steve gives a brief update on his situation, (b) Mia and Steve relate the previous session to the present, (c) they set the agenda, (d) they review the homework, (e) they discuss the issues on the agenda, (f) they construct new homework, and (g) Mia summarizes the session and asks for Steve's feedback—how he felt about the session and what will he take with him. Both Steve and Mia offer input.

THERAPEUTIC TECHNIQUES

CT advocates are flexible in use of techniques, employing interventions that target cognition, emotion, behavior and physiology (e.g., sleep, eating; K. S. Dobson, 2012). "Cognitive therapy is highly eclectic, but not theoretically 'neutral'" (Alford & Beck, 1997a, p. 90). Techniques are selected to serve the overall conceptualization developed via cognitive theory (Alford & Beck, 1997a):

> Techniques can be selected from other psychotherapeutic approaches, provided that the following criteria are met: (1) The methods are consistent with cognitive therapy principles and are logically related to the theory of therapeutic change; (2) the choice of techniques is based on a comprehensive case conceptualization that takes into account the patient's characteristics (introspective capacity, problem-solving abilities, etc.); (3) collaborative empiricism and guided discovery are employed; and (4) the standard interview structure is followed, unless there are factors that argue strongly against the standard format. (Alford & Beck, 1997a, p. 91)

A general term for anything that changes client cognition is *cognitive restructuring* (Clark, 2014). Behavioral techniques are used in the interest of *behavioral activation* (e.g., to help a severely depressed client get moving as in activity scheduling) or to teach new skills (such as

Client: Steve	**Counselor:** Mia	**Date:** 6-12-16
Presenting Problems	Alcohol use, immature behavior, acting out, sadness/depression, unsatisfactory relationships.	
Relevant History	Difficulty in school ("acting up"), family turmoil (distant parents, parental divorce), diagnosis of bipolar disorder at age 25, serious automobile accident, alcohol problems resulting in multiple courses of inpatient treatment, breakup of significant relationship.	
Modes, Core Beliefs, and Schemas	Loss, victim, overactive self-enhancement modes. Self-schema negative ("I am worthless"). Believes that the world is generally hostile and unforgiving ("Others won't treat me well anyway"). Values the approval of others but doubts that he will get it ("I must be loved. Others disapprove of me.").	
Conditional Beliefs	"If I don't keep my parents happy, then I am worthless. If others don't treat me well, they are evil and the world is a rotten place. If I am not perfect at work, I am a failure."	
Situational Factors	When others criticize, interactions with parents, perceived failure of any kind.	
Automatic Thoughts and Beliefs	*Associated with loss mode:* "No one loves me; I'm a failure and worthless; I must be perfect; I must not get angry; it's no use; I can't do anything right." *Associated with victim mode:* "Others are mean to me; others won't give me a break." *Associated with self-enhancement mode:* "I'm invincible; others can go to hell."	
Emotions	Sadness and depression, anger and irritation in work environment, exhilaration in manic phases.	
Behaviors	When depressed, becomes lethargic and may drink. In victim mode, can behave angrily and disrespectfully to others. Social/assertiveness skills weak?	
Integration/Cognitive Construction of Current Presentation	Bipolar tendencies may be partly biological in origin. They are associated with loss, victim, and self-enhancement modes. Negative self-schema is a function of sociotropic tendencies combined with early family environment and relationship with parents. Primal modes were also shaped by these factors. Different modes, when activated, are associated with emotions, behaviors, and cognitions as indicated earlier. Alcohol use appears in either loss or self-enhancement modes.	

FIGURE 10.2. CT Case Formulation for Steve.

assertion or problem-solving training). *Homework* is considered essential in CT, and many of the techniques described in this section can be transformed into homework assignments (J. S. Beck & Tompkins, 2007).

The majority of presentations of CT focus on modifying or eliminating schemas, core beliefs, and ATs (e.g., J. S. Beck, 2011; Leahy, Beck, & Beck, 2005). Less is written about addressing modal processing; however, Beck and Weishaar (2014) identified three ways to deal with dysfunctional modes: "(1) deactivating them, (2) modifying their content and structure, and (3) constructing more adaptive modes to neutralize them" (p. 233). According to Beck (1996), corrective information from the counselor activates a "safety" mode that contains more functional beliefs (p. 16). Basic cognitive-behavioral interventions that emphasize mastery and pleasure build or strengthen adaptive modes. Other interventions are oriented toward deactivating the protective primal modes. Routes to modal change include changing the appraisal of the situation (e.g., from dangerous to benign), distraction, and reassurance from the counselor (i.e., corrective information leads to change in how the client interprets the situation). The most significant change in primal modes, however, is through changing the underlying beliefs in the mode, the rules the individual uses to interpret the world. This belief change results in activation of adaptive modes and deactivation of dysfunctional modes (Beck & Weishaar, 2014). For example, a client who initially interprets a rapid heartbeat as the sign of an impending heart attack changes two beliefs: (a) that rapid heartbeat always leads to heart attack, and (b) that he is a good candidate for a heart attack (when he has very few risk factors). Modifying these beliefs would presumably deactivate the danger or fear mode.

There are many, many techniques available to the CT counselor, so the following sections describes only a sample of these. An excellent resource for those who wish to learn more is D. Dobson and Dobson (2009).

Questioning

One of the most prominent techniques in CT is questioning. In fact, one of the most basic interventions in CT is to ask the client, "What was going through your mind just now?" when the counselor notices a change in the client's affective state (Newman & Beck, 1990). The idea is that emotions are good indicators of the presence of ATs.

Socratic questioning refers to the strategy of asking questions that prompt clients to examine distorted thoughts and dysfunctional beliefs and challenge them (K. S. Dobson, 2012). A favorite question of cognitive therapists is "Where is the evidence for this thought/belief?" It is the counselor's job to devise questions that help clients alter their current views to "a state of inquisitiveness and curiosity" (Wright & Beck, 1996, p. 1021).

Six types of questions are considered effective in helping clients test ATs:

> (1) What is the evidence that supports this idea? What is the evidence against this idea? (2) Is there an alternative explanation or viewpoint? (3) What is the worst that could happen (if I'm not already thinking the worst)? If it happened, how could I cope? What is the best that could happen? What is the most realistic outcome? (4) What is the effect of my believing the automatic thought? What could be the effect of changing my thinking? (5) What would I tell _____ [a specific friend or family member] if he or she was in the same situation? (6) What should I do?" (J. S. Beck, 2011, p. 172)

Mia asks Steve about what goes through his head when he gets mad at work. He reports, after some consideration, that sometimes he thinks "they are mean" and "they hate me." At other times, he thinks "I screwed up" or "I can't do this job." Mia asks Steve what evidence he has that others hate him and are mean. He replies that they criticize his performance on the job. "Do you deserve the criticism?" asks Mia. "Well, yes," Steve replies, "I did screw up." "But does that automatically mean that they hate you?"

Mia asks. "Well, I guess not," replies Steve. Mia then follows with "What's the effect of thinking that people at work are mean and hate you?" Steve acknowledges that his belief leads to easily triggered anger and subsequent "immature" behavior. Afterward, he finds himself depressed.

Downward Arrow

Also known as *vertical descent*, this technique is used to identify core beliefs (Kellogg & Young, 2008). It is so named because the therapist starts by examining thoughts relatively close to the "surface" and proceeds downward to core beliefs. First, a key AT is identified that the counselor thinks is related to a core belief. The counselor then asks the client what this thought means, assuming it is true. Repeating this question for each client response will eventually lead to the core belief. Judith Beck (2011) noted that asking the client what the thought means *to* the client often leads to an intermediate belief, whereas asking what the thought means *about* the client leads to a core belief (p. 207).

Mia asks Steve to examine the belief that his parents think he is an alcoholic manic-depressive. She directs Steve to assume this is true and asks him what it means to him. Steve divulges that it means that his parents think badly of him. "OK, so assume that's true," Mia says. "What does that mean, that they might think badly of you?" Steve replies, "Well, it means that I am a failure as a person and worthless." Mia and Steve have identified a dysfunctional core belief or schema.

Thought Recording

Cognitive therapists almost always instruct clients in some form of thought recording (Wright & Beck, 1996). One commonly used instrument is the Thought Record (TR), formerly known as the Daily Record of Dysfunctional Thoughts, shown in Table 10.4 (J. S. Beck, 2011). The TR is often first used in session to teach the client how it works. Then the counselor generally gives the client the TR to take home, asking him to record occurrences of ATs between counseling sessions. At the next session, the counselor and client review the TR, evaluate the client's responses to the ATs, and work on alternatives, if necessary. An alternative form, the Testing Your Thoughts Worksheet, can be used if the therapist thinks the TR might be too complicated or confusing (J. S. Beck, 2011, p. 196).

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Video Example 10.3 Watch cognitive therapist Dr. Lundgren and client Helen complete a thought record exercise.



Steve records his AT that occurred after disagreeing with a coworker, Sue. Thinking "she hates me" leads to Steve's sadness. Mia and Steve review the form and find that Steve did not really convince himself with the adaptive response he devised, although he did feel less sad. Mia and Steve work to find a response that will help Steve further reduce the sadness or eliminate it entirely.

Behavioral Experiments

Behavioral experiments are assignments that are tailored to a specific belief. The therapist and client design a task or activity that challenges a faulty cognition (Clark & Beck, 2010). For example, Nancy, who believes that she has no fun in life, is asked to pick one activity that might

TABLE 10.4
STEVE'S THOUGHT RECORD

Date/Time	*Situation*	*Automatic Thoughts*	*Emotions*	*Adaptive Response*	*Outcome*
	1. What event, image, or recollection led to the emotion?	1. What thoughts/ images	1. What emotion did you feel?	1. (optional) What cognitive distortion did you make?	1. How much do you now believe your AT?
	2. Any physical sensations?	2. How much did you believe them?	2. How intense? (0–100%)	2. Use questions at bottom to form a response to the AT.	2. What emotions do you feel now? How intense? (0–100%)
				3. How much do you believe the response? (0–100%)	3. What will you do (or did you do)?
6/19/16	1. Disagreed with coworker	1. She hates me	1. Sad	1. Magnification? Overgeneralization? (not sure)	1. 40%
			2. 80%	2. Just because I disagreed with Sue doesn't necessarily mean she hates me	2. Still sad, but less
				3. 70%	3. Nothing

Note: Questions to help compose an alternate thought: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? How could I cope? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking? (5) What should I do about it? (6) If _____ [a friend] was in the situation, what would I tell him/her?

Source: From Beck, J. S. (2011). *Cognitive Therapy: Basics and Beyond.* (2nd ed., p. 195). New York: Guilford Press. © 2011 by The Guilford Press. Adapted with permission.

possibly be fun, such as going to the zoo. She is asked to go to the zoo and report what happens. If she has fun, then her belief is disconfirmed. If she doesn't have any fun, then the thoughts she had at the zoo can be examined.

Mia and Steve develop a behavioral experiment for him that tests his belief that "it's no use; I can't do anything right." They identify something that would be "right"—he could negotiate a conflict in his living situation without getting so angry that he "blows up." For example, Steve wants to be able to see a certain show on TV but is afraid to ask the others in the residence about it (the TV is communal). Mia and Steve work on strategies to help Steve ask this question.

Activity Scheduling

When clients are very depressed or for other reasons have low motivation, it is often helpful to have them create a daily schedule, on paper, to follow between therapy sessions (Newman & Beck, 1990). The counselor may ask the client to simply keep a record of daily activities at first, to establish baseline information. After reviewing these data, the client and counselor then work together to fill in the blocks of an activity chart, which lists the days of the week across the top and hours along the left side (J. S. Beck, 2011). Part of recording daily activities often involves rating each on a scale of 1 to 10 for mastery and pleasure (Beck & Weishaar, 2014). This technique is sometimes called *mastery and pleasure therapy*, particularly when activities are developed to create successful outcomes (Beck, 1976).

Because Steve is in the work–therapy program, he does not need to schedule activities during the week. However, he does admit that he has difficulties on the weekends. Mia and Steve develop a schedule for Saturdays that includes important errands that Steve would like to accomplish (e.g., go shopping) along with some fun activities (watch a Little League baseball game). Specific times are set up for the activities, and Steve is to record his completion of each, along with ratings of mastery and pleasure.

Graded Tasks

When a client faces what seems to be an overwhelming task, the counselor and client can work to make it less intimidating by breaking it down into smaller steps. This procedure is called creating a graded task assignment (Beck & Weishaar, 2014). Concrete steps are formulated to reach the agreed-upon goal, and the client then works on the steps one at a time, focusing on the achievement of each. The first steps devised should be relatively easy so that the client is not overwhelmed and, ideally, experiences some initial success (Freeman, Schrodt, Gilson, & Ludgate, 1993). In fact, Beck also called this technique *success therapy* (Beck, 1976, p. 272). Self- and therapist reinforcements are important in this process.

Mia and Steve examine Steve's goal to get a job. Because this is an intimidating task for Steve, they break it down into a number of steps using the graded task approach. The first step is to have Steve read a good reference book on job searching. Next, Steve constructs his résumé and brings it to Mia for review. Steve decides he wants to go into the restaurant industry, so he and Mia problem solve about how to get a job there, given his lack of experience. They decide that he should have lunch in a moderately priced restaurant and try to engage in some chitchat with one or two staff members about how to get a job. These steps are just a beginning, but Steve and Mia write them down, and as he tackles each they examine his cognitions about them. Mia is careful to praise Steve when he accomplishes his task for the week, and she makes sure that Steve does something nice for himself, too.

Social Skills Training

Borrowed from behaviorism, social skills training involves teaching clients skills that promote harmonious and productive interactions with others. Role play is frequently used, along with simple, concrete teaching of information, coaching, and modeling (Mueser, Gottlieb, & Gingerich, 2014). A common form of social skills training is assertiveness training, which teaches people skills that support their rights without violating the rights of others (Duckworth, 2009a).

Mia teaches Steve about assertive behavior. She suggests that he read a book on assertiveness training. Together, Mia and Steve decide that assertiveness training is in order for Steve because it should help his relationships at work and in the residential facility. He notes that his immature behavior is not assertive because it is either passive (he walks out) or aggressive (he gets angry and yells). They generate a list of problem situations and examine Steve's thoughts, feelings, and behaviors while in the situations. They then generate alternative assertive behaviors to replace Steve's previously passive or aggressive ones. Mia helps Steve rehearse these new behaviors in session.

Problem Solving

Problem-solving techniques involve identifying and clarifying the problem, generating alternatives, evaluating the alternatives, implementing an alternative, and then assessing the utility of the new approach (Newman & Beck, 1990). In CT, this approach is often used to evaluate dysfunctional beliefs, such as when the benefits and costs of maintaining a given belief are explored.

Steve and Mia problem solve around his desire to remain abstinent from alcohol. One thing they decide is that when Steve gets depressed, he is likely to drink. They examine his cognitions and behaviors and devise alternative responses to use when Steve notices that he is down.

Imagery

When a client is having difficulty identifying ATs, the counselor can resort to using imagery or role playing to vividly conjure up the problem situation (Wright & Beck, 1996). Because these techniques are likely to evoke the emotions associated with the problematic situations, they should help the client identify cognitions associated with the feelings. The *turn-off technique* can be used to help clients learn that they can control images (Beck & Emery, 2005). In this technique, the therapist and client think up a way for the client to sharply disrupt the image, such as clapping his hands or blowing a whistle. Images can also facilitate the development of adaptive cognitions, and then the client can practice this in session or as homework. Beck and Weishaar (2014) advocate "rewriting the script" or helping the client change the imagery to empower himself with the goal of making the problematic situation less disruptive in the client's life (p. 252).

Steve wants to work on feeling good about his interactions with his parents. He is terrified to contact his mother because he has heard that she has "disowned" him. Mia helps Steve imagine making a phone call to his mom, and they examine his thoughts and responses.

Role Playing and Other Behaviorally Oriented Techniques

Also known as *behavioral rehearsal*, role playing can be used to help the client practice behaviors useful in social situations (Beck & Weishaar, 2014). The counselor can first model social skills for the client, which the client then rehearses.

Exposure is also used in CT, particularly with clients who present with anxiety-related problems (Clark & Beck, 2010). Typically a graded approach is used, in which the client takes baby steps toward the feared situation or object. Self-instruction can be added to exposure: The client uses a prepared set of self-coaching statements to help himself cope with the stress of confronting the feared situation (Clark & Beck, 2010). Wenzel (2012) cautions that the therapist must avoid actions or verbalizations that make the client feel safer during the exposure, thus interfering with habituation to the feared stimulus, like reassuring the client that all will be well. Instead, the therapist should express her confidence in the client's ability to tolerate the anxiety.

Mia and Steve role play the telephone call to his mother. Mia plays Mom; Steve practices what he will say, using adaptive thoughts rather than negative automatic ones.

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Video Example 10.4 What technique is Dr. Lundgren using in this segment?



EVALUATION OF THE THEORY

CT has evoked criticism from many fronts. Early on, it was attacked by the behaviorists and psychoanalysts alike (Arnkoff & Glass, 1995). Behaviorists thought that cognition is superfluous to behavior change. According to Meichenbaum (1993), a subgroup of behavioral therapists threatened to throw the "cognitivists" out of the Association for Advancement of Behavior Therapy. Psychoanalytic folks tended to dismiss CT as surface-oriented, dealing with symptoms rather than the important issues. Behaviorists, at least, seem to have changed their opinions: In a 1990 survey, 69% of the members of the American Association of Behavior Therapy reported that they use cognitive techniques (Craighead, 1990).

On first examination, CT appears relatively simple to use. It provides clear explanations for problems and allows the use of a wide variety of techniques. However, counselors may find that identifying cognitions, particularly ATs, is not as simple as it may seem.

Paradoxically, a common criticism of CT is that it is too simple and mechanistic. It is said to ignore the client's emotions and history in favor of the client's thinking. It is thought to be too narrowly focused on symptoms and the present (Spiegler, 2013b). CT theorists respond to these criticisms by pointing out that the client's early experiences are seen as very important in determining schemas and core beliefs (Beck et al., 2004; Beck & Weishaar, 2014). The relative sensitivity of modes to activation (which determines the degree of dysfunction) is also linked to early experience.

A strength of CT is that Beck and his associates have continually evaluated, modified, and advanced the theory. Loads of outcome research support this approach, showing good outcomes for many client problems (K. S. Dobson, 2012). If you believe Beck and his advocates, CT is efficacious and specific for many disorders, meaning that it works and has been found to work better than control or credible alternative interventions in randomly controlled trials (Hollon & Beck, 2014). However, as you will read in the following sections on research, not everyone agrees with the assertion that CT is superior to other bona fide treatments.

The modal perspective is an interesting addition to CT theory, although it makes the theory sound a lot more psychoanalytic. I personally find the addition of constructs such as modes, personality types, and so on confusing because it is not clear how they relate to earlier CT theory. Depending on which source you consult, the modes and personality types might or might not be discussed.

For example, Judith Beck is silent about modal processing. Also, the specific modes hypothesized seem to change depending on what source you consult.

QUALITIES OF THE THEORY

Precision and Testability. To his credit, Beck was one of the leaders in the development of treatment manuals; Beck et al. (1979) presented the first treatment manual for CT (it should come as no surprise that the behaviorists developed the very first manuals). The presence of treatment manuals makes the testing of CT outcomes easier and more valid. There is a massive amount of data that tests the outcome of CT, but despite the theory's apparent simplicity, the testability of CT is debated. Coyne and Gotlib (1986) argued that the CT constructs were difficult to test, calling them "slippery and indeterminate" (p. 697). In addition, Oei and Free (1995) suggested that measurement problems plagued CT theory in that the standard measures of cognitive dysfunction (the ATQ and the DAS) might be assessing psychological dysfunction generally rather than cognitive distortion specifically. S. C. Hayes, Luoma, Bond, Masuda, and Lillis (2006) maintained that, although there is much research on CT, the link between cognitive change and improvement is not well established (more on this later).

Empirical Support. CT is perhaps the most well-researched counseling approach in existence, with an overwhelming amount of empirical support for its effectiveness with a variety of client problems (K. S. Dobson, 2012; Hofman, Asmundson, & Beck, 2013). However, evidence for the theoretical assumptions and structure is less impressive.

RESEARCH SUPPORT

Outcome Research. Outcome research has uniformly supported CT. Hundreds of studies have examined the efficacy of CT, probably because it was one of the earliest manualized treatments and also because good outcome measures exist, particularly for depression (e.g., the BDI-II and the Hamilton Rating Scale for Depression [M. Hamilton, 1960]).

Numerous studies have tested the efficacy of CT with various diagnostic categories. For the most part, CT has been found to be as effective as other treatments, more effective than no-treatment controls, and in some cases more effective than placebo control groups. Not surprisingly, a significant amount of this research has focused on depression. One of the best-known trials of CT is the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program, summarized in Chapter 1. As you may recall, the results of the NIMH study were disappointing because the treatment approaches (CT and interpersonal therapy) did not produce greater improvement in comparison to the placebo group. However, the lack of significant differences seemed to result from improvement in the placebo–clinical management group. Several more recent studies have found similar results. A randomized controlled trial (RCT) comparing CT to REBT (see Chapter 9) and pharmacotherapy was conducted by David, Szentagotai, Lupu, and Cosman (2008) and found results similar to the meta-analytic ones: All three treatments were equally effective for major depressive disorder. Similar results were found in a carefully conducted RCT comparing CT to interpersonal therapy for depression (Verdeli & Weissman, 2014; see Chapter 1). Both approaches were effective after 16–20 sessions of therapy and more so than a waiting list control. These changes were maintained at follow-ups, including at one-year assessment (Lemmens et al., 2015). In general, CT has also been found to

be modestly effective for depression in children and adolescents (Hollon & Beck, 2014). Evidence for the superiority of CT over other approaches, though, is not evident.

Meta-analytic studies have generally supported the efficacy of cognitive-behavioral therapy (CBT), which could generally be construed as support for CT, although the specific treatments used in the many studies analyzed likely do not precisely replicate the classic form of CT described in this chapter. For example, in one meta-analysis, emotion-focused therapy was classified as CBT (Wampold et al., 1997). Hofmann, Asnaani, Vonk, Sawyer, and Fang (2012) reviewed 106 meta-analyses on outcome studies of CBT and found that it was effective over a wide range of dysfunction, such as depression, anxiety, schizophrenia, chronic pain, and personality disorders. The strongest support was found for anxiety disorders, bulimia, anger, somatoform disorders, and general stress. Evidence for the superiority of CBT relative to other approaches, however, was not demonstrated. A fairly recent meta-analysis of CBT for depression, schizophrenia, and bipolar disorder, which controlled for blindness of outcome evaluators and included only studies that had a control condition, found that it was ineffective for treating schizophrenia and that, although CBT was effective for depression, its effects were relatively mild (D. Lynch, Laws, & McKenna, 2009). B. V. Watts et al. (2013) performed a meta-analysis of interventions for post-traumatic stress disorder (PTSD) in which they separated out studies of treatments considered primarily cognitive, meaning that the majority of treatment time was devoted to working with cognition and emotion. An interesting feature of this study was the comparison of the effects of various psychotherapeutic approaches to those of medication, which revealed that psychotherapy had a significantly larger effect size. Cognitive, exposure, and eye movement desensitization and reprocessing were declared effective therapies for PTSD, although it should be noted that cognitive-behavioral approaches were the most frequently used interventions, so they are more fully tested than others. Some less often used approaches did have strong effect sizes, as did, for instance, acupuncture, used in a single trial. CBT has also been found to be more effective than placebo or control conditions for obsessive-compulsive disorder using meta-analytic methods (Olatunji, Davis, Powers, & Smits, 2013). It is interesting that this analysis showed that effect sizes were smaller when CBT was compared to placebo controls than when it was compared to waiting list controls.

Once comparisons to control groups have established the effects of treatments, researchers often compare interventions to "treatment as usual," which typically involves some form of clinical management or nonspecific supportive treatment (Jakobsen, Hansen, Storebø, Simonsen, & Gluud, 2011, p. 2). In one such meta-analysis, CT was found to be more effective than treatment as usual on one measure (the Hamilton Rating Scale for Depression; M. Hamilton, 1960), but not when the Beck Depression Inventory was the outcome measure (Jakobsen et al., 2011). However, the authors reported that all eight studies used in the meta-analysis had significant potential for some form of bias (e.g., no blinding of raters, selective outcome measure reporting; Jakobsen et al., 2011).

Meta-analyses of studies directly comparing two or more recognized therapeutic approaches are considered the gold standard for testing the relative efficacy of the approaches (Wampold et al., 1997). Baardseth et al. (2013) attempted to implement this approach as specifically as possible to test the ever-lurking notion that CBT is more efficacious than other approaches for depression and anxiety disorders. Seeking to improve on earlier meta-analyses, Baardseth et al. used careful methods to define CBT treatments (ratings by members of ABCT) and looked at both symptom-related outcome measures and more global indices (e.g., quality of life). For depression,

a very small advantage for CBT compared to non-CBT was found on symptom-specific measures, but no difference emerged for global measures. For anxiety, CBT and non-CBT treatments were equivalent on both types of outcome measures. Similarly, Jakobsen, Hansen, Simonsen, Simonsen, and Gluud (2012) meta-analyzed seven trials comparing CT (according to Beck et al.'s 1979 definition) and interpersonal therapy (Verdeli & Weissman, 2014) for clients with major depressive disorder. Their results showed no differences in the efficacy of the two approaches regardless of whether the outcome measure was the Beck Depression Inventory or the Hamilton. Spielmans et al. (2013) meta-analyzed studies comparing treatments for bulimia nervosa and binge eating disorder and found an advantage for CBT, but noted that methodological issues limited the confidence we can place in that conclusion.

Because depression is commonly treated with antidepressant medication, investigators in this area have been interested in the relative efficacy of CT and drug treatment. A meta-analysis addressing this question examined studies published between 1977 and 1997, including 48 trials consisting of 2,765 clients (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998). In all of these studies the outcome measure was the BDI. Gloaguen et al. found that CT produced better results than waiting lists, placebo treatments, and antidepressant drug treatment. Comparisons with a set of "other" therapies also showed CT to be more effective, except that CT was found to produce about the same amount of change as behavior therapy. However, a later reanalysis of these data (Wampold, Minami, Baskin, & Tierney, 2002) that separated the comparison therapies into those that are well established ("bona fide") and those that are not (e.g., supportive therapy as a control condition) showed that CT was as effective as, but not superior to, the bona fide therapies.

As I noted in Chapter 1, one criticism of RCTs is that they are not "real world"—clients have a single diagnosis, treatment is manualized, therapists are intensively supervised, and so forth. In response, Gibbons et al. (2010) set out to test CT for depression in real life—at the Center for Cognitive Therapy at the University of Pennsylvania. Therapists at this clinic are not constrained to manuals and were not intensively trained before seeing the clients in the study. Although weekly symptom assessments are required of clients (the BDI, of course), research is not conducted in the clinic. In essence, Gibbons et al. argued, this is CT in a naturalistic setting. The 217 clients Gibbons et al. studied had all been diagnosed with major depressive disorder. Results showed that 61% of the clients achieved reliable symptom change during counseling (sessions were not limited except by insurance requirements or client finances), and 36% of the sample were declared recovered (with BDI scores in the normal range as determined by reference to an appropriate sample). The researchers then compared their sample to one that had completed an RCT, demonstrating similar levels of change except for the most severely depressed clients, who did better in the RCT. So, clinic-based CT and that provided in RCTs produced similar outcomes for many clients, at least in this particular study. Clients with more severe depression may benefit from more structured CT, although again it is risky to generalize from the results of one study.

The voluminous research on CT also served to warn the profession about a potential problem in psychotherapy research: allegiance effects, or the tendency for studies conducted by proponents of a given approach to show results favorable to that approach. Robinson, Berman, and Neimeyer (1990) examined the effects of investigator allegiance and found this state of affairs true for studies of depression. When allegiance was *not* controlled, cognitive, cognitive-behavioral, and behavioral approaches appeared to produce better outcomes than other approaches.

However, when investigator allegiance was controlled, these effects disappeared. In addition, as a group, all therapies did not significantly improve on the effects of placebo treatments. When comparing psychotherapy to pharmacological treatments, Robinson et al. also found investigator effects: An initial apparent superiority of psychotherapy disappeared once allegiance effects were taken into account. Gaffan, Tsaousis, and Kemp-Wheeler (1995) replicated this effect, but found less evidence for allegiance effects in a set of more recently published studies that were not included in Robinson et al.'s analyses. A possible recent example of allegiance effects is exemplified by D. Lynch et al.'s (2009) meta-analysis (described earlier), which found positive effect sizes for two studies of CBT for schizophrenia in which client evaluations were not blind (i.e., the assessors knew the treatment condition of the clients) and no improvement when they were. Jauhar et al. (2014) reported similar results in their meta-analysis of 52 studies; they found only small effect sizes for CBT for schizophrenia, which got even smaller when the effects of blinding of outcome evaluators were taken into account.

CT appears to be effective for anxiety disorders, including generalized anxiety, panic disorder, agoraphobia, and social phobia (Epp & Dobson, 2010; Hollon & Beck, 2014). However, it should be noted that in many cases the trials involved treatments that combined pure CT with standard behavioral techniques, such as relaxation training, desensitization, and biofeedback. It is not clear that CT is effective for these disorders (particularly agoraphobia) on its own or that it is superior to behavioral approaches. An interesting finding from Wenzel, Sharp, Brown, Greenberg, and Beck (2006) was that beliefs specific to panic decreased over CT treatment, which would seem to partially support the cognitive conceptualization of anxiety disorders proposed by CT (Clark & Beck, 2010).

Beck and his colleagues are also very interested in suicidal behavior (Beck, 2005). An example of a study that assessed the effects of CT in reducing repeated suicide attempts was reported by G. K. Brown et al. (2005). In this RCT of CT and treatment as usual (TAU) with clients who had been evaluated at a hospital for attempted suicide, those who received CT were less likely to reattempt and had lower rates of self-reported depression at a 6-month follow-up compared to the TAU clients. CT clients also reported less hopelessness than the TAU clients. Although this study attests to the effectiveness of CT, only cautious conclusions about the relative superiority of CT over TAU can be drawn because of the differences in the ways that CT and TAU are administered. Chapter 1 discussed some of the issues involved in comparing TAU to manual-guided treatments. Ghahramanlou-Holloway, Bhar, Brown, Olsen, and Beck (2012) further studied the same clients as Brown et al., showing that problem-solving skills improved similarly for both groups but that CT was associated with a more rapid improvement in attitudes toward life problems than among clients in TAU.

Research has also looked at whether CT helps clients retain the gains made in counseling. Hensley, Nadiga, and Uhlenhuth (2004) compared five trials of the long-term effects of CT versus antidepressant medication (tricyclic antidepressants) and found that CT was superior in terms of preventing relapse. Van Oppen, van Balkom, de Haan, and Van Dyck (2005) found that clients diagnosed as having obsessive-compulsive disorder maintained their outcomes 5 years after treatment, but there was no difference between groups receiving CT and exposure treatment alone and those receiving psychological treatment plus antidepressant medication. However, they cautioned that, because there are very few good studies of the long-term effects of CT and other therapies, strong statements about prevention effects associated with CT should be avoided at present. Hollon and Beck (2014) were more confident in their assessment;

they contended that CT had long-lasting effects in treating a full range of depression compared to medication and placebo-pill treatment groups.

Guess what? Therapists may not be necessary for CT to work. Efforts to increase treatment accessibility have led to efforts to provide CT via offline computer programs or through the Internet; for the purposes of our discussion both forms will be referred to as computer-based CBT (CCBT). For example, Grist and Cavanaugh (2013) performed a meta-analysis of CCBT interventions for common mental health disorders (e.g., depression, anxiety disorders, eating disorders). CCBT was declared effective in comparison to control conditions. In most cases of CCBT, therapists provide some but very limited support to clients (such as email reminders or motivators, or in some cases clinical advice). Newby et al. (2013) used an RCT design to compare therapist-assisted CCBT to a wait-list control condition. The treatment was a six-session Internet program for depression and anxiety called the Worry and Sadness Program. Clients responded well, and decreases in depression and anxiety were maintained 3 months post-treatment. The researchers then moved the program to an outpatient primary care setting with similar results, but unfortunately more clients dropped out before completing treatment (59%).

Hofmann, Wu, and Boettcher (2014) were interested in the effects of CBT on quality of life (you might have noticed that most outcomes studied are symptom change measures). They meta-analyzed studies of CBT for anxiety disorders that included a number of delivery methods. Their results indicated that CBT had strong positive effects in reducing symptoms, and the effect size for quality of life was also robust, although not as strong. Hofmann et al. also looked at the effect sizes for various delivery methods and, again, all modes had positive effects, but face-to-face (individual and group) methods had stronger effects than did Internet-based interventions. This pattern would suggest that something is lost in remote delivery. However, Hedman et al. (2014) reported different results based on data from a sample of 1,203 clients who received Internet-based CBT for depression in an outpatient clinic setting. In this study, the effect size for pre- to post-treatment change was large and was comparable to those found in other trials of Internet and face-to-face CBT. Finally, Holländare et al. (2011) tested a 10-week computer-based CBT program for relapse prevention. Compared to a control group, the CBT clients showed lower rates of relapse and there was a trend toward a larger reduction of depressive symptoms as well.

Theory-Testing Research. Overall, research support for the validity of CT theory is mixed. Much of the controversy has focused on the CT model of depression. In the 1980s, Coyne and Gotlib (1983, 1986) announced that the evidence for the causal role of cognitions in depression was unconvincing, but more recently several elements of the cognitive model of depression have been declared to be strongly empirically supported, such as a bias toward recalling negative information (Gotlib & Joormann, 2010). CT theory also predicts that anxious individuals will demonstrate negative interpretations of, for example, bodily sensations; research also seems to support this proposition (Gotlib & Joormann, 2010). However, you should note that in both cases we are considering the descriptive theory of depression and anxiety, not the causal theory proposed by Beck (Haaga, Dyck, & Ernst, 1991). Depressed individuals, according to theory, are thought to display more negativity, which involves their views of the self, world, and future (the cognitive triad) as well as other biases or distortions in information processing when compared to nondepressed individuals. Thus, there seems to be support for the negativity hypothesis, the cognitive triad, and bias in information processing in both depression and anxiety (Garratt, Ingram, Rand, & Sawalani, 2007; Gotlib & Joormann, 2010; Haaga et al., 1991).

Evidence for the causal model of CT (that cognitions cause depression) is less convincing (Bieling & Kuyken, 2003; S. C. Hayes et al., 2006). Controversy has long been evident, and still is, around the issues of what is generally known as the diathesis–stress model, which is a fancy name for the idea that both cognitive vulnerability (i.e., the presence of negative cognitive systems or predispositions) and an external stressor are required to produce dysfunction. Early on, Haaga et al. (1991) asserted that no single study has completely tested the proposed relationships among personality dimensions (sociotropy and autonomy), dysfunctional beliefs, stress, and depression. They concluded, "We thus find little convincing support for causal hypotheses of cognitive theory, but at the same time, it would be premature to abandon them" (1991, p. 231).

More recently, Zuroff, Mongrain, and Santor (2004) reviewed the literature specific to sociotropy and autonomy and concluded that the picture was less bleak and that there was merit in continuing to investigate the diathesis–stress model. An attempt to perform such research is represented by Dozois and Backs-Dermott's (2000) study of sociotropy and negative outcomes. This was an experimental study in which participants listened to an audiotape depicting an interpersonal rejection and then completed checklists of self-relevant adjectives and a reaction time task. Consistent with predictions, participants high in sociotropy showed more-negative reactions than those low in sociotropy. Studying more generalized dysfunctional attitudes in an experimental design, Abela and D'Alessandro (2002) found some support for the model in that such attitudes predicted depression for students who had received negative feedback on a college admissions decision. Although the experimental nature of these designs appears to be a far cry from actual depressive processes in the "real world," these studies still yield some support for CT theory.

Another way to assess CT theory is to examine the evidence for the proposition that cognition explains or causes depression, and further, that CT causes cognitive changes that lead to good outcomes (and that other theoretical approaches don't). As we have seen, we have little evidence that cognitions cause depression. However, there is some evidence that cognitive changes are associated with reduced symptoms (e.g., A. D. Adler, Strunk, & Fazio, 2015). Interestingly, Adler et al. found evidence that self-report measures of cognitive changes were evident in a sample of clients undergoing CT for depression, but these changes did not appear on a measure thought to tap nonconscious thought (the Implicit Association Test). In a review of research on these issues, Garratt et al. (2007) concluded that there is evidence for the mediation hypothesis, but the evidence for the idea that only CT produces cognitive change is mixed. In fact, cognitive changes targeted by CT (e.g., automatic thoughts, dysfunctional attitudes) have been documented among individuals in psychopharmacological treatment and wait-list groups. Other psychological therapies also seem to produce cognitive changes, which is not necessarily problematic for CT theory, but we would expect significantly more or better changes among clients in CT. For example, in a study of clients receiving CT, REBT, and pharmacotherapy Szentagotai, David, Lupu, and Cosman (2008) found that all three interventions affected automatic thoughts, intermediate and core beliefs, and irrational beliefs. Also, other researchers have demonstrated that symptom change can happen without cognitive change or before cognitive change attempts were implemented (Kazdin, 2007).

In summary, research generally supports the effectiveness of CT with a wide variety of clients. However, claims of its superiority to other treatments are less convincing. Although some evidence has been in favor of the theoretical propositions of CT, other studies have produced results

that are not. Kazdin (2007) gave a bleak appraisal of the state of our knowledge, writing "Perhaps we can state more confidently now than before that whatever may be the basis of changes with CT, it does not seem to be the cognitions as originally proposed" (p. 8). My conclusion is that the jury is still out (Garratt et al., 2007). Probably the safest conclusion is that it is extremely difficult to really test the underlying assumptions of the CT model.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

In general, there seems to be much agreement that CT can be adapted to a wide range of client diversity (Hays & Iwamasa, 2006). Horrell (2008) reviewed 12 studies of CBT with adult, ethnic-minority clients and concluded that overall it was effective for these individuals over a wide range of dysfunction. However, because the number of studies of actual counseling intervention was small and because many of the studies reviewed could be considered pilot studies, she indicated that her results should not be seen as definitive. Nezu, Greenberg, and Nezu (2014) followed up on Horrell's review, scrutinizing the literature for research performed subsequently, reviewing articles published between the years 2000 and 2009. They found that despite the repeated calls for research on the efficacy of CBT with diverse clients, the average number of articles on this topic published per year was about 11 out of 372 published papers. However, Nezu et al. did acknowledge that efforts had been made to adapt CBT to clients from diverse cultures and reviewed a number of these. Space considerations prevent me from describing the various adaptations, but those interested should review Nezu et al. and the sources cited therein.

S. G. Hoffman (2006) noted that an individual's culture will influence how he perceives the world, including his own behavior, and thus interventions should take this into account. Drawing on literature from social psychology, Hoffman suggested that individuals from non-Western cultures are more likely to accept contradictory thoughts or ideas than are Westerners. For example, explaining anxiety as worry about an upcoming job-related presentation rather than as a sign of an impending heart attack might be acceptable to a client from a Western culture. This client could pick the first rather than the second explanation. In contrast, a non-Western client might be much more comfortable in holding both explanations simultaneously (so to speak). Differences such as this one clearly could have some important implications for cognitive-restructuring efforts.

Other Western-based principles of CT conflict with the values and norms of other cultures. CT assumes that the individual is largely responsible for his own fate; this individualistic outlook may clash with collectivistic values such as those found in some Asian, Hispanic/Latino/Latina, and Native American cultures. Clients who are highly spiritual may not respond well to the emphasis on individual choice and control because they believe in the influence of higher powers in human activity. Some evidence indicates that the logical, linear nature of CT may be problematic for Native Americans and other groups with similar worldviews (Jackson, Schmutzer, Wenzel, & Tyler, 2006; Spiegler, 2013b). At the same time, Ivey, D'Andrea, and Ivey (2012) argued that the structure and clarity of CT may appeal to minority clients. Chen's (1995) comments about the consistency of REBT values (the emphasis on logical thinking, cognitive control of emotion, counselor as teacher, and the active–directive nature of therapy) and Chinese culture probably apply to CT as well. In fact, Zu et al. (2014) demonstrated that CT was effective for depressed clients in China (moderate or severe major depressive disorder); for both immediate outcome and remission rates, CT performed as well as medication only, combined medication and CT, and standard treatment (psychoeducation and/or medication).

Scorzelli and Reinke-Scorzelli (1994) collected data that countered the notion that CT is helpful to clients from other cultures, illustrating the problem with the individualistic stance of CT. They surveyed a group of graduate students in India about the fit of CT (REBT and CT) with their culture. Most of the students were female and identified Hinduism as their primary religion. About 87% of these students judged that CT was inconsistent with their cultural values—most prominently with the belief in karma, that one's destiny is fixed. These students also saw CT as conflicting with cultural values such as obedience to family and sex-role expectations.

In contrast, Wong, Kim, Zane, Kim, and Huang (2003) found that for clients who did not buy into Western culture (i.e., who were presumably more Asian in orientation), CT was viewed as more credible than time-limited psychodynamic therapy. In this study, Asian clients who varied in ethnic identity were exposed to treatment rationales for depression based on the two approaches. Asian participants who identified more strongly with Western culture did not differ in their reactions to the two rationales, whereas those lower in Western identity responded more favorably to a CT rationale. Wong et al. suggested that the emphasis on individual control in CT was responsible for this effect. Clients who were less identified with Western culture in their orientations (presumably more identified with Asian culture) preferred interventions that stressed individual adaptation to unchanging extrapersonal factors. Shen, Alden, Söchting, and Tsang (2006) adapted CT to work with Chinese immigrants in Canada, finding that, although treatment was effective overall, specific issues were challenging in working with these clients. For example, they reported difficulty in helping clients understand that very rigidly held cultural beliefs could lead to problems (e.g., "anger is bad" and "I must take care of others before myself," p. 524).

D. Davis and Padesky (1989) suggested that the collaborative nature of the CT relationship promoted the egalitarianism that is important when working with female clients. Encouraging the client to evaluate therapy sessions and giving the client the opportunity to set the counseling agenda and discuss diagnoses should empower women who may have experienced cultural pressure to be passive and submissive to men. On the other hand, the presentation of the counselor as an expert, almost in the doctor–patient mode, would seem to contradict the egalitarian spirit endorsed by Davis and Padesky. The use of traditional diagnosis doesn't sit well with many feminists, either (K. M. Evans, Kincade, Seem, 2011).

Clients who are stigmatized by society may also develop negative self-schemas as a result of cultural pressure. Individuals who are lesbian, gay, bisexual, or transgender (LGBT) or members of groups who have been the subject of prejudice or discrimination would seem particularly vulnerable in this respect. However, stereotype threat research suggests that schematic effects can be seen for race, sex, and age, too (Inzlicht & Schmader, 2012). Although the sensitive cognitive therapist could help modify a client's self-schema, this intervention would not immunize the client from social pressures (D. Davis & Padesky, 1989). The therapist would also have to direct attention toward helping the client deal with cultural disapproval.

In general, the relative neglect of environmental factors and influences in CT theory may be problematic when working with women and culturally and individually diverse individuals. People who have experienced prejudice, discrimination, and oppression might have more difficulty locating the sources of their discomfort solely in their cognitive processes. Counselors using CT should be careful to incorporate any critical sociocultural factors in their CT case formulations (Duckworth, 2009b).

THE CASE STUDY

Some aspects of Steve's presentation fit well with a CT approach, and others do not. Steve is a White male, so cultural issues may not be paramount. The classic client for CT is one with prominent depression. Although Steve does report some depression, it does not seem severe. However, CT has been applied to a variety of client dysfunctions, including substance abuse, which is clearly a central issue for Steve. In fact, Steve is not reporting a lot of affect in general and seems to be more focused on changing his life situation. Thus, the problem-focused CT approach works well for him.

Beck's modal view describes Steve's manic behavior as hyperactivation of the self-enhancement mode. Thus, his diagnosis of bipolar disorder is captured by activity in the loss and self-enhancement modes. Mia hypothesized that his victim mode was also active, which raises the question of how many modes are likely to be sensitized for a given person.

Summary

CT proposes the cognitive model of therapy: Our behaviors and feelings are a result of our cognitive process and structures. Specifically, clients' ATs, intermediate beliefs, and core schemas are associated with depression, anxiety, and a variety of other kinds of psychological dysfunction. ATs are brief, telegraphic statements or images that are related to core beliefs or schemas. Beliefs and schemas are more elaborate structures that sometimes function outside of our everyday awareness. Schemas are complex cognitive structures that aid in the organization of experience and can influence the ways we interpret events. One important schema is the depressogenic schema, which features the cognitive triad of a negative view of the self, world, and future.

Cognitive therapists help clients by engaging them in collaborative empiricism—the process of examining their thoughts, assumptions, and beliefs as hypotheses rather than truths. The cognitive therapist is an expert and the client a learner who is expected to take increasing responsibility for counseling as he learns the system. Both cognitive and behavioral techniques are used in CT, and homework assignments are considered indispensable.

CT has the strength of being relatively straightforward and structured. It is probably appealing to clients who expect the therapist to be an expert. The efficacy of CT is well established; however, the support for the theoretical predictions of CT is less impressive. Concerns can also be raised that CT's emphasis on internal processes and individual responsibility may clash with the views and values of clients who are from non–Western European cultures, female, LGBT, or in other ways diverse. However, the collaborative relationship found in CT can be empowering to clients who are members of groups that have been historically subject to oppression.

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Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy*, Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 2.

CHAPTER 11

Reality Therapy



William Glasser

Donald is a 31-year-old White male who is currently living alone. He and his wife are separated, and he has recently been fired from his job as a financial advisor. Donald reports that he is experiencing financial stress, but does not want to take "just any old job." He has a history of frequent job changes.

Donald's appearance is neat and appropriate. He speaks very quickly and appears agitated. His manner is somewhat grandiose. Donald appears to have difficulty making eye contact with his female counselor and becomes extremely anxious when asked to talk about his feelings.

Donald says that he has no close friends, but that he is active in community service (e.g., a volunteer group at a local hospital). He reports that he gets along well in these situations by carefully presenting an image that he wants others to see. In his spare time, Donald likes to read magazines and watch movies. His favorite topics are mystery and science fiction.

Donald was raised in a large family with three brothers and several step-siblings. His father was violent when he was young and was imprisoned for some time. Donald does not know why his father was in prison. His mother filed for divorce while his father was in prison and remarried soon after. After his father was released from prison, Donald went to live with him. At the time, his father was self-employed, but Donald does not know in what kind of business or work. Donald expressed resentment when talking about his mother and sees her as being weak and a Valium addict. He says that his father is his idol.

Donald's current marriage is his second. He divorced his first wife after catching her in bed with a female friend. Donald's present relationship has lasted 4 years. His wife, Tammy, moved out about a month ago, saying that she no longer loved or respected Donald. He wants very much for his wife to come back to their relationship.

Donald is seeking counseling because of his job loss and marital difficulties. He believes he functions well in other aspects of his life. He says that physically he is OK, but he does complain of weariness, occasional nausea, and a "tired" back and tense neck muscles that cause "migraines."

Donald says that he feels addicted to excitement and tends to move from job to job for this reason. He is an impulsive spender, and his spending habits are part of the conflict with Tammy. Donald sees himself as a superficial person who is unable to share his feelings with his wife and unable to sustain relationships. He says that he feels like a failure and that there is something wrong with him and he wants to know what it is.

BACKGROUND

William Glasser developed reality therapy (RT) out of his dissatisfaction with traditional psychoanalytic theory. Glasser, a son of immigrant parents, was born in 1925 and grew up in Cleveland, Ohio, during the Depression years. He described himself as very shy as a young person, certain that he did not measure up to other people. A first-generation college student, Glasser obtained his bachelor's degree in engineering and worked for a year afterward as a chemical engineer (Wubbolding, 2000).

Realizing that he was unhappy in his job, Glasser wanted to go to medical school, but thought that his poor grades as an undergraduate would prevent his admission. Instead, Glasser obtained his master's degree in clinical psychology from Case Western Reserve University in 1948 and began work toward his doctorate. In the meantime, he was persuaded by one of his psychology professors to apply for medical school and was admitted as one of six or seven students who did not have the usual qualifications to be admitted to Case Western's program (Wubbolding, 2000). Glasser survived medical school and was board certified in psychiatry in 1961 (Howatt, 2001).

Howatt (2001) related an interesting story about the early origins of Glasser's conviction that people choose their behaviors. During his psychiatric residency at an inpatient veterans' unit, Glasser decided to conduct a quick study to determine if his ideas were on target. Knowing that the clients on the ward loved pinball, he moved all of the pinball games into one area and decreed that "no crazy behavior" was allowed in this area (Howatt, 2001, p. 8). Clients could hallucinate, yell at invisible people, or engage in other nutty behavior anywhere else, but if they did so in the game area, they would be asked to leave. What happened? Most of the clients were able to abide by the rule, suggesting that they chose to play games over acting crazy.

Also during his psychiatric residency, Glasser became a consultant to the Ventura School, a state institution for troubled girls. The best-selling book *Reality Therapy* (Glasser, 1965) is based on Glasser's experiences in this school. RT principles were the basis for the conduct of this school: Punishment was eschewed, and relationships among the girls were nurtured (Glasser, 1965).

Glasser closed his practice in 1986 in favor of teaching and writing about RT. We lost another of our great theorists of psychotherapy when he died in August 2013. Glasser's best-known book is probably *Reality Therapy* (1965), but he radically revised RT theory in 1996 to emphasize the importance of relationships. He also changed the name of the theory underlying RT from control theory to choice theory (Wubbolding, 2000). I will present the revised version of RT in this chapter. The best description of choice theory is found in *Counseling with Choice Theory: The New Reality Therapy* (Glasser, 2000a). In 2011, Glasser and his wife, Carleen, revised his 1984 book, *Take Effective Control of Your Life*, retitled *Take Charge of Your Life: How to Get What You Need with Choice Theory Psychology*. If you are interested in working with couples using reality therapy, check out *Contemporary Issues in Couples Counseling* (Robey, Wubbolding, & Carlson, 2012).

In 1967, Glasser established the Institute for Reality Therapy, known since 1996 as the William Glasser Institute (www.wglasser.com). The title "Reality Therapy Certified" is earned by completing an intensive training program with the institute (Wubbolding, 2000). Currently, over 5,000 people hold this title worldwide. RT is internationally known and practiced, with RT counselors active in many countries around the world (e.g., Norway, Sweden, Australia, and

Hong Kong). The *International Journal of Reality Therapy* was initiated in 1981 and is still published, but in 2010 it became the *International Journal of Choice Theory and Reality Therapy*, moving to an online format.

RT is seen as very useful with kids and in school settings (Fuller, 2015; Gilchrist, 2009). Glasser wrote about Quality Schools (Glasser, 1990) in which the principles of RT are applied to education. Schools can apply to the Glasser Institute to be certified as a Quality School after key individuals are trained in RT and students and parents are taught choice theory. More information about these efforts is easily found on the Glasser Institute website (www.wglasser.com).

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Video Example 11.1 Watch this role play of a reality therapy–oriented conference between a principal and an angry parent.



https://www.youtube.com/watch?v=0_3oeqyrmoE

Another RT theorist of note is Robert Wubbolding, who worked with Glasser at the institute for years. He heads the Center for Reality Therapy (www.realitytherapywub.com) and recently produced a second edition of his 1999 book, *Counselling with Reality Therapy* (Wubbolding, 2015). You can read an excerpt from Wubbolding's book *Reality Therapy* (Wubbolding, 2011a) in Box 11.1.

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Video Example 11.2 Watch Robert Wubbolding do reality therapy with a young client.



Box 11.1

An Excerpt from Wubbolding's *Reality Therapy*

Reality therapy, formerly seen as the methodology of one man, founder William Glasser, is more appropriately described as a system or a school of thought. Glasser's monumental contribution serves as a foundation and an inspiration for professionals around the world who seek practical and proven skills for assisting clients. He continues to expand his original ideas and seeks to use reality therapy to strengthen human relationships, especially applied to the unique intimacy of marriage. If there could be one goal and one root cause of happiness, it would be better interpersonal relationships. Glasser and others have demonstrated a consistent effort to teach reality therapy as an antidote to poisonous societal influences undermining healthy relationships at work, at play, and in the home. His vision includes individuals adopting the principles of choice theory and reality therapy, thereby seeing their behavior as controlled from within. They are then willing to relinquish control of other people while extending a helping hand to them. The converse of this vision, attempting to control other people, is doomed to failure, creates unhappiness, and leads to ineffective and often harmful behaviors such as those described in the *Diagnostic and Statistical Manual*.

As an alternative to external control psychology, which is deplored by Glasser throughout his writings, internal control psychology, or choice theory, goes hand in hand with its delivery vehicle, the WDEP (wants, doing, self-evaluation, and planning) system of reality therapy.

(continued)

Box 11.1 *(continued)*

Clients influenced by societal values often ascribe responsibility for current behavior backward to childhood influences or trauma. Sometimes they project responsibility to their environment, especially to the coercive and external controlling behavior of other people. The reality therapist, while shunning blame and criticism, helps clients focus on their current wants, behavior, and plans. Throughout the therapeutic process clients conduct a serious and often courageous self-evaluation directed toward the attainability of their wants and the effectiveness and reasonableness of their actions. This ongoing assessment, a *sine qua non*, of the efficacious use of reality therapy has many manifestations such as: "Is what you're doing helping you?" "Is what you are doing helping or hurting others?" "Will your current actions get you what you want?" "Are your wants realistically attainable?" "If they're fulfilled, will they contribute to or diminish your need fulfillment or that of others?"

Source: Excerpted from Wubbolding, R. E. (2011). *Reality Therapy* (pp. 131–132). Washington, D.C., American Psychological Association.

BASIC PHILOSOPHY

RT theorists believe that the essential nature of humans is positive (Glasser & Wubbolding, 1995). They are careful to point out, however, that they are not naïve in their approach; although humans can be altruistic, forgiving, loving, and productive, they also "can be beguiled, bedeviled and bewildered. . . . Our actions can be hesitant, halting and horrifying to others. . . . We can be selfish, self-absorbed, self-indulgent and self-aggrandizing" (Wubbolding & Brickell, 1998, p. 48).

RT is a social constructivist theory. Glasser acknowledges the existence of a "real world" that is defined by consensual agreement. At the same time, he recognizes that total objectivity is a figment of our imaginations; it could exist only if we all had the same values or levels of need (Glasser, 1998).

RT theory places people firmly in the driver's seat—they choose their own behaviors. The belief that folks are helpless in the face of forces outside of them is an element of what Glasser calls external control theory (Wubbolding, 2007).

A lively writer, Glasser has challenged the traditional psychiatric community, pointing to the trend toward understanding mental illness within a biological model. Glasser (2003) criticized the psychiatric community on the grounds that "there is no longer any concerted effort . . . to establish a doctor–patient relationship and counsel you about what's on your mind. You are told that the mental illness is caused by an imbalance in your brain chemistry that can only be corrected with drugs" (p. 2). Further, Glasser maintained that prescribed psychotropic medications have the potential to be harmful and that the emphasis on biological causation of psychological distress creates the perception that you personally are unable to do anything about your condition (Glasser, 2003). Glasser, a psychiatrist who claims to have never prescribed a psychotropic drug, says the solution to this dilemma is choice theory, which you will read about later (Glasser & Glasser, 2007).

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Video Example 11.3 William Glasser talks about his views on diagnosis and psychotropic drugs



https://www.youtube.com/watch?v=AghOT3oCaM4

Mei Ling is Donald's RT counselor. Her basic orientation toward Donald is that he is a person who has the potential to take charge of his life. Over their time together, Mei Ling is confident that she will see the goodness in Donald as well as aspects of his behavior that may seem less desirable. However, Mei Ling realizes that the way Donald sees the world will be a major factor in how he behaves and that she needs to understand this in order to help him.

HUMAN MOTIVATION

The most obvious human motivation is to maximize pleasure and minimize pain (Glasser, 2011a). The source of these feelings of pleasure or pain is the satisfaction (or nonsatisfaction) of basic needs. The basic needs are survival, love and belonging, power, freedom, and fun (Wubbolding & Robey, 2012). When we manage to get a need satisfied, we feel really good. When we experience a need that is unmet, we feel lousy. The gap between what we want and what we have is the most concrete motivator of our behavior.

Donald seems to be currently in pain, which suggests that he has not managed to satisfy one or more of his needs. Mei Ling knows that to help Donald she must discover which of Donald's needs are unmet and help him satisfy them.

CENTRAL CONSTRUCTS

Basic Needs

The five basic human needs—survival, love and belonging, power, freedom, and fun—are innate and universal (Wubbolding, 2011a). As a part of being human, we inherit the ability to remember the behaviors that made us feel good or bad (i.e., that satisfied or did not satisfy needs), and these memories guide our future choices of behavior (Glasser, 2011b). It is interesting that Glasser sees only humans as having the need for power; other mammals do not, in his view (Glasser & Glasser, 2007).

All of our behavior represents our best effort, at the time, to satisfy needs (Glasser, 1998). Individuals meet their needs in different ways, and the specific people or things that they identify as need-satisfying are sometimes called *wants*. For example, I may have a need for power that is to some extent satisfied by the sense of accomplishment derived from writing this book and possibly helping people help others. Finishing the book becomes, for me, a want that helps satisfy a need.

Love and belonging is the most important need because it is through relationships that we satisfy our needs (Glasser, 2011b). The need to give and receive love extends to family, friends, and intimate partners. Glasser distinguished among love, belonging, and friendship and cautioned that, while sex is sometimes involved in love, it is not synonymous with love.

Most people have no difficulty fulfilling belonging needs through friendships; the process is fairly easy. Love is much more difficult to find, and Glasser maintained that this is because we tend to believe we "own" our lovers and are therefore more likely to use external control psychology (discussed later) in these relationships (Glasser, 1998).

The need for fun is satisfied through play (A. V. Peterson, 2000), but it is also related to the capacity of humans to learn. Glasser (2002) wrote that "having fun, which produces a very good feeling, is our genetic reward for learning" (p. 20). The need for fun is one of the most easily satisfied needs because it can be fulfilled in many ways (Glasser, 1998). Glasser observed that successful relationships satisfy the need for fun because they involve learning and laughter (which is one sign you are having fun).

Wanting power for the sake of power, rather than as a way to survive, is unique to humans, according to Glasser (2004). People inherently want to feel important and to have their importance recognized by others. Power needs are also satisfied by getting our way, telling others what to do (and watching them do it), being right, getting more stuff, and punishing others when they are "wrong" (Glasser, 1998). This controlling aspect of our power need often leads us to try to coerce others.

Other ways of satisfying power needs are less malevolent, such as doing things for the good of others. The good feelings we get from a job well done result from the satisfaction of power needs. We will work hard for the recognition that satisfies our power needs (Glasser, 2002). Power needs also lead us to want others to listen to us; if we are ignored by important others we feel powerless, and that is painful. These latter considerations led Wubbolding (2011a) to broaden the definition of the power need to include inner control, achievement, self-esteem, and recognition.

The need for freedom involves our perception that we can control our own lives (Wubbolding, 2013). We are most concerned with freedom needs when they are threatened (Glasser, 1998). Freedom to make choices is an important aspect of this need, although we sometimes forget we have this power.

The relationships among the needs are complex. Sometimes several needs can be satisfied simultaneously, as when relationships satisfy needs for love and fun. On the other hand, fulfilling our need for love and belonging is often complicated by our need for power. "Power destroys love," wrote Glasser (1998, p. 42), because nobody likes to be bossed around. In Box 11.2, I summarize Glasser's ideas about two types of personalities that are troublesome in relationships.

Our basic survival need for sex may lead us to unloving sex, which deprives us of satisfaction of love and belonging needs. Freedom and belonging needs can conflict in relationships in which partners have different levels of these needs yet seek to satisfy both simultaneously. Successful relationships are those in which partners negotiate, so that needs are satisfied by both partners.

Donald's presenting problems suggest to Mei Ling that Donald is failing to satisfy a number of his needs. Love and belonging needs seem to be central in that he wants to reconnect with Tammy. Power needs also seem to be important; for example, Donald says that his job loss is upsetting. Impulsive spending, Mei Ling knows, can also be a way to satisfy power, fun, and freedom needs. In the context of his relationship with Tammy, this spending is probably an attempt to satisfy freedom needs. Donald's tendency to move from job to job may also be related to his need for freedom. Mei Ling also suspects that Donald's power needs have been tempting him to try to control Tammy's behavior and therefore play a part in the troubled relationship.

Box 11.2

The Two Personalities Unsuitable for Long-Term Significant Relationships: The Sociopath and the Workless

Glasser (1998) maintained that most individuals have significant needs for love, loving sex, and belonging. However, he recognized that two kinds of individuals are not very successful in committed, long-term relationships: sociopaths and the workless.

Sociopaths seem to care only about power and freedom. Glasser suggested that they are likely to be male because he thinks males genetically have lower needs for love and belonging and higher needs for power than females. According to Glasser, the sociopath will tell a woman that "he's been looking all his life for a woman like you, and that's true. But you have not been looking for a man like him" (1998, p. 107). He is out to get what he can and does not care about his victim, exiting as soon as she expresses any belonging needs. A sure sign of a sociopath is that he has no friends.

The *workless* individual is more puzzling on first glance. Male workless types seem more prevalent in our society, but this may be because it is still more acceptable for a woman to be unemployed than it is for a man (and therefore we don't notice them as much). Workless people seem to have low needs for survival and high needs for power. They have some belonging needs (compatible with their power needs), which lead them to want to talk about themselves and how wonderful they are. The prominent dynamic is the mismatch between their strong needs for power and the lack of energy to institute the power strivings that is the result of the low survival need.

Source: Based on Glasser, W. (1998). *Choice Theory: A New Psychology of Personal Freedom.* New York: HarperCollins.

Quality World

The quality world, also called the world of wants, refers to a set of mental images of need-fulfilling things or people (Wubbolding, 2011a). Because they satisfy needs, these people or objects make us feel good. The construction of the quality world begins shortly after we are born, and it is revised continuously over our lifetimes. Images that we maintain in our quality worlds are those of individuals we want to be with, things and experiences that make us feel good, and beliefs or ideas that guide our lives (Glasser & Glasser, 2007).

For the most part, we consciously choose to put these people or objects in our quality worlds, with the exception of our parents or other primary caretakers, who are there by the time we are aware of them (Glasser, 1998). Glasser (2002) went so far as to say that your mother is the first person that you put in your quality world because she is the source of food and love. Parents also put their children in their quality worlds almost automatically and they are stuck there for life (Glasser, 1998). Sometimes we put unrealistic pictures in our quality worlds, such as a young man carrying an image of himself as a professional football player when he is a benchwarmer on his high school team.

We can remove images from our quality world, but doing so can be a painful process. The kid who desperately wants to be a pro football player will have difficulty coming to terms with the loss of that image of himself. Removing people from our quality worlds is particularly difficult,

as when a significant intimate relationship ends. However, when a person or object is repeatedly experienced as contrary to our needs, he, she, or it is banished (Glasser, 1998).

Donald's quality world probably includes his father, Tammy, spending money, and the objects obtained by spending. Mystery and science fiction magazines and movies are there as well because they satisfy his fun need. These people, things, and behaviors contribute to the satisfaction of Donald's needs, making him feel good. Mei Ling is not sure whether Donald's mother is in his quality world. The hostility he expresses about her suggests that she may have repeatedly denied his needs for love and belonging as a child. As a result, Donald may have engaged in the painful process of removing a parent from his quality world.

TOTAL BEHAVIOR

The term *total behavior* is used to accentuate the multidimensional nature of human behavior. All behavior comprises four components: acting, thinking, feeling, and physiology (Glasser, 2000b). Glasser used the image of a front-wheel-drive car to explain the relationships among these components. The front two wheels are acting and thinking, and the rear wheels are feeling and physiology. Steering the car is accomplished through changing the direction of the front wheels, and the rear wheels generally follow. This image makes two points: (a) Acting and thinking are more under our control than feeling and physiology, and (b) feelings and physiology can be influenced by acting and thinking (Glasser, 2002).

Mei Ling knows that Donald's total behavior is composed of his actions, thoughts, feelings, and physical sensations or state. The way he thinks about his situation has great influence on how he feels, as does his behavior. He may be thinking that Tammy should obey his wishes and come back to their marriage. Thinking this way connects to anger and then depression and loneliness. He behaves in a depressed way, gets fired from work, and feels even more depressed. So Donald's actions are sitting at home, his thinking is that he is worthless, his feeling is depression or anger, and his physiology is that his neck and head ache.

CHOICE THEORY

Choice theory is the ideological basis for RT. The most important tenet of choice theory is that humans always have choices; we choose absolutely everything we do (Glasser, 1998, p. 3). We therefore have control over our own behavior, but *we cannot control the behavior of others*. We can only give others information.

Choice theory is contrasted with external control psychology, which rests on the premise that human existence is controlled by the environment (including other people; Wubbolding, 2007). The idea behind control theory is that others who don't do things our way are wrong and should be punished so that they change their ways. Then we can give them love, money, or other treats to keep them in line (Glasser, 1998). External control psychology persists because it is sometimes effective—those who have the power to control others sometimes get what they seek. Those who are powerless are aware that external control sometimes does work, and they hope to one day employ it. Also, those who are controlled (a) believe that they have no choice other than to submit (wrong) and (b) are aware that fighting would likely make the situation worse (and they are often right; Glasser, 1998).

Three basic beliefs underlie external control psychology: (a) My behavior is controlled by external factors; (b) I can make other people do what I want them to do, and they can do the same to me; and (c) it is my obligation to punish and reward others depending on whether they meet my standards for behavior (Glasser, 1998, p. 16). The *seven deadly habits* of external control psychology are criticizing, blaming, complaining, nagging, threatening, punishing, and bribing (Glasser & Glasser, 2007, p. 34). Contrast these to the seven caring habits: supporting, encouraging, listening, accepting, trusting, respecting, and negotiating differences (Glasser & Glasser, 2007, pp. 34–36).

Glasser was adamant in his assertion that living by the principles of external control psychology is a major mistake. It ruins relationships because we don't like to be controlled (remember the need for freedom). He warned that external control psychology "is the cause of most of the violence, crime, drug abuse, and unloving sex that are pervasive in our society" (1998, p. 7).

*Donald, who is having trouble with a significant relationship, has likely fallen into believing external control psychology. It is possible that others have used external control psychology to try to influence his behavior as well. He blames others for his situation and feelings rather than realizing that he has choices. He feels bad because Tammy left. However, he resents that she tried to make him spend less money when they were together. They probably used the seven deadly habits on each other. Donald is feeling inadequate because those *&%$# at work fired him for no reason. He is sitting around because he is depressed and deserves better than just any old job. Donald sees himself as a superficial person who is "unable" to relate to others and believes that something is definitely wrong with him.*

Mei Ling believes that, if Donald would adopt choice theory, he would realize that all of his behavior is chosen and that he can make better choices. No magical entity can make him depressed, addicted to excitement, or in general a faulty human being. Further, he can't control others' behaviors, and trying to do so is simply frustrating and drives them away. When others try to control his behavior, he gets mad and uncooperative, such as at work.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

According to RT, "personality" is based on the relative strengths of a person's basic needs (Glasser, 1998). Glasser maintained that the relative strength of the needs is fixed at birth; thus, personality does not change. For example, Irene's strong need for freedom makes her seem like a very different person from Casey, who is much less interested in freedom and more interested in love and belonging. These two individuals may have difficulty negotiating a relationship because of the differences in their needs. They might be able to work out some compromises. However, when two people in a relationship have high needs for power, negotiation is more difficult because negotiation implies that one person has to give in.

RT does not have a formal theory of personality development. However, Glasser (1998) thought that the roots of human unhappiness are found in early experience, when we first run into folks who think they know what is best for us. This kind of behavior on the part of parents or other powerful people (the use of external control theory) leads to poor relationships characterized by mistrust of the child on the part of the parents. This mistrust will affect future relationships (Glasser, 1998). An extreme example of this process is seen with abused children. If you can't be safe with your parents, how can you be safe with others? Children who are abused

never learn to trust their parents and, as a result, have great difficulties establishing relationships in general (Glasser, 1998). Using external control theory with children also prevents them from learning to be responsible for their own choices.

Emphasizing the need to use choice theory rather than external control theory with kids, Glasser had a great deal to say about parenting as well as our current educational practices (Glasser, 1968, 1990, 1998, 2002). Choice theory parents reject the use of punishment and instead give their kids massive amounts of love, which is not conditional on behavior. Parents should evaluate their own behaviors based on whether they bring more closeness with their children, not on their need to be "right," which is an expression of power needs and an endorsement of external control theory. According to Glasser, this criterion ("Will this choice bring me closer to this important other?") is helpful in any relationship.

However, Glasser did concede that the parent must at times hold her ground because a child is not ready to handle making a choice. For example, the decision about going to school is not negotiable for an 8-year-old. On the other hand, as soon as you determine that it is safe to allow the child to be around the home without direct supervision (but with parents or other responsible adults present), you can allow him to choose his bedtime. The child will learn responsibility through experiencing the consequences of his choice about how much sleep he needs. Of course, waking-up time is not negotiable because he must attend school.

Donald seems to be relatively high in his needs for power and freedom. His movement from job to job and compulsive spending are probably choices meant to meet these needs. He also shows interest in relationships, suggesting relatively high belonging needs. Donald's survival and fun needs seem weaker. Mei Ling wonders whether Donald's characterization of himself as being addicted to excitement is related to his need for fun or power.

Donald clearly carries with him some issues around trust that stem from his relationships with his parents. Although his father appears to be in Donald's quality world, the violence Donald reported (and may have experienced) could have influenced his views of relationships and his level of trust in others. Clearly, he has great difficulties relating to his mother, and Mei Ling is uncertain about whether Donald's mother is in his quality world. Because Donald's parents divorced, Mei Ling guesses that they both probably endorsed external control theory; this kind of separation suggests an escalation of freedom needs that may have occurred in response to the attempt by the parties to control each other.

Donald's history of relationships is probably related to how he behaves in his current relationships. He demonstrates a need for love and belonging, but may be trying to force Tammy into his version of their relationship in an attempt to satisfy his freedom and power needs. Also, Mei Ling suspects that Tammy has tried to use external control theory on Donald and force him to change his behaviors through punishment (yelling, criticizing, leaving) and reward.

HEALTH AND DYSFUNCTION

Healthy people, from the RT perspective, are advocates of choice theory. They are happy because they have found ways to satisfy their needs without violating the rights of others to satisfy theirs; most importantly, they have satisfying personal relationships (Glasser, 2011a).

The source of dysfunction in RT theory is the failure to satisfy one's needs. Glasser (2000b) contended that "when we are unable to figure out how to satisfy one or more of the five basic needs built into our genetic structure that are the source of all human motivation, we sometimes choose to behave in ways that are currently labeled mental illness" (p. 1).

We are always in the business of choosing behavior aimed at satisfying our needs. To more clearly emphasize the power of humans to choose their psychological dysfunctions, the suffix *ing* is added to traditional behavioral labels. Depression, for example, becomes *depressing* (Glasser, 1998). You don't have a headache; you are *headaching*. These choices are simply the best we can generate at the time to satisfy our needs (Wubbolding, 2011a).

We make bad choices for three reasons:

1. When we get lonely because we don't have the relationships we need, our first response is to get angry. Choosing funky behavior like depression restrains the anger, which is important because we realize that expressing it might further damage the relationships we do have.
2. People learn that choosing such behavior, particularly depression, is an effective way to get help. Also, depressing (or other maladaptive behavior) is much more functional than angering—civilization would not have survived if we all acted on our initial anger.
3. Choosing to depress avoids tougher alternatives—like facing problems and risking rejection (Glasser, 2000b, p. 5).

Even psychotic behavior is seen as a bad choice aimed at meeting needs. Glasser (2000b) wrote:

> But when we are unhappy we are capable of bizarre and unrealistic creativity as commonly seen and labeled schizophrenia, bipolar disorder, obsessive compulsive disorder, relentless phobia, disabling panic attacks or clinical depression. But as much as these creative symptoms, which include hallucinations, delusions, obsessions, compulsions, disabling fear and severe depression, appear to be beyond the client's control—they seem to materialize as if they are happening to him or her—they are not. (p. 4)

Because connection to other people is essential to satisfying other needs, Glasser believes that most, if not all, dysfunction happens when an individual feels disconnected from others. The person has one or more of these four problems: (a) Someone is trying to make the person do what he doesn't want to do, (b) the person is trying to make someone else do something he doesn't want to do, (b) two people are trying to make each other do something they don't want to do, or (d) we are trying to make ourselves do something we don't really want to do, and failing in this, we are frustrated (Glasser, 2011a, p. 141). The typical RT diagnosis is *unhappy person*. "All unhappy people have the same problem: They are unable to get along well with the people they want to get along well with" (Glasser, 1998, p. 5). Further, "barring grinding poverty, incurable illness, or living under tyranny, unhappiness is the only human problem" (Glasser, 2002, p. 2).

Wubbolding (2011a) described three stages of healthy and unhealthy behaviors. In the healthy behaviors, or growth progression, the first phase is seen when clients commit to making more effective choices (e.g., "I want to improve"; p. 20). In the second stage, *positive symptoms* appear; or actions, thoughts, feelings, or choices related to physical functioning are healthy. Most people stop here, instead of progressing to the third stage, *positive addiction*. When engaged in this third stage, individuals choose activities that are need-satisfying, health-enhancing, and facilitate their sense of inner control (p. 22). They are engaged in these activities freely, and not competitively. Unfortunately for most of us, it takes 12–18 months of practice to get positively addicted.

The phases of ineffective behavior are the opposites of the effective ones. *Giving up* characterizes the first, *negative symptoms* the second, and *negative addictions* the third. Actions, thoughts, feelings, and physical functioning are failed attempts to satisfy needs (Wubbolding, 2011a).

Donald is clearly displaying unhappiness that stems from an unsatisfactory relationship with his wife. He is lonely because he fails to connect in other life relationships—for instance, he has no close friends. Mei Ling knows that he is in pain because his love and belonging need is going unmet. He has chosen to depress about this situation and appears to be headaching as well. Donald's depressing behavior is probably also a bid to establish a relationship with others or to get Tammy to continue to attend to him. Underneath the depression is the angering resulting from the dissatisfaction he experiences.

Mei Ling guesses that Donald's job loss resulted from his depressing behavior. He was ineffective on his job and listless with his clients, and he missed a lot of days at work. These behaviors compromised Donald's ability to satisfy his power needs through work accomplishments. His freedom needs are unmet because he can't spend money because he doesn't have any.

Mei Ling thinks that Donald is showing characteristics of stage 2 of ineffective behaviors. He is displaying negative symptoms, trying to get needs met through depressing, angering, and seeking harmful excitement (his compulsive spending).

NATURE OF THERAPY

ASSESSMENT

No assessment is used in RT counseling, other than figuring out what relationship(s) is (are) problematic. Given his views on traditional psychiatric approaches, it is probably no surprise that Glasser is very critical of formal diagnosis (Glasser, 2003). According to Wubbolding, Glasser has been known to call the *Diagnostic and Statistical Manual of Mental Disorders* "the big book of unhappiness" (Robey, 2011, p. 235). However, contemporary RT practitioners express a range of opinions on diagnosis (Wubbolding, 2011a).

Mei Ling does not use any formal assessment with Donald. She simply tries to understand what relationship or lack thereof is related to his troubles (i.e., his loss of the relationship with Tammy). Mei Ling diagnoses Donald as an unhappy person.

OVERVIEW OF THE THERAPEUTIC ATMOSPHERE

The client–therapist relationship is very important in RT. Ultimately, the RT counselor wants to become a picture in the client's quality world (Wubbolding, 2011a). The counseling relationship can also be seen as a way of meeting the client's love and belonging needs. Further, the therapist approaches the client with the confidence that he can learn to better satisfy his needs, and this confidence becomes part of the client's view of himself (Wubbolding et al., 2004).

To achieve the quality relationship needed in RT, the counselor is genuine, empathic, and supportive (Henderson, Robey, Dunham, & Dermer, 2012). The RT counselor is straightforward and, as a way of being genuine, has the options of self-disclosing or using humor to connect with the client (Henderson et al., 2012; Wubbolding, 2000). Although some might call the RT counselor confrontational, Glasser (1992b) said that "reality therapists are among the least pushy of all people" (p. 282). He meant that RT counselors, while directly addressing the clients' current choices, take great care to avoid using external control theory with their clients, encouraging them instead to make their own choices.

RT is very active, focused on behavior and thinking. It is firmly centered in the present (Fulkerson, 2015). To describe the RT relationship, Wubbolding (2011a) used the acronym ABCDE, which stands for "Always Be Courteous, Determined, and Enthusiastic" (p. 74).

RT tends to be short term in nature; most clients need 12 sessions or so (Glasser, 2011a). However, Glasser cautioned that the length of counseling is ultimately determined by how quickly the therapist can establish a good relationship with the client (Glasser, 2000a).

Mei Ling works hard to enter Donald's world and to genuinely relate to him. She appreciates him as a human being and works hard to convey this positive regard in an unconditional way. Her enthusiasm and determination will give Donald hope that he can change his life. Mei Ling will be honest and direct in asking Donald about his current situation.

Roles of Client and Counselor

RT counselors ask lots of questions and challenge the client to evaluate his behavior (Wubbolding, 2000). Because the counselor is directive, the relationship can resemble one of doctor–patient. The counselor is an expert on choice theory and human behavior, and the client is there to receive this knowledge. Clients in RT are often taught the principles of choice theory, necessitating the use of the teacher–student role. However, the RT counselor's rejection of external control theory makes the client the expert in the sense that he is the only one who can determine what is right for him. The client must accept responsibility in the counseling sessions because he must evaluate his current situation and decide if and how he will institute change. In this way, the therapeutic relationship can be seen as a collaboration (Fulkerson, 2015).

Wubbolding and Brickell (1998) suggested that the effective RT counselor needs to have a positive view of human nature, energy, and the ability to see the bright side of situations. They also added that the RT counselor must have "some degree of mental health" (p. 47). Glasser (2011a) added that it is difficult to practice RT if the counselor doesn't use choice theory in her own life on a daily basis.

Mei Ling is energetic and active in her sessions with Donald. She teaches him about choice theory and points out the ways external control theory can be detrimental to human relationships. Mei Ling expects Donald to listen to her ideas, but accepts that he may disagree or decide not to put them into action. She appreciates his ability to evaluate and choose for himself and does not pressure him to do things her way. Mei Ling expects that Donald will take some responsibility for what happens in counseling sessions.

Goals

RT counselors are interested in helping their clients make better choices that are helpful to them and don't interfere with or hurt others (Glasser, 2000a). Ultimately, the reality therapist teaches the client to reconnect in the critical relationship(s) central to the client's discomfort or to establish new, more satisfying relationships. As a part of counseling, the client learns about bad choices, and in the ideal RT, he learns choice theory so that he can use it in future situations. Thus, the client learns to take responsibility for his choices and make more effective choices that will re-establish effective, satisfying relationships—more broadly, to make choices that better satisfy his needs (Wubbolding, 2011b). Wubbolding (2007) further clarified that the RT counselor can help the client determine specific wants related to the basic needs.

Changing feelings is a goal of interest to most clients. RT counselors believe that feelings can be changed only by making more effective acting and thinking choices (Dermer et al., 2012). According to Glasser (1998), "When we want to stop choosing a painful behavior like depressing [we must] (1) change what we want, (2) change what we are doing, or (3) change both" (p. 71).

Mei Ling helps Donald evaluate his current situation and decide if he would like to invest in his relationship with Tammy by changing his way of relating to her. If he decides to attempt to regain his relationship with Tammy, Donald needs to choose behavior other than depressing. He should use the criterion of closeness to choose his new behaviors—that is, he should always ask himself, "Will this behavior bring me closer to Tammy or not?" Mei Ling reminds Donald that, despite his new choices, Tammy might still choose to end their relationship. Donald needs to begin thinking in terms of how he could change his thoughts and actions, not in terms of how Tammy should be, act, think, or feel differently. It is possible that, if Donald chooses behaviors based on choice theory, Tammy will feel less coerced and more loved and be more able to relate to Donald.

PROCESS OF THERAPY

RT is present oriented, and RT counselors see dwelling on the past as a bad thing. No faultfinding or blaming is allowed. The emphasis is on what to do now and how the client can make new choices (Wubbolding, 2011b).

Good reality therapists should let go of the past and help the client get to work on the present interpersonal relationship problem. Bad therapists view clients as helpless in the face of their circumstances and are therefore unlikely to help them.

The RT counselor doesn't like to spend a lot of time talking about symptoms the client is choosing because doing so allows the client to avoid the real problem, the major unsatisfying relationship (Glasser, 2000b, p. 9). There is no sense in devoting a lot of time to stuff the client can't control (the behavior of others or the past). If the client protests that these externals are important, the therapist is likely to tell the client that there is no guarantee that life is fair; the only sure thing is that you are the only person you can change.

Wubbolding (2000, 2011a) presented the acronym WDEP to describe the counseling process. The RT counselor helps clients explore *wants* and describe the *direction* of their lives and what they are currently *doing*. Most important, the therapist helps clients self-*evaluate* by asking if their current actions are effective. Clients are then helped to make simple and attainable action *plans*. Once the plan is made, the RT counselor accepts no excuses for not following through on the plan. If one plan doesn't work, another is tried—there is no perfect plan (Glasser, 1992a).

MyCounselingLab

Video Example 11.4 Watch Robert Wubbolding help a client evaluate.



RT counselors do not relate to psychoanalytically based constructs such as transference and countertransference. The reality therapist should just be herself. Any talk about transference is simply the client and counselor avoiding responsibility for the current relationship.

Fuller (2015, pp. 227–235) presented an eight-step approach to the process of RT. Not all of these steps are truly stages; instead, some are cautions or admonitions to the counselor.

Step 1: Involvement. The counselor makes friends with the lonely client.
Step 2: Focus on Present Behavior. Counselor and client describe what the client is doing now.
Step 3: Value Judgment. Client and counselor work to evaluate the client's current choices.
Step 4: Planning Responsible Behavior. Plans should be reasonable, specific, and positive.
Step 5: Commitment to the Plan. The counselor asks the client, "Will you do it or do you want to make another plan?"
Step 6: Accept No Excuses. The client is not punished if he does not follow the plan, but the counselor doesn't listen to why either. The counselor asks, "When will you do it?"
Step 7: Do Not Punish. RT counselors believe in allowing the consequences of the client's behavior to happen rather than imposing negative outcomes, or punishment. In fact, all of the seven deadly habits of external control theory are forbidden.
Step 8: Never Give Up. RT counselors always endeavor to send the message that the problem can be solved, even if it takes many tries.

Information from Fuller, G. B. (2015). Reality therapy approaches. In H. T. Prout & A. L. Fedewa (Eds.), *Counseling and psychotherapy with children and adolescents* (5th ed., pp. 217–278). Hoboken, NJ: Wiley.

After she is sure that she has established a good relationship with Donald, Mei Ling focuses on the current situation and asks him to describe what he is currently doing. She asks him if his current behavior is getting him what he wants. Donald, with a little squirming and discomfort, acknowledges that his current situation is not the best and that he'd like things to be different. Mei Ling teaches Donald that the only thing he can change is his own behavior and proceeds to help Donald look at new choices and develop a plan to better meet his needs. If he decides to pursue his relationship with Tammy, Mei Ling helps him develop a plan to choose different behaviors in relating to her. Alternatively, Donald may decide that trying to recapture the relationship is futile, and Mei Ling will then help him plan to go through the painful process of removing Tammy from his quality world and eventually establishing new relationships.

No matter what Donald does, Mei Ling will not give up on him. If he tries to talk to Tammy and blows up, Mei Ling will not criticize this behavior. She will only ask Donald how he wishes to be the next time he talks to Tammy.

THERAPEUTIC TECHNIQUES

Unlike some other approaches, RT does not identify a host of techniques available to the counselor. The practice of RT is more aptly described as a process of discussion leading to the identification of (a) the client's current need-related behavior that is problematic and (b) ways in which more-functional behavior can be chosen that still meets the client's needs. Teaching choice theory is almost always an important part of RT. With that said, I will present several interventions that have been discussed by reality therapists.

Questioning

RT counselors are quite likely to ask the client a lot of questions. Howatt (2001, p. 9) identified four that are commonly used: (a) What do you want or what do you really want? (b) What are you doing? (c) What is your plan? (d) What will happen if you continue to do what you are doing? Another key question is, "Is what you are now choosing to do (your actions and thoughts) getting you what you want?" (Glasser, 1992a, p. 277). This last question is a good example of a self-evaluation question.

Questions are aimed at identifying needs and current behavior, and they serve to reinforce the client's choice in maintaining it. The last two questions are intended to help clients self-evaluate. The general motive of the therapist is to help the client develop a simple plan to take charge of his life.

One further question is of great importance to RT counselors. The RT counselor almost always asks the client what is going right in his life (Wubbolding, 2000). This question builds hope and identifies client strengths that might be used to make new choices.

Mei Ling asks Donald if his current behavior is getting him what he wants. Donald acknowledges that he is unhappy and that he wants to find a new job and to fix his relationship with Tammy. In response to Mei Ling's question, he reports that he is not doing much of anything and that, if he continues, he'll end up homeless and never get Tammy back.

Mei Ling guides Donald through a specific, detailed description of his current functioning. She asks what his plans are to be different. Donald says that he will do two things over the next week: He will call Tammy and ask her out for a date, and he will start to explore job options. Mei Ling insists that Donald create a more specific plan to look at job opportunities.

BIBLIOTHERAPY

Clients in RT are often encouraged to read books, particularly Glasser's books. *Choice Theory* (Glasser, 1998) is the most general of these. Glasser has written other books directed toward understanding relationships and working with kids (Glasser, 2002; Glasser & Glasser, 2000; Glasser & Glasser, 2007).

Mei Ling gives Donald the books Choice Theory *and* Eight Lessons for a Happier Marriage*. Donald jokes that he likes science fiction better, but he agrees to read one of them prior to the next counseling session.*

DOING THE UNEXPECTED

Rather than a specific technique, doing the unexpected is an admonition to be creative in helping clients assume responsibility for their lives. Under this heading, a reality therapist would consider using paradoxical techniques that require the client to perform the symptom. If the client can perform the symptom, he acknowledges his choice and control. If he doesn't perform the symptom, the problem is solved. For example, a child could be given the choice to cry now or wait until later (Glasser, 1998). Attending to the client's strengths or successes can also be doing the unexpected (Wubbolding, 2011b).

REFRAMING

Reframing is a paradoxical approach that involves helping the client find a different perspective on his situation (Wubbolding, 2015). For instance, compulsive client behavior could be reframed as "careful and deliberate."

Mei Ling reframes Donald's "addiction to excitement" as energy that he could use in his work. She could prescribe this behavior by having him visit 15 potential places of employment in one day.

HUMOR

RT counselors are likely to poke fun at themselves and, carefully, at the client's problem. For example, in Glasser's (2000a) fantasy RT with Jerry, the client's girlfriend spontaneously adapts

the tune "Here We Go Round the Mulberry Bush" to describe Jerry's compulsive behaviors: "This is the way he locks the door, locks the door, locks the door" (p. 96). Jerry's problem becomes funny, while at the same time his control of the behavior is emphasized.

Mei Ling gently teases Donald about his shopping "addiction." Referring to his "black belt in shopping," she suggests that the perfect job for Donald would be as a buyer for a department store or, better yet, as a personal shopper for a very rich person.

Self-Disclosure

RT counselors are encouraged to be warm and human, and one way to do that is to disclose to the client. Wubbolding (2011b) maintained that disclosing some relevant information about yourself is a great path to a closer relationship with your client. I would add that self-disclosure needs to be used carefully to ensure that the relationship stays focused on the client rather than on the therapist.

Mei Ling considers how to use self-disclosure with Donald. She is very careful in her approach and decides simply to tell him that she thinks that relationships are one of the best and worst things we have to experience in life. She does not reveal her own struggles specifically. She could self-disclose more specifically about her attempts to set up an exercise program—particularly about the things that helped her.

Metaphors

Creating or adopting the client's own metaphors can be very helpful in conveying understanding of the client's perceptions of his world (Wubbolding, 2011b). For example, a client may say that she feels like the lamb being taken to the lions when she goes to work. The RT counselor might then ask what the lamb could do to seem less tasty to the lions or, better, what the lamb could do to befriend the lions.

Donald uses the image of a slug in describing himself. He is lethargic and slow moving, has little motivation, and very rarely has fun (he maintains that slugs have no fun in life). Mei Ling thinks about this image briefly and then decides that Donald is close, but not quite, because he is really a caterpillar that is going to turn into a butterfly (and butterflies do indeed have fun). He is simply going into his cocoon right now. Mei Ling begins to ask Donald what he can do to (a) make the best cocoon and (b) become the best butterfly.

Physical Activity and Meditation

Glasser and reality therapists have long endorsed the benefits of physical activity. In his book *Positive Addiction* (1976), Glasser identified running as a very common form of positive addiction, but other activities can induce this state, too. The key component of positively addicting activities is the mental one; these activities induce an extremely pleasurable, trancelike state. Glasser believes that this mental state allows the mind to "spin free," and the result is a joining of mind and body that leads to unusual levels of performance and creativity (Glasser, 1976). It is not easy to get to the level of positive addiction; it takes at least 6 months of daily running, for instance.

Glasser (1976) maintained that meditation is the second most common way of achieving positive addiction. As is the case with exercise, not all meditators achieve the truly addicting mental state.

Donald does not think he can focus long enough to meditate, so Mei Ling encourages Donald to think of some form of physical activity that he could tolerate. Donald says that he used to like boxing. Mei Ling asks Donald if he could find a way to do some boxing, and he agrees that he could start by visiting some gyms over the next week.

Allowing or Imposing Consequences

The typical consequence of problem behavior is the temporary loss of freedom or a privilege (Fuller, 2015). The distinction between consequences and punishment may seem fuzzy at times (Wubbolding, 2000), so this approach must be used carefully. Advocates of RT say that the attitude of the one who allows consequences is critical. Mistakes should be seen as chances to learn; the individual has been told about the rules and what happens when they are broken (Fuller, 2015). Punishment embodies the opposites of those characteristics and is often delivered in an angry way, whereas consequences are imparted in a friendly manner, according to Fuller (2015). The most effective consequences are probably those that happen naturally, such as being too sleepy because you stayed up too late the night before. Second best are consequences based on social rules. An example of the latter would be when a disruptive child is removed from the classroom to a special room and is helped to evaluate her behavior.

Donald has already experienced the consequences of his depressing in that he lost his job. He can also see that his spending behavior has some undesirable consequences (having no money, hurting his relationship with Tammy).

EVALUATION OF THE THEORY

RT has the great strength of being relatively simple and easy to understand. Glasser, particularly, writes in a friendly, common sense manner that can be quite entertaining to read. He also devotes a great deal of attention to illustrating his ideas using client case studies or applying his ideas to characters in popular movies and books.

Critics have charged that RT is too simple, or simplistic. Although commonly used language was deliberately chosen to make RT easy to understand, its advocates warn that this simplicity is deceptive when it comes to putting the theory into action (Glasser & Wubbolding, 1995; Wubbolding & Brickell, 2000). Glasser (1992a) argued that "the fact that what we do is relatively clear-cut and understandable does not make it easy. It takes a skilled counselor to persuade clients that they are choosing what they are complaining about or doing and further, to persuade them that it is to their benefit to choose a more effective total behavior" (p. 274).

RT is faulted by some for ignoring social influences on behavior (Zeig, 1992). Glasser would probably say that going along with the crowd is more a result of a failure to wake up and make choices than of any magical power of social forces.

Qualities of the Theory

Precision and Testability. Operationalizing some RT constructs—the quality world, for instance—would seem quite difficult. This set of photos could never be observed directly, and it would seem difficult to devise a way to clearly observe its effects on behavior. Other aspects of

RT seem to be general assumptions that are not amenable to empirical tests, such as the idea that we choose our behavior.

Empirical Support. Continued calls resound for increased efforts to test the effectiveness of RT (Glasser, 2010; Parish, 2010). Research has not been the strong point of RT. The propositions of the theory are not often directly tested, and outcome research is sketchy at best. Sansone (1998) reported that only 9% of the articles in the *International Journal of Reality Therapy* were research related.

Research Support

Outcome Research. Outcome studies of RT counseling exist and are supportive of the theory's effectiveness. Radtke, Sapp, and Farrell (1997) conducted a meta-analysis of 21 RT studies and found a medium effect size. The studies included in the analysis varied widely in methodological sophistication, sample sizes, treatment characteristics, and presenting concerns of participants. Many were school based, suggesting that there is some evidence for the effectiveness of RT in these settings, but far fewer studies supported the utility of RT as an approach to counseling more generally. To my knowledge, RT has not been used in a randomly controlled trial.

Wubbolding (2000) presented a traditional review (i.e., not meta-analytic) of a long list of outcome studies that varied considerably in quality. Many were case studies, either of individuals or of schools implementing RT principles. Generally, the results were favorable to RT. However, few if any of these studies approached the highest standards of methodology generally accepted in the study of therapy outcome (random assignment to more than one condition, treatment versus control group comparisons, checks on therapist adherence, etc.). A relatively recent study can serve as an example: Omar and Barzan (2012) taught the principles of reality therapy to teachers in Iran over 8 weeks, pre- and post-testing their students' performance on a range of academic content. Although the students' performances were significantly improved at the end of the teacher training, the lack of a control group and random assignment seriously threatens our ability to determine what created the changes. In fact, the most logical explanation would be that teachers were teaching that very content! However, the authors are still to be commended for their efforts to verify their beliefs.

Many studies have attempted to assess the effect of RT on self-concept. For example, A. V. Peterson, Chang, and Collins (1998) tested the efficacy of RT among Taiwanese university students. They randomly assigned students to instruction about choice theory, group RT, or a no-treatment control group. Using self-concept as the outcome measure, Peterson et al. found that the RT groups did not differ, but were better off than the no-treatment group. Fuller (2015) reviewed a number of studies that implemented some kind of RT treatment (and the quality of these varied greatly) and found inconsistent results in terms of its effect on self-concept. Overall, Fuller concluded that the results of research on RT were mixed, varying depending on the dependent measure used. Fewer effects were found on self-concept, academic achievement, or locus of control; however, a number of studies showed that RT was associated with reduction in behavior problems. It is difficult to offer general conclusions of the research Fuller reviewed because of the wide variability in participants, interventions, and settings.

Other studies have looked at the effects of RT interventions on a variety of outcome variables. These studies also varied in methodological sophistication. Loyd (2005) examined the effects of

giving high school students five sessions of teaching about RT. In this quasi-experimental study done in the school, students who learned about RT reported higher levels of satisfaction of their power, freedom, and fun needs after treatment (in comparison to a control group that did not receive the intervention), but not of their belonging needs. However, the lack of random assignment of students to treatment conditions somewhat compromises this study, as does the lack of psychometric information on the measure of needs. A similar method was used by J. Kim (2006) to study the effects of an RT bullying prevention program on 16 fifth and sixth graders. Although differences were found in self-responsibility and frequency of victimization in the expected direction, pretreatment differences on these variables and design concerns decrease confidence in the results of this study. Likewise, Lawrence (2004) assessed the effects of RT group intervention (in comparison to a support-group control condition) for individuals with developmental disabilities. He found that scores on self-determination were significantly higher for the treatment group than for the control group. Burdenski and Faulkner (2010) compared outcomes of at-risk college students enrolled in randomly selected class sections who received the RT intervention used by Loyd (2005) to students in classes where the intervention was not used. They found that total needs satisfaction, and specifically belonging needs satisfaction, increased significantly among students in the RT classes over the 5-week intervention. Also, the treatment group's self-esteem scores significantly increased, but the prediction that they would show more internal locus of control as a result of the RT intervention was not supported. Using the same intervention with first-semester college students in a developmental math class, Faulkner and Burdenski (2011) documented the same pattern as Burdenski and Faulkner (increased satisfaction of belonging and overall needs in the RT group) and also increases in academic self-efficacy scores, which were significantly different from pretest results among only treatment group students.

K. Kim (2002) evaluated the effects of an 8-week RT intervention program on fifth graders' locus of control and social responsibility. This study is notable because, although there were only two groups in the study, control and treatment (and they were very small groups of 12 and 13), students were randomly selected and assigned to groups. Analysis of changes in the variables from pretest to post-test verified that the RT treatment group changed in the expected direction and the control group did not. Thus, this very small study supports the effectiveness of RT, at least for these two measures.

Much of the research on RT is published in the *International Journal of Choice Theory and Reality Therapy*, which raises some questions about the objectivity of the review process applied to the manuscripts. A critical analysis of the RT literature suggests that many of these studies violate traditional tenets of experimental design through, for example, the absence of random assignment to treatment versus control or comparison conditions. In addition, the length or amount of treatment administered is often too limited to expect changes in such variables as self-concept and locus of control. These problems probably contribute to the mixed results found in RT research.

Theory-Testing Research. Reports of direct tests of RT theory are few and far between. Instead, RT proponents argue that research not specifically conducted as a test of RT theory provides support for their approach. For instance, Wubbolding (2011a) maintained that Ryan and Deci's (2008) research on self-determination theory supports RT theory because it confirms the idea that basic needs are a powerful and lasting determinant of behavior in comparison to extrinsic motivation.

LaFond (2000, 2012) described the development of an instrument intended to measure the relative intensity of an individual's basic needs. Called the Choice Theory Basic Needs Scale, this

instrument may spur the theory-testing research that is badly needed to support RT. Unfortunately, LaFond found that psychometric analyses indicated that the needs seemed to be multi- rather than unidimensional, which is not supportive of RT theory, and the concurrent validity data she collected (correlation with a measure of marital satisfaction) were weak. V. S. Harvey and Retter (1995) also developed a measure of basic needs for use with children, the Basic Needs Survey, which showed adequate retest reliability. However, they provided no validity information for this measure.

In conclusion, it seems that the research base of RT is somewhat spotty, and somewhat dated, when it comes to controlled outcome studies of counseling and direct tests of the theory. However, RT can be considered a "bona fide" approach to counseling, so if one aligns with Wampold's (2001, Wampold & Imel, 2015) thinking, it can likely be considered an effective approach to psychotherapy.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Most RT writings seem to have a heavy emphasis on heterosexuality—particularly married heterosexuality. Glasser's book *Counseling with Choice Theory* (2000a) presents cases that deal exclusively with heterosexual couples, and his books about relationships seem to show the same leaning (Glasser & Glasser, 2000, 2007). In the core RT literature, discussions of relationships seem to focus on marital relationships with little acknowledgment that other types of relationships exist. Although the emphasis on heterosexual relationships does not, in itself, equate with an inherent bias, it is important to note these leanings in light of the theory's significant emphasis on relationship over other aspects of human functioning. Recognition of other forms of relationships, including those involving lesbian, gay, bisexual, and transgender (LGBT) individuals, would broaden this theory's appeal.

The assumption that humans have choice is subject to criticism from the perspectives of cultural minorities, women, LGBT individuals, and other groups that have been the targets of oppression and mistreatment (Ballou, 2006; Linnenberg, 2006). In fact, members of these groups have been forced to behave in certain ways under the threat of punishment or even physical harm; Glasser would agree and would characterize these events as perfect examples of the use of external control theory. For example, external control theory was clearly demonstrated when the choices of African-Americans in the 1960s were limited when it came to dining, riding the bus, or drinking from public water fountains.

RT theorists would respond by saying that individuals cannot control the environment, only how they react to it (Howatt, 2001; Tham, 2001). Individuals can choose how they respond to adverse circumstances, and those choices will determine how well they function psychologically. For example, in an article in which she described teaching choice theory to Albanian women, Tham (2001) maintained that these women found the ideas useful, despite the perception that, for Albanians, freedom of choice seems like an illusion. Wubbolding (2007) pointed out that "seeing clients, especially minorities, as victims disempowers them, demeans them, and condemns them to a mental state characterized by self-talk such as 'I can't because they won't let me.' Reality therapists believe that no matter what people have suffered they need not remain in the position of victim" (p. 203).

The needs identified in RT theory could be seen as culturally bound (especially, for instance, power and freedom). Facing these criticisms, its advocates would argue that there are many ways to meet needs, and the way in which an individual does this is dictated not by RT, but by the

individual's own quality world. The quality world is influenced by the person's culture, and the good RT counselor respects these choices (Sanchez, 1998; Wubbolding, 2011a). However, Wubbolding, Brickell, Burdenski, and Robey (2012) do acknowledge that truly connecting with another who has a very different quality world is a difficult skill that requires "a positive and compassionate choice" (p. 24).

A brief review of the RT literature seems to support this sensitivity to issues of diversity among RT proponents (Holmes, White, Mills, & Mickel, 2011; Mason & Duba, 2011; Mickel, 2013). Jusoh and Ahmad (2009) examined the applicability of RT with Islamic, Asian, and Australian clients and concluded that RT could be adapted for use with clients of many backgrounds. Holmes et al. (2011) considered the applications of choice theory and RT with African-American women and Mason and Duba (2011) with minority youth. In presenting an African-centered model of RT parenting, Mickel (2013) argued that spirituality should be added to Glasser's list of basic needs when considering RT with African-American clients. Wubbolding et al. (1998) endorsed the cultural competencies of the Association for Multicultural Counseling and Development (Arrendondo et al., 1996) for RT counselors and further elaborated on ethical issues relevant to the applications of RT in a diverse world. In addition, Wubbolding (2011a) pointed to three qualities that make RT friendly to individuals from diverse backgrounds: brevity, respect for the client, and the emphasis on inner control, which Wubbolding contends leads to a sense of empowerment (pp. 111–112).

Some research evidence suggests that RT may be a very acceptable approach for diverse clients (Wubbolding et al., 2004). For example, Okonji, Ososkie, and Pulos (1996) reported that a sample of African-American adolescents (Job Corps participants) responded more favorably to a videotape sample of RT counseling than to one depicting person-centered counseling—particularly when the counselor was an African-American male. However, it is always risky to draw conclusions based on one research study. Also, these clients did not actually experience RT counseling; they only watched it.

Wubbolding et al. (2004) suggested that in working with clients from other than the Western European cultures, a safe therapeutic relationship becomes critical, writing that "clients unfamiliar with the nature of counseling and who see it as foreign to them can be helped when they realize that the reality therapist is genuinely empathic and concerned about their welfare and committed to assisting them" (p. 223). Wubbolding (2000) detailed other modifications to RT that are necessary with diverse clients. For example, he suggested that RT counselors working with clients of Japanese heritage use gentle, indirect questioning styles. They should also recognize that the individualistic values of Western society are inappropriate for these clients; evaluation of life is more commonly based on family or community well-being. Wubbolding (2000) performed this kind of analysis for clients from other diverse groups, such as African-Americans, Puerto Ricans, and Koreans. He mentioned differences in perspectives based on spirituality as well. However, Wubbolding is silent on the issue of sexual orientation.

THE CASE STUDY

Donald's presentation fits with the RT assumption that relationships are the core of psychological dysfunction. His grandiose presentation and addiction to excitement might seem less consistent with RT assumptions, but, conceptualized as ways to meet power or fun needs, these inconsistencies seem less troubling. Generally, the details of Donald's presentation are easily

understood through choice theory—he is angering, depressing, and generally making bad behavior choices.

Summary

RT is based on the assumption that people are motivated to meet their basic needs of survival, love and belonging, fun, freedom, and power. The most important of these needs is that for love and belonging. Each individual constructs his quality world, which is a mental collection of need-satisfying people, experiences, and objects. Behavior represents the best effort of the individual at a given time to meet his needs.

Psychological dysfunction results when we make bad choices. At the root of all problems is a key relationship—the individual is having difficulty satisfying love and belonging needs. When these needs are frustrated, the person becomes angry, but typically turns to other behaviors because angering behavior can have very severe consequences. Dysfunctional behavior, particularly depressing, usually gets the person attention from others and allows the person to avoid trying other behaviors that might be riskier.

The RT counselor is first interested in establishing a warm, empathic relationship with the client. She avoids blaming or criticizing the client and instead helps the client examine his current behavior in light of what he really wants. Together, the client and counselor formulate a plan for the client to choose different ways to meet his needs.

Very little research exists that directly tests RT theory. The outcome research that has appeared, for the most part, does not meet the current methodological standards for empirical validation. RT has been characterized as simplistic and culturally bound. The assumption that all behavior is chosen has been the target of criticism because it ignores the fact that social and environmental factors influence behavior. The writings of RT theorists seem to ignore LGBT relationships in favor of an emphasis on traditional marriage relationships.

MyCounselingLab

Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy,* Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 17.

CHAPTER 12

Feminist Therapy



Susan is a 30-year-old Korean-American woman who is recently divorced from her husband of two years. She is a full-time student beginning her third year of medical school and lives with her mother. Susan arrives for sessions neatly dressed, usually in hospital scrubs. She generally appears younger than her stated age, demonstrates poor eye contact, and shows very little emotion.

Susan was referred for counseling following an incident in which she verbally confronted another student during class and was asked to leave the classroom. The counselor at the medical school who referred her suggested that she may have difficulty managing and appropriately expressing anger; Susan does not agree that this is a problem. She says that she was justified in her anger because the other student, a man, had called her "crazy."

Susan is adopted. She has no knowledge of her biological parents. Susan's adoptive father is White; her adoptive mother is Asian. She is an only child. Her father, who died two years ago, had a history of alcohol abuse. Initially, Susan reported having "basically a good childhood." She described her mother as "the disciplinarian, hard working, and loving." She further stated that, although her father abused alcohol, this was not a stressor; she "adored him" and he was "very good" to her. In later counseling sessions, Susan described her home life growing up as uncomfortable; her mother and father argued frequently. She further disclosed feelings of resentment and guilt related to her father's alcohol abuse.

Susan reported having problems with interpersonal relationships for many years. Her ex-husband, who lives in another city, recently told her that she should seek counseling because she has difficulty letting go of relationships. She agreed with his assessment, characterizing herself as "codependent." Susan reports a lack of self-confidence, feelings of numbness during conflict, insecurity with authority figures, and a desire to avoid uncomfortable situations.

Susan provided an example of her difficulty with relationships in describing a long-term female friend. Susan and her friend Leah met during their first year of high school, and they immediately became friends, studying together, shopping, having lunch together, and so forth. Susan described her relationship with Leah as "very close right from the beginning," saying that they were "practically inseparable." They decided to pursue careers in medicine, attended the same

Note: In tribute to the egalitarian spirit of feminist therapy, the image I chose for this chapter is intended to represent the many diverse contributors to this theoretical approach.

college, and now are in medical school together. Susan reported that Leah was always very protective of her and that when Susan had a problem with another acquaintance or family member, Leah was there to defend her.

Susan recalled a time when she was dating a man and believed that he was cheating on her. She discussed her suspicions with Leah, who convinced her that the two of them should slash the tires on his car and spray paint the windshield to "teach him a lesson." Susan and Leah went through with their plan and vowed never to disclose what they had done. Susan reported that they engaged in other activities similar to this one throughout the years and that she felt "somewhat guilty" about some of the things they have done to other people. Susan further reported currently feeling "smothered" by Leah; she would like to pursue friendships with other people. However, Susan reports being unable to end her friendship with Leah because she feels it is necessary to remain loyal to her.

With men, Susan says she is unable to express her feelings when she senses disagreement and describes herself as fearing abandonment. She says these kinds of things happened in the relationship with her ex-husband. Susan reports that a previous significant relationship was physically abusive. She felt responsible for the abuse because she was, at times, verbally abusive toward the man. During the abuse, she would feel calm, and when it was over, she would simply leave the situation. She had great difficulty ending this relationship because of her feelings of loyalty to this man.

Susan comes to counseling somewhat reluctantly (mostly because the counselor at school suggested it), although she recognizes her difficulties with relationships. She says that she'd like to work on her "temper" and her feelings of abandonment.

BACKGROUND

> Traditionally, psychotherapy has let women down. The same is true for members of disempowered groups. Created by the mainstream to serve the mainstream, psychotherapy has failed marginalized people in fundamental ways. This is not to say women and other minority-group members have never received help or felt more able to cope after counselling or therapy but, rather, that therapy they received made little attempt to address the root causes of their problems. In focusing narrowly on the personal and individual, which mainstream psychotherapists insist is their domain, they ignore the big picture and miss the point. A therapy which fails to address power issues in people's lives works, automatically, to reinforce oppression. (McLellan, 1999, p. 325)

Feminist therapy (FT) is a rather different approach to counseling; it seems more a philosophical approach than a specific theory and technique. The preceding quote is a good illustration of the ideology of a radical feminist approach to counseling. However, feminist philosophy spans an ideological continuum that ranges from radical to more conservative positions. These variations of feminist philosophy will be described later in the chapter. You can read the writing of prominent feminist therapist Laura Brown in Box 12.1.

MyCounselingLab

Video Example 12.1 Watch a feminist therapy session in action.



Box 12.1

Laura Brown on Feminist Therapy

The project of feminist therapy is one of subversion as a strategy for effecting growth and healing for people in distress (L. S. Brown, 1994). Subversion is a concept that broadly represents the psychotherapeutic strategies by which therapist and client, working together collaboratively, use the tools of psychotherapy to undermine the internalized and external patriarchal realities that serve as a source of distress and as a brake on growth and personal power for all humans. In the feminist lens, psychotherapy is itself construed as a potential component of systems of oppression, with therapy as usual operating in the absence of an analysis of gender and power, practiced in ways that can actively or inadvertently uphold problematic status quos and reinforce hierarchies of value inherent in dominant cultures. Consequently, in feminist therapy, almost every taken-far-granted aspect of business-as-usual for a therapist, from where the office is located to how diagnosis is done to how therapist and client relate, is analyzed, questioned, and challenged with the tools of feminist theory, with the goal of making psychotherapy not only nonoppressive but actively liberatory.

Patriarchies are the near-universal hierarchical social systems in which attributes associated with maleness are privileged and those attributed to women are denigrated, no matter the sex of the individual in whom these qualities are found. Patriarchal systems are identified by feminist therapy and theory as the primary sources of human distress, including those kinds of distress that are organized into diagnostic categories and labeled psychopathology by the mental health disciplines. The actual distress or dysfunction about which an individual initiates therapy is thus not seen as pathological per se, no matter how much it impairs a person's functioning, but most likely a response to being immersed in toxic patriarchal realities. Such toxic social hierarchies of value are construed inherently inimical to personal power and healthy functioning for all people, even those apparently privileged by patriarchal norms of dominance and hierarchy. Feminist therapy, while viewing all psychotherapies as inherently political due to their participation in sustaining such oppressive norms (even via passive disengagement from an analysis of those norms), actively positions itself as having a political impact in the direction of social change.

Source: From Brown, L. S. (2010). Feminist therapy. Washington, DC: American Psychological Association. Pages 4–5.

FT developed out of deep dissatisfaction with traditional approaches to psychotherapy (Gilbert, 1980), the emergence of a psychology of women and gender, and the feminist movements of the 1960s and 1970s (Remer, 2013; Worell & Johnson, 2001). A significant aspect of the movement was protest against the prevalent societal attitude blaming women for assaults against them such as rape and domestic violence. In her classic book *Subversive Dialogs*, Laura Brown (1994) defined FT in the following way:

> Feminist therapy is the practice of therapy informed by feminist political philosophy and analysis, grounded in the multicultural feminist scholarship on the psychology of women and gender. This approach leads both therapist and client toward strategies and solutions advancing

feminist resistance, transformation, and social change in daily personal life and in relationships with the social, emotional, and political environment. (pp. 21–22)

No single individual developed FT; rather, it emerged from the application of feminist political philosophy (L. S. Brown, 1994). It is considered a grassroots phenomenon, and its proponents generally eschew the idea of "experts" (L. S. Brown, 1994; L. S. Brown & Liss-Levinson, 1981). Feminism in counseling actually has a long history, beginning with Alfred Adler, who recognized the cultural effects on women's behavior (but who still saw women as needing to adjust to the role of mother). Another early feminist was Karen Horney, a psychoanalyst who rejected the idea of penis envy and substituted the woman's envy of men's privileged, power-wielding position in society (Forisha, 1981; Nutt, 1979). Many writers and therapists are currently active in the FT world, and producing a list of them here would surely lead to leaving someone out, not to mention that creating such a list would be contrary to the egalitarian principles of FT.

Numerous organizations are devoted to feminist psychology, psychotherapy, and the psychology of women. The American Psychological Association (APA) established the Committee on Women in Psychology in the 1970s, and this committee initiated the APA Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice. Division 17 of the APA, the Society of Counseling Psychology, established a Committee on Women and produced *The Division 17 Principles Concerning the Counseling/Psychotherapy of Women* (Fitzgerald & Nutt, 1986), which has been revised as *Guidelines for Psychological Practice with Girls and Women* (American Psychological Association, 2007). Division 35 of the APA is the Society for the Psychology of Women, which sponsors the journal *Psychology of Women Quarterly*. Division 35 can be found online at www.apadivisions.org/division-35. In 1993, Division 35 was instrumental in holding the first National Conference on Education and Training in Feminist Practice, which produced the Core Tenets of Feminist Therapy, shown in Box 12.2 (Worell & Johnson, 1997).

Box 12.2

Core Tenets of Feminist Therapy

1. Feminist therapy recognizes that being female always occurs in a cultural, social, political, economic, and historical context and affects development across the life span.
2. Feminist therapy focuses on the cultural, social, political, economic, and historical factors of women's lives as well as intrapsychic factors across the life span.
3. Feminist therapy includes an analysis of power and its relationship to the multiple ways women are oppressed; factors such as gender, race, class, ethnicity, sexual orientation, age, and ablebodiness, singly or in combination, can be the basis for oppression.
4. Feminist therapy acknowledges that violence against women, overt and covert, is emotionally, physically, and spiritually damaging.
5. Feminist therapy acknowledges that misogyny exists in all women's lives and is emotionally, physically, and spiritually damaging.
6. Feminist therapy's primary focus is on strengths rather than deficits. Therefore, women's behaviors are seen as understandable efforts to respond adaptively to oppressive occurrences.
7. Feminist therapy is committed to social change that supports equality forever.

(continued)

Box 12.2 *(continued)*

8. Feminist therapy is based on the constant and explicit monitoring of the power balance between therapist and client and pays attention to the potential abuse and misuse of power within the therapeutic relationship.
9. Feminist therapy strives toward an egalitarian and nonauthoritarian relationship based on mutual respect.
10. Feminist therapy is a collaborative process in which the therapist and client establish the goals, direction, and pace of therapy.
11. Feminist therapy helps girls and women understand how they have incorporated societal beliefs and values. The therapist works collaboratively with them to challenge and transform those constructs that are destructive to the self and helps them create their own perspectives.
12. Feminist therapy empowers girls and women to recognize, claim, and embrace their individual and collective power as girls and women.
13. Feminist therapy expands girls' and women's alternatives, options, and choices across the life span.
14. Feminist therapy is a demystification process that validates and affirms the shared and diverse experiences of girls' and women's lives.
15. Feminist therapy involves appropriate types of self-disclosure. However, because self-disclosure may be harmful, it must be both value and theory driven and always in the client's best interest. Therapists must develop methods of continually monitoring their level of self-awareness.
16. Feminist therapists are committed to continually monitoring their own biases, distortions, and limitations, especially with respect to cultural, social, political, economic, and historical aspects of girls' and women's experiences.

Source: From Wyche, K. F. & Rice, J. K. (1997). Feminist Therapy (p. 69). In J. Worell and G. Johnson (Eds.), *Shaping the Future of Feminist Psychology.* Washington, DC: American Psychological Association. Copyright © 1997 by the American Psychological Association.

The Association for Women in Psychology (AWP) emerged in 1969 as a parallel organization to the APA. The AWP was instrumental in the creation of Division 35 of the APA. Its members picketed the APA board of directors meeting at the 1969 convention to argue for its creation. The AWP created the first Feminist Therapy Roster in 1971 (L. S. Brown & Liss-Levinson, 1981).

Another famous hotbed of feminism is Wellesley College, which sponsors the Wellesley Centers for Women (www.wcwonline.org). The Stone Center, a well-known feminist think tank, is also at Wellesley, as is the Jean Baker Miller Training Institute, which produces research and training centered on the relational model of women's development (see the section "Theory of the Person and Development of the Individual").

BASIC PHILOSOPHY

Feminism is, according to Laura Brown (1994), "the collection of political philosophies that aims to overthrow patriarchy and end inequities based on gender through cultural transformation and radical social change" (p. 19). Patriarchy refers to the pervasive norms of most cultures

that favor men over women, giving them power automatically (i.e., male privilege, particularly White male privilege), while at the same time devaluing women and keeping them in subordinate positions. This political perspective translates into a core belief for feminist therapists that the ultimate cause of psychological dysfunction resides in the oppression of the individual by society (Remer, 2013). Women, particularly, are expected to adhere to a rigid set of expectations, and both overadherence to and deviation from these behaviors are labeled mental illness (Chesler, 1972).

Feminists, and feminist therapists, tend to be activists and are sometimes pretty noisy about it. For example, Laura Brown (2006), the self-proclaimed subversive (as in the title of her book *Subversive Dialogues*, 1994), evaluated the current state of feminism in this way:

> The most subversive thing that feminist practice still brings to the table after all these years is a belief that the civilization we know as racist, sexist, heterosexist, classist, neglectful, colonizing, occupying, and violent is the problem, for which feminist activism in and outside of the therapy office, the classroom and the lab, is one solution. (p. 22)

Mary Ballou (2005) called attention to the hegemony of the medical model, traditional science, health insurance industry, professional associations, and licensing boards (p. 202). She saw the dominance of these institutions, as well as the increasing conservative political swing in our current lives, as limiting the visions of therapists, feminist or otherwise, in their efforts to understand and help others. So given even these limited examples, you can see that FT writers are not shy in their critical evaluations of the current state of our world.

Feminists are always aware of power differentials and are attentive to features of human interaction that promote such differentials (Gilbert & Rader, 2007). One important influence is language; how we speak is assumed to both reflect and influence our views of the world. Thus, you will *not* hear a feminist using the pronouns *he* and *him* to refer to both sexes. More subtly, feminists argue that those traditionally in power (men) typically are referred to by their last names, whereas women and children are called by their first names. As a consequence, feminist writers often use both first and last names in their references to others' writings. To be true to FT ideology, I will use both names in the first reference to writers in this chapter (other than in parenthetical references).

Feminist theory, which forms the basis of feminist counseling, encompasses a wide range of perspectives. Next, I will review some feminist philosophies, but you should keep in mind that the boundaries between these categories are not as distinct as you might gather from my presentation of them. Complicating matters, different writers sometimes use different terms when apparently referring to a similar feminist stance. For example, one variant of feminism, woman of color feminism, can be enacted from a liberal, radical, or cultural feminist perspective. It is also worth noting that Laura Brown (2010) saw these as historical stages; in her view, the cutting edge of FT today is multicultural, global, postmodern feminism.

For the most part, feminist stances vary primarily in the degree to which they (a) emphasize unique qualities of women; (b) advocate the rejection of masculine, or patriarchal, models; and (c) integrate issues of culture and class into their viewpoints. For a more detailed review of these philosophies and their histories, read Carolyn Zerbe Enns's (2004) book *Feminist Theories and Feminist Psychotherapies*, or Laura Brown's (1994) book *Subversive Dialogues*.

Liberal feminists emphasize women's equality within a rational framework (Worell & Johnson, 2001). Also called *reformist feminists*, advocates of this perspective emphasize equality of

women and men and tend to focus on changing legal structures and interventions to promote access for women. Betty Friedan, who identified "the problem that has no name" (i.e., the malaise of the traditional 1960s "housewife"), can be seen as a liberal feminist because she meant by this phrase that women were blocked from reaching their potentials and that the patriarchal society did not want to discuss these issues (Friedan, 1963). Friedan was instrumental in establishing the National Organization for Women (NOW), which worked for the passage of the Equal Rights Amendment (ERA) to the U.S. Constitution. The ERA, of course, failed, but other initiatives did not (such as paid maternity leave and the right of women to control reproduction). The liberal position is criticized by other feminists for encouraging women to become members of the male club and, by doing so, to deny the paternalism in societal structures. It is dangerous, in this view, to teach women to be "more like men" because this view inherently assumes that women are deficient (L. S. Brown, 1994, p. 54).

Radical and social change (or *socialist*) feminists are those who see oppression based on gender as the most fundamental and stubborn form of injustice and seek to eliminate all forms of male domination (Enns, 2004; Worell & Johnson, 2001). Socialist feminists, who base their arguments on Marxism, add that capitalism is a second major factor in the oppression of women and would prefer communal living environments that emphasize equality of work roles for men and women (Enns, 2004). Radical and socialist feminists point to the many ways that society represses women, including subjecting them to violence and harassment and restricting their reproductive rights. The liberal feminists' efforts to promote women into positions of power in society are seen by these feminists as tokenism (L. S. Brown, 2000) because this practice is more likely to change the woman to fit male norms than to change the patriarchal, capitalist system. Nothing less than abolishing patriarchal systems is acceptable to the radical and socialist feminists, so they are likely to advocate separatism, or the refusal to participate in institutions that perpetuate the patriarchy, including engaging in psychotherapy (Remer, 2013). *Lesbian* feminists would add heterosexism to the list of cultural dominations, defining this bias as the heteropatriarchy (L. S. Brown, 1994; Worell & Remer, 2003).

Cultural or *difference* feminists revere women's unique qualities, such as relatedness and cooperation. They tend to emphasize the differences between men and women in such values and associated behaviors (L. S. Brown, 2010). Unlike radical and socialist feminists, who are critical of norms of femininity, cultural feminists celebrate what they would see as qualities unique to women (e.g., connectedness, cooperation; Worell & Remer, 2003).

Woman of color feminism, or *womanism*, is a reaction to mainstream feminism's neglect of the experiences of women of color or, to put it a little more bluntly, the racism inherent in early feminism. These feminists reject the primacy of gender as a category of oppression, arguing that gender interacts with race, social class, and other categories in affecting individuals' lives (Rice, Enns, & Nutt, 2015). Although some authors equate womanism with Black feminism, Enns (2004) pointed out that this term is also used more broadly, to refer to one who loves all things woman. Some woman of color feminists prefer the term *colonization* to *oppression* as a way of emphasizing that people of color are pressured to adopt the values and norms of White, Eurocentric culture (Comas-Díaz, 1994, p. 288). Lillian Comas-Díaz (1994) argued that "colonized individuals are not only exploited and victimized for the benefit of the colonial power, but also

serve as the quintessential scapegoats" (p. 289). Much as other feminists might emphasize examining one's internalized sexism, woman of color feminists advocate distinguishing between internal and external colonization (Comas-Díaz, 1994). Supporters of this orientation sometimes see men and women of the same race or ethnicity as more similar to each other than women from different ethnicities.

Another FT ideology is labeled *postmodern* feminism (L. S. Brown, 2010; Enns, 2004). Postmodernists reject the idea that there is one real, objective truth out there in the world. Instead, postmodernists contend that reality is constructed in relationships and that truth is often determined by who is in power. Some versions of lesbian/queer feminism can be classified as falling into postmodernist approaches. Finally, Enns (2004) described *third-wave* feminism, a post-modern approach that, although appreciating the contributions of earlier feminisms, struggles to deal with the backlash against feminism and to push for further progress in combating violence, solving problems in health care, and addressing economic and environmental concerns.

Postmodernism is difficult to describe because within it are views that vary from mild to radical on the notion of whether there is a reality to be comprehended. Among those taking postmodernist approaches are writers who view radical relativism (i.e., the view that there is no one reality, only shifting views) as problematic because it would disallow statements about historical (and present) oppression of women and other marginalized individuals. Social constructivists adopt this perspective so that problematic constructions of gender, race, and so forth can be addressed (Enns, 2004). The point of all postmodernists, as I see it, is to emphasize that we and our clients can bring many ideas to counseling that we treat as "truth" that can be profitably considered as products of social reality training (Hare-Mustin, 1994).

As I noted earlier, Laura Brown (2010) opined that the newest wave of feminism is multicultural and global. Earlier writers who explored colonialism have had a great impact on feminist thought and are seen in global feminism, along with attention to spiritual issues and the acceptance of the possibility that men can be feminist therapists.

MyCounselingLab

Video Example 12.2 Start at 4:26 in this video to get a sense of current feminist perspectives.



https://www.youtube.com/watch?v=czc2_uidOm8

Chandra, Susan's feminist therapist, is first aware that Susan is a woman and of Asian heritage in a culture infused with the values of European men. Characterizing herself as a global feminist who also respects the contributions of radical and cultural feminisms, Chandra recognizes that Susan's female sex and Korean heritage will likely have a significant impact on who she is and how she operates in the world—and how the world reacts to her. Chandra assumes that Susan experiences the power disparity in mainstream culture and that the behavior that others label "dysfunctional" is a reaction to these inequities.

HUMAN MOTIVATION

Feminist counselors don't spend a lot of time discussing human motivation—they are too busy intervening. According to Mary Brabeck and Laura Brown (1997), the lack of traditional theory in FT can be partly attributed to the fact that FT developed in the field rather than within the confines of academia.

In considering motivation, feminist counselors might draw their views from an existing theory of human behavior, provided that it was not sexist. Nancy Chodorow (1978, 1989) modified classic psychoanalytic theory to eliminate the "penis envy" bias. She focused on the role of mothering in child development—particularly on the individuation of boys and girls. Modern versions of psychoanalytic theory such as attachment theory have received feminist criticism, as has the evolutionary perspective (Contratto, 2002). Ultimately, the identification of motivation is dependent in part on the origins of sex differences (if they exist), which is a controversy far from settled.

Another way of addressing motivation might be to adopt a system associated with a humanistic (e.g., Gestalt or person-centered) orientation because an actualization perspective is compatible with a feminist orientation (Enns, 2004). However, person-centered theory, for example, has been faulted for its lack of attention to the social factors that contribute to the development of the self. Also, the emphasis placed on individualism in humanistic/existential approaches is reflective of traditional American values (rugged individualism, or the John Wayne syndrome) and can obscure commonalties in women's experiences in the oppressive culture (Enns, 2004).

Chandra sees Susan as motivated to grow to her full potential as a human. An advocate of humanism, Chandra views Susan from a positive perspective, but is careful to attend to social influences that are significant in Susan's life.

CENTRAL CONSTRUCTS

GENDER

No matter what FT ideology one adopts, gender, considered the social manifestation of sex, is a critical construct. Feminist therapists use the term *sex* when biological differences (such as anatomical ones) are the subject. *Gender* is the term used to emphasize that differences between men and women are more than the product of biology and that social learning and social context are important influences on what our cultures define as "male" and "female" (Yoder, 2003). As you might suspect, liberal feminist therapists are adamant that gender is a construction of culture and that most apparent psychological differences between men and women are a product of societal influence rather than biological sex (Gilbert & Scher, 1999). I have friends who are parents who are convinced that raising boys is different from raising girls. Boys are active and aggressive and girls are sweet and compliant—you know, the "boys will be boys" phenomenon. Liberal feminists would point out that many of these behaviors are known to be differentially reinforced by parents when children are very young (Etaugh & Bridges, 2010). Female and male infants are treated very differently from one another from very early on. Baby boys wear blue, and baby girls wear pink; boys are given toy trucks or tool kits, and girls are given dolls or kitchen sets.

Cultural and to some extent radical and socialist feminists are more likely to see gender differences as inherent to the sexes. This position is sometimes called the *essentialist* stance (L. S. Brown, 1994). For instance, the traditional female emphasis on relationships is to be celebrated, not to be treated as an artifact of socialization (Enns, 2004).

Janice Yoder (2003) presented an integrationist perspective on these arguments. While noting that biology seems to be more "basic" than environment and so more immutable, she asserted that research is amassing that experience can affect physiology. She wrote, "I believe that as the flexibility of biology becomes more and more acknowledged, feminist psychologists will find it useful to let go of the presumed distinction between sex and gender, nature and nurture. This opens the door to regarding *sex and gender as inseparable and intertwined* so that a holistic understanding of women and men, girls and boys, will include biology (sex) and what our culture makes of our biological sex (i.e., gender)" (2003, p. 17; emphasis in original).

In any case, all feminist therapists recognize that society has devalued women and the qualities typically associated with them. Power and gender are therefore tightly bound in most cultures in the world (L. S. Brown, 1994).

Chandra works to identify multiple influences on who Susan is now. Some of the important factors are her biological sex, family background, social class, and Korean heritage. Chandra does not know how much each of these factors influences Susan, but she guesses that gender is a powerful influence. Susan has probably been reinforced for exhibiting traditionally "female" behaviors and punished for displaying traditionally "male" behaviors.

The Personal Is Political

In contrast to traditional psychological theory, which tends to focus on internal determinants of behavior, this basic principle of FT emphasizes that women's experiences are connected to factors external to them, embedded in social norms and traditions (Remer, 2013). FT theorists are very conscious of the traditional gender imbalance in society, which dictates that power and status are bestowed on men. Women's problems are seen as resulting from social, political, and legal systems that oppress and disempower women (Worell & Johnson, 2001). Feminists believe that the "personal experience is the lived version of political reality" (L. S. Brown, 1994, p. 50). In other words, the distress of the individual woman (the personal) is a function of the social and political rules and norms of the culture in which she lives (the political).

Chandra assumes that the difficulties Susan brings to counseling are a product of factors in her environment, especially the cultural context in which she was raised and now exists. She suffers from society's disempowerment of women, and some of her current behavior is likely a reaction to these very real feelings of helplessness. For example, her low self-confidence is surely influenced by the societal devaluing of women.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

There are a number of ways of examining personality and development from the FT perspective. First, the FT approach attends closely to theory and research on sex differences. Liberal feminists assume that males and females do not differ in any important psychological ways at birth

(L. S. Brown & Liss-Levinson, 1981). Subsequent experiences in the social environment are thought to account for any later observable differences.

What is the outcome of this lifelong process of learning to be a gendered person? Stereotypically, men are thought to be independent, assertive, competitive, unemotional, and invested in their careers. Women are seen as emotional, relationship oriented, passive, and willing to put others' (particularly men's) needs before theirs. Men are dominant, and women are submissive. Men are career and work oriented; women are family and child oriented.

Arguments over the "reality" of gender differences began as early as 1914 and have continued to this day (Hyde, 2005). Generally speaking, differences are found, but the origins of these are still argued (e.g., whether they are socially constructed or genetic; Etaugh & Bridges, 2010). In what is now considered a classic contribution to the literature, Janet Shibley Hyde (2005) looked at 46 meta-analyses of studies of gender differences and found that 78% of these differences were in the zero to small range. The categories she reviewed included ones in which differences are traditionally expected, such as math and verbal ability; in these two cases, differences again were small or nonexistent. Three general areas did show moderate or large differences: motor performance, some sexual behaviors/attitudes (but not sexual satisfaction), and aggression, particularly physical aggression. Surely of interest to many feminists is Hyde's assertion that the reported difference in relationality between men and women (women are nurturers and men are not) was not supported by the data. Subsequent to Hyde's analysis, numerous meta-analyses examining gender difference have appeared, enough so that Ethan Zell, Zlatan Krizan, and Sabrina Teeter (2015) located 106 of these and performed a meta-synthesis (a broad and powerful way to aggregate the findings). Zell et al. reported that over all of these studies, the average effect size was 0.21, which is considered small. The effect sizes studied ranged from 0.02 to 0.73, with the latter effect, associated with masculine versus feminine traits, the only one in the analysis that was considered large. About 19% of the entire group of the effects were medium in size. Examples of traits or characteristics that were higher in men were mental rotation ability, aggression, importance of beauty in mates, and confidence in physical abilities. Women were higher in peer attachment, interest in people more than things, and film-induced fear. So although there are very few moderate to large differences they are interesting, and the real question becomes what causes them? It is not enough to know that men and women are from different planets—we need to look at the workings of the spaceships in which they fly around.

Evidence exists that children are treated differently based on their sex, giving rise to the opinion that this learning, termed *sex-role socialization*, is responsible for observed differences in the behaviors of men and women. Cultures endorse clear values of what it means to be a male or a female, and parents, peers, and teachers tend to treat children accordingly. Claire Etaugh and Judith Bridges (2010) summarized this research well. For example, parents play more roughly with boys than girls, tend to buy gender-consistent toys, and assign stereotypically consistent chores. Laura Berk (2007) noted that parents' reactions to violations of stereotypical behavior are more negative for boys than for girls and that the same pattern appears among children's peers. Etaugh and Bridges's summary also demonstrated that boys and girls are treated differently by their teachers; for example, boys get more attention and corrective feedback, whereas girls are generally given bland and ambiguous responses, such as a simple OK. Typically, boys are reinforced for being smart, girls for being tidy and compliant. Boys are more severely punished by peers for displaying stereotypically female behaviors, whereas girls who are "tomboys"

tend to be more accepted. Finally, the media, although somewhat more balanced than in the past, still depicts males in more prominent and dominant roles than females. Perhaps you've noticed that many cartoon characters are male (think about SpongeBob and Scooby-Doo). Stacy Smith and colleagues at the Geena Davis Institute on Gender in Media analyzed the portrayals of almost 12,000 speaking characters in family films, prime-time television programs, and children's TV shows (Smith, Choueiti, Prescott, & Piper, 2013). The highest percentage of female characters was found in prime-time TV, but it was 38.9%. The lowest was in family films, 28.3%. Female characters were more likely to appear in sexy attire and to show skin. Turning to employment of characters, Smith et al. found that, particularly in family films, females were way underrepresented in high power/prestige jobs (e.g., politicians, physicians, high-level corporate executives). So the next time someone tries to tell you that our society is now gender neutral, you can tell them to spend a few hours watching television or go to a family movie, which, incidentally, had poorer representation of women in powerful positions than did prime-time programming.

A second perspective on development is offered by scholars at the Jean Baker Miller Training Institute at Wellesley College. Jean Baker Miller (1991) proposed a model of feminine development that could be loosely called "self-in-relation." Although initially intended to explain the experiences of girls and women, the model has been broadened to include all human experience and is now called relational-cultural theory (Frey, 2013; J. V. Jordan, 2010). According to this perspective, both boys and girls first develop a sense of self that is tied to relationships because parents (most likely mothers) are continually attending to the infant's well-being. The infant learns to attend to the caretaker's emotional state, but the link of relationship to self largely disappears for boys as they develop because they are encouraged to become active and separate from mom. In contrast, girls are encouraged to maintain their focus on the feelings of others. The girl's sense of self-esteem thus becomes linked to maintaining relationships. Miller wrote about the Oedipal conflict in girls: "We may ask whether one reason that people, beginning with Freud, have had such trouble delineating this stage in girls is that it may not exist. There is no major crisis of 'cutting off' anything, and especially relationships" (1991, p. 18). However, at this stage, girls likely get the message, based on cultural beliefs, that they should turn their relationship focus to men.

In adolescence, boys are encouraged to explore and expand their sense of self. Girls, however, are taught to contract their identities because achievement and sexuality are not acceptable in young women. These natural strivings are diverted to relationships, so a girl's sense of who she is and how she achieves is once again linked to relationships. Thus, Miller described very different paths to adult identity for men and women, which produce values and characteristics consistent with traditional roles.

Another perspective on female development is feminist identity development theory (FIDT; Downing & Roush, 1985; Moradi, Subich, & Phillips, 2002). This model is typically thought of as a stage model, with women traversing all five stages to reach "higher" levels of feminist identity. However, some authors argue that it is more useful to see the "stages" as attitudes or statuses, and rather than finding out what stage someone is in, it is more useful to look at the extent to which she endorses all five statuses (Fischer & DeBord, 2013).

The first stage of FIDT is *passive acceptance*, in which women accept the status quo, not recognizing or denying oppression and discrimination. They tend to endorse traditional gender roles and gender-based (patriarchal) power structures.

Women move into the *revelation* stage, according to Downing and Roush (1985), when they experience either positive feminist experiences (e.g., consciousness-raising groups) or adverse experiences that seem gender related (e.g., divorce, denial of a credit application). A primary characteristic of women in this stage of identity development is anger at the sexist society and at themselves for their participation in the system.

The third stage of FIDT is *embeddedness–emanation*, and it is composed of two phases. In the first phase, embeddedness, women tend to immerse themselves in women's culture, adopt feminist ideology wholesale, and become involved in very close relationships with female friends. However, because most women are involved with men on a daily, if not intimate, basis, they realize that uncritical adherence to feminist theory and the associated anger may not be the most productive stance to take. They move on to the emanation phase, becoming more relativistic and flexible, but are still tentative in their relationships with men.

Even more flexible perceptions of life are evident as women move into the *synthesis* stage. Their reactions to men are less "automatic," and they are more flexible in their evaluations of life events and therefore less likely to attribute sexism.

The final stage of FIDT is *active commitment*. The hallmark of this stage is the energy devoted to eliminating all forms of oppression through social change action.

Chandra sees evidence of sex-role socialization in Susan's behavior, but also notes that some of her behavior is contrary to stereotypical norms. The angry outbursts, for example, are not within the traditional female role of being sweet and nice. On the other hand, low self-confidence, worries about abandonment, and loyalty to relationships (even "bad" ones) are embodiments of the stereotypically feminine woman. Chandra guesses that Susan's parents reinforced these behaviors as unwitting agents of the paternalistic society. In addition, the world in which Susan grew up was fraught with sexism and oppression. Susan complies to some extent with these pressures, feeling insecure and helpless. Occasionally, though, her anger comes through, and she acts in ways contrary to traditional roles. This behavior tends to get her in trouble with others, even the authorities. Susan may be in the passive acceptance or the revelation stage of feminist identity development, but she clearly is not in the embeddedness–emanation stage.

HEALTH AND DYSFUNCTION

An important aspect of the FT approach is its critique of traditional approaches to psychological dysfunction and intervention (Ballou & Brown, 2002; Worell & Remer, 2003). A powerful statement was offered by Phyllis Chesler (1972) in her classic book *Women and Madness*:

> What we consider "madness," whether it appears in women or in men, is either the acting out of the devalued female role or the total or partial rejection of one's sex-role stereotype. Women who fully act out the conditioned female role are clinically viewed as "neurotic" or "psychotic." When and if they are hospitalized, it is for predominantly female behaviors such as "depression," "suicide attempts," "anxiety neuroses," "paranoia," or "promiscuity." Women who reject or are ambivalent about the female role frighten both themselves and society so much that their ostracism and self-destructiveness probably begin very early. Such women are also assured of a psychiatric label and, if they are hospitalized, it is for less "female" behaviors, such as "schizophrenia," "lesbianism," or "promiscuity." (p. 56)

FT theorists charge that society devalues traits and behaviors that are typically associated with women, labeling them as unhealthy in comparison to male-associated traits

(Worell & Johnson, 2001). Thus, the standard of health resides in male qualities, such as independence, competition, assertiveness, objectivity, and activity (Chesler, 1972). Also, both Chesler and more recent FT writers recognized that gender is not the only influence on perception; qualities and behaviors stereotypically associated with women from non-White, non–middle-class backgrounds are deemed dysfunctional by traditional psychotherapeutic approaches. Generally, society views the problems of women as stemming from internal factors (i.e., something is wrong with her) rather than from social and cultural inequality (Remer, 2013).

Traditional diagnostic categories, such as those found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V; American Psychiatric Association, 2013), are also the targets of FT criticism (Ancis & Davidson, 2013). Feminists see as problematic the assumption that every form of distress is abnormal when, in fact, it is often a normal response to the problems inherent in an oppressive society (L. S. Brown, 2010). For example, the activist group Counselors for Social Justice objected to the addition of the diagnoses "premenstrual dysforic" disorder and "sexual arousal/interest" disorder in the DSM-V as pathologizing women's lived experience (Enns, Rice, & Nutt, 2015). Others have provided critiques of the personality disorders, such as histrionic, dependent, and borderline personality disorders (Ali, Caplan, & Fagnant, 2010; M. Kaplan, 1983; Kupers, 1997; M. R. Walsh, 1997). Box 12.3 shows a feminist take on a popular term used to describe psychological dysfunction, *codependence*.

Box 12.3

Codependent, Female, or Simply Low Power?

Laura Brown and other feminists have critically examined a term we all seem to love to throw around, *codependent*. The term was coined in the late 1980s to recognize that alcoholics were part of a system and that those around them, the codependents, shared some responsibility for the drinking behavior. By protecting the alcoholic from the consequences of his or her abuse, the codependent *enabled* the drinking behavior. Typically, the codependent was a White, middle-aged wife of a White male alcoholic. Based on this conceptualization, the focus of intervention became both the alcoholic's and the codependent's behaviors. Since that time, the term has been used in a much broader way. Feminists have taken exception to this term. Here I present some of their views, based mostly on the writings of Laura Brown and Kay Leigh Hagan.

There are many definitions of codepencency, but most commonly these definitions carry a common thread of descriptions of relationship dynamics of the codependent and significant others. Some of the characteristics offered are as follows:

1. Sacrificing one's needs for those of others
2. Feeling a sense of powerlessness
3. Gaining self-worth through being needed by others
4. Exhibiting low self-esteem
5. Avoiding conflict

The problem, according to Laura Brown (1994), is that no attempt is made to take social and cultural factors into account in understanding the "codependent's" behaviors. She pointed

(continued)

Box 12.3 *(continued)*

out that women in a sexist society are awarded responsibility for taking care of the emotions of men and that codependent behavior very much resembles the expected heterosexual female behavior. The woman's sense of failure in the relationship may indeed cause significant personal feelings of guilt and shame, but again this dynamic is based on the cultural rules rather than on some defect in the individual. Also, this "diagnosis" is likely to be racist because the behaviors described are very typical for individuals in cultures of color.

Kay Hagan (1993) began her dissection of the term by linking codependency and family dysfunction. Dysfunctional families are characterized as oppressive; they have rigid rules, discourage honest expression of feelings, and emphasize perfection among the members. These qualities might logically result in low self-esteem and other characteristics associated with codependency. However, she noted, "most American families might qualify as dysfunctional in that they practice similar oppressive rules whether or not a chemical addiction is present" (p. 31). Thus, codependency really becomes a convenient label for submissive roles inculcated by traditional Western family life. "The oppressive rules of the patriarchal family system train us to accept and expect the paradigm of dominance and subordination. Even the most benign of patriarchal families operates in a manner that cultivates the characteristics of *codependency*, a term that is much more acceptable than *internalized oppression*, which might encourage us to question authority or even to rock the boat" (p. 32; emphasis in original).

Another way of saying it is that behaviors labeled as codependent very much resemble those of individuals in low-power groups toward the powerful (L. S. Brown, 1994). The behavior of the subordinate group members will look like overattentiveness, mind reading, enabling, and so forth. In reality, this approach is adaptive; it helps the individual survive because survival is dependent on the rules and desires of the powerful.

Nowadays the term *codependent* is used very globally to describe anyone who seems dependent on, or "addicted" to, relationships. Unfortunately, Brown maintained, because of the description's resemblance to stereotypical female roles, thousands of women adopt the diagnosis. Sadly, the term has become a stigma associated with addiction and disease, when the set of behaviors it describes appears to be those that are adaptive for members of a low-power group.

FT sees psychological distress, or "dis-ease," as a communication about unjust systems (Brabeck & Brown, 1997, p. 28). Symptoms are seen as normal responses to oppressive environmental conditions (Enns, 2004). They are signs of health and strength because they are attempts to resist patriarchy. Consequently, feminist therapists focus on clients' strengths, not dysfunction (Wyche & Rice, 1997). They see human behavior as resulting from a complex combination of factors, both internal (biological and psychological) and external to the person. The latter set of variables, the social, political, and economic context, is considered critical to understanding individual experience (Remer & Oh, 2013).

For example, depression is diagnosed more often in women than in men. Yoder (2003) pointed to several possible explanations for this finding, all of which are linked with low self-esteem. Is it possible that women get depressed more often than men because characteristics that are deemed typically female (e.g., orienting toward relationship, cooperating rather than competing) are devalued by society? Yet another explanation focuses on the discrimination women face. Achievement behaviors are typically less acceptable in women than in men.

Think for a moment about an aggressive woman. Is she evaluated differently from a man labeled aggressive? The stress of maintaining multiple roles is also exacerbated for women. When was the last time you heard anyone ask whether a man could "have it all," meaning a successful career and family life?

Not surprisingly, FT theorists are also interested in the development of eating disorders and have advanced several hypotheses about these types of behavior (Dohm, Brown, Cachelin, & Strigel-Moore, 2010). For an individual client, a combination of factors might be operative, which include the cultural pressure of the thin body as ideal, body control as a way to gain power from a powerless position, ways of coping with achievement-related anxiety, and the need to remain small to avoid threatening men. Noting that body image disturbance varies across ethnicities, Faith-Anne Dohm et al. (2010) added that disordered eating may well be the expression of psychological distress through physiological means.

The origins of the feminist movement lie in the establishment of battered women's shelters and rape crisis centers in the 1960s. Thus, feminist therapists are especially attentive to problems that are more likely to affect women than men and problems that are linked with patriarchal cultural norms—and particularly with physical, sexual, and emotional violence.

MyCounselingLab

Video Example 12.3 Watch Dr. Linda Moore and Helen discuss a feminist understanding of Helen's distress.



Susan appears to be experiencing some distress associated with the pressure to maintain traditional female roles and behaviors. Chandra will not use any formal diagnostic system to understand her presentation because she believes these to be androcentric. Instead of seeing Susan as "dysfunctional," Chandra sees Susan's strengths in expressing herself when treated badly by others (the guy in class) and in persisting in her attempts to care for others. That Susan is pursuing a traditionally male-dominated career is not lost on Chandra, either.

Chandra wonders what effects Susan's experiences with her alcoholic father have had on her perceptions of the nature of women and men. Her struggles in relationships with men are probably connected in some way because she likely learned very early that men can't be trusted. Susan has been the object of both verbal and physical abuse by men, and the effects of these traumas cannot be ignored.

NATURE OF THERAPY

ASSESSMENT

Feminist counselors are unlikely to use formal assessment methods. In fact, radical feminist therapists would completely reject formal assessment and diagnostic systems, seeing them as rooted in the patriarchal system that controls access to services and reinforces hierarchical systems within society (K. M. Evans, Kincade, & Seem, 2011). Other feminist counselors might use traditional diagnosis if it is a means to provide services to their clients (L. S. Brown, 2010).

Judith Worell and Pam Remer (2003) pointed out that traditional approaches to diagnosis and assessment minimize the effects of environment and culture. Further, as noted earlier, traditional approaches compare women's behavior to a male standard. Carolyn Enns (2000) gave the example of "women have low self-esteem" as compared to "men are more conceited than women" (p. 619).

Traditional approaches may also support the notion that differences between women and men are biological in nature. Just think for a minute about the popular book *Men Are from Mars, Women Are from Venus* (Gray, 1992). Not only are women and men unalterably different, but they are also possibly different kinds of life forms!

Laura Brown (1994) proposed an alternative, a biopsychosocial model of distress, with emphasis on the social. This model emphasizes the strengths of the client, while also acknowledging the influences of culture, such as political forces and traditional social structures (e.g., heterosexuality, notions about "normal" families). As for traditional diagnosis, Brown (2006) contended that, although DSM-V labels are sometimes used by feminist counselors, it is in the context of a much more detailed and broader approach that includes the factors above and an awareness of the therapists' own input into the process. Ultimately, Brown (2010) suggested that when traditional diagnosis is used, the client and counselor should collaborate on choosing the diagnostic category. The potential risks of using the label should be considered, while also thinking about the ways in which symptoms are adaptive and have meaning in context. The FT counselor should also consider how the client's various identities influence her experience of distress and empowerment and whether the diagnosis is helpful in devising intervention (Enns et al., 2015, p. 32).

Chandra does no formal assessment or diagnosis with Susan. She sees these systems as confining and limiting, probably distorting the role of cultural forces in Susan's current distress.

Overview of the Therapeutic Atmosphere

Traditional approaches to psychotherapy are assumed to maintain the androcentric, patriarchal status quo by assisting women to "adjust" rather than to challenge stereotypes and oppression (Worell & Johnson, 2001). In Phyllis Chesler's (1972) words, "For most women the (middle-class-oriented) psychotherapeutic encounter is just one more instance of an unequal relationship, just one more opportunity to be rewarded for expressing distress and to be 'helped' by being (expertly) dominated" (p. 108).

Modern feminists are more confident that therapy relationships can be growth producing, given the right ingredients. Kathy Evans et al. (2011) suggested that four components need to be present in truly feminist therapy: the belief that the personal is political, an egalitarian relationship, the privileging of woman's experiences, and a strengths perspective (pp. 87–88). In addition, the feminist counselor must have "oppositional knowledge," or an awareness of gender issues and an attitude of critical questioning toward commonly held beliefs and assumptions (Evans et al., 2011).

Chandra has given a great deal of thought to the feasibility of feminist therapy. She has examined her own beliefs regarding what counseling is about and blends an empowerment approach with a relational one. She seeks to help Susan accept her "feminine" tendencies, while at the same time accepting her own power as a person.

Roles of Client and Counselor

All FT theorists agree on one thing: The promotion of an egalitarian relationship between therapist and client is essential to FT. Because of the therapist's professional qualifications, an inherent power imbalance in therapy is assumed; the counselor must acknowledge this imbalance and

discuss it with the client (Enns, 2004). That the counselor determines the time and place of meetings and that the client pays the counselor for her time mean that *egalitarian* does not mean *totally equal*. At the same time, the client and counselor are assumed to be equally expert (Enns, 2004; Gilbert, 1980). The client is an expert on herself, and the therapist owns her professional knowledge and expertise. The therapist's power is temporary and lies in her knowledge of the change process and her ability to assist client empowerment (Remer, 2013).

Laura Brown (2000) pointed out that "the empowerment of the client, is not, after all, the disempowerment of the therapist" (p. 372). She suggested that one of the ways in which feminist therapists use power is to remind clients of their own power. Also, feminist therapists see power in the ability to nurture and care and to listen calmly to the terrifyingly painful stories of their clients (L. S. Brown, 2000).

Part of the client's power stems from her willingness to enter the therapy relationship. Acknowledging this temporary form of dependency represents resistance to the patriarchal dictate that dependency needs be expressed only indirectly or in socially sanctioned ways (L. S. Brown, 2000). Further, the client is seen as possessing unique knowledge of herself (Enns, 1995). Feminist therapists emphasize that the client has the power to define herself within a personal and cultural context (L. S. Brown, 2000).

Chandra discloses her own sense of power to Susan, saying that she will do her best to help Susan find her own way in life. Emphasizing Susan's strengths and struggles, Chandra lets her know that she respects Susan's willingness to come for help. Chandra also suggests that she (Susan) is the expert on her life and that she expects Susan to contribute this expertise to the counseling process.

GOALS

The most important objective of FT is simple: to empower clients and create feminist consciousness (L. S. Brown, 2010, p. 29). Feminist counselors work to help clients accept their personal power in life and to teach them the difference between power within and coercive power, or power over others (Enns & Byars-Winston, 2010). They do not encourage the client to adjust to circumstances unless the client has carefully explored her options and freely chooses to do so. Thus, an important part of empowering the client is the therapist's acceptance of the client's goals. However, the therapist helps the client explore a wide range of life possibilities.

Laura Brown (2000) offered a more radical view when she argued that "each act of feminist therapy must have as a goal the uncovering of the presence of the patriarchy as a source of distress, in order to name, undermine, resist, and subvert such oppressive influences" (p. 367). Woman of color feminists see the development of *conscientizacao*, or critical consciousness, as the goal of counseling (Comas-Díaz, 1994). Increasing the client's awareness of colonization and accompanying internalized racism leads the client to be aware of her location in society and consciously criticize social norms and structures. The client can then take action in the environment aimed at transformation.

MyCounselingLab

Video Example 12.4 Dr. Linda Moore talks about her goals in feminist therapy.



Chandra is committed to helping Susan find her way in life and helping her recognize that she has the personal power to do so. Part of her task is to help Susan look at the forces in her life that both support and hinder her journey, particularly societal attitudes and structures that keep women and individuals of non-White cultures oppressed. These are Chandra's general goals; she also is very careful to discover what Susan's goals are, make these clear and concrete, and devise ways to reach them.

Susan wants to "get the world off her back." Chandra empathizes with Susan and supports Susan's goal.

PROCESS OF THERAPY

The principles of FT, as developed at the 1993 National Conference on Education and Training in Feminist Practice (Worell & Johnson, 1997), are shown in Box 12.2. Feminist counselors believe that value-free counseling is impossible (L. S. Brown, 2010). Therefore, the feminist counselor must be aware of her own values and beliefs, particularly those that involve sex, gender, race, and class. She must be aware of her privilege, from whatever sources it springs (e.g., race, socioeconomic status, sexual orientation; L. S. Brown, 2010). Some feminist therapists will directly communicate their feminist perspective to their clients; others hesitate to use the term *feminist* because of the stereotypes associated with it. It is most important, however, that the feminist counselor not impose her value system on clients (Enns, 2004).

One important way the feminist therapist attempts to enhance equality and collaboration with her client is to give the client information about feminist counseling and request the client's informed consent (K. M. Evans et al., 2011). The *therapy contract* was developed first by feminist therapists and has since been widely adopted by adherents of other theoretical orientations (L. S. Brown, 2010). Contracting involves the client and therapist in a collaborative process of determining the goals and pace of the counseling process. The feminist counselor explains her approach to helping, the costs and benefits of counseling, the roles of client and counselor, and other features of the process that she deems relevant (K. M. Evans et al., 2011). These points, along with agreed-on goals, may be put in writing or handled more informally.

One intent of informed consent and contracting is to *demystify* the therapeutic process. To make the FT process accessible to the client, feminist counselors avoid jargon. Another way to demystify the therapy process is through the careful use of self-disclosure on the part of the therapist. Such disclosure is meant to emphasize the shared experiences of client and counselor, and of all women, and to equalize power in the relationship (Remer, 2013). However, the counselor must be careful not to discount the very significant effects of other factors associated with oppression, such as race, sexual identity, and ableness.

In FT, resistance is defined as the person's healthy attempt to defeat oppression (Brabeck & Brown, 1997). In fact, Laura Brown (1994) endorsed teaching clients resistance of the patriarchy as one aspect of FT. Client feelings about or reactions to the therapist and therapy are not typically labeled as "transference" and considered problematic. Instead, feminist counselors welcome client feedback about the process—and especially expressions of anger because women are taught to suppress such expression (Worell & Remer, 2003).

The question often arises as to whether men can be feminist therapists; Box 12.4 presents a perspective on this question. Radical feminists would answer emphatically no! In 1994, Laura Brown, for example, suggested that, although men could not truly be feminist therapists, they could be profeminist and antisexist in their approaches to counseling. However, she has since

Box 12.4

Can Men Be Feminist Therapists?

At first glance, the terms *feminist* and *male* seem to be contradictory. However, recent discussions of FT suggest that men, too, can adopt feminist perspectives that inform their counseling behaviors.

Szymanski, Baird, and Kornman (2002) decided to find out what these feminist male therapists were like. They surveyed 91 male counselors, finding that 18 of these counselors self-identified as feminists. They found that feminist male counselors differed from nonfeminist counselors on attitudes toward the women's movement and gender-role attitudes. They also endorsed counseling behaviors associated with feminist therapy. Self-identified feminist male counselors were more liberal in their gender-role attitudes, more positive toward the women's movement, and more likely to endorse therapy interventions such as establishing egalitarian relationships with clients and emphasizing the social construction of gender. Basically, these male feminist therapists looked very much like female feminist therapists.

come to see this position as "essentialist and problematic" (2006, p. 20). She now asserts that, "if one can think as a feminist, think about gender, power, and social location, and if gender is socially constructed, then neither the biology or the gender of the person thinking like a feminist in the therapist position ought to matter" (p. 20).

Chandra and Susan develop a therapy contract, in writing, which specifies the goals that they have jointly developed. The contract is written in everyday language and includes the following agreements and goals:

1. *Susan and Chandra will actively work toward a useful therapy relationship with input from both parties.*
2. *The role of social and political factors in Susan's distress will be explored.*
3. *Susan and Chandra will explore Susan's thoughts and feelings about relationships, with the goal of helping Susan assume her own power in relationships so that her rights are not violated.*
4. *Susan and Chandra will explore the sources of Susan's anger, with special attention to its roots in social structures, attitudes, or practices that contribute to it.*

THERAPEUTIC TECHNIQUES

FT has few unique techniques. Any technique or approach is acceptable if it is used with feminist goals in mind (L. S. Brown, 2010). Some therapists adopt and modify traditional counseling theories to fit feminist principles. Thus, there are psychodynamic, Jungian, and cognitive-behavioral approaches to FT (Enns, 1995). In this section, I present several techniques that are the most closely identified with FT.

Gender-Role and Power Analysis

Gender-role analysis is practically synonymous with FT. The client is supported in a personal examination of what the cultural rules are about female and male behavior and how these relate to client distress (K. M. Evans et al., 2011). Socialization processes are discussed in terms of how

they relate to the client's current behaviors in the interest of detoxifying them. For example, what might be labeled "dependent" behavior can be construed as behavior that is powerfully reinforced by our society as being appropriate to the female role (Philpot, Brooks, Lusterman, & Nutt, 1997). The client is helped to understand the origins of her behaviors in social norms and oppressive environments as well as the possible consequences of changing them (Enns, 2004). Part of this examination involves identifying the sources and use of power in the client's experience. Clients are taught about different types of power (e.g., legal, normative, resource based), and its workings in the client's life are analyzed (Remer & Oh, 2013). Contemporary feminists extend these critical examinations to the influence of culture and other aspects of diversity, recommending a *social identities analysis* to examine the relative importance of the various social locations of the client (Rice et al., 2015).

Chandra is very interested in Susan's belief that she has trouble letting go of relationships. She guides Susan through an analysis of this characterization and its potential roots in an exaggeration of traditional sex roles that are reinforced by the dominant culture. Chandra and Susan also explore the values of Susan's adoptive mother, who was raised in a very traditional society. How these influences shaped Susan's view of herself and her behavior is examined in an attempt to depathologize Susan's behavior and move the locus of the problem to the political realm.

SELF-DISCLOSURE

Another approach to equalizing power imbalances in FT is for the therapist to use self-disclosure (Enns, 2004). Wyche and Rice (1997) suggested that there is no clear consensus on the use of this technique. As noted earlier, therapist self-disclosure is helpful in demystifying the counseling process and in emphasizing the shared experiences of women. Any self-disclosure by the therapist must be to serve the interests of the client rather than to satisfy any need of the therapist (K. M. Evans et al., 2011).

MyCounselingLab

Video Example 12.5 An example of therapist self-disclosure.



Chandra considers whether disclosure on her part would be helpful to Susan. She decides that, because Susan doesn't seem to have a sense of community with other women, some disclosure is appropriate. Briefly, Chandra speaks of her struggles with autonomy in a world that gives power to males. Susan reacts positively to this disclosure and goes on to a productive examination of her own experiences.

ASSERTIVENESS TRAINING

Assertiveness training teaches the pursuit of one's rights without violating the rights of others (Jakubowski, 1977a). Feminists borrowed this technique from behavior therapists to help women throw off culturally enforced passivity and determine and achieve personal goals (Truscott, 2010). Assertiveness is distinguished from aggression, which involves the violation of others' rights, and nonassertiveness, which is allowing one's own rights to be violated. Patricia Jakubowski (1977a), a well-known writer in this area, commented that assertiveness "is a direct, honest, and appropriate expression of one's thoughts, feelings, and beliefs" (p. 147). Respect for self and others is an important element of assertive behavior. You might have noticed that

nonassertive behavior fits the stereotypical female behaviors, such as putting the needs of others first, withholding opinions, and "being nice."

Rarely mentioned by contemporary feminist therapists, assertiveness training was used in the 1970s and 1980s to teach women to abandon their culturally approved nonassertive behaviors. However, contemporary FT practitioners would certainly agree with the underlying principles and goals of this technique. Most often, assertiveness training was conducted in groups (and typically women-only groups), although it can be used in individual counseling as well. Jakubowski (1977b) identified four components of assertiveness training: (a) teaching the distinctions among assertive, nonassertive, and aggressive behavior and helping clients observe their own behaviors; (b) teaching clients a philosophy that respects individual rights and supports assertive behavior; (c) removing or reducing the salience of factors that inhibit assertive behavior; and (d) teaching assertive skills through practice (p. 169). A combination of teaching and group discussion is used to teach clients the differences among assertive, aggressive, and nonassertive behavior as well as to promote basic assertive philosophy.

Chandra decides to work with Susan on increasing her assertive behavior and decreasing the angry, aggressive behavior that she occasionally displays. However, Chandra is very aware that Susan's anger is a form of strength and stems from her resistance to confining societal norms. For this reason, Chandra does not want to take Susan's anger away; it is a valid and healthy emotion. Susan and Chandra role play situations in which Susan is likely to be nonassertive as well as those in which she is prone to anger.

Bibliotherapy

Feminist counselors often suggest books for their clients to read, depending on their interests and goals. Although some resources may be skills based, others are concerned with raising awareness of power, privilege, oppression, and inequalities. Feminist perspectives on issues particularly linked to women's experiences, such as eating disorders, domestic violence, rape, incest, and sexual harassment, may help reduce self-blame (Remer, 2013).

Chandra considers books that might be helpful to Susan. After some thought she decides to offer her copy of The Dance of Anger *(Lerner, 1985).*

EVALUATION OF THE THEORY

Criticisms of FT come from both within and outside of the women's movement. Most of you are probably familiar with the so-called backlash against feminism: Feminists are man-haters engaged in male bashing. FT can also be criticized for being a political stance rather than a theory of therapy. The inherent stance of feminism to expose and fight social injustice leads some to accuse feminist therapists of imposing their own values on clients (Remer, 2013). The diversity of views within FT leads to the charge that it is not clear what FT actually is, beyond a set of beliefs.

Radical feminists reject FT because *any* kind of therapy is a tool of the patriarchal, oppressive society (Chesler, 1972). Cultural feminists charge that FT is based on the experiences of White, middle-class women and therefore neglects discrimination and disempowerment based on race, social class, sexual orientation, and other factors (Alleyne, 1998). However, current versions of feminism take these influences into account.

QUALITIES OF THE THEORY

Precision and Testability. Although FT is not very testable in terms of a theory of human behavior, it does rely on volumes of research on sex roles and gender issues. Aspects of FT can and have been operationalized, such as assertiveness training, gender-role analysis, and therapist self-disclosure. However, some of these activities are not unique to FT.

Empirical Validity. Outcome research on FT as a counseling approach is sparse. The basic tenets of the approach, such as sex-role issues and socialization, are empirically supported.

RESEARCH SUPPORT

Very little research has been conducted on the actual practice or outcome of FT. Because of FT's philosophical basis and tendency to be technically eclectic, it is difficult for proponents to agree on what exactly constitutes the theory of FT. This situation, of course, is a major factor in the lack of research bearing directly on the theory and practice of FT (Murray, 2006). As a result, I will present a broad selection of research relevant to the FT approach, and in doing so I will dispense with my usual distinction between outcome and theory-testing research.

One relatively recent study tested the effectiveness of group FT for clients who had experienced sexual abuse (Hébert & Bergeron, 2007). Forty-one women participated in the group intervention; 11 women served as wait-list controls. At the end of 15–17 weeks of treatment, women in the treatment group showed fewer symptoms of psychological distress than the wait-list women, and these results were also seen at a 3-month follow-up.

Some of its proponents would argue that FT is not unique—it is simply good therapy (Worell & Johnson, 2001). Nonetheless, Worell and Johnson (2001) maintained that FT is an identifiable approach, basing their arguments on a series of survey studies of therapists and clients. Using an instrument called the Therapy with Women Scale (based on the principles in Box 12.2), differences in philosophy and goals between feminist and nonfeminist therapists can be documented (Worell & Johnson, 2001). Important factors underlying these differences were (a) affirmation of the client, (b) women-centered activism, (c) the use of self-disclosure, (d) adoption of a gender-role perspective, and (e) an egalitarian stance. In contrast, Andrea Chester and Diane Bretherton (2001) found less agreement about the essential elements of FT in their sample of Australian feminist therapists. In their research, the largest area of agreement was that FT involved woman-centered concerns (e.g., sociopolitical analysis of problems, understanding sex-role stereotypes, critique of the patriarchy), with 85% of their sample listing these issues as essential to FT.

Jill Rader and Lucia Albino Gilbert (2005) attempted to test whether counselors who self-identified as feminist exemplified their orientations in terms of egalitarianism, here defined as power sharing and collaboration. Forty-two female therapists were recruited, and 34 clients of these therapists participated as well (some of the clients recruited did not return their materials). Nineteen of the therapists identified themselves as feminists; interestingly, when clients were asked if their therapists were feminists, their identifications matched their therapists' about 50% of the time. The study confirmed the centrality of egalitarianism to FT: power sharing was reported more frequently by therapists identifying as feminist and also by the clients of these therapists when compared to therapists who did not identify as feminist. Another interesting aspect of this study was that when all of the therapists were asked if they used the behaviors considered characteristic of FT (similar to those identified in Box 12.2), no differences were

found between the groups of therapists, mainly because all of them reported that they consistently acted in those ways with their clients.

Studies of FIDT indirectly address FT because it is often used as the basis for thinking about women in counseling. Several measures of FIDT have been developed, but unfortunately, although some psychometric data on these scales are supportive, other data do not confirm the proposed stage structure built into the instruments (Fischer & DeBord, 2013; Moradi & Subich, 2002a). Given the measurement problems, the results of FIDT studies should be viewed cautiously.

One study related to the FT behaviors of women psychotherapists (Juntunen, Atkinson, Reyes, & Gutierrez, 1994) found that the revelation stage attitudes were the best predictor of whether a therapist self-identified as a feminist therapist. Further, therapists who had high scores on synthesis and revelation attitudes and low scores on passive acceptance endorsed more FT behaviors than did those with the opposite pattern.

Is the FIDT model relevant for the young women of today? A relatively recent study asked that question (Erchull et al., 2009), finding that synthesis seems to be where young women now start their journeys rather than at the earlier stages of development. Miriam Liss and Mindy Erchull (2010) tested whether synthesis attitudes were related to adopting the label of "feminist" among undergraduate students, as would be predicted by FIDT theory. Their results were contrary to theory: Self-identifying as a feminist was not related to synthesis scores; in fact, women with higher synthesis scores were likely to believe that the current gender system was just (Liss & Erchull, 2010, p. 85).

Studies of feminist identity development and psychological distress have produced inconsistent results. For instance, Bonnie Moradi and Linda Mezydlo Subich (2002b) looked at the relationships among the stage of feminist identity development, experience with sexist events, and psychological symptoms. Passive acceptance attitudes, which these researchers conceptualized as evidence that the participant was denying the existence of sexism, were related to greater occurrence of symptoms, given the occurrence of sexist events over the past year, which would be consistent with FT theory. Natalie Sabik and Tracy Tylka (2006) also examined the relations between FIDT and perceived sexist events, but they were interested in dysfunctional eating patterns. Synthesis and active commitment attitudes buffered the effects of experiencing sexist events; that is, women lower on these scales tended to score high on disordered eating if they had experienced sexist events, whereas women higher on these scales showed lower disordered eating. Generally, these results are supportive of FT theory, although other relationships that were predicted by the theory did not emerge.

Ann Fischer and Glen Good (2004) studied FIDT, anger, and psychological symptoms and found that only the identity stage of revelation related to symptoms. Anger was associated with revelation attitudes, but not with the other FIDT stages and, except for revelation, did not explain the relationship between FIDT and distress, contrary to Fischer and Good's expectations. However, the authors noted that the anger measured was general, not specific to the patriarchy or other relevant targets. Kendra Saunders and Susan Kashubeck-West (2006) found that feminist identity was related to self-reported psychological well-being: active commitment positively and revelation negatively. That is, women who scored higher on active commitment reported higher levels of well-being than women lower on this dimension, and women higher on revelation reported lower levels of psychological well-being compared to women lower on revelation attitudes.

Oksana Yakushko (2007) took a broader perspective when she performed a cluster analysis of items typically used to measure FIDT, finding that women's responses tended to fall into three groups: women with feminist views, women with moderate values, and women with

traditional values. She also examined the relations between membership in these groups and subjective well-being. Overall, women in the traditional values cluster reported significantly lower well-being scores than women falling into the other two clusters.

In a qualitative study, Kathleen Baird, Dawn Szymanski, and Sara Ruebelt (2007) interviewed 12 men who identified themselves as feminist therapists. Experiences with feminist women—for example, through personal relationships or in training—were common to these men along with feelings of professional isolation. They were also aware of their privileged status as males in the U.S. culture and reported experiencing life events that had increased their awareness of sexism and challenged traditional roles for the sexes.

Rachel Peterson, Stacey Tantleff-Dunn, and Jeffrey Bedwell (2006) tested whether teaching female college students' feminist views on body image could affect their levels of body satisfaction and feminist identity. Participants were pretested by being exposed to a 15-minute audiotape of traditional psychoeducation about body image, a feminist intervention, or no intervention, and then post-tested. No effects of treatment were observed on body image dissatisfaction, but the feminist intervention did appear to create change in satisfaction with appearance (without going into tedious detail, these two measures were different in content and form). Although participants receiving the feminist intervention showed increased self-identification as feminists when compared to the other two groups, only one effect of the intervention was observed for feminist identity: contrary to hypothesis, the active commitment scores of the participants in the feminist intervention group decreased. Peterson et al. speculated that simply completing the FIDT may have made them realize how inactive they really were, thus causing a decline in the scores at post-test.

Before you read the next paragraph, look at Box 12.5.

Box 12.5

Consider the following adjectives:

Independent

Assertive

Strong

Confident

Do these words describe a male or a female? Are they healthy qualities or not?
Here are some more words to consider:

Passive

Easily excited by minor events

Dependent

Cautious

Ask yourself what picture came to mind as you read these words.
These are some of the adjectives presented in the famous study of sexism among counselors conducted by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970).

Some research has focused on whether counselors are sexist. The "grandmother" of this line of investigation is a study conducted by Inge Broverman et al. (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). They asked practicing therapists to describe a healthy man, a healthy woman, and a healthy person, sex unspecified. To the horror of many, they found that the qualities of the healthy person most resembled the qualities of the healthy male. Healthy women were rated lower on qualities such as independence, adventurousness, aggression, and competitiveness than were men. In addition, healthy women were seen as easier to influence, more excitable, and submissive in comparison to men. As you might guess, this study incited great controversy.

Broverman et al.'s study has been criticized for a number of reasons (Phillips & Gilroy, 1985; Widiger & Settle, 1987). On a most basic level, the study could be faulted because the counselor participants were rating hypothetical individuals, not responding to "real" clients. Also, Widiger and Settle (1987) provided convincing evidence that the findings of Broverman et al. could be almost entirely attributed to characteristics of the method used. Subsequent studies have been inconsistent in their findings and are now somewhat dated. Since *overt* sexism in society is thought to be decreasing (Etaugh & Bridges, 2010), it would seem that counselors would be unlikely to respond in sexist ways to research stimuli. Whether this evenhandedness is a result of a true change in attitudes or "underground sexism" is up for debate.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

It would seem obvious that FT is a good approach to use with women. However, some radical feminists would object to using a liberal FT approach because they would see it as upholding the patriarchal status quo. A major bedrock of early FT, assertiveness training, for example, has been criticized as based on a model that views stereotypically female behavior as deficient (Fodor, 1985).

FT is grounded in sensitivity to oppression, so it can be considered very appropriate for use with individuals from diverse backgrounds. Earlier versions of FT, based on White, middle-class experience, have been accused of racism, but contemporary feminist therapists recognize the influence of other important dimensions, such as class, age, ableness, sexual orientation, and race/ethnicity, on people's experiences (L. S. Brown, Riepe, & Coffey, 2005). Feminism recognizes the heteropatriarchy, and lesbian feminism is an alternative for women who are lesbian. Indeed, feminist scholars have always attended to issues relevant in theory and practice with lesbian and bisexual women (L. S. Brown et al., 2005). However it is difficult to find discussion of the issues of gay men in the FT literature or those of individuals from transgender or male bisexual orientations. Increasing attention to issues of diversity have resulted in explorations of the implications of feminism for African-American (W. S. Williams, 2015), Latina (Díaz-Lázaro, Verdinelli, & Cohen, 2012; Gonzáles, Castañada-Sound, & Navarro, 2015), biracial (Nishimura, 2004), Muslim (S. R. Ali, 2009), and Japanese (Machizawa & Enns, 2015) clients, among others.

The question always arises about the appropriateness of FT for male clients. Laura Brown (2010) acknowledged that, although historically FT was for women only, nowadays "feminist therapy is practiced by people of all genders, with every possible type and configuration of client" (p. 6). Andraé Brown (2008), for example, writes convincingly of his journey to become a Black male feminist family therapist. Laurie Mintz and David Tager (2013) examined the

intersection of feminist scholarship with the study of men and masculinity, pronouncing that "feminist therapy is an excellent therapeutic modality for doing psychotherapy with men" (p. 322). Analyzing the influences of power, gender, and social location is just as relevant for men as it is for women, although the restrictions imposed on men are sometimes harder to see because of the power traditionally bestowed upon men.

These observations, along with the recognition that men experience significant gender-role conflict, have prompted the development of gender-aware or gender-sensitive therapy (Philpot et al., 1997; Wester & Lyubelsky, 2005). These approaches integrate feminist principles with a broad examination of gender. Men in gender-aware therapy are encouraged to explore the ramifications of traditional male roles, develop their interpersonal skills, and decrease their emphasis on career and work aspects of identity.

THE CASE STUDY

Susan seems to be an ideal client for FT. She is engaged in the pursuit of a traditionally male-dominated career. However, the adoption of this career goal may be partly a result of the norm of Asian culture that values scholastic achievement above all. Susan reports relationship difficulties that seem to involve both extreme expressions of femininity and violations of the cultural norms that women should not be angry or aggressive. These characteristics would predict a good fit with FT. She has also been the victim of abuse, an injustice that lies at the heart of the feminist movement.

Susan's Asian heritage raises questions about applying FT. If her adoptive mother heavily reinforced the "proper" characteristics of women in the Asian culture, ignoring this influence would be a serious mistake. The goals of empowerment and liberation may be in conflict with Susan's culturally linked values. However, in other ways Susan seems to be fairly acculturated to the United States if the adoption of her nontraditional career goal is any indication.

Summary

FT seems more of a philosophical approach to working with clients than a defined theoretical structure. Feminist therapists are attentive to the norms of society that confer power and status on men and oppress women and individuals from diverse backgrounds. The social pressure to conform to stereotypical notions of what it means to be a man or woman is seen as an important influence on how people behave. Feminist therapists also recognize the effects of social class, race/ethnicity, ableness, and sexual orientation on individuals' lives; individuals who are not of the "majority" on these dimensions are subject to oppression by society.

Feminist counselors believe that the personal is political and that women's (and other oppressed groups') struggles are the result of societal structures and norms that are disparaging of women and celebratory of men. The norm for "healthy person" is based on stereotypically male qualities (e.g., rational, independent, and so forth), whereas traditionally female qualities (e.g., emotionality and connectedness) are seen as less valuable. Women are damned if they do and damned if they don't—social penalties are imposed for expressions of female traits and masculine traits by women.

Feminist therapists approach counseling with an egalitarian attitude, recognizing that true equality will not exist in the therapy relationship. They attempt to recognize and minimize

power imbalances in therapy by forming therapy contracts and demystifying the therapy process. The goal of FT is empowering the client so that she can achieve her life goals. Few techniques are specific to FT, although one very closely tied to this approach is the analysis of social roles.

FT has been criticized for being anti-male and for being a political stance rather than a theoretical system. Radical feminists may totally reject any form of counseling, even FT. Because of the emphasis within FT on societal power imbalances and oppression, it is likely to be a valuable approach for individuals who are of diverse backgrounds.

MyCounselingLab

Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy*, Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 6.

CHAPTER 13

Family Systems Theory



Virginia Satir

Jean and Derril, mother and son, come to counseling because Jean is concerned about Derril's angry behavior. Jean is African-American, and Derril is of multiracial heritage; his father is White. Derril, age 12, is Jean's only son with his father, Al, but she has a daughter from a previous relationship who is 20 years old and married with children. Jean is 42 years old, currently single, and not dating anyone.

Jean and Al, Derril's father, were married for about 6 years. They divorced 2 years ago. Last year Al moved in with a woman who has three children. Derril lives with his mother, but spends Sunday mornings at church with his father. He reports having no real desire to see his father and says that he does not get along with his father's girlfriend or her kids. Jean and Al divorced because of severe relationship conflict, which often resulted in Al physically abusing Jean. On several occasions, Derril attempted to interrupt the abuse. Currently, Jean and Al are on speaking terms but do not appear to get along well. She reports feeling uncomfortable if she is alone with Al.

Jean has a bachelor's degree in business and works as an administrator in a government agency. Her family lives in the immediate vicinity, and although they used to spend a lot of time together, they recently have not done so. Jean says she has few friends. She does not spend much time with her daughter, although Derril sometimes stays the night with the daughter and her children. Both Jean and Derril report that they spend much of their time together.

Derril's behavior became increasingly troublesome, according to Jean, after his father moved in with his girlfriend. The incident that actually brought Jean and Derril into counseling involved an altercation with a security guard at school. Derril reportedly was "talking back" to the officer and became more and more angry as the guard "got in his face." The security guard eventually shoved Derril against a locker. As a result of this incident, Derril was suspended from school for 10 days.

More recently, Derril's problematic behavior appears to have become less severe, but something seems to happen about every other week. For example, Jean reported that Derril was expelled from the extended day program at school because he slapped a boy who was "talking about his mama." Jean says that she is not sure how to handle such behavior and that she is afraid of the way her son treats women and adults. She says that Derril has no respect for his elders and that she has been unable to find any way to change his behavior.

BACKGROUND

At first glance, it might seem a little strange to include a chapter on family systems (FS) theory in a book otherwise devoted to theories focused primarily on individuals. Even if it weren't my favorite set of theories, though, I'd still include this chapter for several reasons. First, FS theory is considered one of the major schools of counseling and psychotherapy. Second, an FS approach can be used with individual clients; FS theorists believe that they can best understand the individual through understanding his experiences as a member of the family. Opinions vary as to whether having the entire family in session is necessary to do effective FS therapy, though.

I will review four major approaches to FS intervention in this chapter: structural, strategic, the family systems theory of Murray Bowen, and the existential/humanistic approach of Virginia Satir. There are others, including the recent additions of the constructivist theories, such as the solution-focused and narrative approaches, which are described in Chapters 14 and 15. Nichols (2014) classified these latter two approaches as the wave of the future. However, he also acknowledged that family therapists readily borrow from various approaches. I have chosen to present the four approaches in this chapter because they are the historical bedrocks of FS theory and still influence many counselors today. In this chapter, I will describe the "classic" versions of these approaches for the most part. However, most therapists probably draw from one or more of these approaches in their day-to-day work, integrating these ideas in a social constructivist framework. Because there is much to cover in the four approaches I have chosen, I will use an abbreviated form of the structure similar to what I used to present the neoanalytic theories in Chapter 3.

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Video Example 13.1 Watch Dr. Paul Anderson do FS therapy with Helen.



A detailed history of family therapy and FS theory is beyond the scope of this chapter. Interested readers should consult Nichols (2014) or P. J. Guerin and Chabot (1995). A fascinating read is Simon's (1992) book *One on One*, which reprints interviews with the leaders of the family therapy movement, including Jay Haley, Cloé Madanes, Salvador Minuchin, and Virginia Satir.

The professional community in family therapy is very active. Not all family counselors are FS advocates, but I think it is safe to say that the majority probably incorporate some knowledge of systems in their work. More so than advocates of other theoretical perspectives, it seems, FS therapists have a wide variety of professional affiliations. They may identify themselves as psychologists, professional counselors, social workers, or simply couples/family therapists. One of the major organizations for FS adherents is the American Association for Marriage and Family Therapy (AAMFT), which can be found at www.aamft.org. AAMFT publishes the *Journal of Marital and Family Therapy* and *Family Therapy Magazine*. Division 43 of the American Psychological Association (APA) is the Society for Couple and Family Psychology, and it publishes a newsletter, *The Family Psychologist*, and has an official APA journal, *Couple and Family Psychology: Research and Practice*. Perhaps the most prestigious FS journal is *Family Process*, founded in 1967. The first editor of *Family Process* was Jay Haley, and the board of directors of the Family Process Institute, which publishes the journal, reads like an FS who's who, including Peggy Papp, Salvador Minuchin, Virginia Satir, Don Jackson, and Gregory Bateson, among others. Murray Bowen was the first president of the American Family Therapy Academy, an organization of

teachers, researchers, and practitioners devoted to FS issues. This organization can be found at www.afta.org.

Before I begin my description of the four FS approaches, I will highlight some important ideas shared by FS theorists. First and foremost is the conceptualization of the *family as a system*. From this perspective, a family is seen as a system defined as a group of interrelated people "*plus the way they function together*" (Nichols, 2014, p. 259; my emphasis). FS theorists are adamant that the best way to approach helping individuals is to see them in context, as a part of a larger system, and they tend to focus on the relationships among individuals who are members of the system (Becvar & Becvar, 2013).

For FS theorists the family is interconnected, and influences on one part of the system will affect other parts. The image of a mobile is helpful to illustrate this idea. Imagine that you have a mobile that consists of two sailboats, three speedboats, and a cruise ship. All of the elements of the mobile are connected by a common supporting structure from which they hang. If you touch one of the sailboats, it floats in the direction of the cruise ship, which also moves. At the same time, your touching the sailboat causes the speedboats to chase the sailboat. Much like the mobile, argue FS theorists, moving one member of a family in any way will create movement in other parts of the system. Also note that there is no clear start or finish to the sequence of movements in the mobile—the cruise ship is not leading the sailboats; it could just as easily seem to be pursuing the speedboats. Note also that factors other than your fingers can influence this system's elements individually and as a group, and that the influence of other factors (such as the social context of the system) can differentially influence its elements. For instance, a sharp breeze might cause all of the boats to move, but the sailboats might be more responsive than the cruise ship. Also, note what happens when a jet ski is added or a sailboat drops off.

Consider this common situation from the human sphere: When a child is acting out, we often observe that on the surface the parents are calm and intent on helping their child. If the child is "fixed," however, all of the sudden the parents begin to have serious battles. In FS terms, one of two things is happening here: The friction between the parents is either diffused by or channeled into the acting-out kid. When the pressure is released by the disappearance of the symptom, the conflict between the parents becomes clear.

Most families present with an individual who has been labeled by them as the "one with the problem." Because systems theorists resist the idea of problems within individuals, most FS therapists call this person the *identified patient* (IP).

Systems thinking leads to the attitude that the causes of a given behavior or problem are irrelevant because the system is an interlocking chain of events. Designating one event as causal to another is silly; doing so is kind of like asking whether the chicken or the egg came first. Systems theorists use the term *circular causality* to describe this view of interaction. Contrast this circular view with a typical linear view of behavior A (of the IP) *causing* behavior B (parent's rage, grief, etc.). For example, Amy, an adolescent girl, likes to dress in a style reminiscent of Miley Cyrus (or Cher, for you older folks). Her mom shrieks that Amy looks horrible in these clothes. Does Amy back down and wear golf shirts and khaki pants? Of course not. She continues to favor her usual provocative things and even manages to acquire more extreme examples or perhaps threatens to shave her head. Mom yells more, and so on. Did Amy cause Mom's yelling in the first place? Unlikely, say the systems theorists. Mom's focus on Amy may have been influential in her attempts to individuate by dressing like her peers. In this simple case, it is clearly difficult to say who caused what, and that is the point that the systems

theorists want you to get. For this reason, FS therapists are usually more interested in the *process*, or how things happen in a family, than the *content* (the what) of the happenings (Becvar & Becvar, 2013).

Systems can be open or closed (Nichols, 2014). Open systems are those in which the parts are interactive and information flows into and out of the system easily. Closed systems don't allow information in or out, and this impermeability leads to rigidity and thus the inability to change and adjust with the environment.

Another important quality of systems that FS theorists emphasize is homeostasis—that is, the idea that systems tend to self-regulate and are therefore resistant to change. Even more important, this view implies that, if you change one member in isolation, when he returns to the system the system will attempt to get him to change back. Nichols (2014) suggested that early in the history of systems theory this tendency was overemphasized, causing theorists and therapists to overlook the inherent flexibility and growth displayed by families.

THE SATIR APPROACH

OVERVIEW

Although most refer to this orientation as the Satir approach, Satir herself called her system the human validation process model. Virginia Satir (1916–1988) began her career as a family therapist when she enrolled in the master's degree program at the School of Social Service Administration at the University of Chicago in 1941 (McLendon & Davis, 2002). One of the original group of researchers at the Mental Research Institute (MRI) when it began in 1959, Satir published her influential book *Conjoint Family Therapy* in 1967. Prior to her move to MRI, she had been seeing families in independent practice and then directed the formation of a family therapy training program at the Illinois State Psychiatric Institute (Nichols, 2013). It is an interesting tidbit that she had also been reading the works of Murray Bowen and had met him in 1958 (Brothers, 2000).

Satir left MRI formally in 1964. For quite some time she had been involved in the interesting things going on at the Esalen Institute in Big Sur, California, then one of the hotbeds of the human potential movement (W. T. Anderson, 2004; McLendon & Davis, 2002). Many leaders of the movement came through Esalen at that time, including Fritz Perls. As a result, Satir's ideas became more experiential and humanistic than those of the other family therapy schools, and she incorporated attention to emotional and physical experience into her work. Satir emphasized that people are unique and that "contact with the self and the other was a sacred, spiritual event" (Haber, 2002, p. 23).

From a professional/theoretical standpoint, Satir's ideas became less influential in the 1970s, and she eventually moved away from the family therapy profession (Nichols & Schwartz, 2001). A pivotal public debate in 1974 truly seemed to alienate Satir from mainstream family therapy. During this debate, Salvador Minuchin criticized her humanistic stance. Nichols and Schwartz (2001) summarized it this way:

> Minuchin argued that [family therapy] was a science that required skills rather than just warmth and faith, and that the main job was to fix broken families. Satir stuck to her belief in the healing power of love, and spoke out for the salvation of humankind through family therapy. It turned out that Minuchin was speaking for the field. (pp. 174–175)

According to Gurman and Fraenkel (2002), Satir felt "unappreciated and marginalized by the newer waves of (male) family systems engineers" (p. 215).

Satir was renowned as a therapist adept at moving large groups while demonstrating her work. Her 1972 book *Peoplemaking*, according to McLendon and Davis (2002), "became a household guide to healthy family living" (p. 177). Satir was as naturally charismatic as Minuchin, and that is really saying something.

In 1977, Satir created Avanta, an educational organization, now international in scope and currently called the Virginia Satir Global Network (http://satirglobal.org). In 2006, the Satir Institute of the Pacific (http://satirpacific.org) launched *The Satir Journal: Transformational Systemic Therapy*.

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Video Example 13.2 Watch Virginia Satir in action.



https://www.youtube.com/watch?v=hLfaNQF7trs

CENTRAL CONSTRUCTS

Self-Esteem. The cornerstone of Satir's approach is self-esteem or self-worth. Self-esteem is defined as the degree to which the individual values himself regardless of the opinions of others (Satir & Baldwin, 1983). Loving the self is a precondition for loving others (Satir, 1988).

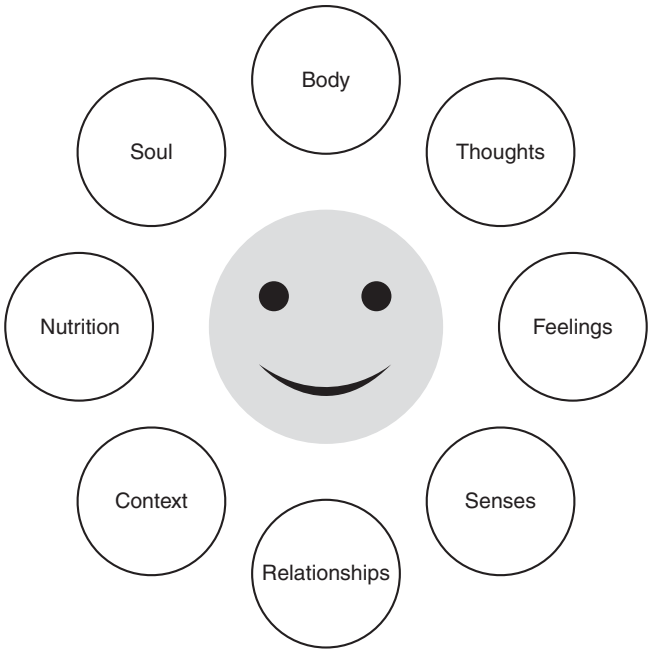
Low self-esteem is thought to be catching. Satir and Baldwin (1983) asserted that "often a person with low self-esteem selects to marry another person with low self-esteem. Their relationship is based on a disregard of inner feelings, and any stress tends to augment their feelings of low self-esteem. Children growing up in that environment usually have low self-worth" (p. 195).

One's level of self-esteem is a product of early family experience. Parents who have good self-esteem are able to teach what they already know (Satir, 1988). Parents who have shaky senses of self-worth cannot teach what they don't have. However, people can learn self-esteem even as an adult if they are willing.

For Satir, self-esteem resides in the acknowledgment of the uniqueness and worth of each individual. She wrote, "You are a member of the human race, and as such, *you are a miracle*. Furthermore, you are a one of a kind miracle" (2009, p. x; emphasis in original).

Alice considers herself to be a proponent of Satir's approach. As she begins her relationship with Derril and Jean, she assumes that they are unique individuals with great potential. Because they are experiencing life difficulties, she suspects that both of them have low self-esteem. Likely Jean and Al have difficulty talking about their own feelings and respecting those of others. It appears to Alice that Derril has learned some of this orientation from his parents.

Self Mandala. Satir used the idea of a mandala (in this case a concentric set of rings) to illustrate her view that human essence has eight aspects: the body, thoughts, feelings, senses, relationships, context, nutrition, and soul (Satir, 1988). None of these parts functions independently. Attention to each of these spheres is critical for individuals' health, both psychological and physiological.



Alice sees her clients as multifaceted. In this case, she notes that Derril and Jean are very preoccupied with thoughts and feelings and seem to neglect attention to other important areas of the self. She thinks that it might help Derril and Jean to focus on body, senses, context, nutrition, and soul. Clearly, their relationship is in need of attention.

Communication. For Satir (1967), the process and outcome of communication are critical to family life. We must be able to communicate with others to survive. Functional communication is clear, complete, and assertive. Congruent communication refers to communication in which verbal and nonverbal messages match; in incongruent communications, they don't (Brothers, 2000). Metacommunication (i.e., communication about communication) can affirm or disqualify a message and often conveys something about the relationship between interactants.

At the most basic level, a communication between two individuals is a request for validation of one by the other. If Tammy's supervisor is acting unpredictably, Tammy wants me, her friend, to validate her experience by saying, "That woman is impossible!"

When individuals are stressed, they usually resort to one of four problematic patterns of communication, or survival stances (Satir, 1972; Satir, Banmen, Gerber, & Gomori, 1991): *placating, blaming, computing*, and *being irrelevant*. These are also called *survival coping stances*, to emphasize that the individual is only trying to do the best she can when faced with difficult circumstances (Banmen & Maki-Banmen, 2014). In all cases, these stances are the product of low self-esteem and are attempts to cover up vulnerability. All of us usually can communicate in these modes, but we frequently have a preferred stance (Satir & Baldwin, 1983).

The *placator* is the "yes person," the one who is always trying to get others to approve of him. He ingratiates and apologizes. He communicates in whiny tones. To experience this stance, Satir recommended that you get down on one knee, stretch one hand out in begging fashion, and stretch your neck and head upward.

The *blamer* is the bossy dictator. She has a loud, shrill voice and is tense and tight. The stance of the blamer is one hand on hip with the other forming the pointing finger.

The *computer* analyzes everything and shows very little feeling about anything. Sometimes referred to as the "superreasonable" (Brothers, 2000), this person is sensible and rational but distant and cool to others. Physically, the computer is stiff and still, as though she has a long metal rod running from the base of the spine to the nape of the neck.

In *being irrelevant*, the person seems to pay no attention to others or context. Also known as *distractors*, these folks are the buzzbrains of the world. They divert attention from topics of conversation, are constantly in motion, and are always multitasking. The image of the irrelevant one is someone twisted and twitching or a lopsided top spinning randomly (Satir, 1967; Satir et al., 1991).

The healthy person, contended Satir, operates from the stance of *leveling*. This person communicates coherently, and body, words, and vocal tone all fit together. Another term that Satir used for healthy communication is *congruent*. One who is congruent and who levels has high self-esteem and thus has no need to hide; communication is free and honest. Of all of the stances, "only the leveling one has any chance to heal ruptures, break impasses, or build bridges between people" (Satir, 1972, p. 73).

Alice watches Jean and Derril interact in the counseling session. It seems clear to Alice that Jean and Derril are taking blaming stances in their interactions a lot of the time. In talking with Jean, Alice decides that Jean and Al probably take this stance in relation to each other as well. However, every now and then Alice observes authentic, caring interchanges between Jean and Derril, signs of the very real connection that sustains both of them.

Alice senses many messages in the communication that she observes between Jean and Derril. Jean tells Derril to respect others with a very bossy tone of voice that is not respectful to him. Derril says he wants to act like a grown man, but something in the way he says this conveys that he is not really convinced that he can.

Primary Triad. The concept of the triangle is an important one in all FS theories. A triangle is any grouping of three family members or, for that matter, any three people. Satir labels the mother–father–child triangle the *primary triad*, and this relationship is the most important influence on an individual's life functioning (Satir et al., 1991). Children learn from the primary triad how to cope with the world, the nature of relationships (whether one can trust others), and how to understand communication.

Inconsistencies in communication (i.e., discrepancies between verbal and nonverbal channels) are inevitable in the family, and how children interpret these is an important form of early learning. For example, if Mom comes home from work mad, she may say nothing's wrong. Little Kevin, however, picks up on the nonverbal message of anger. If the confused kid mistakenly thinks Mom's anger is his fault, his self-worth is likely to be undermined. According to Satir, it would be better for Mom to simply explain that she had a rotten day at work and that her boss is a jerk.

It is the nature of triangles that one person often feels excluded from the relationship of the other two. How the child interprets the occasional exclusion from the parental dyad is critical. If Mary believes that she is being rejected, she is likely to develop low self-worth.

The child's ideas about personal power are also formed in relation to the primary triad (Satir & Baldwin, 1983). Parental interactions demonstrate power operations. Also, kids often learn that they can persuade one parent to take their side against the other parent. This pattern is often seen when one parent disciplines the child and the other breaks in to rescue him.

Satir emphasized that, although many theories of family life seem to promote the negative aspects of the triangle, it is important to remember that the power of the triangle can be positive, too (Satir & Baldwin, 1983). Much support can be gained from the three-person configuration. If the three parties in the triad have good self-esteem, they can work together to use the resources in the relationships.

Alice concludes that the primary triad is critical in understanding Jean, Derril, and Al. Derril learned much about relationships from watching Jean and Al—mostly that blaming and arguing are what relationships are made of. Power is often expressed in verbal interaction, and occasionally physical force is used.

Alice wonders if Derril felt excluded by his parents. It is hard to be in contact with two people who are alternating between fighting and the silent treatment. There are also some signs that Derril is caught between his mother and father in that Jean seems to want Derril to side with her against Al. Derril admits that his parents' physical confrontations frightened him very much. He would try to yell at them to stop until the one day he intervened and prevented his father from hitting his mother.

Alice guesses that Derril's response to the years of exposure to this triangle has affected his relationship with both parents and his self-esteem. He has learned that the most powerful communications are ones that are shouted and angry and that physical force bolsters verbal anger. Derril has also learned that to have influence with others (and thus to be worthwhile), one presents a noisy, blaming front rather than communicating in an authentic leveling way.

Family Rules. The rules by which a family operates can be overt or covert. For example, the overt rule for Debbie's bedtime is 8:00. The covert rule might be that she could stretch it to 8:30 by whining a lot. More serious examples of covert rules are found in troubled families, such as when there is a rule not to speak of Auntie Mame's drinking.

Rules should be doable or, as Satir put it, "humanly possible" (Satir & Baldwin, 1983, p. 202). She gave the example of a rule that members must *always* be happy. Abiding by this rule is clearly impossible and leads members to conceal their feelings, resulting in isolation and emotional distance. In addition, if one is not happy, one is bad and disobedient; this assessment can lead to low self-esteem.

Flexibility and age appropriateness are also important to family rules. As children grow, families must adjust the rules to match. For instance, a bedtime of 7:00 P.M. might be OK for a 5-year-old, but would be silly for a 12-year-old.

Rules should allow for diversity among members' ways of operating in the world and also should allow members to share information freely. Family secrets are a no-no in the Satir approach. Feelings and opinions should also be accepted, including the expression of intimacy and anger (Satir & Baldwin, 1983).

The rules in Derril's family are not immediately evident to Alice, except that anger is power, but dangerous. Jean struggles to teach Derril not to express anger, yet she often does so herself in relationship to Derril and clearly did so with Al. When Jean or Derril expresses anger, it is in a volatile rather than a leveling manner, and it gets them into trouble.

The rules around Derril's role in the family seem unclear or, at the least, inconsistent. He is asked to take a lot of responsibility in the home and is assigned many household tasks (e.g., cleaning, laundry, taking out the garbage, and mowing the lawn). He also feels free to comment on his mother's appearance, critiquing her clothing choices on a daily basis.

On the other hand, Jean seems at times to treat Derril as younger than he is. She keeps him close to her, much as one would an 8-year-old child. She addresses him more as a child than as a young man entering adolescence.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Satir proposed no formal theory of personality or personality development. She did see life as a journey, describing five basic life stages: conception to birth, birth to puberty, puberty to adulthood, adulthood to senior status, and senior status to death (1988, p. 306).

Families are the crucibles of individuals. According to Satir, adults are "people makers" (1972, p. 3) and the parents are "the architects of the family" (1988, p. 141). Four dimensions of family are important: the individual self-esteem of the members, communication patterns, the rules of the family, and the family's relation to society (Satir, 1972).

Seven dimensions or processes are essential to becoming fully human: differentiation (distinguishing between self and others), relationships (knowing how to connect with self and others), autonomy (knowing how to rely on self), self-esteem (feeling worthwhile), power (using personal power to direct one's own behavior), productivity (demonstrating competence), and loving (Satir, 1988, p. 307). Satir particularly emphasized the human need for love, saying, "I believe in love—in loving and in being loved. I think that love, including sexual love, is the most rewarding and fulfilling feeling any human being can experience. Without loving and being loved, the human soul and spirit curdle and die" (1988, p. 141).

Alice has assessed this family's self-esteem, communication, and rules. She would describe Jean and Derril's relationship to society as guarded and protective. She thinks that Derril and Jean are both facing growth in the areas of differentiation and relationships. Derril is learning how to be autonomous and to find his personal power. It is clear that these two share a deep connection and love for each other, but that sometimes it is hard to express.

HEALTH AND DYSFUNCTION

Satir, because she was a humanist, had lots of positive things to say about healthy human beings. In her view, "All human beings carry with them all the resources they need to flourish" (Satir & Baldwin, 1983, p. 208). Behavior is motivated by good intentions and represents the best that the individual knows (Woods & Martin, 1984). Brothers (2000) wrote of Satir: "Utterly convinced that no evil people exist, she was passionately devoted to showing how the 'evil'—the destructiveness—lay, instead, in the process between people" (p. 5; quotes in original).

The healthy person is open and honest with self and others, takes risks and is creative, and can change and accommodate to new situations (Satir, 1972). Playful, loving, and authentic, the healthy person stands on his own and can "love deeply and fight fairly" (Satir, 1972, p. 3). As described earlier, self-worth is very prominent in Satir's view of people. Satir et al. (1991) pointed to congruence and high self-esteem as major indicators of psychological health.

In the healthy, or nurturing, family, communication is open, individual self-worth is strong, and rules are flexible and humane and can change if appropriate. For the most part, communication is congruent, although Satir recognized that nobody, no family, is perfect (Satir, 1975). Further, the healthy family's connection to society is open and hopeful (Satir, 1972, p. 4).

Just the opposite is true in dysfunctional or troubled families. Communication is fuzzy, and self-esteem is low. These families are fearful in relationship to society and can be blaming or placating in response. Family rules tend to be set in stone and inhumane. Family members are not friends.

In Satir's system, symptoms are signs that communication is faulty or rules are dysfunctional, and these things are blocking the growth of one or more family members (Satir & Baldwin, 1983). When individuals are stressed beyond their capacities, they become fearful and develop primitive methods of survival that are their best attempts to cope (Haber, 2002). That is why Satir said that the problem is not the problem; coping is the problem (cited in Haber, 2002, p. 28). Many of these coping strategies stem from early childhood experiences and are carried into adulthood because we are not fully aware of them (Banmen & Maki-Banmen, 2014).

Alice thinks that Derril is doing his best to grow, to differentiate from his mother and become an adult. At the same time, Jean is struggling to be the best parent that she can. These two are having great difficulty communicating at times and talk to each other in blaming, disrespectful ways. These problems in communication seem to replicate those between Jean and Derril's father. Jean is feeling as though she is losing control of Derril and resorts to yelling and blaming as ways of trying to get him to behave. She also seems to alternate the rules of their relationship, sometimes treating Derril as a much younger child and sometimes as her partner.

Alice thinks that Derril's angry behavior is no real surprise, given what he observed in his family between his parents. He watched two individuals whom he loved attack each other angrily. Alice thinks that Jean and Al were so quick to take offense at each other's behavior because they had very weak senses of self-worth. They also did not know how to manage conflict in ways other than yelling, labeling, and blaming.

Jean often has very little to say about Derril that is positive. In counseling sessions, she criticizes him almost continuously. At the same time, she calls him her "baby" and her "hope." These communications are very inconsistent. Alice thinks that without really recognizing it, Derril and his mother are both suffering from the lack of genuine love, mostly because they have difficulty expressing it.

Nature of Therapy

Assessment. A counselor practicing the Satir approach relies greatly on her powers of observation to perform critical assessments of the family. She observes the relationships among individuals to gauge communication patterns. Self-presentations of members can give information about self-esteem (Satir & Baldwin, 1983), and interactions among family members can yield information about covert and overt family rules.

In *Conjoint Family Therapy*, Satir (1967) discussed the use of formal diagnosis, warning about the tendency to treat individuals solely in terms of such labels. The therapist can tell the client, "You are behaving now with behavior which I, as a clinician, label 'schizophrenia.' But this label only applies *at this time, in this place*, and *in this context*. Future times, places, and contexts may show something quite different" (Satir, 1967, p. 103; emphasis in original).

Alice carefully observes Jean and Derril as they interact in the counseling session. Jean berates Derril for his lack of respect; Alice notes Derril's sulky response. Sometimes Derril will resort to blaming Jean for his behavior. Both seem to be using these styles to cover up vulnerability that results from shaky senses of self-worth. At other times, Jean expresses her love for her son and her concern that he will get into big trouble.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. Satir (1988) believed that anyone can change at any point in his life. This positive outlook leads to a therapeutic approach that is optimistic, warm, and positive. A primary concern for Satir was to create a safe environment in which all clients feel valued (Martinez, Hollingsworth, Stanley, Shephard, & Lee, 2011).

Humanistic approaches typically emphasize the use of the therapist's person in counseling, and Satir was masterful in this respect. The use of the self of the therapist is therefore considered critical to this approach (Satir, 2000). What sometimes makes the implementation of the approach difficult is that—like Ellis and rational emotive behavior therapy, for example—the person of Satir is practically synonymous with her therapeutic approach.

A prime criterion for the therapist following Satir is that she must be in touch with and accepting of herself, which allows her to be authentic in the session. The therapist must take a nonjudgmental and genuine approach while responding to the overt and covert communications of the family (Satir & Baldwin, 1983).

In Satir's approach, the therapist is characterized as a resource person (Satir, 1967, p. 67). Although Satir (1967) recognized the therapist as an expert, she is not "God, parent, or judge" (p. 67). A certain amount of humility is required to be a good family therapist. However, the counselor *is* an experienced observer and a model for functional communication. The teacher role is essential to Satir's approach because families need to learn to communicate more effectively.

According to Woods and Martin (1984), Satir's approach can be summarized in four elements:

1. The warmth and acceptance of Carl Rogers
2. The strong experiential here-and-now techniques reminiscent of Fritz Perls
3. The "detective" genius of Satir
4. The comfortable, humanistic presence of Satir (p. 8)

Alice tries to be authentic in her relationship with Jean and Derril. She knows that she is an imperfect human being, but she has had good training and has devoted a lot of energy to self-exploration. Alice sees the strength in Jean and Derril and is optimistic about the outcome of the counseling. She is accepting and warm in her relationship with Jean and Derril.

Goals. Therapy is essentially an "experientially based educational program for families in pain" (Woods & Martin, 1984, p. 8). There are a number of interlocking goals of this approach; they center on releasing the blocked potential of families and engaging the healing powers of the client (Satir, 2000). One important goal of therapy is to enhance the self-esteem of family members (Banmen & Maki-Banmen, 2014). The therapist also wants to help the family communicate more clearly and freely, to rely less on the problematic communication styles of placating, blaming, being superreasonable, or irrelevant (Hale-Haniff, 2013).

Alice intends to help Jean and Derril grow, to acknowledge their strengths, uniqueness, and individuality. She hopes that they gain in self-worth. She expects that their ways of communicating with each other and those outside of their relationship will change and become more like the leveling or congruent communication described by the theory.

Process of Therapy

Satir tended to emphasize the process of therapy over its content (Woods & Martin, 1984). She believed that the major curative element in therapy is changing how the family relates and giving them new experiences in the counseling relationship. What they are actually talking or arguing about is not as important as is *how* they are doing it.

Satir's approach generally involves three stages of counseling (Satir & Baldwin, 1983, p. 209). Families can cycle through the stages many times before they leave counseling, although as I outline the stages, it will become apparent that stage 1 is different after the first cycle. The following is a summary of the stages based on Satir and Baldwin's (1983) description.

Stage 1: Contact. Families who come to therapy are in pain. The counselor's first job is to attempt to create an atmosphere of hope and trust. Every family member is greeted and acknowledged as an important member of the group. As the therapist works to make the family comfortable, she is also gathering information by observing family patterns. According to Satir and Baldwin (1983), the therapist's main goal is to "make manifest for family members what she has observed and to make explicit what family members often know implicitly" (p. 213). Sometimes, but not always, a specific therapy contract is established.

Stage 2: Chaos. The second stage of therapy appears when one family member ventures into risky territory. The therapist helps the individual to reveal hurt, pain, or anger that has previously remained hidden. The therapist also helps the client stay in the present (rather than focusing on past fears or uncertainty about the future). Also, the therapist must support other members of the family if necessary. Often, the family feels stuck and hopeless.

Stage 3: Integration. When the family finds a way to move past the issue that created the chaos, stage 3 begins. The family develops new ways of being, and some closure is gained on the pivotal issue.

Alice anticipates that she, Jean, and Derril will journey through the three stages of therapy. Initially, they get to know each other in the first stage, and Alice may point out the ways that Jean and Derril relate to each other (blaming, disrespectful). After a while, Alice is confident that either Derril or Jean will take the risk to reveal the hurt, pain, and anger they are hiding behind the bossy exterior. No matter who risks, this sequence of events will be very scary for both clients. The one who risks has taken a big leap into unknown territory, but the other will have to tolerate a different experience of the risk taker, as vulnerable. Alice is certain that eventually this pair will find a way out of the chaos.

Therapeutic Techniques

Describing specific techniques in Satir's approach is somewhat difficult because of her emphasis on uniqueness and also the experiential nature of this theory. Satir was adept at devising experiences for the family that changed the way they experienced life. Spontaneity was crucial, and she often used touch to intensify her connection with family members (Nichols, 2013). I will attempt to describe several experiences that Satir and others have most commonly used in their work with clients. For space reasons, these descriptions are brief, and one very elaborate major technique, family reconstruction, is not included. If you are interested in this technique, consult Satir et al. (1991).

Family Sculpting. Satir's emphasis on the integration of the physical, intellectual, and emotional led to the development of sculpting, which involves having family members physically take positions that exemplify the family's interactions. Most commonly, family members would take the poses reflective of one or more of the four communication types (i.e., blaming, appeasing, computing, or

being irrelevant), and Satir would help them explore their thoughts, emotions, and physiological reactions (Haber, 2002). Placing members higher or lower than one another can denote power relations (Satir et al., 1991), as when a superreasonable parent is asked to stand on a chair. In a manner somewhat reminiscent of Gestalt therapy, the therapist then directs questions to the various members, such as "What are you feeling right now? What body feelings do you have? Can you exaggerate that movement?" However, sculpting is not restricted to posturing the communication stances.

Family members can be used as sculptors (Satir et al., 1991). One member of the family—a creative adolescent, say—can be asked to place family members in positions that resemble his view of the family atmosphere. In this approach, the sculptor is asked to give commentary on what he is doing. In an extension of sculpting, the *family stress ballet*, the family can be asked to move in ways that illustrate their experiences (Satir & Baldwin, 1983).

Alice asks Jean and Derril to assume the pose of blamers, facing each other. She asks them to exaggerate their accusing vocal tones and to shake their fingers really hard at each other. Then she asks them to change how they talk and try to relax their bodies. Afterward, Alice, Jean, and Derril talk about how it felt to be in the various positions and how it felt to change.

Communication Analysis. Satir spent a lot of time examining family communication and creating experiences that promoted healthy communication, including support and validation of each individual in the family (Woods & Martin, 1984). Family members are encouraged to express their feelings and respect these communications. Later, Satir developed the ingredients of interaction technique, in which family members think of a specific interaction and answer the following questions: (a) What do I hear and see? (b) What meaning do I make of what I hear and see? (c) What feelings do I have about the meaning I make? (d) What feelings do I have about these feelings? (e) What defenses do I use? (f) What rules for commenting do I use? (Satir et al., 1991, p. 124).

Alice asks Jean and Derril to talk about respect. Alice notes that Jean does not seem very validating of Derril during this discussion; she accuses him, demanding that he always show respect for his mother! Derril responds by getting mad and then quiet. Alice intervenes and asks Jean to describe her experience during this conversation and to own her frustrations rather than accusing Derril. Once Jean communicates in a congruent way about her feelings and what she'd like in her relationship with Derril, Derril is asked to respond in a different way to his mother. In this interaction, Alice emphasizes that it is essential to express anger, but that it must be done through owning it rather than laying it at the feet of the other person.

Therapist Communications. Therapists in the Satir tradition are very deliberate in their use of language. Reframing can be used to help families view things in a different light. Humor can also be used to the same end. Metaphors are often employed. One well-known metaphor is the notion of the "pot" when discussing self-worth (Satir, 1988). The pot can be full or close to empty, boiling or calm.

In talking about the recent incident in which one of his peers reportedly dissed Derril's mother, Alice reframes Derril's reaction as a way of caring for his mother. She asks if there might be some less active ways that he could have used to demonstrate his caring.

Another way Alice intervenes is around the issue of respect. She points out that a strong value in this family is respect. Derril is only trying to get respect in his own world by reacting when someone gets in

his face. She uses a metaphor of the bull and red flag to describe Derril's behavior, but then also applies this metaphor to Jean's interactions with Derril.

Family Thermometer. In her 1988 revision of the classic *Peoplemaking* (1972), Satir described the construction of the family thermometer. Five themes are discussed by the family in this process: appreciation, negatives of life, puzzles, new information, and hopes and wishes (Satir, 1988, pp. 190–191). Families give their opinions on where the family is on each theme and are encouraged to physically construct the thermometer and hang it in the home to remind them that they should periodically take readings on each of the themes.

The family thermometer is perfect for Derril and Jean because it offers an opportunity to discuss many things they have not ever touched on—and some areas that are tricky. For instance, in the hopes and wishes zone, Derril admits that when his mother calls him her hope, he feels very pressured and scared. Derril and Jean discuss this issue in a careful way with Alice as their guide.

Parts Party. Really a group technique, the parts party (Satir et al., 1991) begins with the client, who is the host, identifying between 6 and 10 people who are either attractive or repulsive to him; these should be individuals who are readily recognizable to most people (e.g., Martin Luther King, Hillary Clinton, Michael Jackson, Kim Kardashian). These folks are assumed to represent parts of the host, hence the name of the technique. The rest of the group is asked to play these parts and interact, with the counselor (the guide) observing and directing the interaction. The players must understand the qualities of their respective roles *as the client/host perceives them*. The parts meet and interact (and sometimes conflict) and can be asked to change how they deal with each other. Finally, the host is asked to ceremoniously accept each of the parts while verbalizing his feelings.

In her book *Your Many Faces* (2009), Satir described a modified version of the parts party that can be done by the individual or perhaps by all members of a family. The counselor asks the client to make a list of famous people, both admired and detested, along with the first adjective thought of in relation to each person. The list should include individuals with whom we associate both positive and negative aspects. Satir thought that the list represented parts of ourselves. Naturally, we want to see the "good" adjectives as part of ourselves and reject the "bad" ones. Satir (2009) urged readers to find the good and bad parts within themselves because "there is a germ of usefulness in each negative part and a germ of destruction in each positive part" (p. 54).

A formal parts party doesn't seem to be efficient or particularly helpful with Derril and Jean. Alice thus decides to bypass this intervention. However, she assigns them homework: Each is to create a list of their five most admired and detested people and the adjectives associated with them. When they next return to counseling, she will help them find and accept these as parts of themselves.

STRUCTURAL FAMILY THERAPY

OVERVIEW

The name most associated with structural family therapy (SFT) is Salvador Minuchin. His book *Families and Family Therapy* (1974) is considered a classic in the field, and Nichols (2013) contended that SFT "owned" the profession of family therapy in the 1970s. Minuchin is a charismatic figure who uses his personal qualities to boost his impact in working with families.

In fact, some argue that the power of Minuchin's theory can be attributed more to his personality than to the system per se (Nichols, 2013). Minuchin freely acknowledges the influence of his person in his work; he says that over time "my style has grown softer, and more effective. I feel free to use my compassion and humor in joining with families. I have learned to use my life experiences and my fellow feeling for families as part of the therapeutic processes. Having made my share of mistakes in my life, I don't expect my patients to be perfect" (Minuchin & Fishman, 1981, p. 289).

Quite the colorful guy, Minuchin is the son of Russian Jewish immigrants who were transplanted to Argentina. He was ambivalent about Argentina as his psychological home and aligned himself more with Zionism (Simon, 1992). In 1943, Minuchin was arrested in a student protest of Argentinean dictator Juan Peron. Minuchin served in the Israeli army for 2 years during that country's struggles for independence.

After he earned his medical degree, Minuchin began work at the Wiltwyck Center, a school for troubled inner-city youths. Here Minuchin, in league with his able colleagues, began to think about family therapy in his work with poor African-American families. He eventually wrote his influential book *Families of the Slums* (Minuchin, Montalvo, Gurney, Rosman, & Schumer, 1967).

Leaving Wiltwyck, Minuchin assumed the position of director at the Philadelphia Child Guidance Clinic. He hired Jay Haley as director of research and, along with Haley and Braulio Montalvo, developed what is now known as the structural approach. Probably his greatest claim to fame is his work with very difficult clients—and in particular, his work with the families of anorexic girls. These "psychosomatic families" helped Minuchin refine his theory considerably (Minuchin, Rosman, & Baker, 1978).

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Video Example 13.3 Watch Dr. Sal Minuchin talk about the origins of structural family therapy.



https://www.youtube.com/watch?v=2evU02UocpQ

Minuchin retired in 1986 but is still actively writing and training family therapists; in fact a recent book, *The Craft of Family Therapy: Challenging Certainties* (Minuchin, Reiter, & Borda, 2014) is the result of his supervision of graduate students in a family therapy program. Also of note is a second edition of *Working with Families of the Poor* (P. Minuchin, Colapinto, & Minuchin, 2007), with his wife, Patricia, as one of the authors.[1] The Minuchin Center for the Family (www.minuchincenter.org), located in New Jersey, trains professionals and consults with families and organizations. Although the practice of "pure" SFT is probably not as prevalent as it once was, it is notable that many current integrative perspectives on family therapy draw significantly from the structural model (e.g., functional family therapy, Alexander & Sexton, 2002; brief strategic family therapy, Szapocznik & William, 2000; multisystemic family therapy, Littell, 2005). For example, ecosystemic structural family therapy, developed at the Philadelphia Child and Family Therapy Training Center (formerly the Philadelphia Child Guidance Clinic), is based in SFT but adds attachment theory as a foundation and places significant attention to cultural and ecological influences on family functioning (Lindblad-Goldberg & Northey, 2013).

[1]For ease of reading, references to Salvador Minuchin's work are cited without an initial.

Central Constructs

Family Structure. "Family structure is the invisible set of functional demands that organizes the ways in which the family members interact" wrote Minuchin (1974, p. 51). In essence, family structure is a set of rules that determine who talks to whom, who plays with whom (and in what ways), and so forth. Family members can join together in *coalitions* (two or more members become close buddies, so to speak). Who sides with whom in arguments is particularly important. Interaction patterns are critical because they tend to be repeated and institutionalized, become part of the family's and individual members' identities, and determine how everyone is to behave. Patterns of interaction also tell you about *hierarchy*, or power, in families (P. Minuchin et al., 2007). In essence, these repeated patterns of interaction are the family structure. Certain forms of family structure are conducive to individual and family dysfunction, as will be described in the "Health and Dysfunction" section.

John, the structural therapist working with Jean and Derril, first notes that there are several structures in their immediate household. Mother and son clearly have formed a coalition. Father is distant from the family. He decides to look at these in terms of subsystems.

Subsystems. Families naturally differentiate into subsystems, or smaller groupings within the family (Minuchin, 1974). Subsystems help to get the work of the family done, such as when the adult partners form a parental subsystem to raise children. An individual can even be a subsystem, and larger subsystems can be formed according to sex, generation, interest, or function (Minuchin, 1974, p. 52). An individual can be a member of more than one subsystem and, further, a member of subsystems in multiple families. For example, a woman can be a youngest daughter, a spouse, a mother, an aunt, and so forth. If she and her brother-in-law like to ride horses, they can form a subsystem around this interest.

According to structural theorists, it is important to differentiate between the parental and partner (sometimes referred to as spousal) subsystems because these have different functions. Parental subsystems raise kids. The partner subsystem is important for children because it serves as a model for mature relationships (Minuchin & Fishman, 1981).

John sees the subsystems of kid (Derril), woman (Jean), and parental (Jean and, in some ways, Jean and Al). Al's family represents another system with a sibling subsystem of which Derril is not a part. Jean's daughter is yet another relevant subsystem, and her family has spousal, parental, and kid subsystems, too. John thinks that Derril and Jean also are a subsystem of sorts. Although the interaction seems limited, Jean is a member of subsystems of her family of origin—the sibling subsystem.

Boundaries. Critical to structural therapy is the idea of boundaries, or the rules that specify who participates in a subsystem (Minuchin, 1974). Boundaries protect the integrity of a subsystem and should be flexible, but clear. A too-rigid boundary around a subsystem creates isolation of those individuals, depriving them of the protection of the family and opportunities to learn about life from other members. Blurred boundaries between subsystems create a situation in which everyone's business is everyone else's. Such a system can become overwhelmed and stressed beyond its capacities. Family members have trouble being individuals and kids have difficulty growing up.

When boundaries are too rigid, the system is said to be *disengaged*, and when boundaries are very unclear it is said to be *enmeshed* (Minuchin, 1974). For example, a teenage girl is acting out, yet when her mother tries to correct her, her father interferes. Minuchin would say that this

pattern is indicative of a weak boundary between the parental subsystem and the daughter—the father and daughter are in coalition or enmeshed.

Boundaries in a system can be observed in a number of ways (Minuchin & Fishman, 1981). Where family members sit during a counseling session can provide hypotheses about subsystem functioning. Do the children sit next to each other, or does one sit between the parents? How the family talks is also indicative of boundaries—who speaks for whom, who interrupts whom, and who is quiet.

John sees that there are boundary issues in Jean and Derril's situation. The boundaries are weak between the parental and child subsystems (i.e., Jean and Derril seem to have more of a sibling relationship than a parent–child one). This family seems to be enmeshed. Also, it appears that this new subsystem has rigid boundaries around it: Dad does not join it, and it seems to be impervious to any input from the surrounding environment.

Earlier in the family's history, the parental subsystem seems to have involved Derril at times, particularly when Al and Jean were fighting. Now the spousal subsystem is nonexistent, and the parental subsystem is disengaged in that Al is not taking a parental role with Derril.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Structural family theorists are more interested in the development of the family than that of the individual. Minuchin and Fishman (1981) proposed four main stages of family development: couple formation, families with young children, families with school-age or adolescent children, and families with grown children (p. 23). Each of these transition points involves either the addition of a subsystem or a challenge to already established ones. Minuchin and Fishman admit that this description fits the stereotypic middle-class family with 2.2 children and neglects larger networks that are influential, such as extended family or friends. However, it is useful to keep these stages in mind because they are transitions experienced by many clients who will present for therapy.

When becoming a couple, partners must shift loyalties from their families of origin to the new entity, the partnership (Minuchin, 1974). Boundaries must be established around the couple so that its identity is secured. When children arrive, the system must undergo a serious realignment, as the parental subsystem is born along with the child. Needless to say, this is a very stressful time!

A natural feature of human development is that at some point an adolescent will begin to differentiate from the family of origin. Ultimately, he will separate from them by going to college or moving out of the family home for other reasons. This change will seriously affect the family subsystems. If he was a member of the kid subsystem, his role and function will be missing. If he was a caretaker for younger children, his parents will need to adjust to his absence. If she was in coalition with either parent, her loss will be traumatic. These are just a few examples of the stresses brought on by developmental transitions.

Minuchin (1974) maintained that the individual's personal identity is composed of a balance between individuality and belonging. Families are a critical source of the individual's sense of separateness and togetherness, primarily through subsystem membership (remember, an individual can be considered a subsystem, too).

One thing that structural theorists are sure about is that systems change. If you watch families, social service agencies, hospitals, or any other kind of system, you will observe periods of stability, but also, because human systems are open-ended, times of transition (P. Minuchin et al., 2007).

Derril is entering adolescence. John notes that this transition seems difficult for Jean and Derril. They are both struggling with his change from a small child who is always near mother (belonging) to an adolescent who is developing his own personhood (individuality). Part of this process is Derril's struggle to strengthen his subsystem boundaries.

Health and Dysfunction

At the most general level, structural family therapists discuss dysfunction in terms of the ways in which the family relates. Families tend to experience difficulties when old patterns of relating don't work. These dynamics are particularly evident in times of transition, whether the transitions are "normal" parts of the cycle of life (e.g., the birth of a new child) or not (such as a natural disaster; P. Minuchin et al., 2007).

Most important in SFT is the recognition that problems are in *relationships*, not in people. Families tend to come in with the idea that one person in the group is the problem, called the *identified patient*. Minuchin's conviction about the location of problems led him to declare that "all families that come to therapy are 'wrong' in their assumptions," and further that "the family's certainty is the enemy of change" (Minuchin et al., 2014, p. 4). Further, the narrow view of the family prevents them from using all the resources of the family.

Aponte and VanDeusen (1981) offered that "functional and dysfunctional levels are determined by the adequacy of the fit of a system's structural organization to the requirements of an operation in a set of circumstances" (p. 313). Something about the structure is not adaptive to the events of life, and often enmeshment or disengagement is not helping the family (although sometimes these patterns are fine).

More specifically, Minuchin tended to speak in terms of too-rigid or too-blurred boundaries among subsystems—in other words, enmeshment or disengagement (Minuchin, 1974). When the disengaged family is stressed and needs to adapt, it does not respond because the rigid boundaries in the system keep the stress from being transmitted to all members of the system. Members of the family are involved with their own issues and may fail to respond to other members, needs for help or support (Becvar & Becvar, 2013). In enmeshed families, the diffuse boundaries between members and subsystems can result in a lack of independence and autonomy in the children. The weak boundary between the parental subsystem and the kid subsystem is seen in ever-present parenting—doing too much for the children. Also, the blurred boundaries between subsystems enable the immediate and intense transmission of stress and potentially excessive reactions to it (Minuchin, 1974). In essence, the enmeshed family responds instantly to threat by freaking out. In contrast, the disengaged family seems not to care about its members. Disengaged families tend to allow a lot of individuality, whereas enmeshed families expect conformity and loyalty (Minuchin, 1974).

Minuchin and his colleagues learned valuable things about family structure and function from observing psychosomatic families. Psychosomatic families are those in which children present with symptoms that are more severe than would be expected based on the biological aspects of the disorder, such as asthma or anorexia nervosa. These observations led Minuchin et al. (1978) to theorize that these families have five important similarities. Although originally intended to describe psychosomatic families, these qualities have acquired a more general usage in describing family structure.

Minuchin et al. (1978) maintained that psychosomatic families are enmeshed, overprotective of members, rigid in the face of change, and have difficulties resolving conflict. However, the key characteristic in these families is the child's involvement in the parental relationship. In essence, the

child's symptom serves as the regulator in the system, assisting in the avoidance of conflict between the parents. Three such situations generally characterize the types of alignments found in families (Aponte & VanDeusen, 1981). Although these alignments may temporarily relieve stress, they have long-term consequences because they negatively affect the functioning of the children (Kerig, 1995).

In one common pattern, parents who are in conflict and can't deal with it bind together to focus on the afflicted child, a pattern called *detouring* or *scapegoating* (Minuchin, 1974). The couple system looks calm and united, but the parents are channeling their stress to the child. The child is defined as the family's problem, becomes a victim, and develops symptoms. The process is perpetuated when the parents in some way reinforce the symptom.

Two other patterns are evident when the parental dyad is openly split: *parent–child coalition* and *triangulation*. Parent–child coalition refers to the situation in which the child is recruited into a stable partnership with one parent in opposition to the other. In triangulation, the child finds himself caught in the middle—he can't risk expressing his feelings or opinions because to do so would be to side with one parent over the other. Essentially, the parents are competing for the validation of the child, and a parent may attack the child if he or she perceives the child as joining with the other parent (Minuchin, 1974). It is important to note that, although these patterns are often described in terms of parent–child relations, triangulation and detouring occur among other family member configurations, such as when two sisters triangulate their little brother.

Healthy families are those in which structures are clearly defined and flexible and adequate for the tasks at hand. Typically the parents are in charge and there are clear parental and partner subsystems. Healthy systems can change as needed, such as when a new stage of development is imminent (Aponte & VanDeusen, 1981). Minimal levels of triangling, detouring, and parent–child coalition are present in healthy families because the parental dyad is appropriately boundaried. Within the spousal system, togetherness and individuality are balanced (Becvar & Becvar, 2013). The spouses are supportive and accommodating of each other.

In a healthy family, the kid subsystem benefits from the support of the parental subsystem and learns from the spousal and sibling systems (Becvar & Becvar, 2013). Children feel free to explore and grow. In structural theory, the healthy individual can maintain a good balance between individuation and belonging to the family. Individuals are assumed to be inherently competent in SFT, although this competence can be obscured by problematic family structures (Lindblad-Goldberg & Northey, 2013).

John knows that somehow the system of this family is not adaptive. He has an idea that Derril is involved in a coalition with his mother, but Derril is also a factor in the parental subsystem. Jean and Al argue quite a bit about what is to be done with Derril, a sign that Derril is incorporated in that subsystem. The weak boundaries around the child and adult woman subsystem are allowing stress to be transmitted freely from Jean to Derril, and vice versa. Further, the system is stressed by Derril's attempts to establish a clearer identity. His angry acting-out behavior appears to be a facet of this struggle to become a person separate from his mother and father. Al, who is disengaged from the family, seems relatively unaffected by the processes in the family; he is the outsider in the Derril–Jean–Al triangle.

NATURE OF THERAPY

Assessment. The first thing the structural therapist does is assess family structure. No formal assessment methods are used; the therapist simply asks himself a series of questions (Minuchin, 1974), such as these: Who is the spokesperson of the family? Who selected or designated the

spokesperson and why? Who is the true executive of the family? What are the other members doing while the spokesperson talks? Are they attentive or dismissive? Aponte and Dicesare (2002) noted that contemporary structural therapists have been known to use genograms to assess what Minuchin, Nichols, and Lee (2007) called the *structurally oriented historical explanation* (see the section on Bowen theory for a more detailed description of genograms).

John watches Jean and Derril interact and wishes that he had Al in the room as well. However, Jean contends that she and Al would fight too much to make sessions productive.

Jean and Derril's interaction mostly consists of Jean telling Derril how disrespectful he is. She does most of the talking, explaining that she doesn't understand why he does what he does. Derril responds minimally unless he gets angry. Then he tells his mother to leave him alone. Jean and Derril report that they sometimes "play" with each other, but when Jean asks Derril to stop and he doesn't, Jean gets angry. John also infers that Jean and Derril are in an enmeshed system, based on the report that they spend most of their free time together, Derril's role in the home, and his freedom to comment on his mother's appearance. A mother–child cross-generational coalition has been formed, probably having its roots in the conflict between Jean and Al.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. Originally, SFT was strictly present focused. Rebelling against the psychoanalytic tradition in which he was originally trained, Minuchin (1974) wrote, "the tool of this therapy is to modify the present, not to explore and interpret the past" (p. 14). More recently, "structurally-focused exploration of the past" is seen as a way to tap valuable information regarding the sources of relationship behaviors or qualities that are seen in the present therapy (Minuchin et al., 2014, p. 58).

The role of the counselor in SFT is that of expert. The therapist joins the family (more on joining later), but maintains a stance as a leader in the counseling process. Minuchin et al. (2007) contended that it is easier to say what a structural therapist is *not* than what he is, writing

> A therapist isn't fair or just, or a politically correct practitioner; not an ethicist, not a logistician, not all knowing. The therapist is a practitioner of change. But change is always resisted: by the familiarity of well-traveled pathways, by a family's conviction about the way things are, by the competitive tension between the "selves in relation" that make up a family, and by the demands for change that family members make on each other. (p. 13; quotes in original)

The personality of Minuchin is often confused with the qualities and roles of the structural therapist. Minuchin is a very charismatic guy who is not afraid to be pushy. Obviously, it is not a requirement that one be pushy to be a structural family therapist, but one must be willing to be very active and, as you can see from the foregoing quote, at times willing to violate social norms (at least according to Minuchin).

Minuchin strongly emphasizes the use of the self of the therapist as a tool for change (Minuchin et al., 2014). Here Minuchin means two things. First, the therapist must devote a part of himself to observing the process of therapy while simultaneously being engaged with a family. Minuchin et al. (2014) evoke the image of a homunculus self sitting on the shoulder of the therapist. In learning to use the self, SFT theorists also mean that because each therapist is a unique individual, he will need to develop a sense of how his personal qualities influence the ways in which he can help families change.

John takes an active role with Jean and Derril, asking questions and generally directing their conversation. He joins with both of them in small ways, identifying with Jean's frustration and with Derril's attempts to be an individual. John is aware that who he is influences his relations with Jean and Derril. Maybe he can bond with Derril as a brother he's never had and with Jean as a fellow parent figure. However, John is aware that these types of bonds will affect the process and outcomes of the therapy, so he is careful to monitor the therapeutic interaction in session.

Goals. The structural therapist is intent on changing the structure of the family system, and thereby the experiences of its members (Minuchin, 1974). The problem presented is to be solved, but the structural therapist does so by joining the family in "ways that impede old patterns of thinking and relating and build on their strengths to generate new patterns leading to immediate, palpable results" (Aponte & Dicesare, 2002, p. 1).

Other goals of SFT include changing the family's view of the presenting problem and broadening the identities of individuals, particularly that of the identified patient (Minuchin et al., 2014). The functions and activities of subsystems beyond the individual are also explored. The overriding goal of these dissections is to explore alternatives to the family's current way of relating to build a more adaptive structure.

John's goal is to help Jean and Derril become individuals, but still remain connected as mother and son. In essence, he wants to rearrange the boundaries in this system, tightening those around the individual subsystems (Jean's and Derril's personal spaces) and creating a stronger boundary between the parental and child subsystems. John hopes he can help Jean and Derril see their situation differently: Perhaps Derril's behavior is a way of asserting his growing independence and identity—maybe together they can find more adaptive ways in which he can do this.

PROCESS OF THERAPY

The structural family therapist is the leader of the system, but also must become a member of it, a process that Minuchin called *joining* (Minuchin & Fishman, 1981). As Minuchin and Fishman put it, the "therapist is in the same boat with the family but he must be the helmsman" (p. 29). Joining is not a technique, but a mental set on the part of the therapist that conveys to the family that he is on their side and will work with and for them. Structural family therapists join the family by disclosing similarities with them, by supporting family members, or by conveying understanding of their perspectives. However, Minuchin was careful to point out that family therapists must be able to move in and out of family interaction—sometimes acting as a pseudomember of the family and other times as an observer (Minuchin, Lee, & Simon, 2006).

Minuchin et al. (2007) outlined a four-step model of family assessment (pp. 9–12). In step 1, *opening up the presenting complaint*, the therapist's job is to help the family reframe the problem as systemic. Nichols and Tafui (2013) caution that the goal in this stage is twofold: understand the problem from the family's perspective and also to challenge them to consider systemic factors. Step 2, *highlighting problem-maintaining interactions*, involves clarifying and emphasizing what the family does to maintain the problem, with particular attention to interactions that support the problem. In this step, the therapist must be particularly careful to think in terms of circular causality—which you will recall is an orientation that is really not causal at all (Nichols & Tafui, 2013). A circular orientation involves describing the sequence of events that maintains the

problem with the intent to figure out who in the sequence can interrupt it. Who started it does not matter, and it is probably impossible to absolutely answer that question in any case.

A structurally oriented historical exploration is in order in step 3, *structurally focused exploration of the past*. The adults in the family are asked to look at how their experiences have shaped their present (restricted) views of themselves and others. The structural counselor is most interested in keeping this conversation focused on history that bears directly on the presenting problem. Finally, in step 4, *an exploration of alternative ways of relating*, clients and therapist explore alternatives to the present problem-maintaining interactions.

P. Minuchin et al. (2007) pointed out that it is important—particularly when working with really stressed families—to recognize and acknowledge family strengths. It is also critical that counselors realize that it is inevitable that the counselor, as he joins the system, will be tempted to also join the family's view of the problem and how it should be solved (P. Minuchin et al., 2007). If you are working from a structural perspective, it is your job to keep in mind that the task is to help the clients see the world differently and act accordingly.

John carefully joins Jean and Derril in their plight. He understands Jean's worries about Derril's future. He talks with Derril about their mutual interest in sports, particularly basketball. Because John is African-American, his personal qualities are a joining point with this family.

As John explores Jean and Derril's world, he struggles to help them see the problem in context. What is the meaning of Derril's "acting-out" behavior in relation to peers, parents, mother, father? Are there pressures on Derril to "be a man"? How does Jean's distance from her family play into the picture? What's up with Derril's relationship with his father and father's new family? John explores the interactions between Jean and Derril, looking at what maintains the ones they see as problematic. Turning to historical factors, John wonders if there are lingering effects of Jean and Al's conflicts in the present.

John notes and comments on the family's strengths: the close bonds between Jean and Derril, Jean's strength as an only parent, and Derril's willingness to stand up for himself. John also notices that Derril wants to grow up and be somebody.

Therapeutic Techniques

General strategies used in structural therapy are challenging the family's view of the symptom and the certainty that their explanation of the problem is correct (Minuchin et al., 2014). The structural therapist also challenges the family structure, asking members to look at alternative ways of organizing and relating.

A number of techniques can be used in the service of these general strategies. Perhaps the most important technique in structural therapy is enactment, which is used both for assessing and changing family structure. Several techniques are intended to change the family's view of the symptom, such as reframing, focusing, and achieving intensity. To challenge the family structure, the therapist engages in boundary making, unbalancing and teaching the family about the complementarity of roles and functions (Minuchin & Fishman, 1981, p. 69). Structural therapists will also use metaphor and paradoxical techniques to challenge the family's certainty about the problem and to change structure. Here are descriptions of several techniques used by structural family therapists.

Enactment. Minuchin is famous for having families perform interactions in the therapy session. This strategy is based on the notion that families won't often tell the counselor about their problems in relating to one another, so watching their interactions in session is instructive.

The therapist can simply observe, or he can choose to intervene in the sequences the family demonstrates (Minuchin & Fishman, 1981). For example, if the children in a session are acting out, Minuchin will ask the parents to solve the problem. Observing how the parents interact with their children provides valuable information about how the parental and kid subsystems operate. If one parent is abdicating her role, the counselor can step in and ask the parent to engage, thereby encouraging the re-establishment of the two-person parental subsystem.

John thinks that mini-enactments are going to help Jean and Derril. He accomplishes this by talking to each alone after sending the other out of the room. Sometimes he simply tells the other that the topic is not his or her business. He also has them talk about problem areas and everyday things, directing the conversation so that Jean is parental in her approach to Derril, keeping her cool and making reasonable decisions and rules that respect Derril's growing up. Speaking calmly, rather than in her accusing sibling mode, helps to establish the parent–child boundary.

Reframing. In reframing, the therapist helps the family change their view of themselves from one that is narrow and negative to a picture that is more positive and flexible (P. Minuchin et al., 2007). Minuchin et al. (2006) suggest that reframes often involve describing the distance-regulating properties of behavior, such as when an adolescent acting out is characterized as trying to get his parent's attention. Typically, behavior is reframed in a positive way. For example, my favorite positive reframe is describing my dog's rowdy misbehavior as enthusiastic.

John considers potential reframing for Jean and Derril. The obvious one is characterizing Derril's acting up as representing his struggle to be an adult in relation to his mother, father, and peers. Jean and Derril's close relationship could be reframed positively (as "good buds" they need to be sure that they are respectful and kind, just the way they would treat any friend) or in a way that might encourage change (by pointing out that the relationship is keeping Jean isolated and Derril from adulthood).

Focusing. In any counseling session, the therapist must choose a focus for his attention because the family presents a wide array of data about how it functions. Basically, the therapist chooses the most important element in the family's presentation, and that choice is dictated by structural theory. A potential pitfall, warned Minuchin, is theoretical tunnel vision (Minuchin & Fishman, 1981). The counselor must be aware of his choice of focus and sensitive to the effects of narrowing his focus. Focusing can be used to take the spotlight off the IP by examining other dynamics in the family, such as the relationship between the parents or the caretaking efforts of a sibling.

John focuses on parenting with Jean, asking her to discuss what she thinks good parenting is. He asks if she can talk these things over with Al, wondering if she wants to get Al more involved with the parenting process. John also asks a lot about Derril's social life, implying that he needs to develop a network of supports outside of the family.

Achieving Intensity. Because families have a shared way of looking at the world, they often have difficulty hearing the therapist's message. Hearing the message really means that the family experiences the therapist's reality in a way that will help the family structure shift. Achieving intensity is not a separate operation; several interventions can be used to achieve this goal, and

they vary depending on the level of involvement with the family (Minuchin & Fishman, 1981). The counselor may simply repeat her message many times during a session. For example, the therapist may decide that 6-year-old James is acting incompetent to help others in the family feel better about themselves. The counselor will make this statement many times and will also ask all the participants how they experience this sequence.

Intensity can also be enhanced when the counselor asks families to go beyond the point at which they tend to interrupt stressful interactions. Most dyads or families have a point at which things get too hot and the interaction is discontinued. Asking the participants to "hang in there" at that point will continue the heat, and this journey into new territory has the potential to create new perceptions and patterns. Changing the distance between the therapist and family members (e.g., getting down on one's knees to talk to a small child or getting very close to an adult) can also increase intensity. Although primarily used as a boundary-creating maneuver, changing the seating arrangements among family members can also be used to intensify the counseling process (Minuchin & Fishman, 1981).

John repeats his contention that Derril is still trying to take care of Mom—protecting her from the world as he has protected her from his father at times. He asks Derril to talk about how he does this, and he asks Jean how it makes her feel.

When Jean and Derril are talking about a recent fight he had at school, Derril becomes sulky and quiet. John jumps in and helps Derril continue the conversation with his mother, encouraging him to talk more like a grown-up.

Boundary Making. Another well-known structural technique involves tactics that create better boundaries within a family system. Boundary interventions can be very simple, such as when the counselor insists that the person to whom he asked a question answer the question (rather than someone else in the family). Members of the family can also be asked to change seats. The classic example is when a child who is psychologically between the parents is moved from a chair between them to one next to the therapist, who sits facing the couple.

Many of John's interventions could be described as boundary making. When John helps Jean and Derril speak to each other differently, it is a boundary intervention. John stops Jean from interrupting Derril, and vice versa. This allows each to speak his or her own piece and become more of an individual. When John talks with Jean or Derril individually, this is a boundary intervention. He asks Jean or Derril to complete some task or attend a social event separately over the period between sessions. If John succeeds in bringing Al into therapy, he will try to establish a boundary around the parental subsystem. This intervention might be more effective if John sends Derril out of the room for some period of time or if he asks Derril to sit off to the side and observe. However, just having Al and Jean talk about parenting Derril would be helpful.

Unbalancing. This technique is intended to change the hierarchy within the family. The structural family counselor sides with a less powerful person in the system, or with a subsystem, and thereby steals the power of the more powerful. Alternately, a family member or system can be ignored. Needless to say, these are tricky interventions, and they raise ethical issues about the potential effects on the family and individual members. Minuchin and Fishman (1981) cautioned that the counselor must always be aware of the stress level of family members, particularly

when siding with one member against more powerful others. They also pointed out that unbalancing may be difficult for the therapist, first because it is not fair (by definition). Also, the therapist may be uncomfortable with the proximity required in this technique or with finding himself on the side of someone behaving badly.

John considers siding with Derril in an attempt to gain him more autonomy. He could do this by telling Jean that he and Derril are going to have a heart-to-heart about what Derril should do to keep his mother out of his business so he can grow up. John thinks that this intervention would be stressful for both Derril and Jean. Derril would feel the stress of abandoning his mom and also the pressure of growing up. It is possible that Jean could become anxious and then angry in reaction to this intervention.

Directives. The structural family therapist often gives directives to families, both within session (in a sense, instructions for enactment are directives) and as homework. Directives can be (pardon me) direct or paradoxical. Papp (1981) advised direct interventions (e.g., advice suggestions, task prescriptions) when the family is likely to comply with the directive. If the family is consistently defiant, paradoxical interventions can be considered, and there are three elements of this technique: redefining, prescribing, and restraining (Papp, 1981, p. 246). Paradoxical interventions are reverse psychology—they are successful if they produce the opposite result to the one they require. The idea is to use the family's defiance to banish the symptom. Redefining is the same as positive reframing, described earlier. The symptom is defined positively and connected to the dynamics behind it; since it is now a positive quality, the logic is that the family should continue to enact it (prescribing). Prescribing often involves giving the family a task to complete, most often outside of the therapy sessions. Typically the task involves the symptom, and the family finds it difficult or distasteful to complete it, effectively making the symptom go away. However, when the family returns and reports change, the therapist is guarded about the advisability of changing, worrying about the loss of the support to the family resulting from the symptom's disappearance. This last part is the restraining element.

John considers directives that he might use with Jean and Derril. He decides to take a direct approach, asking Jean to spend more time with her family and Derril to choose whether he wants to go along with his mother on these visits or establish some other acceptable activity.

STRATEGIC THERAPY

OVERVIEW

Strategic therapy evolved from the work of the early systems theorists, primarily the "Palo Alto group" at the Mental Research Institute (MRI), a collection of researchers studying communication processes, most notably in the families of schizophrenics (P. J. Guerin & Chabot, 1995; Watzlawick, Beavin, & Jackson, 1967). The MRI researchers included Gregory Bateson, Jay Haley, Don Jackson, and John Weakland, and they are perhaps most famous for their description of *double-bind communication*. Observed repeatedly in families of schizophrenics, double-bind communication occurs when one family member gives a message to another that is really two contradictory messages, one conveyed on the verbal channel of communication and the other on the nonverbal channel. The target of this communication is unable to escape the situation and, as a result, over time develops psychological symptoms as a way of dealing with an impossible

predicament (Nichols, 2013). A simple example of double-bind communication might be the following. Imagine your partner or parent saying, "Of course you should go to the quilting party." However, the way she says it conveys "Going to the quilting party is the last thing I want you to do; as a matter of fact, I will fall apart if you do go and it will be your fault." Two messages are expressed, but they conflict. What do you do?

Jay Haley extended the MRI group's work and went on to become the foremost proponent of strategic therapy. Haley, to say the least, was a bit of a maverick. Rather than the traditional degree in psychology or medicine, Haley's degree was a master's in arts and communication (Becvar & Becvar, 2013). Haley consistently delighted in critically questioning values and procedures of the traditional psychotherapy club. One of his books, *The Power Tactics of Jesus Christ and Other Stories* (1969), does quite a bit of this skewering of entrenched institutions (as you could guess by its title), including an analysis of the power dynamics of psychoanalysis and in the mental hospitals of the 1950s and 1960s. Haley died in 2007, but his website can still be found at http://jay-haley-on-therapy.com.

Haley was much influenced by master therapist Milton Erickson (see Chapter 14 for more information on Erickson). It is also helpful to know that he spent 10 years working with Minuchin developing structural family therapy, which probably accounts for the attention to hierarchy found in Haley's work (Becvar & Becvar, 2013). The definitive statement of strategic therapy is probably Haley's book *Problem-Solving Therapy* (1987), which actually has first and second editions. Another leading proponent of strategic therapy is Cloé Madanes, who was at one time married to Haley. Madanes's book *Strategic Family Therapy* (1981) is considered an excellent resource on this approach. Madanes's website is www.cloemadanes.com. Another noted source on this approach is Haley and Richeport-Haley's 2003 book *The Art of Strategic Therapy*.

Strategic therapists, like structural therapists, are interested in family hierarchy; power within the family is an essential way of understanding symptomatic presentations. The difference between strategic and structural therapists, according to Haley and Madanes (1981), is that strategic therapists pay more attention to the repetitive patterns of communication and behavior within the family than do the structuralists.

This theory is shorter on concepts and techniques than others, possibly because the strategic therapists believe that the way to change is to design specific tasks for each individual problem. There is no theory of personality associated with this approach.

Central Constructs

Communication. Strategic therapists are interested in the repetitive sequences of interaction that are seen in families and dyads. Haley (1987) pointed out that most of the time when we communicate our statements can have meanings on multiple levels; most importantly, they are messages about the nature of the relationship between or among the interactants (Ray & Sutton, 2011). For example, when Sara and John fight over who is going to clean the bathroom, the fight is overtly about the cleaning, but it is also a statement about how they relate. According to the strategic therapist, relationships between people happen on the level of analogic communication. For example, Haley (1987) maintained that the symptom or problem bringing the client to therapy is really a metaphor for his current relationship situation.

Haley (1987) recognized two levels of communication: the report (or content) and command (or relationship) aspects. The report level is concerned with the actual content of a verbal message.

The command level is largely nonverbal, and it conveys the relationship between the interactants. Continuing the example of Sara and John above, if the tense and angry Sara says to John, "I am so tired of having to remind you to clean the bathroom," the content level is exactly what you read (she is tired of reminding him), but the relationship message is that Sara gets to tell John that he has to clean, a clear statement that she is in charge.

Morgan, the strategic therapist, wonders how Derril's behavior is a metaphor for the family's distress. One possibility is that the metaphor resides in the "in your face" routine. This family has a history, it seems, of getting in each other's faces. When one tries to coerce the other, or blame or label, the other retaliates in kind, somewhat like Derril's behavior at school. Morgan looks closely at Derril and Jean's communication patterns to see what the command level is suggesting about their struggles.

Hierarchies. Any organization has hierarchies, and families are no exception. Hierarchies involve power, and thus this concept is often seen as problematic. The traditional hierarchy in a family defines the parental dyad as in charge of the kids (Madanes, 1981). Even more traditionally, this structure often implies that the man is in charge and all must obey him. Haley (1987) protested that, although we must accept the existence of hierarchies, this admittance does not dictate that a particular structure *must* exist. He cautioned that simply seeing an unjust hierarchy in a family is not justification for changing it. Hierarchies are to be changed when necessary to change symptoms, and only then.

Morgan sees that the hierarchy in this family is not entirely clear. Jean is the mom, yes, but often she seems to act like a teenager with Derril. Derril sometimes acts much younger and sometimes much older than he is in relationship to his mother. Dad's role is that of outsider. Morgan wonders who is really in charge here?

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Strategic therapists don't have a formal theory of personality. They have some ideas about development, but generally they attend to points of transition in the lifespan. According to Haley (1973), the important life stages in strategic therapy are (a) the courting period, (b) early marriage, (c) childbirth and dealing with the young, (d) middle marriage, (e) weaning parents from children, and (f) retirement and old age. In his book on Milton Erickson's methods, *Uncommon Therapy* (1973), Haley devoted a chapter to each of these stages, illustrating them with examples from Erickson's work.

Morgan notes that Derril is on the verge of adolescence. Although Derril is only 12, he is showing signs of growing up. Will it soon be time to wean Jean from Derril?

HEALTH AND DYSFUNCTION

Strategic therapists define dysfunction as rigid, repetitive interactive behavior (Haley, 1987). In addition, Madanes (1981) and Haley (1987; Haley & Richeport-Haley, 2003) locate problems in families that result from problematic hierarchies, or what Madanes (1981) calls "incongruous hierarchical organization in the family" (p. 67). These hierarchies, it is implied, are inextricably linked to the rigid interactive behavior of family members. Ray and Sutton (2011) suggest that looking for the effects of the problem in a system will yield clues as to the rules of relationship

in it. For example, when George has a symptom and thereby distracts the parents from difficulties in the couple's relationship, he is assuming inappropriate power within the family system. The parents focus on George and do "more of the same" with him, trying the same responses to his behavior time and time again (and typically, escalating each time). In this sense, the solution maintains the problem.

If there is a problem child in a family, according to Haley (1987), then someone has crossed a generational boundary and become too involved with a child (not necessarily the symptomatic one, although that is common). The situation is at its worst when the dysfunctional coalition is denied or concealed. Also, the ganging-up process is repeated—that is, cross-generational coalitions are not necessarily problematic unless they become routine (Haley, 1987). Haley and Richeport-Haley (2003) also pointed to two other common problems seen in family hierarchy: parents forming coalitions in opposition to one another and in-laws violating boundaries.

Ironically, the symptom is seen as a metaphor for the problem, but it can also be an attempt to solve the problem (O'Connor, 1986). Kids cooperate with feuding parents by appearing with symptoms that distract them from the conflict (S. Cheung, 2005). So George's temper tantrums express the rage between the two parents, but are also attempts to distract his parents from this painful situation.

You might have guessed by now that strategic therapists spend little time discussing healthy people and families. Haley (1987) noted that confused or distorted hierarchies can reside even in healthy families. Ray and Sutton (2011, p. 171) maintained that strategic therapy requires a "nonnormative, nonpatholgical orientation," and no problem exists unless the clients identify one.

By deduction, we would assume that healthy families, from a strategic perspective, would have clear hierarchies that are consistent with the family's context (i.e., the culture in which it lives; Stanton, 1981). Few entrenched cross-generational coalitions would be observed in these families. These families would somehow figure out how to navigate the transitions in the family life cycle without confusion or collusion. Communication patterns are clear and flexible.

Morgan observes that Jean and Derril seem to have a cross-generational coalition. However, this teamwork is not denied, and in some instances it is adaptive, such as in completing household chores. However, Derril's behavior suggests that something is not working, and Morgan guesses that his acting-out behavior is both symbolic of the conflict between his parents (in your face!) and a way of distracting Jean from her loneliness and pain. Morgan asks if Jean calls Derril's father in to help with the problem, and if so, what tends to happen then.

Nature of Therapy

Assessment. No formal assessment or diagnosis is used in strategic therapy. In fact, strategic therapists in the past were seen as radicals because they were critical of diagnostic labels, suggesting that "to label someone as 'schizophrenic,' 'delinquent,' or 'manic-depressive' is to participate in the creation of the problem that the therapy must solve. Sometimes the label creates a problem, so that the solution is made more difficult to cure" (Madanes, 1981, p. 20). Even more outrageous to some was the strategic camp's insistence that psychoactive medication should be immediately discontinued because it defines the client as "mentally ill" instead of simply misbehaving (Madanes, 1981). This kind of pronouncement coupled with the associated stance that rejects any biological basis for psychological dysfunction led to much displeasure

with the strategic approach (Lebow, 2014). Nowadays strategic therapists seem much less adamant about these issues, advocating that the therapist work to establish good relationships with other professionals, including psychiatrists who are prescribing medication (Haley & Richeport-Haley, 2003).

The strategic therapist assesses the family through observation of interactions, which will provide information about hierarchies and where they might be dysfunctional. The strategic therapist can also gain information by deliberately intervening in the family and observing how it responds (Stanton, 1981).

Morgan watches carefully as Jean and Derril discuss what brings them to counseling. She looks at who presents the problem (Jean), how Derril responds to this presentation (by presenting his own version), and how Jean reacts to Derril's presentation. The actual content of these presentations is not as important as the quality of their interaction; the two seem to be operating from approximately the same level of power. Morgan asks a series of questions, trying to get a complete and detailed picture of this family's interactions, including those with Derril's father.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. Strategic family therapy is generally brief, and the therapist is very active and directive (T. N. Smith, Ruzgyte, & Spinks, 2011). The focus of counseling is generally on the present, and the therapist assumes responsibility for the structure of the counseling process.

Unlike most other approaches, strategic therapy considers the social context of the presenting problem to include professionals who have influence and control over the clients, such as medical professionals who prescribe drugs and administer inpatient treatment (Haley, 1987; Madanes, 1981). These institutions and individuals can be problematic because they "not only focus on an individual, but are also antifamily" (Haley, 1980, p. 53). Strategic therapists should be flexible in their use of locations and time frames for therapy (Haley, 1987). Sessions can be held in homes, in schools, or in the traditional office space. Sessions are known to range from the sacred 50 minutes to multiple hours (Haley, 1987).

The strategic therapist shoulders the total responsibility for the outcome of therapy (Carlson, 2002). Relatively few expectations are expressed about the role of the clients in strategic therapy.

Morgan takes charge of the therapy situation. She is active and begins her task of helping Jean and Derril define a solvable problem. Although she is aware of the role of Derril's school in this situation (defining Derril as a problem kid), she decides that she will not intervene there unless at some point it seems necessary.

Goals. The goal of the strategic therapist is very simple and straightforward: to resolve the presenting problem (Madanes, 1981). The problem "should be something one can count, observe, measure, or in some way know one is influencing" (Haley, 1987, p. 39). Ultimately, the strategic counselor wants people to *behave differently*; she doesn't care much about insight (Haley, 1987; Nichols, 2014). In fact, Haley and Richeport-Haley (2003) pointed out that pushing for insight can be a problem because many clients are not comfortable with interpretations. Another way to look at the goal of therapy from this perspective is that counseling helps individuals navigate the transition between the life stages. That is, clients become clients because they have

experienced a crisis in one stage of development and are therefore unable to move to the next stage. For example, Haley (1980) maintained that adolescents become schizophrenic because they are having difficulty leaving home.

The strategic therapist's interest in patterns of communication that support distorted hierarchies also leads to interest in changing the routine patterns presented by clients. Thus, the strategic therapist strives to help clients learn more complex ways of communicating and interacting with their systems (Madanes, 1981). As Stanton (1981) put it, "Strategic therapists more commonly use the family's overtly expressed goals or target complaints as rallying points for actually altering dysfunctional sequences" (p. 366).

The agreed-upon goal is to help Derril stay out of trouble. The number of times he gets in trouble at school can be counted. Morgan thinks that to do this, she will help Derril grow up and help Jean develop a life outside of her relationship with Derril. Achieving these goals requires changing how this pair relates to each other and to the outside world.

PROCESS OF THERAPY

One of the first tasks of the strategic therapist is to work with the family to formulate a problem that is solvable (Haley, 1987). Therapy can then proceed, but beware, because Haley and Richeport-Haley (2003) warned us that "what makes therapy difficult for trainees is that life is so complex that you have to design therapy for each case and you have to be innovative" (p. xv).

Haley had quite a bit to say about the conduct of the first session of counseling. He thought that it was important to have everyone in the household present for at least the first session, saying, "It is possible to change a person by seeing him alone, but the skill required is often too much to ask of the average therapist" (1987, p. 11). Carlson (2002) had a different view—he opined that effective therapy could happen without everyone there.

Haley (1987) divided the first counseling session into five stages: social, problem, interaction, goal setting, and task setting. In the *social* stage, the therapist chitchats with the family, getting to know the members. It is important to get everyone to talk in this stage so that all family members know they are important to the counseling process. The counselor also uses the behavior of the family in the social stage to observe important family processes, such as parenting, general family mood, and roles and power structures in the family. The strategic therapist formulates *tentative* hypotheses based on these observations, but does *not* divulge these to the family (Haley, 1987).

The *problem* stage begins when the therapist asks what brought the family to counseling. Family members' responses to this question are informative. Everyone must have a chance to give his or her views on the problem, but Haley recommended that the adult who is least involved with the identified problem be queried first. However, the counselor must be very careful to be respectful and courteous to the individual who has the most power to bring the family back to therapy. These individuals are typically not the same people! Haley also cautioned that it is inadvisable to start with the problem child because he might conclude that the counselor blames him.

In the problem stage, the therapist should have an attitude of "helpful interest" (Haley, 1987, p. 27). He should not offer advice, even if someone requests it. Family members should be asked for their opinions, not their feelings, about the situation. All the time, the counselor is making observations about the family, but again she is not to convey these or any interpretations about

what she sees. The discussion of the problem should move from general statements to a more specific construction, and the latter should ideally involve more than one person.

The next stage of the first session is the *interaction* stage (Haley, 1987). Family members are directed to talk to each other about the problem. The intent of the strategic therapist is, ideally, to actually see the problem in its full glory. If someone in the family is anxious, she can be asked to get anxious in the session so that the counselor can observe what happens. The therapist can also get a good view of the family's hierarchy through this process.

Once the family members have interacted, they move to the *goal-setting* stage, in which the problem is clearly defined in a solvable way (Haley, 1987). The problem must be observable so the family and the therapist know when things are getting better. Rather than setting the goal to, say, reduce John's anxiety, the therapist wants more specific goals, such as stopping John's stuttering, increasing John's excursions outside of his home to three per week, and so on.

Sometimes, but not always, a final stage of the first session is entered, called *task setting* (Haley, 1987). If the counselor is clever enough, she will prescribe some homework for the family to complete before the next session. Directives of this sort are essential to strategic therapy and will be discussed in more detail in the section on techniques.

Strategic therapists deal with client resistance in a unique way—they "go with" the family and thereby avoid power struggles (Stanton, 1981). They also use indirect or paradoxical directives as a way of inducing change through resistance. These interventions are discussed in more detail later.

When Morgan asked Jean to bring Al to the first therapy session, Jean reacted very emphatically, saying that it would be of no use because he was not part of the family. Although Morgan thought this arrangement was not quite ideal, she accepted it.

Morgan greets Jean and Derril and chats with them a little about everyday stuff. She asks if they had any difficulty finding her office, where they live, and so forth. Fairly quickly, though, Morgan proceeds to asking Jean and Derril what brings them in. Jean mostly describes the problem, with Derril remaining silent. At one point, Derril gets angry and breaks into his mother's monologue. Morgan observes these events and begins to form hypotheses. She moves Jean and Derril into the interaction phase by asking them to talk to each other about the problem. Observing this discussion, Morgan notes that the two relate as equals rather than as mother and son. Mother blames a lot, and Derril blames others for his behavior—they get in his face.

Morgan struggles to help Jean and Derril define the problem as solvable. She defines the problem as a joint effort of Jean and Derril to keep him out of trouble at school. Jean needs to take charge in this process of helping Derril to grow up and take responsibility for his own behavior. Perhaps if he grows up, he will find some new ways to deal with conflict.

Privately, Morgan decides that Derril is taking care of his mother at the expense of taking care of his own life. Jean needs to help Derril see that she doesn't need to be taken care of. If Morgan can create a more functional hierarchy for Jean and Derril, this problem should take care of itself.

THERAPEUTIC TECHNIQUES

Directives. The strategic therapist almost always issues directives to the family, often as tasks to be performed at home over the intervals between sessions. Directives are used to accomplish the therapeutic goal of getting people to behave differently. They also change the relationship with the therapist—it is intensified because the clients live with the therapist in the form of her

directives for a whole week (Haley, 1987). The use of directives also helps the counselor gather information. Whether the clients obey or disobey, they are still communicating something to the counselor.

Two kinds of directives are used in strategic therapy: direct, or straightforward, and indirect, or paradoxical (Haley, 1987; Haley & Richeport-Haley, 2007). Direct interventions are those in which the counselor simply tells the client what to do. They are used when the therapist expects that the family will comply (O'Connor, 1986). Directives are not the same as giving advice. Haley (1987) noted that "giving good advice means the therapist assumes that people have rational control of what they are doing. To be successful in the therapy business, it may be better to drop that idea" (p. 61). Good advice is what everyone gives the family, so that, for example, "telling people that they should treat each other better is not useful to them" (Haley, 1987, p. 61). More useful are directives that alter the patterns of communication, and hence the hierarchy, in the family.

One example of a straightforward directive is penance (Haley & Richeport-Haley, 2003). This form is used when clients feel sorry and awful; the therapist gives them something to do that is helpful to others (p. 9).

Paradoxical directives are used when the therapist thinks the family will probably resist a direct intervention. Two general forms of paradox are described by Haley and Richeport-Haley (2003): restraining orders (which instruct the client *not* to change) and symptom prescription. These interventions are designed to place the client in a no-win situation. To illustrate this dilemma, O'Connor (1986) described the directive given to a child obsessing about vomiting. The 10-year-old was told to sit for an hour each day in the family kitchen and think about vomiting (and only then). If Charlie obeys, then he demonstrates control over his symptom. If Charlie disobeys, the symptom is gone.

MyCounselingLab

Video Example 13.4 Watch strategic therapist Dr. Jim Coyne give a gentle paradoxical homework assignment.



Any directive given must be clear, precise, and understood by all members of the family (Haley, 1987). Ideally, all members of the family should have a part in the task. Directives should clarify, not confuse, hierarchies. Of course, Haley noted that sometimes (but not very often) it is helpful to give confusing directives, involve less than the complete family, or confuse the family hierarchy. Finally, someone in the family should be made responsible for reporting on the family's performance at the next counseling session. If the family has followed the directive, fine. If they have not, they should not be let off easily (Haley, 1987).

A special form of paradoxical directive is the *ordeal*. The goal of the ordeal is to make the symptom more trouble than it is worth in terms of controlling relationships with others. The client will then voluntarily give up the symptom. The assumption behind this approach is that the individual who gives up her symptom will then have to find new ways of relating to others that are more adaptive.

Haley (1984) described three characteristics of ordeals. First, as noted earlier, the ordeal must be worse than the symptom. Second, the ordeal must be something the person is able to do and

not object to on moral or ethical grounds. Third, the ordeal must not harm the client or anyone else (p. 7). As with directives, there are two kinds of ordeals. A *straightforward ordeal* requires the performance of an unpleasant but "good for you" task upon occurrence of the symptom. Clients are asked about things that they should do more of (e.g., exercising, cleaning house). Once the symptom is clearly specified, the client is told to perform the ordeal if the symptom occurs. Haley (1984) noted that it is best if the ordeal is performed in the middle of the night! I once gave a client an ordeal to help him with insomnia. He decided that he needed to clean out his garage. I instructed him that, if he was not asleep 20 minutes after getting in bed, he should get up and clean his garage. This client found that he had very little trouble getting to sleep in the next few weeks and that his garage remained dirty.

Paradoxical ordeals are directives that demand the performance of the symptom. From one perspective, simply having to perform the symptom could be considered an ordeal. Another tactic is to require the performance under aversive conditions. One interesting aspect of paradoxical ordeals is that, if the client complies, the symptom becomes voluntary, under the client's control (Haley, 1984). The alternative, noncompliance with the directive, is to give up the symptom.

In addition to straightforward and paradoxical directives, which at times can be ordeals, therapy itself can be viewed as an ordeal. There are numerous ways to *make the therapist the ordeal*. On a very basic level, the fact that the client has to pay to discuss her inadequacies in front of what seems to be a problem-free person makes the therapist troublesome. Haley described several instances of using payments to the therapist as ordeals, with the agreement that the therapist can do whatever he wants with the money. In one case, each time a client binged and vomited, she had to pay the therapist, beginning with a penny. Every time she repeated this behavior, the amount doubled (Haley, 1984). The first time she vomited, she owed 1 cent, the second time 2 cents. The third time the client threw up, she owed 4 cents, then 8 cents, then 16 cents, and so on. For the client who throws up 10 times a day, this can be a very expensive contract. She went from vomiting from 4 to 25 times a day to vomiting only 6 times in the first week after the assignment. In the second week, she vomited only once and then stopped completely.

Confrontation and interpretation of the client's behavior by the therapist often result in clients having to acknowledge things they'd rather not. Reframing or redefining the client's behaviors in ways the client does not like constitutes an unpleasant experience. Anger can be redefined as a way of caring about someone. If the client is resisting a certain task, the counselor can characterize this behavior as the client being protective of herself or others. This reconceptualization puts the client in charge of her behavior.

Morgan considers the directives she could give Jean and Derril. Some straightforward options are telling Jean to get a life (i.e., directing her to do something on her own over the next week) and devising a way for Derril to help her out in this. She considers having Jean give Derril more autonomy when it comes to school, not calling his teachers weekly as she has been. Derril must help by giving his mother a daily summary of events when she gets home from work.

Paradoxical alternatives might involve moving Jean and Derril closer together, hoping for noncompliance. Morgan considers asking Jean and Derril to devise more ways to spend time with each other and could intensify this directive into an ordeal by having them play cards for 2 hours every night. She also thinks about having Jean go to school with Derril every morning. She could get detailed daily reports on his behavior.

Reframing. Sometimes changing the way the client perceives the problem is helpful. In fact, reframing can be one way to transform a problem from intractable to solvable. Obsessions can be transformed into worrying or even thinking about, which seems much less threatening. Szapocznik, Zarate, Duff, and Muir (2013) also advocated reframing to eliminate negativity in families; for example, reframing parental anger as concern can go a long way toward easing resentment on the part of a rebellious adolescent.

Morgan can reframe Derril's acting out as a way of taking care of his mother—he keeps her busy with his problems, distracting her from her struggles to be a single mom who has few friends.

Working with Hierarchical Problems. Straightforward directives are often used to rearrange family hierarchy (Szapocznik, Hervis, & Schwartz 2010). For example, if there is a cross-generational coalition between a mother and a child (and a consequently distanced father), the therapist can require the father and child to do some pleasant activities together over the time between sessions.

Haley (1987) also used paradoxical intervention to exaggerate hierarchical problems to disrupt coalitions. Haley (1973) described a case in which Erickson intervened with a mother concerned about her 12-year-old son's bed-wetting. Erickson prescribed an ordeal, insisting that the mother get up at 4:00 A.M. every morning and check her son's bed. If it was wet, she was to wake him, and he was to then improve his handwriting by copying passages out of a book until 7:00 A.M. The bed-wetting disappeared very quickly.

Pretend Directives. Madanes (1981) contributed the idea of pretend directives to the strategic arsenal. She suggested that it was useful to use these directives in two ways: (a) have the symptomatic person pretend to have the symptom in the counseling session or (b) have the parents of a symptomatic child pretend to need the child's help. When an adult is directed to pretend to have a symptom, the partner or spouse is directed to give a critical analysis of the presentation. In the second instance, in which the parents pretend to need help, the child is to pretend to help. In this approach, the symptom becomes less real, and pretending to have it serves the same function as having it. Thus, the client can give up the "real" symptom (Nichols, 2014). Also, the individual might be more likely to experiment with different kinds of behaviors if the situation is framed as play (Becvar & Becvar, 2013).

Morgan considers using a pretend directive in session, telling Jean to pretend to be lonely and asking Derril to figure out how to help her.

BOWEN FAMILY SYSTEMS THEORY

OVERVIEW

This version of FS theory is the brainchild of Murray Bowen (1913–1990). To distinguish it from other systems approaches, I will refer to it as Bowen family systems theory (BFST). This approach is widely acknowledged as the most elegant theoretical construction among the FS theories (Gurman & Kniskern, 1981).

Bowen, a psychiatrist, began his theoretical work while working with schizophrenics at the Menninger Clinic from 1946 to 1954. He later moved to the National Institute of Mental

Health (NIMH) and then to Georgetown University. A detailed history of the development of Bowen's thought is found in Kerr (1981).

Bowen is best known for two pioneering advances in the family therapy area. First, while at NIMH, he experimented with hospitalizing the entire families of schizophrenics, practicing what Kerr (1981) called family group therapy (p. 230). In these studies, he began to note the intense emotional processes in these families, but his concurrent outpatient work suggested that the differences between these families and those with less severe dysfunction were a matter of quantity, not quality.

A second contribution of Bowen was his analysis of his own journey to differentiate from his family of origin (a version of this paper can be found in Bowen, 1978, and you can read a little bit of it in Box 13.1). Bowen presented this analysis to a group of family therapy theorists and researchers and soon began teaching this approach to his students.

Box 13.1

An Excerpt from Bowen's "On the Differentiation of Self"

An important triangle at work at this time was the one between my mother, my second brother, and me. I had worked very hard on the triangle with my parents and me, assuming that my problem would be solved. Now a new version of the problem had been displaced onto the new triangle. When conflict arose in the business, my mother would communicate by some means, if not directly, that I was on her side, and my brother would react as if this was reality. I began to perceive some of this development on trips. The process would emerge in the form of gossip-type stories which in an emotional system communicate, "We two are together on this issue. We are in agreement about that other third person." One of the better ways to disengage from such a triangling "secret" communication is to go to the third person and report the message in a neutral way. I was out of effective contact with my second brother then and the only move I could make was to tell my mother that I was neutral. She would say that she respected my position and I would assume she was acting neutral about me with others. I would leave town and the family would react as if I was on her side.

Action is required when words fail to detriangle in emotional systems. My mother has always used "secret" communications to facilitate her position in the emotional system. One of my early responses to her communication was to listen, and I thought I could listen without taking sides. In retrospect, this maneuver was one of the key triggers for my early fusions into the emotional system. Listening to such communications without response, pretending that one is not involved, does not fool an emotional system. When I was aware that "no response" was not effective, I began using comments such as, "That's one of the better stories." This method was a little more effective. In retrospect, I undoubtedly was responding while I kidded myself that I was neutral. I had worked much more actively on the triangle with my father, mother, and myself and I had been more effective in detriangling from that. There had been several exchanges about "secrets" that turned the tide in that area. The first one was a letter in which mother communicated some negative story about my father. In the next mail I wrote to my father to say that his wife had just told me this story about him, and I wondered why she told me instead of telling him. He showed the letter to her, and she fussed about not being

able to trust me. Several letters such as this, plus similar exchanges when I was with both parents, had been reasonably effective at detriangling me from them. During that period, mother made comments about my reading too much between the lines, and I made comments about her writing too much between the lines.

The triangling pattern in my family of origin, which is the usual one in all emotional systems, was most intense during stress periods. Various family members were grouped on the corners of the primary triangle, except that the grouping would be somewhat different, depending on the emotional issues. The two on the togetherness side of a triangle would talk about the outsider. With various versions of different issues being discussed in four separate households, and with me in reasonably good contact with them all, it was possible to keep a good reading of the family emotional tension. My first brother has hardly been mentioned in this report. His lifelong position in the family has been one of moderate involvement and acting uninvolved, with statements that he would be willing to help anytime if he was needed but that he did not want to "just talk."

Source: Excerpted from Bowen, M. (1978). *Family Therapy in Clinical Practice* (pp. 505–506). New York: Jason Aronson. Reprinted with permission.

One of the best known resources for BFST is Kerr and Bowen's (1988) book *Family Evaluation: An Approach Based on Bowen Theory*. If you read a lot of BFST literature, you will find that some authors distinguish between traditional and nontraditional BFST, or Bowen and Bowenian variants, according to K. Guerin and Guerin (2002). The traditional form is that practiced by Bowen himself, which is long term and focused on getting the client to work on family-of-origin issues. Bowenian therapy is a broadened version of the therapy and in which the therapist is as likely to intervene in the present (e.g., working with the current family system or focusing on the presenting symptom) as he is to focus on multigenerational issues (Murdock, 2007). In this chapter, I will attempt to offer points from both perspectives.

Central Constructs

Differentiation of Self. The most basic construct in BFST is differentiation of self in relation to the family of origin. According to Bowen, it is an inherent feature of all living organisms that they must balance pulls of togetherness and separateness (Titelman, 2014). Differentiation of self is a lifelong process of balancing these forces (Kerr & Bowen, 1988).

Differentiation is both an individual and a family construct. Individuals have characteristic levels of differentiation, but the overall levels of differentiation of their families of origin mostly determine the individuals' levels. Differentiation should be thought of as a continuum; people and families fall along a range from very low differentiation to relatively high differentiation. For purposes of explanation, though, we tend to compare the characteristics of individuals with low and high levels of this construct.

Individuals who are relatively well-differentiated have a solid sense of self; they are clear about where they end and others begin. Able to distinguish thought from feeling, their behavior is guided by their own principles and cognitions rather than emotional factors (K. Guerin & Guerin, 2002). Individuals who display low levels of differentiation are said to be *reactive*; they respond

based on emotions as compared to individuals with higher levels of differentiation, who respond on the basis of objective thought, or what some term "clearheadedness" (E. H., Friedman, 1991).

In relationships, individuals with higher levels of differentiation are able to stay in intimate contact with others while maintaining a solid sense of self (Kerr, 1984). This quality, termed *emotional autonomy*, should not be confused with denying one's needs for other people. Distancing on the basis of such denial is termed a "pseudo independent posture" (Kerr, 1984, p. 9) and is evidence of a lack of emotional autonomy.

The term *fusion* is almost synonymous with low differentiation of self (Titelman, 2008), and it seems to have at least two meanings in BFST. In Bowen's early writing, he spoke of fusion as meaning that the individual's emotional and intellectual systems are inseparable (Bowen, 1978). The emotional system tends to dominate behavior, and usually the emotionality is activated by anxiety in an important other or in a critical relationship (K. Guerin & Guerin, 2002).

A second definition refers to the low-differentiated individual's tendency to fuse the self into a "common self with others" (Bowen, 1978, p. 472). This process is seen most clearly in intimate relationships such as marriages. Such fusion creates "emotional bliss" (1978, p. 473), but it is difficult to maintain. The pull to be a separate individual will eventually surface, so the partners must juggle the tendencies to fuse and distance. Sometimes one individual in the dyad tends to absorb higher levels of self and becomes dominant, or stronger, whereas the other adapts and looks weaker. This pattern is called the *underfunctioning–overfunctioning* dynamic (Titelman, 2014). The weaker-appearing individual is likely to develop symptoms. The emphasis here is on terms such as *looks* and *appears* stronger or weaker, because Bowen maintained that we tend to involve ourselves with significant others who are at about the same level of differentiation as we are (Bowen, 1978). The borrowing of self in the fusion process makes one individual look more together than the other looks.

Jacob, Jean and Derril's BFST therapist, starts his work with the premise that both Jean and Derril are relatively low on the range of differentiation of self. They appear to be fused in their relationship—neither has a strong sense of self separate from the other. Both seem to be emotionally reactive, as evidenced by what happens when conflict erupts.

Chronic Anxiety. Closely related to differentiation is what Bowen called chronic anxiety. Both constructs are considered to be natural biological phenomena (E. H. Friedman, 1991). Chronic anxiety is a nonthinking phenomenon that is basic to survival. It is essentially the organism's response to *imagined* threat as compared to acute anxiety, which is a response to real threat (Kerr & Bowen, 1988). Although Bowen maintained that chronic anxiety is not caused by any specific factors, it is seen as generated mainly by relationship disturbance (Kerr & Bowen, 1988, p. 113). Chronic anxiety is integral to understanding psychological dysfunction. Symptoms are a method of controlling—or in Bowenian terms, binding—anxiety. E. H. Friedman (1991) wrote, "*Chronic anxiety is understood to be the primary promoter of all symptoms, from schizophrenia to cancer, from anorexia to birth defects. The antidote, and the preventive medicine, always is differentiation*" (p. 140; emphasis in original). Here I will pause to comment that the definitions of differentiation, chronic anxiety, and stress seem to overlap in Bowen's system, causing some fuzziness in at least my understanding of the relations among these concepts. Sometimes stress, differentiation, and anxiety appear to be separate, independent constructs. However, at other points Bowen seemed to use these terms interchangeably, or at least he implied that the three qualities covary perfectly.

Jacob guesses that there is a great deal of chronic anxiety in Jean and Derril's system and that it is a significant factor in the struggles they face. In fact, Jacob is fairly certain that Jean responds to this undercurrent by focusing intently on Derril. Derril responds to the pressure by acting out.

Triangles. Bowen thought that the most basic unit of human interaction is the triangle (Kerr & Bowen, 1988). In the strictest definition, triangles involve three living people (Titelman, 2008). At any time, two of the people are the "in" group, and the third is on the outside. Triangles generally form when the level of anxiety rises in a relationship or family (Titelman, 2008). The tension is absorbed when one member of a dyad fuses with a third person and the triangle is born, with the fused individuals on the inside and the third on the outside. The "out" person may feel relieved or very uncomfortable with his position. Triangling is connected to differentiation in that individuals who have lower levels of differentiation (or families low in differentiation) are more likely to triangle because of the higher levels of emotionality present (Kerr, 1981).

P. J. Guerin, Fogarty, Fay, and Kautto (1996) noted that triangles keep people stuck. They maintained that "in active triangles, people are never free. Their responses to events are constrained and predictable. They are unable to consider alternatives" (p. 35). So, when you see your client acting in repetitive ways in relation to others (particularly to a specific other), you should suspect that a triangle is activated. However, P. J. Guerin et al. also noted that not every three-person structure is a triangle. It is possible for three people to interact with each other in two-person relations without creating an outsider.

Jacob sees a triangle with Jean and Derril on the inside and Al on the outside. The original conflict arose between Jean and Al, and apparently she fused with Derril to bind the anxiety in the system.

Emotional Distance. Our distance from others can be chosen, or it can be the result of reactivity. Everyone uses distancing sometimes, which is also called *emotional cutoff* (Papero, 1990). People with relatively high levels of differentiation can choose to distance from one another because they are busy with other things. However, folks with lower levels of differentiation often reactively distance from important others (family) because the level of anxiety in relationships is intolerable. Cutoff can be good because it decreases anxiety or bad because it deprives the individual of the support of the family (Kerr & Bowen, 1988).

Derril's dad, Al, has dealt with the conflicted relationship with Jean by cutting himself off from her and Derril. In this process, he has probably fused into his relationship with his new girlfriend as a way of dealing with anxiety in that relationship because he has likely joined up with someone who has an equivalent level of differentiation.

Sibling Position. Borrowing from Toman's (1961) work, Bowen wrote about the influence of birth order on individuals' relationship tendencies (see Chapter 4 for more information on birth order). Declaring that "I believe that no single piece of data is more important than knowing the sibling position of people in the present and past generations" (Bowen, 1978, p. 385), Bowen thought that deviation from what was expected based on a particular birth position provided information on levels of differentiation and family functioning. For example, if an oldest child acts like we expect an "only" to act, triangulation is probably occurring. The gender composition among a set of siblings is also important: it is one thing to be a youngest daughter with two

older sisters and quite a different thing to be the same in relation to a male sibling dyad. Sibling position also influences couple functioning: Two eldests are likely to fight about who gets to be in charge, whereas a youngest and an oldest might have fewer disagreements in this area (Papero, 1990).

Jacob notes that Derril is an only child in the current system. His 20-year-old sister is considered to be of another family from a conceptual standpoint. Derril does not share the limelight with anyone, and this undoubtedly has influenced who he is. He notes that Jean is an eldest (with younger brothers and sisters) and Al a youngest with an older sister. At first glance, this pairing should be relatively complementary, so Jacob wonders why this was not the case for Jean and Al.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

For Bowen, the essential feature of human life (and further, in nature) is differentiation, the balancing of the two natural forces of individuality and togetherness (Titelman, 2008). Both processes are considered to be biologically rooted, but the relative level of differentiation is transmitted by the family.

Bowen thought that families projected their levels of differentiation onto their members through the nuclear family emotional system (Titelman, 2014). Kerr and Bowen (1988) asserted that "people who marry have the same level of differentiation of self. When they marry, the two spouses become the primary 'architects' of the nuclear family emotional atmosphere . . . and each child born . . . is incorporated into that atmosphere" (p. 225; quotes in original). Further, this process operates across generations, and it is called the *multigenerational transmission process*.

MyCounselingLab

Video Example 13.5 Watch Dr. Paul Anderson and Helen explore her family from a multigenerational perspective, using metaphor.



As a result of the qualities of its members (their levels of differentiation) and factors external to the family, each family has an average level of chronic anxiety over time. The total amount of chronic anxiety experienced and the ways in which it is bound (triangles, couple conflict, symptoms, etc.) determine the average level of differentiation of family members. Some kids may be a little more differentiated than others, but these differences are not likely to be extreme (Kerr & Bowen, 1988). If one child becomes the object of the family projection process, then she will develop lower differentiation than the family average, while other kids may achieve higher levels. When Frank, the kid with the lowest level of differentiation, takes a partner, the partner, according to BFST, will be at Frank's level of differentiation, creating a system with a lower level of differentiation than Frank's family displayed. The same pattern would be true for Nicole, who has a level of differentiation higher than that of her family of origin. These divergences, according to the theory, account for the range of differentiation observed over generations of a family and also across people in general.

Jean and Al have transmitted their levels of differentiation to Derril, who is now struggling to individuate as an adolescent. The multigenerational process of transmission of differentiation predicts that Jean's and Al's families of origin probably showed a lot of anxiety, triangulation, and cutoff.

Health and Dysfunction

From a BFST perspective, symptoms appear as a result of the characteristic style of emotional functioning of the family (Kerr & Bowen, 1988). Symptoms appear most often in families with low levels of differentiation. Given a group of individuals who are low in differentiation, symptoms could potentially pop up in any member when stress levels rise, according to Bowen. Four general patterns of relationship problems are seen: conflict in the couple's relationship, dysfunction in a member of the parental couple, dysfunction in a child, and emotional distance (Bowen Center for the Study of the Family, n.d.). In each case, these patterns can also be seen as the operation of triangles: the conflicting couple will pull in a third to calm their relationship; a child or other relative may align herself with the dysfunctional member of a couple, which is typically in an overfunctioning–underfunctioning pattern; and in the case of a dysfunctional child, the parents are in a fused relationship and project their anxiety onto the child (Titelman, 2008). In emotional distance, the individual is likely to be fleeing closeness with another, and that person (the other) will likely draw in a third person. Families with higher levels of differentiation are not immune to symptoms. Kerr and Bowen noted that, if stressed enough for a long enough period of time, even well-differentiated families can develop dysfunction.

Dysfunction can also be conceptualized from a more individualistic perspective, using the construct of differentiation of self. An important construct in BFST is anxiety, defined as the "response of an individual or organism to threat, real or imagined" (Kerr & Bowen, 1988, p. 112). Differentiation of self and anxiety combine to determine the level of an individual's functioning, and specifically, the level of *chronic anxiety* in an individual's relationship system is key. "Symptom development, therefore, depends on the amount of stress *and* on the adaptiveness of the individual or family to stress" (Kerr & Bowen, 1988, p. 112; emphasis in original). One important source of stress is the level of chronic anxiety in relationship systems (Kerr & Bowen, 1988). Because individuals low in differentiation are less adaptive to stress, they tend to get into trouble more often and more easily than do individuals with higher levels of differentiation.

Healthy families, from a BFST perspective, will show relatively higher levels of differentiation of self and individuals will be calmer, less reactive, and less likely to fuse or distance. Triangulation, when it occurs, will be short lived and less rigid (Titleman, 2014). Healthy individuals relate to others from an I-position, being clear to own their positions on things but at the same time allowing others to be who they are.

Jacob thinks that this family's style shows two of the three patterns of dealing with anxiety. Formerly, the anxiety erupted as fights between Jean and Al. However, when Al cut off and fused with his current girlfriend, the anxiety resulted in symptoms in Derril—his acting-out behavior. Periodically, the stress in the environment combined with Jean's focus on Derril results in his disruptive, emotionally reactive behavior.

Nature of Therapy

Assessment. Assessment in the Bowen approach is accomplished through two basic techniques, one informal and one formal. Informal assessment is accomplished through questioning; the BFST counselor uses a directed set of questions to assess the characteristics of the individual, his family of origin, and his current nuclear family, if applicable.

BFST counselors are very interested in the level of emotionality present in clients because "emotional intensity is not to be feared, but it is to be respected" (Kerr & Bowen, 1988, p. 328). If a client is under a lot of stress and is fairly low in adaptability (differentiation), the therapist must take care not to disturb this precarious position.

Assessment in this model can also involve looking at the primary method of anxiety binding used by the client. Remember, anxiety can be bound into relationship conflict, symptoms in one of the partners, symptoms in a child, or emotional distance. The BFST therapist wants to see which of these is prominent in a client's presentation because he believes that treatment may need to proceed differently depending on the mode (Kerr & Bowen, 1988). For example, if the major method is the continual adaptation of one relationship partner to the other stemming from couple conflict or the avoidance of it (resulting in loss of self and the appearance of symptoms), the BFST counselor may decide to see the partners separately. Counseling them together may even make the de-selfed partner worse!

Kerr and Bowen (1988) recommended that, if the major mechanism for anxiety is overinvolvement with a child (triangling), the therapist probably wants to have the parents work on their own differentiation from their families of origin first, excluding the child from therapy. The rationale for this approach is that the emotional bond with the child is just too intense for much progress to be made. Getting the parents to differentiate is thought to help them be more observant and objective in their relationships with the child.

The *genogram* is the primary method of formal assessment in BFST. Basically, a genogram looks like a family tree that shows the members of an individual's family, usually over three generations. Some BFST counselors developed fancy notation that symbolizes the nature of the various relationships depicted on the genogram. For example, if you absolutely hate your cousin Fred, a zigzaggy line would be drawn between you and him on your genogram.

Jacob's genogram for Jean and Derril's family is shown in Figure 13.1. He notes that Al is unemployed. This underfunctioning in respect to his current partner (who is a nuclear physicist) replicates the situation in his family of origin. Also, Al is a youngest child, a boy, and therefore likely to be the object of much parental attention. Jean is an eldest, probably used to taking care of her siblings, and in particular, Jerome, who may be the focus of Jean's family's tension. Is it the role of women in Jean's family to take care of men?

Jacob observes the high level of emotionality present in Jean's communication and Derril's tendency to alternate between being sulky (cutting off) or reacting angrily to Jean. He asks questions about how Jean's family communicates (anger followed by emotional cutoff) and about her siblings and their relationships, both current and historical. Jacob decides that, because the issue seems to be overinvolvement of Jean and Derril, his first task should be to help Jean differentiate from her family of origin.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. Because the basic goal of BFST is differentiation, and differentiation is such a difficult task, traditional BFST can be much longer in duration than other types of family therapy. The therapist is very active in this approach, but in a way that could be seen as very different from that observed in other approaches to counseling. The BFST therapist, above all, seeks to "*stay detriangled* from the emotional process" (Kerr, 1981, p. 255; emphasis in original). The therapist presents objectively and unemotionally. BFST therapists maintain that to stay detriangled, one needs to deal with facts, not feelings, and practice a calm vocal tone (Nichols, 2013). If a therapist finds himself reacting emotionally to the work with clients, P. J. Guerin et al. (1996) would say that the therapist has become triangled and

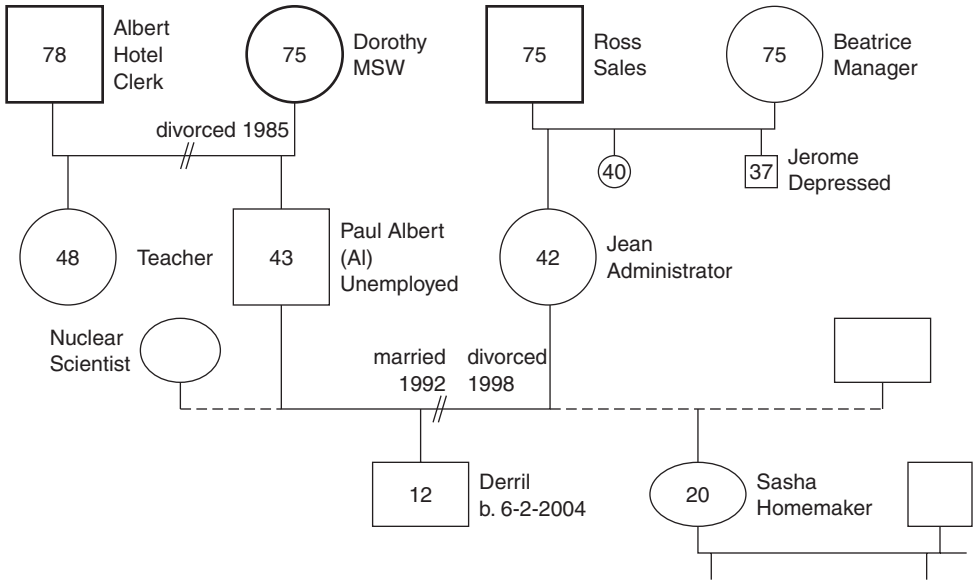


FIGURE 13.1. Genogram of Jean AND Derril's Family.

the work of therapy will be compromised. For example, if I find myself getting mad at one member of a couple, I need to recognize this as triangulation and find a way to free myself.

BFST therapy is often described as *coaching* (McGoldrick & Carter, 2011). The therapist is the coach, and the client is the athlete; the analogy is apt because BFST counselors believe that most of what happens in therapy is the result of the client's work. The therapist just helps him get started and cheers him on through the process of differentiating from the family of origin (Bowen, 1978). Coaching as a process in which the coach supports the client without becoming triangled into the client's system, maintaining clear boundaries and managing his own anxiety (Baker, 2014). For example, siding with the client against other family members would be bad coaching. In essence, the BFST counselor will "expect and resist attempts to get him to provide direct emotional support, approval or reassurance. The coach will not want to become emotionally more important to a client than his family members are, nor to be more concerned or responsible for the client's life decisions and actions than the client is himself" (Carter & Orfanidis, 1976, p. 216).

Jacob is neutral in his approach to Jean and Derril. He asks a lot of questions and works to stay detriangled. Although he feels pulls from Jean to side with her and chastise Derril for his bad behavior, he also notices that Derril wants him to recognize his mother's constant nagging. Jacob is respectful to both as individuals, asking for their opinions on the situation. As he begins to move into helping Jean work on differentiating in relation to her family, he will act as a coach to her in this process.

Goals. The goal of BFST is to help the individual (or individuals) differentiate in relation to the family of origin (Titelman, 2014). Kerr and Bowen (1988) noted that the reduction of anxiety in the individual or system is critical, too, because it will relieve symptoms. It is important to note that differentiation does not mean cutting off from one's family, emotionally or otherwise. The differentiated person is in contact with the family system, but her behavior is not dictated by

family patterns. Altering her level of differentiation will help the client become more adaptive to stress and less reactive in relationships, all of which will contribute to the demise of symptoms.

Because of the typical pattern of this family, Jacob decides that the best way to intervene is to encourage Jean to differentiate in relation to her family of origin so that Derril will be more free to do the same. This should decrease the fusion between them. Most likely, Jacob will begin to see Jean alone as she negotiates this process. However, for the first part of therapy, Jacob will work with the dyad, decreasing the level of anxiety so that both Jean and Derril can function a little more effectively in their lives.

PROCESS OF THERAPY

The BFST therapist emphasizes insight, but action in the form of interacting differently with family-of-origin members is critical. As you will see in this section, one of the most common assignments to clients in BFST is to journey home and observe family interactions. The therapist teaches the client about the operation of family systems, but the client must go and watch for herself how her family puts the principles into effect. Then the client is expected to change how she interacts with her family.

Bowen thought that counselors wanting to do BFST should work on their own levels of differentiation. Kerr and Bowen (1988) noted that "the more a therapist has worked on differentiation of self in his own family, the more he will be able to get closely involved with a clinical family and still be 'outside' the system" (p. 285; quotes in original). The idea is that the therapist is a neutral, objective observer who avoids the clutches of the clients' emotional system. Transference, although recognized by Bowen theorists, is to be avoided (Titleman, 2014). Therefore, the therapist needs to undergo BFST therapy himself so that he can competently provide help to others.

Jacob is sure that he will need to work with Jean to schedule visits with her family of origin. He teaches her about triangles, reactivity, and emotional cutoff.

THERAPEUTIC TECHNIQUES

There are really not many set techniques associated with BFST (Kerr, 1981). In fact, Bowen was evidently dismissive of technique, preferring to emphasize understanding of the family system (Nichols, 2013). The BFST therapist then coaches the individual in his struggle for differentiation from the family of origin.

Commonly, clients go on "journeys" to work on differentiating, and it is best that they go alone rather than with a spouse, children, or sibling. Other approaches are to use telephone conversations or letters. The goal of these journeys, which should be taken when emotions are running high in the family, is to have the client observe the process of the family and attempt, if she is ready, to act differently. Detriangling (see below) is particularly important in these journeys.

One of the major tactics used by BFST counselors is *process* questioning (Nichols, 2013). The therapist uses these questions about how clients participate in their lives and relationships to avoid the emotionality often associated with content questions. An example of a process question might be when Terry, the therapist, asks Amy, "What happens in your family when your little brother Dayton has a temper tantrum?"

In the 1978 book *Family Therapy in Clinical Practice*, a compilation of Bowen's papers, Bowen described three methods by which the client works toward better differentiation of self. First, he

endeavors to establish and maintain *person-to-person relationships* with members of his family (Bowen, 1978, p. 540). Difficult to achieve, these relationships involve talking directly to another without talking about third parties or topics that are impersonal. Bowen (1978) recommended that the client establish a person-to-person relationship with every (living) person in the family of origin.

A second objective for individuals wishing to increase their levels of differentiation is to *learn to be a better observer of family interactions and better at controlling emotional reactions*. These two tasks are linked, according to Bowen, because observing and learning about our families leads to less emotional reactivity, which then frees us to be better observers. However, Bowen warned that no one is perfect. It is impossible to be a completely objective observer of one's own family, but one can make progress with hard work.

Detriangling is the third route to differentiation; in fact, Bowen (1978) called it "an absolute necessity" (p. 542). To detriangle, one needs to be in continual contact with two other family members around an emotional issue. You can't take sides with either of the other members, nor can you defend yourself—you must be objective and neutral. You can't even be silent on the issue because that will be perceived by the others as an emotional response. Detriangling is best practiced when there is some form of emotional upswing in the family, because under calm situations families will try to bury emotional issues and therefore triangles will be less visible. Clients are thus encouraged to "go home" to visit during holidays (always stressful!) or when there are illnesses or deaths in the family. In the broader Bowenian approach to BFST, the therapist can also bring the members of the triangle into therapy and intervene directly to reorganize the interactions (P. J. Guerin et al., 1996).

I would be remiss if I neglected to mention the role of *taking an I-position* in BFST counseling. Both the therapist and the client are expected to use the I-position, which is "a clear statement, neither offensive or defensive, of one's thoughts and feelings on a subject" (Carter & Orfanidis, 1976, p. 202). Taking an I-position is an important component of differentiation.

Now that Jean understands the basic ideas of BFST, Jean and Jacob devise journeys home for her. She is to visit with her mother, sister, and brother, observing how she is pulled into triangulation, even though these family members live separately from one another. Mother wants to talk about Father with Jean. Sister wants to talk about their brother's problems with depression. Jean, the eldest child, is expected to intervene in her parents' relationship and help her little brother. She feels pulled to take Mother's side against Father.

Jean struggles to maintain a person-to-person relationship with each family member and to not talk about other family members in the context of another relationship. As Jacob coaches Jean, he asks her to describe the family's ways of interacting with her. He explores the triangle between the parents and little brother and also the sibling triangle of Jean, her sister, and her little brother. Together, they devise ways for Jean to stay out of these triangles and to function more autonomously.

EVALUATION OF THE FAMILY SYSTEMS APPROACHES

Critics of family systems theories have commented on all of the variants I present in this chapter. Strategic therapy draws a good deal of the fire for its use of strategies such as paradoxical interventions. These strategies are questioned on ethical grounds because they are seen as manipulating the client without the client's consent (Hampton, 1991). Haley (1987), of course, retorted that it is impossible to do counseling without manipulating clients because you are trying to get them to change.

Feminists have been quite clear in their criticisms of systems approaches as maintaining the patriarchy (see the later discussion of cultural and gender issues). Still others accuse FS theory of being simplistic and mechanical.

The roles of therapist as powerful expert and clients as passive objects have also been questioned. The postmodern, constructivist theorists maintain that, because we construct all reality, there is no absolute truth for the therapist to know. This position implies that the client is as much of an expert as the counselor (Becvar & Becvar, 2013).

Innes (2002) reviewed Satir's approach and found fault with its focus on the individual at the expense of context. He also pointed out that the relationship between theory (e.g., constructs, assumptions) and practice is underdeveloped in this approach, a quality that Innes argued relegates this approach to a relatively minor status within the realm of FS theories.

As you will see from the section on research that follows, several approaches have emerged that combine aspects of the structural and strategic approaches, primarily. The most highly recognized models are brief strategic family therapy (Szapocznik, Schwartz, Muir, & Brown, 2012; Szapocznik, et al., 2013), functional family therapy (Alexander & Sexton, 2002), multidimensional family therapy (Liddle & Hogue, 2001) and multisystemic therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). These approaches, to a large extent, were developed to work with those notoriously difficult customers, families with adolescents who are acting in socially unapproved ways (e.g., substance abuse, other law breaking; Baldwin, Christian, Berkeljon, & Shadish, 2012).

QUALITIES OF THE THEORY

It is difficult to evaluate FS approaches on my usual dimensions because the four theories presented here are very different from one another. For instance, some aspects of BFST seem to be relatively *operationalizable* and *testable*, but others are less so (e.g., binding anxiety). Satir's theory is, at times, pretty vague. On the other hand, we have certainly learned how to measure self-esteem. Strategic and structural propositions about structure and hierarchy have been tested (see the discussion of this under "Research Support"), and the results are somewhat supportive of these concepts.

FS therapy is considered *empirically supported* in some forms. Family therapy in general has been found to be effective, although you will see from the following reviews that at least one study found that the effects of systems interventions appear not to be as strong as those resulting from behavioral approaches.

RESEARCH SUPPORT

Outcome Research. Reviews of family and relationship (i.e., "marital") therapy generally find that, overall, these approaches produce desired client change (Diamond & Josephson, 2005; Rowe, Gozez, & Liddle, 2006; Sexton & Alexander, 2002; Shadish & Baldwin, 2003). Early assessments of the efficacy of family interventions, particularly when they were using meta-analysis, tended to lump all of the approaches discussed in this chapter under the label "systems interventions" rather than separating them out. Although systems approaches are found to be effective in these reviews, it is often difficult to determine exactly what this means. For example, Shadish and Baldwin (2003) reviewed 30 meta-analyses of couples and family interventions and declared them effective in comparison to control or wait-list conditions. The meta-analyses included tested a very wide range of interventions (e.g., parent training, behavioral couples therapy, family therapy for schizophrenia). One of them, Shadish et al. (1993), meta-analyzed 163 studies (all using random assignment of

participants to groups) and found that, although systems approaches as a group produced an effect size significantly different from zero, this effect (0.28) appeared to be much smaller than that found for behavioral or psychoeducational approaches (0.56), for instance. A more specific analysis of these data (testing only studies that compared two or more approaches in the same project) found that for family therapy, behavioral approaches did better than all other orientations except systems approaches. In a more recent meta-analysis, Pinquart, Oslejsek, and Teubert (2016) found different results in an analysis of 37 randomly controlled trials comparing explicitly systemic interventions with either control or alternative treatments for adult clients with a range of diagnoses (e.g., eating disorders, schizophrentia, mood disorders). Systemic approaches produced stronger effect sizes than control groups and outperformed alternative treatments at post-test, although the effect size for the difference was small. However, the differences between systemic and other approaches disappeared when follow-up data were analyzed.

As data have accumulated, however, more recent meta-analyses can evaluate specific approaches to family therapy. For instance, Baldwin et al. (2012) meta-analyzed studies that compared one of four contemporary adaptations of family systems theory (brief strategic, functional, multidimensional, multisystemic) to either another specific treatment, treatment as usual, or a control condition. No differences in the effects of the four approaches were found, and all seemed to have modest effects when compared to treatment as usual (Baldwin et al., 2012, p. 281). Effects were larger in comparison to control conditions, but because there were only a small number of studies using this method they were not statistically significant.

Using a traditional review method, Diamond and Josephson (2005) pronounced family-based approaches to treatment effective across a wide range of presenting problems. They noted, however, that very little research is available that addresses the underlying theoretical structures of the treatments that have been tested. Similarly, von Sydow, Beher, Schweitzer, and Retzlaff (2010) located 38 randomly controlled trials of systemic therapy, finding that 34 of these showed positive results (e.g., the systemic therapy produced better outcomes than control groups or was as effective as or more so than comparison treatments) for a wide range of diagnostic categories.

Weaver et al. (2013) reported that structural family therapy produced favorable changes in mothers' levels of depression and anxiety, but that children of these families didn't report significant changes in symptoms. An interesting finding was that mothers did report changes in their children's levels of dysfunction. The study was a one-group, pre- and post-test design, and although two follow-up assessments were included, the absence of a control or comparison group leaves open the possibility that something other than structural family therapy was the cause of the change.

Several research programs that test the contemporary systems approaches described earlier have succeeded in clearly specifying treatment packages and have produced good results. Multisystemic therapy (MST) is one of these, and true to its name it involves intervening in a wide range of contexts involved when kids get in trouble (e.g., school, home, family). Family interventions focus on family affect and parenting practices. Research findings for this approach, including the results of randomized controlled trials, are very supportive (Letourneau et al., 2013). Another systemic approach with good research support is brief strategic family therapy (BSFT; Szapocznik et al., 2012; Szapocznik et al., 2013). This intervention seems helpful for at-risk adolescents and their families, and perhaps most significantly, those from traditionally underserved populations (e.g., Latina/o, African-American; Santisteban & Mena, 2009; Santisteban et al., 1996; Szapocznik et al., 1988). A further offshoot of BSFT is structural ecosystems therapy (SET; Mitrani, Robinson, & Szapocznik, 2009), developed for use with women who are HIV positive.

A large clinical trial of SET produced positive results on a number of outcomes among urban women and their families, mostly low-income clients of Hispanic or African-American backgrounds. For example, Mitrani, McCabe, Robinson, Weiss-Laxer, and Feaster (2010) demonstrated that SET was associated with decreased psychological distress and reduced drug relapse among a sample of mostly Hispanic and African-American women who were HIV positive when compared to a health education control group. Children of these mothers seen in SET showed reductions in distress as well (e.g., anxiety, depression, aggressive behaviors). Feaster et al. (2010) compared SET to a supportive treatment and treatment as usual, finding that SET improved medication adherence for low-income HIV positive African-American women who also reported reductions in family hassles compared to women in the other two conditions.

Rakowska (2011) tested a form of strategic therapy that was based on the MRI version (the precursor to Haley's strategic therapy). Clients diagnosed as either socially phobic with personality disorder or socially phobic without personality disorder were randomly assigned to manualized strategic therapy or supportive therapy. After 10 sessions of therapy, treatment group clients who were diagnosed with only social anxiety showed improvement relative to those who received supportive treatment, and the results were maintained at a 3-month follow-up.

Theory-Testing Research. It seems that although theory-testing research has been conducted that is relevant to the classic FS approaches, the coherence and quality of these investigations vary. Many studies have tested the predictions of structural family systems therapy and, indirectly, strategic therapy because the majority of these studies look at family hierarchy. Some of these studies are explicitly tests of one of the theories (mostly structural), whereas others are presented as tests of more general statements that would be endorsed by many orientations. For example, research has supported the prediction that parental conflict is related to dysfunction in both kids and parents (B. T. Davis, Hops, Alpert, & Sheeber, 1998; Fivaz-Depeursinge, Lopes, Python, & Favez, 2009; Kerig, 1995). I will review a select group of studies here.

Many studies have examined family alignment patterns, which would seem to be fairly direct tests of structural or strategic ideas. Bascoe, Davies, and Cummings (2012) conducted a longitudinal study of boundaries around sibling relationships and found that both enmeshment and disengagement predicted problems of adjustment among adolescents (e.g., sadness, anxiety, conduct problems). Fivaz-Depeursinge et al. (2009) verified that cross-generational alliances, detouring, and triangling could be observed in families parenting toddlers and that the toddlers actively contributed to these interactions. In families where the parents were in conflict, these patterns were more severe and consistent. Kerig (1995) studied families characterized (by the members) as triangulated, detouring, cohesive, or disengaged. She found much support for structural theory. Parents in families that were characterized as relying on triangulation reported more conflict and more negative affect in comparison to cohesive and detouring families. Kids in detouring families reported feeling more responsible for their parents' problems and were found to have more internalizing problems (e.g., depression and anxiety in comparison to acting out) than kids in other kinds of families. Contrary to predictions, children in triangulated families did not show more dysfunction than children in other families, but Kerig maintained that the lack of difference was because most of these kids were involved in a coalition with a parent. She reasoned that the coalition was a source of support for these children.

Two longitudinal studies have verified that triangulation leads to negative outcomes for adolescents. Buehler, Frank, and Cook (2009) found that triangulation of adolescents into

parental relationships had negative effects on both the psychological and social functioning of the adolescents. Fosco and Grych (2010) demonstrated that adolescents who were triangled between conflicted parents responded with self-blame and reported increased discord in their relationships with their parents. Because triangulation preceded the negative outcomes in these studies we can be more confident in the SFT prediction that triangulation is the cause of the adolescent distress than if the research were cross-sectional, because the latter design would allow for the possibility that the causal pattern was reversed (i.e., that adolescent dysfunction led to triangulation).

Although the research is dated, several studies of structural family therapy's hypotheses about psychosomatic families produced conflicting support. Northey, Griffin, and Krainz (1998) found that families with asthmatic children appeared to avoid disagreement and engage children in parental discourse. However, they found no support for the contention that the primary motivation for detouring is to decrease marital conflict (asthmatic couples detoured regardless of the level of couple distress). Following up on Northey et al., Griffin, Parrella, Krainz, and Northey (2002) confirmed that children in asthmatic families were more involved in the parental dyad than in families that did not have an asthmatic child, consistent with SFT theory. However, this pattern appeared in families regardless of the level of marital distress, which is counter to SFT theory, which predicts that child intrusion should occur more in dysfunctional families. On the basis of these results, Griffin et al. questioned the SFT view of psychosomatic families, suggesting that child involvement might be better seen as the children actively participating in the family, or a sign of health.

Rynes, Rohrbaugh, Lebensohn-Chialvo, and Shoham (2014) presented an interesting study of demand and withdraw patterns among adolescents and their families in brief strategic family therapy. I include it here under theory-testing research because demand–withdraw (DW) patterns are a general assumption of family systems approaches—couples or families get stuck in this destructive cycle of one person (e.g., a parent) demanding change and the other person running away (the kid). Further, Rynes et al. investigated this pattern as a parallel process in therapy, where the therapist and adolescent client replicate the DW pattern in the client's family. They hypothesized that when the DW was severe in the client family, outcomes (in this case, drug use) would be worse if the pattern was replicated between therapist and client. Results showed exactly that: High DW in therapy was associated with increased drug use among adolescents whose families showed significant DW. For clients from families with low DW, drug use and DW were not related.

Empirical tests of Bowen's theory have produced promising results (Skowron, Van Epps, & Cipriano-Essel, 2014). R. B. Miller, Anderson, and Keala (2004) reviewed the literature and found support for the theory in terms of relationships among differentiation, anxiety, relationship satisfaction, and psychological dysfunction. Subsequent research has confirmed these relationships (Knauth, Skowron, & Escobar, 2006; Murdock & Gore, 2004; Hooper & DePuy, 2010). For example, Skowron, Stanley, and Shapiro (2009), using a longitudinal design, found that college students who demonstrated a greater differentiation of self reported fewer psychological symptoms and interpersonal problems when assessed 12 weeks later. Those who reported that they were emotionally reactive, had difficulty maintaining a sense of self in relationships, and tended to engage in fusion or emotional cutoff experienced the greatest interpersonal distress and psychological problems 3 months later, even after controlling for early semester stress. One interesting additional finding indicated that greater emotional reactivity led to greater aggression and insensitivity in one's relationships, characterized by fighting, being irritable, being quick to anger, holding grudges, and feeling little concern for others' happiness or welfare.

Skowron, Kozlowski, and Pincus (2010) studied families (mothers and children) at high and low risk for child maltreatment; notably, their sample was over 75% African-American, further supporting the utility of Bowen's theory with diverse populations. Results indicated that mothers who reported lower emotional reactivity and less emotional cutoff also scored lower on the index of child abuse. Mothers at higher risk of engaging in physical child abuse were more emotionally reactive, more likely to be emotionally cut off in relationships, and more self-attacking. Conversely, mothers at lower risk for child abuse were significantly more differentiated.

The applicability of BFST across cultures and sex have been questioned, particularly the construct of differentiation of self. One of the earliest cross-cultural studies established that the construct of differentiation seemed to be applicable for a sample of Filipino individuals (Tuason & Friedlander, 2000). Chung and Gale (2009) also found that differentiation was related to family functioning in expected directions among Korean and European-American samples, but that the relationships were stronger for European-American families than Korean, providing qualified support for BFST cross-culturally. Speculation that differentiation would be a construct not related to positive outcomes among Koreans led H. Kim et al. (2014) to hypothesize that younger South Koreans, who identify more with Western culture, would show higher levels of differentiation of self than would older individuals. Surprisingly, Kim et al. found the opposite: Differentiation was positively related to age and was also related to measures of family functioning. However, this study did demonstrate that high fusion levels were related to family cohesion, a finding that would seem consistent with the collectivistic values of Korean culture.

Ross and Murdock (2014) investigated the relationship between self-construal, differentiation of self, and psychological functioning. Although conducted with U.S. college students, the study has implications for the utility of BFST across cultures because self-construal refers to the degree to which one's self is perceived to be independent of or related to important others. Ross and Murdock demonstrated that differentiation was positively correlated with independent self-construal and negatively with interdependent self-construal, as would be expected by critics of BFST. Further, for individuals with low levels of differentiation, high independent self-construal appeared to protect them from psychological symptoms as compared to individuals with low differentiation and lower levels of independent self-construal.

Various studies have found correlations between differentiation and sex. Peleg and Zoabi (2014) studied a sample of Jewish and Arab college students, concluding that "on the whole, results lend support to the universality of Family Systems Theory" (p. 221) but did find that women scored higher than men on emotional reactivity and fusion, which could be seen as consistent with gender stereotypes (women are emotional and likely to be overinvolved in relationships). Jewish students were found to have higher I-position and lower emotional cutoff in comparison to the Arab participants.

Tests of the BFST prediction that levels of differentiation are the result of multigenerational transmission have yielded conflicting results. Tuason and Friedlander (2000) found no support for the hypothesis, but in contrast, D. M. Harvey, Curry, and Bray (1991) demonstrated that parents' levels of individuation and intimacy were directly related to those of their children, which supports it. Gardner, Busby, and Brimhall (2007) demonstrated that partners' reports of their family-of-origin experiences were linked to emotional reactivity and relationship satisfaction, which would also confirm the multigenerational hypothesis of BFST.

Bowen predicted that individuals would choose partners who had levels of differentiation similar to their own. This hypothesis has received very mixed support in the literature, with

some studies confirming and others disconfirming (Day, St. Clair, & Marshall, 1997; Greene & Mabee, 1992; Kosek, 1998; R. B. Miller et al., 2004). In summary, it appears that Bowen's ideas about differentiation of self are supported when it comes to psychological functioning, but perhaps are less supported with family or couples processes (R. B. Miller et al., 2004).

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Feminist therapists have had great difficulty with traditional FS theory (Braverman, 1988; Nichols, 2014). Feminists believe that the neutral stance of systems theory and concepts such as circular causality can result in excusing the perpetrators of battering and child abuse. The very common "dysfunctional triangle" of the overinvolved mother, distant father, and smothered child is based on the patriarchal system, because women have few options outside of the home. Lerner (1988) observed that

> as long as men are the makers and shapers of culture in the world outside the home, as long as women are not free to define the terms of their own lives, as long as society continues to convey the message that mother *is* the child's environment, then the basic dysfunctional triad of distant, overfunctioning father, emotionally intense, overinvolved mother with a child with little room to grow up, is a natural outgrowth and microcosm of the culture. (p. 51; emphasis in original)

Feminist therapists argued that FS theory reinforces traditional family structure, which is based on the patriarchal model of male in power. Structural family therapy was, in particular, a target of these criticisms (Simon, 1992). The idea that "enmeshment" of the mother and child is pathological is seen as problematic. The argument is that, even if this structure is pathological (and that is questionable), it is the result of cultural factors that deprive women of other outlets and pressure them to conform, and it should be recognized as such (Bograd, 1990). Feminists also point out that very often, if someone in the family is absent in therapy, it is the father, which can reinforce the stereotypical perception of the mother as caregiver and the father as breadwinner.

Several scholars have found fault with Bowen's construct of differentiation. Lerner (1988) pointed out that the description of highly differentiated individuals is synonymous with the stereotypical view of men, whereas low differentiation appears identical to stereotypes about women. Similarly, Knudson-Martin (1994), also noting the equation of separateness = health in Bowen theory, argued that separateness and togetherness are reciprocal processes necessary for healthy functioning and that "at low levels of differentiation, neither can develop" (p. 41). Further, whereas in Bowen theory healthy behavior is the result of objective thought, Knudson-Martin contended that at higher levels of differentiation of self, both feeling and intellectual systems guide behavior.

FS approaches are also susceptible to the charge of cultural bias. Most models of ideal family functioning were developed based on the White middle-class nuclear family (Falicov & Brudner-White, 1983; Imber-Black, 1990). However, structural family therapy is an exception to this characterization; Minuchin developed his theory during his work with poor inner-city youth and their families. Also, the research on brief strategic family therapy referenced earlier demonstrates that this approach is applicable with Hispanic youths and their families.

Nichols (2014) urged counselors working with families to pay more attention to social class issues, commenting that most therapists do not experience economic hardship and, as a result, have difficulty understanding the trials experienced by clients from lower socioeconomic statuses and the impact of these on psychological and family functioning. Attempting to address

this issue, McGoldrick and Carter (2011) included social class in their examinations of cultural issues in working with families. Data on the topic of cultural issues were provided by Keeling and Piercy (2007), who performed a qualitative study of 20 family therapists from a wide array of countries and cultural backgrounds. They found these therapists to be very aware of culture, gender, and power issues in therapy.

Bermudez (2008) was interested in the strengths and weaknesses of the Satir approach in working with Hispanic families. She consulted with six expert Satir therapists, and in summarizing their responses she provided an excellent evaluation of the approach and suggested modifications to fit this client group. For example, Bermudez described the potential pitfalls associated with the Satir maxim that people are doing the best they can, suggesting that this statement could be perceived as supporting the actions of oppressors. She further pointed out that children in Hispanic families might not be willing to comment on family rules because this could be seen as disrespectful to elders. Overall, though, Bermudez and her experts concluded that Satir's approach had significant strengths in terms of cultural applicability, including its flexibility and emphasis on the importance of family in individuals' lives.

Although G. Cheung and Chan (2002) acknowledged that Satir was personally and in her teachings extremely sensitive to cultural differences, they nonetheless found problems with applying her theory to Chinese clients. They pointed out that the individualistic emphasis in Satir's approach was inappropriate for Chinese clients for a number of reasons. Focusing specifically on the issue of the congruence of communication, Cheung and Chan argued that to emphasize direct, authentic expression of feelings in relationships is counter to Chinese culture. Affirming the self, in this culture, comes only after affirming the other. Avoiding conflict is a way of preserving harmonious relationships, and in Chinese culture this harmony is more important than self-expression. However, the holistic perspective of the model (think about the Self Mandela) would be consistent with the values of Chinese culture (Epstein et al., 2012).

Falicov and Brudner-White (1983) argued that the bias toward structures, norms, and practices of middle-class European-American families could lead therapists to ignore the adaptiveness of other family structures and processes. For example, "intrusion" by grandparents might be adaptive in cultures in which close extended family ties are common. Further, theories that encourage the exploration of extended family relationships, such as Bowen's, have the potential to be culturally insensitive because they tend to support separating (differentiating) from the extended family, an individualistic value that is contrary to the norms of many cultures. Encouraging a close-knit Latino family to differentiate might be counter to the tradition of *familismo* found in Hispanic/Latino cultures (Sue & Sue, 2013). African-American families also involve the extended family in a wide range of family issues and functions, so FS approaches could be problematic with these clients as well.

On the other hand, too much attention to cultural features can be hazardous, according to the family theorists. Montalvo and Gutierrez (1983) warned that the FS therapist can become "merely delighted and empathic toward the exotic aspects of the family's culture rather than focused on how these are employed to facilitate or block problem solving" (p. 18).

FS theorists have extensively addressed issues of cultural diversity in their work (McGoldrick, Carter, & Garcia-Preto, 2011). Minuchin often commented on the cultural differences among families and family structures (Minuchin, Lee, & Simon, 1996). Chang and Yeh (1999) reviewed several of the approaches to FS theory described in this chapter, noting that each has strengths for working with families of Asian origin. For example, the emphasis on multigenerational issues in Bowen's theory is consistent with the values of Asian cultures, and Chang and Yeh

suggested that coaching can help these families balance the powers of the family and the individual. Bowen's approach and structural theory can also help these families in the struggle to acculturate to other cultures that are more individualistic than traditional Asian ones, according to these authors. Also, the role of the therapist as an active, expert coach or leader in the FS approach is consistent with the expectations of individuals who are of Asian origin.

Haley and Richeport-Haley (2003) noted that strategic therapy is appropriate for many clients from cultures other than Western European cultures because

> (1) The family and/or social network is included in the therapy. (2) Therapy does not stress exploration nor insight. (3) It is action oriented, not discussion oriented. (4) The therapist maintains a position of expertise and authority. (5) The client receives concrete advice. (6) The therapist maintains a posture of courteous concern. (p. 28)

They describe four different ways to approach clients who have belief systems that diverge from those typically seen in Western European cultures. First, and perhaps most controversial, would be to ignore cultural differences and treat the problem as usual. Although acknowledging that this approach can be counter to the values of some clients' cultures, Haley and Richeport-Haley contended that this mode would help clients challenge cultural behaviors that are giving them trouble in "mainstream" American reality. They described a case in which this method was used with a violent Hispanic family, noting that they violated the traditional values of respect for authority (*respeto*) in encouraging the wife to be less submissive and obedient to the husband. Dragging the husband into therapy and requiring him to bare his personal life was also counter to this value. A second approach is to use aspects of the client's belief system to solve the problem. For example, good spirits can be enlisted to fight against evil ones. The third and fourth ways to deal with alternative belief systems are to refer the client to an indigenous healer and to collaborate with such a healer in therapy.

Less attention is paid to other-than-heterosexual couples in traditional FS theory. Only fairly recently have the experiences of lesbian, gay, bisexual, and transgender couples and families become a topic of interest, but this interest is clearly increasing (Ashton, 2011; Nichols, 2014).

THE CASE STUDY

The case of Jean and Derril lends itself well to the classic FS conceptualization of overinvolved mother and distant father. I chose it because it allows an opportunity to evaluate the tendency in FS theory to pathologize this structure. That the clients are of different cultural groups is an interesting addition to the complexity of this presentation.

Feminists would question the characterization of Jean and Derril as enmeshed or undifferentiated—or at least the assumption that this situation is the problem. They would point out that Jean's behavior is simply fierce protection of her son in the face of a racist world (Bograd, 1990). Jean is likely struggling economically as a single parent, and this dynamic finds its way into her relationship with Derril in her hope that he will succeed according to the prevailing cultural norms.

Should Derril's father be brought back into the system? He has been physically abusive to Jean in the past and shows few signs of wanting to be involved with Derril. Many would question the validity of the idea that two parents are better than one.

What are the cultural implications of encouraging Derril and Jean to differentiate? Is this construct or process adaptive in doing counseling with members of the African-American culture?

Summary

FS theorists see human behavior as stemming from the power of the system, which is composed of the members of a family structure and their various relationships, roles, and interactions. FS theorists assume that influencing one part of the system will influence all the other parts. Thus, they do not locate psychological dysfunction in an individual; rather, they see dysfunction as a product of the circular, repetitive interactions observed in a family.

The four theories reviewed in this chapter share the basic systems assumption, but vary in how they think about systems and how they intervene in them. Satir focused mostly on communication patterns and members' sense of self-esteem. She strives to bring love and caring to a situation often fraught with faulty communication and dysfunctional rules, which are exacerbated by the members' low self-worth.

Structural family therapy focuses on the interplay of the family's subsystems in terms of how the arrangements in the family help it achieve life tasks. These theorists emphasize a balance between togetherness and individuality, like Bowen, but they tend to intervene by changing the structure of the family or the permeability of its system boundaries.

Strategic systems therapists focus on interaction patterns and hierarchies. They are attentive to issues of control and power in relationships and find that when families are in distress, a hierarchy is out of whack. Interventions in strategic therapy are intended to change interactional patterns and thus the hierarchical arrangement of the family.

BFST emphasizes differentiation in the context of the family emotional system. Triangles are considered key in the functioning of individuals within systems, and clients are taught to recognize these and escape functioning within them. Many times BFST counselors will urge adult clients to differentiate from their own families of origin before attempting to deal with current relationship or family issues.

Outcome research seems to support family interventions, but the largest portion of these efforts has been directed at interventions other than systemic ones. Still, a significant number of studies support the utility of an FS systems approach. Theory-testing research, which largely assesses concepts taken from structural therapy, strategic therapy, and BFST, is generally supportive. Contradictory or nonconfirming findings have been reported in all areas, though.

FS theorists have been criticized for upholding a model of White, middle-class families that is not applicable to individuals from other cultural or ethnic origins. The model originated with a distinct heterosexual bias, and feminists argue that cultural norms about the roles of men and women are embedded in these systems.

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CHAPTER 14

Solution-Focused Therapy



Insoo Kim Berg

Kelly is a 22-year-old White male who comes to counseling to deal with problems of anger control. Currently working as a technical writer, Kelly earned his bachelor's degree in journalism three years ago.

Kelly is single (never married) and lives with his parents in their home in a large city. He has a steady girlfriend, Janet, and they plan to be married but are not formally engaged.

Kelly reports that he wants to work on "problems with my temper." He sees himself as an "angry person" and reports being easily offended and tending to "blow up" when really frustrated. In the past, Kelly has occasionally thrown things when extremely angry, but never directly at anyone. Most often, these incidents happen when he is in conflict with his parents and less often with his girlfriend, Janet.

Kelly is perfectionistic about his appearance, environment, and work and says that this perfectionism sometimes leads to an overconcern about details and frustration with others who do not share his standards. Although Kelly admits that he resents authority figures, he says that he does not have problems with his anger in work settings. Occasionally, his "perfectionism" causes Kelly to be frustrated with the performances of his coworkers, but he is generally able to deal with this feeling in a constructive way. In fact, Kelly reports that he is more likely to be passive at work, accepting "mistreatment" from employers and remaining in an unfulfilling job despite feeling that he is not challenged by his work.

Kelly's nonverbal presentation is somewhat stiff and tense. He alternates between seeming angry and sad when he talks about his troubles.

BACKGROUND

What I am going to call solution-focused therapy (SF therapy for short) draws from two separate approaches, both of which are rooted in early communications/systems theory and draw from the work of Milton Erickson (more on this to follow). The first variant of SF therapy was developed by and primarily associated with Steve de Shazer and Insoo Kim Berg, who founded the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin. A second version of SF therapy is attributable to Bill O'Hanlon and colleagues. O'Hanlon has used the terms *solution centered, possibility therapy*, and *collaborative, competency-based counseling* to refer to his approach, but most recently seems to refer to it as possibility therapy. Because *solution-focused therapy* seems to be the most widely recognized term, I will use it in this chapter. A review of the history of this theoretical approach can be found in Cade and O'Hanlon (1993) and Nunnally, de Shazer, Lipchik, and Berg (1986).

De Shazer, Berg, and several other colleagues (principally Elam Nunnally and Marvin Wiener) established the Brief Family Therapy Center in 1978 (Nunnally et al., 1986). This group reported that its earliest sessions were conducted in the de Shazer–Berg living room, with one member of the team handling the video camera. From these small beginnings, SF therapy is now international in scope.

Most of the writers in the SF tradition share an admiration of the work of Milton Erickson (see Haley, 1973, for a description of Erickson's work). In fact, Bill O'Hanlon served as Erickson's gardener for a year because he desperately wanted to train with Erickson and could not afford to pay for it (O'Hanlon, 1986). The SF theorists were intrigued by Erickson's use of language, metaphor, and hypnosis to draw out clients' strengths so that they can be applied to current problems (de Shazer, 1982). In this process, Erickson could be seen to accept the worldview and life patterns of the client, helping the client to use them in new ways. De Shazer and colleague Joseph Berger spent a significant amount of time trying to develop a theory around Erickson's work, which, although it obviously involved interactional (communication) elements, seemed almost magical. De Shazer (1998) reported that these efforts were not successful; indeed, "Erickson, it turned out, was correct in saying that he did not have a Theory. He perhaps had many theories, but not quite one per case" (p. 3).

Steve de Shazer and Insoo Kim Berg met at the Mental Research Institute (MRI) in Palo Alto, California. Thus, SF therapy incorporates some of the ideas from the communications orientation to psychotherapy that originated at the MRI (Watzlawick, Weakland, & Fisch, 1974). These researchers initially began their work by studying communication in families of people diagnosed as schizophrenic, finding that certain patterns of interaction were particularly common in such families. They later broadened their ideas to conceptualize most psychological dysfunction as rooted in interactional patterns. One of the most significant aspects of the MRI group's work as far as SF therapists are concerned is the conceptualization of clients' problems as resulting from "more of the same" syndrome, a cycle wherein clients' failed efforts to solve problems result in their trying even harder, but using the same strategies. You can read about the beginning of the "miracle question," a fundamental technique in SF therapy, in Box 14.1.

Box 14.1

The History of the Miracle Question

Insoo and her colleagues discovered the miracle question serendipitously. Insoo was interviewing a woman who seemed burdened with the weight of the world: Her children were out of control, the school was calling about their unruly behavior; and her husband of 17 years had been drinking more heavily, with the result that he seemed about to lose his job and, with it, the family's livelihood. The woman was discouraged and talked as if she could not cope with another day. Insoo asked the woman, "What do you suppose needs to happen so you could say the time we are spending together has been useful to you?" The client said, "I'm not sure. I have so many problems. Maybe only a miracle will help, but I suppose that's too much to expect." Committed to picking up on her clients' words and ideas, Insoo asked, "OK, suppose a miracle happened, and the problem that brought you here is solved. What would be different about your life?"

To Insoo's amazement, this woman, who had seemed so overwhelmed and unable to go on, began describing a vision of a different life. She said that her husband would be "more responsible, keeping his job and managing the money better." She said her children would "follow rules at school and at home, doing their chores without putting up such a fuss." Most of all, she said that she would be different: "I will have more energy, smile more, and be calmer with the children and, instead of snapping at them, talk to them in a normal tone of voice. I might even start having normal conversations with my husband, like we used to when we first were married."

Insoo and her colleagues thought about what had happened in the session with this woman. It occurred to them that, even though we do not normally think of miracles as realistic, this client's description of her life after the miracle had happened was certainly a reasonable and realistic picture of a well-functioning family. Her description of her miracle turned out to be a worthwhile set of goals from her point of view. Thus, the miracle question was born. Insoo and her colleagues began asking it regularly.

The miracle question is useful for at least a couple of reasons. First, by asking about a miracle, it gives clients permission to think about an unlimited range of possibilities. They are asked to think big as a way to get started on identifying what changes they want to see. Second, the question has a future focus. It evokes a picture of a time in their lives when their problems are no longer problems. It begins to move the focus away from their current and past problems and toward a more satisfying life.

The miracle question has been asked thousands of times throughout the world. It has been refined as practitioners have experimented with different ways of asking it. The question is best asked deliberately and dramatically.

> Now, I want to ask you a strange question. *Suppose* that while you are sleeping tonight and the entire house is quiet, a *miracle* happens. The miracle is that *the problem which brought you here is solved.* However, because you are sleeping, you don't know that *the miracle has happened.* So, when you wake up tomorrow morning, *what will be different* that will tell you that a miracle has happened and the problem which brought you here is solved?

Source: De Jong, P., & Berg, I.K. (2008). *Interviewing for solutions.* Belmont, CA: Thomson Higher Education, p. 84. Used with permission.

De Shazer and Berg were married for 28 years and died within a year and a half of each other. Steve de Shazer passed away in 2005. His last book, *More Than Miracles: The State of the Art of Solution-Focused Therapy* (with Yvonne Dolan), was published posthumously in 2007. Insoo Kim Berg died unexpectedly on January 10, 2007. Berg had recently completed a book on coaching from an SF perspective (Berg & Szabo, 2005).

MyCounselingLab

Video Example 14.1 Watch Steve de Shazer and Insoo Kim Berg welcome participants to a conference on solution-focused therapy.



https://www.youtube.com/watch?v=v6rXeglulT4&list=PLkdC1bxKsrHZJ4gpORpRdYd7FsxLF4CwJ

Bill O'Hanlon's website can be found at www.billohanlon.com, and the title of a recent book is *Out of the Blue: Six Non-Medication Ways to Relieve Depression* (2014). Two major professional organizations in SF therapy are the European Brief Therapy Association (www.ebta.eu), created in 1994, and the Solution-Focused Brief Therapy Association, founded in the United States in 2002 (www.sfbta.org).

MyCounselingLab

Video Example 14.2 Bill O'Hanlon on depression.



https://www.youtube.com/watch?v=NYGteG-ANdI

BASIC PHILOSOPHY

SF therapists are serious optimists. They believe in the power of language to create and define reality and therefore that there are no absolute truths (de Shazer, 1994).

The dual influences of the MRI approach and Milton Erickson's work fused to produce a constructivist theory that proposes that humans create their realities, and if trouble develops, they can re-create their realities in ways that are more helpful to them. SF therapists emphasize the joint psychological construction of the therapy situation that allows therapists and clients to create new ways of viewing their lives and through these constructions formulate solutions to the problems clients bring to counseling. Approaching clients with the attitude that they have strengths and resources to solve their complaints, SF counselors create an interaction designed to maximize client potential.

The SF therapist calls the client the "customer" and the problem the "complaint." In this way, the SF approach emphasizes that the client knows where he wants to go and is motivated to get there. The counselor is merely "hired" because she has some expertise in constructing solutions.

SF counseling's propositions are presented as countering the assumptions found in so-called traditional approaches to psychotherapy. For instance, whereas other approaches maintain that change is difficult, the SF theorists argue that change is constant. Other "myths" of traditional therapeutic approaches according to the SF theorists are presented in Box 14.2.

Box 14.2

Myths of "Traditional" Therapy

1. There are always deep, underlying causes for symptoms—client problems are symptoms of these causal factors.
2. Awareness or insight is necessary for change or symptom reduction—we must understand the cause of the symptom for people to get better.
3. Amelioration or removal of symptoms is useless or shallow at best and harmful or dangerous at worst.
4. Symptoms serve functions.

5. Clients are ambivalent about change and resistant to therapy.
6. Real change takes time; brief interventions are shallow and do not last.
7. Focus on identifying and correcting pathology and deficits. Traditional therapies look for pathology, the solution-focused therapist says "If you look, you will find it."

Source: From IN SEARCH OF SOLUTIONS: A NEW DIRECTION IN PSYCHOTHERAPY, REVISED EDITION by Bill O'Hanlon and Michele Weiner-Davis. Copyright © 2003, 1989 by Bill O'Hanlon and Michele Weiner-Davis. Used by permission of W.W. Norton & Company, Inc.

In beginning her work with Kelly, Mary, an SF therapist, starts with the expectation that therapy will not take long and that Kelly can easily resolve his complaint. She is on the alert for Kelly's strengths and resources and will surely note that he had the intelligence and persistence to complete a college degree. Mary approaches Kelly with the attitude that change is easy to achieve and that she would be surprised if Kelly did not change.

In countering the ideology of traditional approaches to psychotherapy, O'Hanlon and Weiner-Davis (2003) identified some important assumptions of SF therapy. These principles are as follows:

1. *Clients have resources and strengths to resolve complaints.* The therapist's job is to help the client access these abilities and put them to work in the interest of solving the problem. Clients are often so focused on their difficulties that they forget about their strengths. It is essential that the SF therapist remind them.

   Kelly worries that his explosions of anger prove that he is out of control, that he is indeed an "angry person," and that his relationships will be destroyed if he does not change. His counselor, Mary, acknowledges Kelly's concerns, but she is also alert for Kelly's personal strengths and brings them to Kelly's attention. For instance, Mary commends Kelly for his sensitivity to and caring for others, which resulted in his coming to counseling. She asks Kelly about his work and comments on his ability to concentrate and focus on a task until it is completed to his satisfaction (rather than construing this process as "perfectionism"). Mary recognizes Kelly's desire to get tasks done well, including his motivation to improve his personal relationships.

2. *Change is constant.* According to the SF philosophy, if one assumes that change is constant, one will behave as though change is inevitable. Basically, the SF therapist conveys to the client verbally and nonverbally that she would be surprised if the problem persisted. O'Hanlon might add that clients must work hard not to change—see his 11 ways to stay stuck in Box 14.3 in the section on "Health and Dysfunction."

   Mary presents with the attitude that she expects change and expects it soon. She asks Kelly about what his life will be like when *he changes, not* if *he changes.*

3. *The SF therapist's job is to identify and amplify change.* In any approach to counseling, therapists create a reality with their clients through the questions they ask and the things they choose to

focus on or ignore. SF therapists identify what seems to be working, label it, and work on making it happen more often.

Kelly says that he argues with his parents about many things, from what football game to watch on Saturday afternoon to what his responsibilities and rights are within the household. However, there are times when he does not "blow up." Mary is quite interested in these exceptions to his patterns. Mary tries to find out how Kelly manages to avoid blowing up and asks him to do the same things in other situations.

4. *It is usually unnecessary to know a great deal about the complaint to resolve it.* According to O'Hanlon and Weiner-Davis (2003), therapists can get stuck because they have "too much information about the complaint and too little information about the solution" (p. 38). Instead, SF therapists find out what clients are already doing that is working. Once the therapist and client have identified the characteristics of trouble-free times, the client can work toward doing these things all of the time.

   Mary discovers that Kelly can often tell his girlfriend, Janet, when he is upset with her, which usually results in the two of them talking about a difficult issue and resolving it. Mary is not very interested in the particular issue involved, but more in how Kelly was able to approach the situation calmly rather than exploding. Kelly reveals that the solution to the situation is that he distracts himself for a few minutes before he approaches Janet. Mary immediately asks Kelly how he can do this in other situations—for instance, when conflict is impending with one of his parents.

5. *It is not necessary to know the cause or function of a complaint to resolve it.* Going to the therapist is typically the last resort. Before they get to counseling, most clients have spent a lot of time trying to figure out what caused their problems because mainstream culture teaches that, if we can find the cause, the solution will follow (O'Hanlon & Weiner-Davis, 2003). It is obvious to SF counselors that this rumination has not helped their customers. However, because we are brainwashed by society, the media, and therapists, our customers sometimes still ask the "expert" *why* they have the problem. An SF therapist might simply counter with "Would it be enough if the problem were to disappear and you never understood why you had it?" (O'Hanlon & Weiner-Davis, 2003, p. 41).

   Mary is not very interested in Kelly's personal history, nor would she spend much time delving into the history of the anger problems. In contrast, Kelly, who has been brainwashed by society, probably thinks that his anger problem is the result of some very complicated events way back in his childhood. No doubt his troublesome parents had something to do with it!

6. *A small change is all that is necessary; a change in one part of the system can effect change in another part of the system.* A small, positive change raises our clients' confidence, and buoyed by the counselor's support they begin to believe that they can create more changes. O'Hanlon and Weiner-Davis (2003) offered Milton Erickson's snowball metaphor of change as an illustration: once a snowball gets rolling down a hill, "the therapist merely needs to stay out of the way" (p. 42).

   A major goal for Mary is to find, in the first session, some small change Kelly could make that he would perceive as positive. For example, Kelly typically fights with his father over what football

game to watch on Saturdays. Mary discovers that Janet likes football and usually agrees with Kelly about which games to watch. Mary asks if Kelly could ask Janet to bring over her laptop and join him and his father for the coming Saturday games. That way Kelly could alternate between games. Not only might this change his relationship with Dad, it might also enhance his partnership with Janet.

7. *Clients define the goal.* SF counselors dispute the idea that there is any one "correct" way to live (O'Hanlon & Weiner-Davis, 2003). Refusing to believe that there is some "real problem" that underlies the symptom leads SF therapists to insist that clients determine the goals for treatment. The only exceptions to this rule are illegal or patently unrealistic goals.

   Some therapists' first response to Kelly's situation might be to opine that he should move out of his parents' home. After all, he is 22 and employed. Shouldn't he be "mature enough" to live on his own? As an SF counselor, Mary joins with Kelly in his desire to find a solution for his problems with anger, implicitly acknowledging that it is his valid choice to remain in his parents' home.

8. *Rapid change or resolution of problems is possible.* The first session is considered particularly powerful in the SF approach. Through reconstructing their views of their situations along with the counselor, clients typically see that they already know how to resolve the complaint. If the client still sees a need for change at the conclusion of the initial session, the counselor expects the client to go off and do whatever else is needed to create solutions before the next session.

   During his first session with Mary, Kelly realizes that he has the negotiation skills necessary to avoid his outbursts of anger. After all, he is able to get along with his coworkers, and his relationship with Janet is not all that stormy. He need only apply these skills to his interactions with his parents.

9. *There is no one "right" way to view things; different views may be just as valid and may fit the facts just as well.* Although many different views of a situation are valid, some are more helpful than others, according to the SF approach. When clients come to counseling, they are problem focused. Adopting a solution-oriented view is seen as more likely to produce change.

   Our clients' views of problems often promote the "more of the same" syndrome (Watzlawick et al., 1974). Typically, if attempts to solve the problem don't work, the old adage "If at first you don't succeed . . ." seems to apply, and clients tend to "try, try again" with the same strategies. SF theorists maintain that different views of the problem might lead to using different strategies or even to defining the problem as not a problem! My client Jean's 9-year-old son developed a distressing tendency to tell his mother "I hate you" when she corrected his behavior. Jean's typical response was to lecture him about how this was an inappropriate thing to say. What she was doing had little effect on the young man's behavior, so we decided to have Jean stop doing more of the same and instead do something different—ignore these statements because he probably didn't mean them anyway. This strategy was apparently successful; the frequency of the "I hate yous" decreased. Further, when the boy did say this, the mother was not bothered by it any longer, so she was much more relaxed in her interactions with him.

Kelly reports that he experiences his most troublesome outbursts when his parents "pick at him" and "treat him like a child." He views this behavior as controlling and evidence that his parents do not view him as an adult. When he gets angry, he is attempting to convince them of the "wrongness" of their actions, and when they have these talks, Kelly progressively raises the volume of his voice, trying to really get their attention. When the volume approach does not work, he will occasionally throw something. However, Kelly's angry outbursts are not working to change his parents' behaviors, and Kelly begins to realize that his own behavior is, in fact, rather childlike. Mary sees Kelly's escalation as "more of the same" and attempts to get him to do something, anything, different the next time conflict looms with his parents. She might also try to portray Kelly as "sensitive" rather than "easily offended" or "defensive."

10. *Focus on what is possible and changeable rather than on what is impossible and intractable.* The complaints that SF therapists and their clients address are those that are amenable to change.

Mary would never attempt "personality reconstruction," but she might attempt to help Kelly have fewer angry outbursts.

HUMAN MOTIVATION

Hard-core SF therapists really don't care what motivates people in general. They simply observe what clients want to achieve and use clients' identified strengths and resources to help them reach solutions.

Even so, O'Hanlon (2006) distinguished between positive and negative motivations and, further, past, present, and future motivations. Positive and negative motivations refer to our tendencies to move toward things we want and away from those we wish to avoid. In O'Hanlon's view, our behavior can be informed by each of these in the moment or by experiences/expectations of them in the past or future. He provided an example of a young man who was negative past motivated (in O'Hanlon's terminology) by the assertion of his high school counselor that he was not "college material" (2006, p. 3). The young man ended up with a Ph.D.!

Mary is not very concerned with the motivation underlying Kelly's behavior or presenting problem. She simply appreciates that he is eager to change in the interest of bettering his relationships with others.

CENTRAL CONSTRUCTS

EXCEPTIONS

An SF therapist starts with the basic assumption that, regardless of the severity of a client's presenting problem, there are always times when the problem does not happen (Lutz, 2014). The SF counselor takes the stance that she would be very surprised if there were not exceptions to the complaint. The motivation behind this belief is to help clients see that the complaint is not always present and that they already are successful and happy at times. The therapist works with the client to find ways to increase those activities that have produced the exceptions.

Invariably, clients have not paid attention to exceptions. Clients are often quite surprised when the therapist focuses on the times that are trouble-free rather than on the presenting complaint. They are used to thinking about the complaint, and they typically have been exposed to

(some would say indoctrinated by) the traditional models of psychotherapy that spend a lot of time on how and why the problem occurs.

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Video Example 14.3 Watch Insoo Kim Berg explore exceptions with a client. 

Mary will be hard at work from the beginning of the first session to find exceptions to Kelly's "angry personality," which they have since redefined as troubles in expressing anger and negotiating conflict. She will be likely to ask him about when he disagreed with his parents, but did not have an angry explosion, and what he did to manage to avoid it. Kelly has invested a lot of effort in trying to figure out why he is so "angry" with little result. When Mary encourages him to think of times when he isn't angry or can negotiate agreement with someone, he is pleasantly surprised and even smiles in response to her questions.

CHANGE TALK

The goal of an SF interview is to talk about the client's problem in ways that bring about change (de Shazer, 1985). Complaints are discussed in terms of specific behaviors that are amenable to change rather than using negatively valenced labels. Use of the presumptive terms in place of probabilistic language (such as *when* rather than *if*) in talking about change emphasizes that the counselor firmly expects change to occur (Corcoran, 2005). For example, the therapist can ask the client, "When you (perform the exception), what do things look like?"

Discussions with Mary about times when he is not angry (e.g., when he is relaxed and happy) help Kelly construct a situation in which it is acknowledged that anger is transient, not a personality trait fixed at birth. Relabeling the "angry personality" as difficulties in communicating (or perhaps temper tantrums) suggests that the troubles will be easy to banish. Mary asks Kelly, "When you communicate well, how would you describe your relationship with your mother?"

SOLUTIONS

SF counselors believe that, if we "accept the client's complaint as the reason for starting therapy, therapists should, by the same logic, accept the client's statement of satisfactory improvement as the reason for terminating therapy" (de Shazer, 1991, p. 57). Rather than focusing on the client's complaints, SF counseling concentrates on what would be perceived by the client as an acceptable solution to the problem—a difference that would make a difference.

Kelly, by his report, wants to deal with his problems with anger. Mary, accepting Kelly's goals, helps him identify times when he negotiates conflict satisfactorily and works with him to decide how to do this more often.

STRENGTHS AND RESOURCES

The aspiring SF counselor needs to adopt a special view of people. Rather than looking for their weaknesses (because if you look under every rock for pathology, you'll certainly find it), the SF therapist emphasizes the strengths of clients and the resources they already can access. These qualities are put to work finding the solutions to complaints (Lutz, 2014).

Cade and O'Hanlon (1993, p. 138) related the story of a client who was known for her work training difficult horses. After asking her to elaborate how she did so well with these beasts, the therapist asked if these principles could be applied to dealing with her troubles with her husband!

Mary works hard to identify and emphasize Kelly's strengths and the skills he can use in the service of reaching his preferred solution. She discovers that he is bright and likes to solve puzzles. He clearly is good at attending to detail and has the ability to concentrate intensely.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

SF advocates do not postulate a theory of the individual or of development. This theory is more a theory of counseling than a theory of human nature. Listing internal mental mechanisms that are traditionally addressed in theory (e.g., personality traits, attitudes, motivations), McKergow and Korman (2009) wrote, "Solution-focused therapists do not make assumptions about any of the above and they do not try to change them" (p. 39). Likewise, structures or processes external to the individual, such as systems, power structures, and cultural norms, are not important to individual change. McKergow and Korman (2009) opined, "This is not to say that, for example, cultural norms have no influence . . . However, this is not the same as acting as if there were an overarching 'real system' or 'power structure' that must be found, mapped, followed, or changed, or else the work will be in vain" (p. 41; quotes in original).

So an SF therapist does not care where the problem comes from and is not very interested in the history of the individual or of the problem except in special, very rare circumstances. For example, in discussing one of the most difficult problems therapists confront, severe psychological dysfunction such as schizophrenia, O'Hanlon and Rowan (2003) noted that "When some medications were found to be helpful in managing the symptoms of such disorders, it was hailed as proof that the disorders had a biological basis. This is akin to arguing that if you take cocaine and it helps lift your depression, you have a biological disorder involving cocaine deficiency" (p. 19). Acknowledging that the jury is still out about the origins of these dysfunctions, O'Hanlon and Rowan advocated that SF techniques can be helpful if the therapist maintains an awareness of neurological and biochemical influences that wax and wane in these presentations.

Mary spends no time wondering about any personality theory or factors in Kelly's childhood. Such factors are just not relevant to the kind of counseling she offers.

HEALTH AND DYSFUNCTION

The diagnosis in SF therapy is as follows: A customer has come in with a complaint. SF therapists are not concerned with notions of health or dysfunction—they simply listen to the client's construction of the problem, look for exceptions, and construct solutions. The client determines what is healthy; that is, the customer determines the goals of therapy. Therapists who think their personal version of the problem (e.g., its causes and meaning) is the only correct one are suffering from "delusions of certainty or theory countertransference" (Hudson & O'Hanlon, 1991, p.17).

Despite the emphasis on listening to each client as an individual, the SF therapist could also say that "All complaints are alike. In almost all cases, the client's complaint includes wanting the absence of something without having any idea about what a reasonable replacement might be" (de Shazer, 1988, p. 52). Often, the therapist helps the client redefine the complaint in solution-oriented terms, a process called reframing (de Shazer, 1991). In fact, when de Shazer was asked (as he often was in workshops) "How do you deal with _____ (insert diagnostic label such as *depression* here)," he would respond, "I don't understand that question" (McKergow & Korman, 2009, p. 45). This response may sound weird (or worse) at first glance, but McKergow and Korman (2009) explained that from the SF perspective it is totally understandable because SF counselors "don't work with depression; they don't solve problems or work with them at all. They do solution building with people in the same way, whatever their diagnosis" (p. 45). In case you are interested, though, other SF writers have addressed specific client presentations, such as suicide, psychosis, anxiety, and others (Guterman, 2013; Lutz, 2014). I would emphasize here, however, that the discussion of these presentations is always with an emphasis on examining what is going on when the problem is not occurring and in the context of the client's strengths and resources.

Another way of looking at dysfunction is that clients are stuck. O'Hanlon (2006) had some ideas about this, which you can read about in Box 14.3.

Box 14.3

How NOT to Change
Eleven Strategies for Staying Stuck

1. Don't listen to anybody.
2. Listen to everybody.
3. Endlessly analyze and don't make any changes.
4. Blame others for your actions or problems.
5. Blame yourself or put yourself down regularly.
6. Keep doing the same thing that doesn't work.
7. Keep focusing on the same things when that focus doesn't help.
8. Keep thinking the same thoughts when those thoughts don't help.
9. Keep putting yourself in the same unhelpful environment.
10. Keep relating to the same unhelpful people.
11. Put more importance on being right than on changing.

Source: From CHANGE 101: A PRACTICAL GUIDE TO CREATING CHANE IN LIFE OR THERAPY by Bill O'Hanlon. Copyright © 2006 by O'Hanlon and O'Hanlon, Inc. Used by permission of W.W. Norton & Company, Inc.

In Kelly's case, he wants to lose the temper tantrums, but has not decided how to behave instead of having fits. Kelly comes to Mary thinking that he needs to get rid of his angry and compulsive personality. Alternatively, he could think that Mary needs to help him figure out ways to change those around him, particularly his parents. Mary acknowledges these ideas, but will then proceed to help Kelly redefine the complaint in a way that leads to solutions. Probably, they will agree that Kelly wants to have more harmonious relationships with others who are important to him.

NATURE OF THERAPY

ASSESSMENT

SF advocates do not believe in traditional assessment; they would say that assessing the client belongs in the medical, problem-focused approach to counseling. Instead, SF counselors *interview for solutions* from the very start of counseling (De Jong & Berg, 2013). Strengths and resources are very much the focus of an SF interview and an important part of this assessment is to find out about the client's Very Important People (VIPs; Lutz, 2014). VIPs are not just sources of support for clients; they are often involved in deciding if the problem has been solved.

Mary asks lots of questions of Kelly, but they are focused on the exceptions to his complaints of angry outbursts ("disagreements with his parents") and on his strengths and resources. What does he do well? Obviously, Kelly's VIPs include his parents and Janet, but are there others?

OVERVIEW OF THE THERAPEUTIC ATMOSPHERE

Therapists at the Milwaukee BFTC used a team-assisted approach to counseling similar to that used by family systems therapists, although Nunnally et al. (1986) reported that the groups developed the procedures independently. Counselors typically worked with a team of consultant therapists, who are usually behind a one-way mirror. Often, sessions were videotaped as well. Sometime during the session (normally toward the end), the therapist takes a break to consult with the team and normally returns with some compliments for the client and a homework task to be completed between sessions. The team, along with the therapist, is seen as an integral part of the psychotherapy system (de Shazer, 1991). However, many SF counselors likely practice without the benefits of the team approach because they don't have the resources to implement it.

Typically, clients in SF therapy complete four to five sessions, and most find their solutions in fewer than 10 sessions. Sometimes, clients attend only a single session of counseling and emerge as satisfied customers.

SF therapy is seen as a collaborative venture (Guterman, 2006). The therapist's task in the first session is to establish a working, cooperating relationship with the client, a process de Shazer (1988) called "developing fit" (p. 90). In establishing the relationship, the therapist invites client cooperation by initiating cooperating behaviors. Clients will then reciprocate by demonstrating their versions of cooperating behaviors.

The relationship in SF counseling is described as having a special kind of intimacy and harmony. Counselor and client pay attention to what the other says and respect the other's worldview as valid and meaningful (de Shazer, 1988). De Shazer and Dolan (2007) wrote that SF therapists "almost never pass judgments about their clients, and avoid making any interpretations about the meanings behind their wants, needs, or behaviors. The therapist's role is viewed as trying to expand rather than limit options" (p. 4).

O'Hanlon and Weiner-Davis (2003) pointed out that language can be used to help establish the therapeutic relationship. Initially, SF therapists are likely to adopt some of the client's language as a way to join the client. The SF therapist then gently helps the client channel the language used about the complaint into more solution-oriented forms (e.g., change and exception talk).

Berg and Shafer (2004), in writing about working with clients mandated to treatment, summarized the SF approach to cooperating in the following way:

> Cooperating with clients means learning how to stand side by side with them, not facing against them, as in a competition . . . [W]e see things from clients' perspectives and eliminate the "professional posture" of judging them. Clients do not need one more failure or one more label as "incompetent" or "difficult." The most important contribution a practitioner can make during the initial contact is to shape clients' experience in a way that is different from any other negative professional experiences they may have encountered in the past. Clients need the opportunity and the latitude to make choices instead of feeling coerced to comply; to feel understood instead of being labeled. (p. 90; quotes in original)

Mary adopts Kelly's language of "angry person" to begin with, so that he feels at ease in the first session. Kelly, of course, is a little tentative at first because he is afraid that Mary will see him as childish and reject his version of the problem. Mary joins Kelly in his frustration and comments on how he is very sensitive to others, which is demonstrated by his sadness after he has a fight with his parents or Janet.

Roles of Client and Counselor

The SF counselor is expected to take responsibility for what happens in sessions. SF therapists have special knowledge about how problems are maintained and changed. In this sense, the therapist is an expert in change, but not about the client's particular problem. The client is the expert on himself and his situation; it is assumed that clients have all the necessary knowledge about their particular complaints along with the ability to change things (Lutz, 2014). The therapist focuses on the text (what the client says needs to be different) without making any further assumptions (de Shazer, 1994).

SF counseling is an energetic process, with the therapist taking the lead and using a series of questions designed to elicit information relevant to exceptions and solutions. The client is seen as an active collaborator in this process and as responsible for doing whatever is necessary to solve the problem.

De Shazer (1988) identified three types of clients: visitors, complainants, and customers. *Visitors* are clients who don't have any complaints. They are often in the counselor's office because someone else has told them to be there. Thinking about the client as "visiting," rather than "involuntary," avoids creating an "involuntary" therapist. An involuntary client paired with an involuntary therapist is a recipe for trouble. According to de Shazer, the way to deal with a "visitor" is to be nice, be on his side, focus on what works, and give compliments.

Complainants are signaling that therapy can begin. No matter how diffuse, vague, or confusing the problem, at least there is a problem! The complainant has come with some expectation that change will happen as a result of therapy.

Clients who bring a complaint and the desire to do something about it are called *customers*. Ideal clients for any therapist, these individuals can be given tasks to complete with the expectation that they will oblige.

De Shazer later changed his mind about these distinctions among individuals who present for counseling (Ratner, Geoge, & Iveson, 2012). Everyone who comes for therapy wants something to be different, even if that is to get someone to stop nagging him. Trying to determine whether the client is a visitor, complainant, or customer is akin to making assumptions about a client's motivation, which is distracting. Ratner et al. pointed out that "if we take seriously what the

client wants from meeting with us, even if it is not to have to meet us again, then this is the basis for a collaborative working relationship" (p. 23).

Mary is quite active in her sessions with Kelly and confidently accepts her job as an expert in change. Mary expects Kelly to be a collaborator in the change process and to work hard to make solutions happen. If Kelly had been coerced into therapy by his parents or Janet, his girlfriend, the situation might be somewhat different in that the initial focus might be on what Kelly needs to do to get out of therapy, but Mary would emphasize the collaborative nature of this task.

GOALS

Berg and Shafer (2004) noted that "[solution-focused therapy] begins with finding out what the *client* wants" (p. 85; emphasis in original). The counselor works with the client to develop the specific, attainable, and concrete goals that are essential in SF therapy. These goals should be observable. As noted earlier, even very small changes lead to more change, so no reasonable objective should be dismissed as trivial. Often the counselor will ask the client, "What will be the first sign of change?" This question searches for the smallest increment of change that is meaningful to the client.

Regardless of the complaint, the goals of a good SF therapist are as follows:

1. Change the *doing* of the situation that is perceived as problematic.
2. Change the *viewing* of the situation that is perceived as problematic.
3. Evoke *resources*, *strengths*, and *solutions* to bring to the situation perceived as problematic. (O'Hanlon & Weiner-Davis, 2003, p. 126)

The SF counselor is wary of "absence" goals—that is, goals that specify something will go away, but do not specify what fills the vacuum. The best goals are those that specify what replaces the unwanted behaviors (de Shazer, 1988; Lutz, 2014).

When asked what he wants to get out of therapy, Kelly says that he wants to stop being an angry person. He also wants to be less perfectionistic. He mentions "not yelling" or "not flying out of the house in a fury" or "not throwing any object within reach." Mary notes that these are "absence goals" and begins to look for the behaviors that sometimes replace the yelling ones.

Mary asks Kelly if it would make sense to focus on how he will have discussions at normal volume with his parents. He could learn some negotiation skills. Kelly says that he'd like to be more easygoing overall, which might lead to being able to relax at work, too. Mary asks Kelly how he will know he is more easygoing. What will be the first sign?

PROCESS OF THERAPY

SF counselors want action, and right away! The very first and most critical task of counseling is defining (actually redefining) the problem. Client and counselor negotiate the nature and meaning of the client's complaint (Guterman, 2013). For example, a client would be asked, "What do you mean by 'depressed'?" or more likely, "What is it like when you are not depressed?" Adopting the client's lingo, so to speak, is a way the SF therapist enters the client's world and joins with him in constructing the therapeutic relationship.

Once the therapeutic relationship is established, the counselor will gradually begin to use change talk, suggesting words that have less negative connotations than those typically used by the client and that also imply change rather than a static state of affairs. A "speech phobic" client might be

termed "nervous" or a depressed client "sad." Most important, the SF counselor is trying to change labels to specific descriptions of behavior that are more amenable to change (Winbolt, 2011).

SF counselors focus on the present, not the past. Even though clients often think that a detailed exploration of the past is necessary to progress, SF counselors think there is a risk of becoming bogged down in problem talk if there is too much focus on the past. They tend to treat historical information only as a source of possible solutions (Rossiter, 2000).

SF therapists have proclaimed the death of client resistance (actually, they admit to murdering it in cold blood; de Shazer, 1998, p. 5) and have reportedly had a funeral for it (Cade & O'Hanlon, 1993). De Shazer (1994) noted, "When the therapist focuses on what it is exactly that the client wants and lets that be the guide, there is no need for a concept of 'resistance'" (p. 61; quotes in original).

SF counselors don't recognize transference and countertransference in the way that many other theoretical approaches do. However, as I noted earlier, they do identify "theory countertransference," which is the therapist's tendency to get carried away and see everything through the lens of her pet theory (O'Hanlon & Rowan, 2003).

SF counselors place great emphasis on the first session of therapy (Guterman, 2013). At the start of the session, the SF therapist will take some time to join with the client, chitchatting about things that have nothing to do with the problem. However, very quickly the counselor moves into working with the client to reconstruct the problem, what Guterman (2013) called "coconstructing problems and goals" (p. 73). First, the counselor will ask for a brief description of the problem, but immediately follow with a series of questions designed to extract information about exceptions to the problem—times when things are progressing smoothly, past solutions to the current problem, and the person's strengths and resources. Box 14.4 shows a list of questions offered by O'Hanlon and Weiner-Davis (2003). The SF therapist is aware of and asks about pretreatment change (i.e., change between the time the client called for an appointment and the appointment).

Box 14.4

A Series of Solution-Focused Questions

1. What is different about the times when _____ (the exception happens)?
2. How did you get that to happen?
3. How does it make your day go differently when _____ (the exception happens)?
4. Who else noticed that _____ (exception)? In what way could you tell that she/he noticed? What did he/she do or say?
5. How did you get her/him to stop _____?
6. How is that different from the way you might have handled it _____ (one week, one month, etc.) ago?
7. What do you do for fun? What are your hobbies or interests?
8. Have you ever had this difficulty in the past? How did you resolve it then? What would you need to do to get that to happen again?

Source: From *In search of solutions: A new direction in psychotherapy*, revised edition by Bill O'Hanlon and Michele Weiner-Davis. Copyright © 2003, 1989 by Bill O'Hanlon and Michele Weiner-Davis. Used by permission of W.W. Norton & Company, Inc.

The initial goal of the first session is, at the very least, to create a solvable complaint and, at best, to solve the problem. In difficult cases, the SF therapist seeks to introduce uncertainty about the problem—that is, to somehow raise questions about the client's construction of the complaint (de Shazer, 1988). "Therapeutic misunderstanding" of the client's story is often used by the counselor to loosen the certainty with which the client holds his view of the problem. For example, a client might report that he is "compulsive." The SF counselor might wonder if this is really a time management problem because the client finds himself working too many hours.

The remainder of the first session is devoted to finding exceptions to the complaint and exploring these; through this process, the counselor and client construct concrete, solvable goals and then look at ways to reach these goals. In by-the-book SF therapy, the counselor takes a break near the end of the session, leaves the room, and prepares a message for the client (Winbolt, 2011). The message begins with compliments for the client and often includes a solution-relevant task to complete over the interval between sessions, which can range from a week to months.

In the remaining sessions of counseling, the counselor wants to use the "more of the same" principle to her advantage—continuing to do what works and abandoning what doesn't. Sessions often begin with checking the results of homework assignments, although some SF writers advise therapists not to check on homework because, if the client hasn't done it, a failure experience is created (Hanton, 2011; Macdonald, 2007). Hanton (2011) advised letting the client bring up the task or perhaps asking about it at the end of the session. Almost always, counselors ask clients about what happened over the interval that they'd like to continue.

Once clients tell what was good in the interval between sessions, the counselor responds with past-tense questions about these positives. Examples of these questions might be the following: How did you get that to happen? How did it (the positive change) make your day go differently? The SF counselor wants to talk about the good things that happened for the entire session, if possible (and sometimes it is). Although SF theorists would argue that many clients accomplish what they need very quickly (i.e., in one session), O'Hanlon and Weiner-Davis (2003) identified three groups of clients:

1. The miracle group (one-session cure)
2. The so-so group (report having a better week, but are not convinced that the problem is completely solved)
3. The same or worse group
(pp. 147–151)

Working with the *miracle* client is easy—the counselor simply focuses on the change and maintaining it. Clients are asked to think about factors that could lead to setbacks. Plans can then be made to defeat these. Sometimes clients are skeptical that change will last; they have seen improvement in the problem before that did not last long. The SF therapist respects this healthy caution, rather than seeing it as resistance, and helps the client explore previous patterns. The counselor then asks the client to specify a short period of time of change in the problem that would really make a difference. SF therapists do not generally prescribe relapses, but if setback seems likely, then ups and downs are conceptualized as part of the normal process of solving the complaint. At the end of the session, the counselor asks the client if he would like to schedule another session. A "checkup" session is scheduled with most clients.

Dealing with the *so-so* group is a little trickier. These clients respond to questions about what good things happened with a description of the difficulties they encountered. According to O'Hanlon and Weiner-Davis (2003), the counselor should immediately interrupt the client to refocus on positives. The client should always be assured that the difficulties will be discussed later in the session.

After the positives are exhausted, solution-oriented procedures are used to work on the difficulties the client reports. Exceptions are sought, and sometimes scaling questions are used (see the section on "Therapeutic Techniques").

The *same or worse* clients, of course, are the toughest customers. The wise SF therapist never accepts these negative reports automatically. Closer examination often reveals the small change needed to alter the client's perception of his first session outcome. My clients Susan and George came to their first session struggling so mightily with their relationship that they described themselves as "not a couple." At the start of the second session, they characterized their week as no better than previous ones, but I soon discovered that they had spent more time together during the week and had even gone out for a special dinner over the weekend. These behaviors certainly seemed more like a couple to me.

Same or worse clients sometimes truly see the problem as persisting. In this case, the counselor might consider doing something different (Guterman, 2013). Don't give up too easily on a solution-focused attitude, but searching for strengths and solutions can sometimes be "more of the same." As with any therapeutic approach, rigid or dogmatic behavior on the part of the therapist can be detrimental to client progress. Particularly with same or worse clients, it may also be helpful to consider that the therapist and therapy may be part of the problem rather than part of the solution. O'Hanlon and Weiner-Davis (2003) suggested that in this situation it might be wiser to resort to exploring the complaint pattern or occasionally to get pessimistic, such as when a warring couple is asked how in the heck they manage to stay together. Taking a pessimistic stance is considered a last-ditch tactic (Corcoran, 2005). Another tactic might be to re-evaluate the goals set; it is possible that a re-coconstruction of these is needed. You might also look to see if the solution the client is trying is maintaining the problem and consider figuring out how he can do something different (Guterman, 2013).

Mary is aware that redefining the problem is her first task. She asks Kelly to relate situations in which his "attention to detail" is not a problem or even when it is helpful. They explore situations in which he is able to contain his anger or, more simply, when he does not yell or throw things. When Kelly talks about his parents "pissing him off" or treating him like a child, Mary asks, "What is happening when you aren't pissed off? What is happening when they treat you like an adult? When you are able to negotiate differences with your parents without yelling, what is different?"

THERAPEUTIC TECHNIQUES

SF therapy has numerous techniques, many of which are designed so that they can be adapted to a wide range of complaints. However, the therapist has to really pay attention to what she is doing, because "technique" in SF therapy can be as subtle as how you word a question to a client. A very general strategy in SF counseling is to identify exceptions and then encourage the client to do more of the same (Guterman, 2013).

QUESTIONS

SF counselors rely heavily on questioning the client. A special SF tactic is the *presuppositional question*, which gives the respondent few options. The attorney who asks the client, "Have you stopped beating your wife?" has asked a classic presuppositional question (O'Hanlon & Weiner-Davis, 2003, p. 80). In SF therapy, presuppositional questions are used to emphasize change possibilities and the strengths of the client. For example, the classic SF question is, "When the problem is not present, how are things different?" Notice that the phrasing is not "*if* the problem is not present." The good presuppositional question already assumes that success happens. Presuppositional questions are open-ended but do not leave room for negative answers.

Pichot and Dolan (2003) identified several types of questions used by SF therapists. Some of these (the miracle and scaling questions) are discussed next. Others are *difference* questions (e.g., "What difference did it make for you to say good morning to your daughter every day this week?") and *relationship* questions (e.g., "How will your husband know when you are no longer depressed?"). In general, when questions are used they are usually followed with more questions intended to elaborate on details, thus making the solution more vivid for client and counselor.

Mary has used a number of presuppositional questions with Kelly: What is going on when your parents treat you like an adult? What happens? What difference does that make in your relationship to your mother? Your father?

NORMALIZING THE PROBLEM

This technique helps clients feel as though they are not "crazy" or extreme in their situations. One way to normalize is to ask clients, "How can you tell the difference between [the stated problem] and [a normalized explanation of it]?" (O'Hanlon & Weiner-Davis, 2003, p. 97). However, normalizing can involve simply reassuring clients that many people struggle with concerns similar to theirs (Winbolt, 2011). Normalizing compliments are a special case of normalizing the problem and usually take the form of commending the client for his strength in handling a very difficult situation.

Mary asks Kelly how he knows the difference between his parents treating him like a child and their expressing their caring for him. She also tells Kelly, "Given the circumstances, I am very impressed with how often you do keep your cool. It's kind of tough to grow out of being the kid, huh?"

COMPLIMENTS

People love compliments! Counselors should keep this in mind and comment on the great things clients are doing at any opportunity (De Jong & Berg, 2013). Reframing, or positive connotation, is a particularly helpful way of complimenting clients. For instance, when one member of a couple is very vigilant, the therapist can choose to see this behavior as "paying attention to what is going on in the relationship." One other good way of complimenting clients is to point to things that they have already done toward a solution. De Jong and Berg (2013) noted that clients often self-compliment; the therapist should notice and reinforce these. However, it is important in all of these cases that the compliments be real (not used just to cheerlead) and based squarely in information provided by the client.

Mary congratulates Kelly on his success in dealing with situations in which he gets into conflict with his girlfriend, Janet. He is also sensitive to relationships and cares a lot for other people. In fact, he cares so much that he came to counseling!

MIRACLE QUESTION

A trademark technique in SF therapy is the miracle question (Lutz, 2014), the origins of which you read about in Box 14.1. Designed to help clients figure out what they want from therapy without having to spend a lot of time contemplating problems and their causes, the miracle question goes something like this: "Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?" (de Shazer, 1988, p. 5). De Shazer and Dolan (2007) noted that the miracle question can have several functions in SF counseling—for one thing, it helps clients figure out their goals for therapy. They also contended that asking the miracle question helps clients get a sense that parts of the solution are already happening—the detailed questions that are used to follow up invariably get to things that have happened in the client's life that are related to the miracle. Typically, the miracle question is followed with a scaling question (see the following section), which asks the client where he is now on a 0–10 scale, ranging from 0 (just decided to go to the counselor) to 10 (the miracle is accomplished; de Shazer & Dolan, 2007).

Hanton (2011) noted that sometimes clients will respond to the miracle question with an absence response, such as "I won't be anxious anymore." The therapist should respond with an instead question: "What would you be feeling like instead?"

Mary asks Kelly the miracle question in the hope that he can generate some concrete indicators of how he will know when the problem is solved. Mary would also like to know how Kelly's parents (or Janet) will know when Kelly is different.

MyCounselingLab

Video Example 14.4 The miracle question 

SCALING QUESTIONS

Scaling questions can be used in several ways. The most common is "On a scale from 0 to 10, with 0 being the worst the problem has ever been and 10 being the problem is completely solved, where are you today?" (Cade & O'Hanlon, 1993; de Shazer, 1988, 1994). Note that the question stacks the deck in the counselor's favor because it is fairly unlikely that the problem is at its absolute worst when the client is in the session. In addition, Winbolt (2011) suggested that scaling questions have many other benefits, such as helping clients think in small but positive steps and making problems more concrete.

Once clients give a number on the scale, they are often asked, "What one or two things could you do this week to bring you up two points?" Alternately, they can be given homework, such as keeping track of all the seven or eight things that happen between sessions. Scaling questions can also be used as confidence builders by setting the anchors so that 0 represents absolutely no confidence that the complaint will be solved and 10 represents absolute certainty that it will be (Cade & O'Hanlon, 1993).

Mary asks Kelly to rate his anger on a 0-to-10 scale. He says that it is a 6. When asked what one thing he could do this week to bring himself up to a 7, Kelly thinks for a while. Finally, he says that he could count to 10 before he answers any question that his mother or father asks.

Fast-Forward Questions

Fast-forward questions can be used when clients absolutely cannot think of exceptions (O'Hanlon & Weiner-Davis, 2003). The counselor then asks them to mentally project themselves into a future in which the problem does not exist. Because of the speculative nature of this question, a great deal of time must be devoted to getting the client to be specific (asking such things as "How will your life be different?" "Who will be the first to notice?" "What will he or she do or say?" "How will you respond?").

Mary sends Kelly to 2 years from now and asks him to describe his laid-back self. Kelly says that he is able to negotiate with his parents. He reports that he helps folks at work with things that are important to him and is able to relax about the rest of the stuff. Mary is quite pleased with this view of Kelly's future.

Asking About the Problem

Exploring the problem is a last-resort effort used when the client can't think of exceptions (O'Hanlon & Weiner-Davis, 2003). This tactic is typically used to find a pattern in the complaint that can be altered (remember, a small change is a great place to start).

The therapist asks detailed, specific questions in attempting to elicit the exact sequence of events in the problem chain. This inquiry is *not* intended, of course, to elicit causes or any such nonsense, but to document the exact problem sequence so that a small change can be suggested that will hopefully lead to larger change. Also, because the "more of the same" principle suggests that problems are maintained by people's faulty change attempts, information is needed about these to reverse them.

Because Kelly is responding so positively to solution talk and readily finding exceptions, Mary feels no great need to ask a lot about the problem.

Externalizing

Drawing from White and Epston's work (1990), O'Hanlon and Rowan (2003) suggested that giving the problem a name and placing it outside of the client can be helpful. You can read much more about this technique in Chapter 15 on narrative therapy.

Mary and Kelly decide that Temper has gotten the best of Kelly in the past. It is now time for Kelly to look at ways in which he has defeated Temper and put it in its place.

First Session Formula Task

Although not a presuppositional question, this task makes use of the assumption that something good is already happening in the client's life. The SF counselor asks "between now and the next time we meet, I would like you to observe, so that you can describe to me what happens in your (pick one: family, life, marriage, relationship) that you want to continue to have happen" (de Shazer,

1985, p. 137). Clients, who are often very obsessed with what's wrong, are startled when the therapist asks them what's right. According to O'Hanlon and Weiner-Davis (2003), clients often do something new, different, and good in response to this task, even though it requests no change.

Mary assigns Kelly the first session formula task, and he comes back with a list of things he likes about his life. He is happy with his relationship with Janet and mostly likes his work. Mary asks what he likes about his relationship with Janet; she is setting him up for a generic task.

GENERIC TASK

Once goals have been established, the client can be asked to keep track of what he is doing this week that _____ (makes him feel more in control, makes him less stressed, etc.) (O'Hanlon & Weiner-Davis, 2003). The idea is to fill in the blank with the exception situation. A variant of this task that works particularly well with addictive or compulsive processes is the "pay attention to what you do when you overcome the urge to _____" assignment.

Kelly reports feeling tense much of the time, which seems to make it easier for him to lose his temper. As part of reframing Kelly's problem, Mary and he decide that he needs to be more relaxed. Mary therefore gives Kelly the assignment of keeping track of what he does during the week that makes him more relaxed.

BREAKING PATTERNS

Almost anything that changes the pattern of the complaint can be helpful. O'Hanlon (O'Hanlon, 2006, pp. 57–90; O'Hanlon & Weiner-Davis, 2003, pp. 130–132) suggested some ways of interrupting the sequence. Examples of these tactics include the following:

Changing any body behavior associated with the pattern. O'Hanlon (2006) reported directing overeaters to eat with the wrong hand (i.e., the nondominant one). I am sure this would raise my awareness as I clumsily spilled food on my lap.

Changing timing or duration of the pattern. For example, couples can be asked to fight from 6:00 to 6:17 A.M. every day (see the discussion of structured fights later in this section). A person who is anxious about giving a speech could be asked to be anxious 2 hours before the speech and get it over with. Client Denise compulsively checks doors 10 times before she goes to bed (to see if she has locked them). She could be asked to check the doors 25 times instead of 10.

Changing the location of the pattern's performance. O'Hanlon (2006) offered a particularly amusing example of changing the location. A couple reported having nasty fights. They were instructed to go immediately into their bathroom the moment they begin to argue. The husband was told to undress and lie in the bathtub while the wife sits fully clothed on the toilet. The couple was instructed to continue the fight. When they tried to follow the therapist's orders, of course they couldn't and broke into laughter. After that incident, the couple found themselves looking toward their bathroom and laughing whenever a discussion started to get tense.

Adding at least one new element to the complaint pattern. A client trying to quit smoking would be instructed to place his cigarettes in some difficult-to-reach place (a neighbor's mailbox, for instance). O'Hanlon (2006) described having a client put on her most favorite shoes before she allowed herself to binge.

Linking the complaint performance to the performance of some burdensome activity. This technique resembles Haley's (1963) benevolent ordeal. One of my clients was having trouble falling asleep at night because he was ruminating on angry thoughts. Because he had occasionally lamented

that his garage needed cleaning and he hated that task, I told him that, if he did not sleep within 20 minutes of hitting the bed, he was to get up and clean the garage. After all, he might as well use his nonsleeping time productively. At his next session, he reported absolutely no problems falling asleep over the preceding week!

Changing the context of the complaint. A client having trouble eating sufficiently (notice that she was not characterized as anorexic!) who normally eats alone could be instructed to always eat in the presence of others.

Change the clothing worn during the pattern. Watch out if I am wearing purple! It means that I am in a bad mood. I should probably wear green instead.

Mary decides on an ordeal task for Kelly to alter the performance of his temper outbursts. Kelly, who does not like to write about his personal experiences, is asked to write down everything he wants to say to his parents before he tells them about it. The minute he begins to be annoyed with something they've said, he is to go directly to his room, sit at his desk, and write out his complaints. He can then give this written summary to his parents.

SURPRISE TASK

This assignment is often used with couples or families and directs clients to do one or two things that will surprise family members or partners. Clients are instructed as follows: Over the next week, I want you to do at least two things that will surprise your parents/partner. You are to keep these secret—don't warn them. Parents/partner: You try to figure out what the surprises are. You are not to talk about this during the week. We will discuss it in the next session (O'Hanlon & Weiner-Davis, 2003, p. 137). If the target person is a young child, the rest of the family can be asked to leave the room while the counselor coaches the child on strategies that he can use to stump the family (Reiter, 2004).

No one says that therapy can't be fun sometimes! Clients who really engage in this task generally enjoy it. They become solution-focused detectives (i.e., searching for good things, not bad). At the least, this task can introduce change into patterns of interaction in a positive way. Sometimes the surprises even turn into solutions.

Mary wonders what might happen if she could get Kelly's folks into counseling and give them the surprise task. When Kelly and his parents return for the next session, she would not ask them what they did for each other. Instead, she would ask Kelly what he detected that his father did, and vice versa. Mom would be asked the same question about Kelly and Dad. Sometimes this process results in giving credit to the other for things they didn't do intentionally, such as when Kelly praises Mom for cooking his favorite vegetable—boiled carrots. Mom secretly thinks, "I thought he hated boiled carrots," but is gracious in accepting Kelly's appreciation.

WRITE, READ, AND BURN

This task is useful for obsessive or depressive thinking (de Shazer, 1985). The client is instructed to write about the problem on even-numbered days for a specified period of time, even if he only has a few sentences to write. On odd days, the client is to read the notes and then burn them. Between writing, reading, and burning, the client is to put off thinking about the problem until the regularly scheduled time.

As de Shazer (1985) noted, this task literally makes the client's troubles go up in smoke (p. 121)! Also, write, read, and burn helps clients achieve distance from their concerns and

become more objective. Most clients find that after a few days they have better things to do than to dwell on the problem.

Mary tells Kelly that on even days he is to make a long list of things his parents do that make him mad. On odd days, he is to burn his lists after reading them over.

STRUCTURED FIGHT

This technique is a version of changing the pattern of the complaint often used with couples. The SF counselor instructs the clients to fight in the following way: (a) Toss a coin to decide who goes first. (b) The winner gets to bitch for 10 uninterrupted minutes. (c) The other then gets 10 minutes. (d) There must be 10 minutes of silence before tossing the coin again (de Shazer, 1985).

Kelly could invite his parents to argue with him three times in the next week. They follow the 10-minute sequence, each of them complaining and listening. If they are not finished after one round, they wait 10 minutes and repeat the process.

DO SOMETHING DIFFERENT

Designed to disrupt the "more of the same" syndrome that maintains problems, this task is often used when one person is complaining about the behavior of another person and has tried "everything" to get the other to change to no avail (de Shazer, 1985).

Mary tells Kelly to do something different the next time he is headed for an argument with his parents. He takes her advice, and the next time he senses that his parents are going to criticize him, he breaks into a dance, skipping around the living room. His parents collapse in laughter.

SOLUTION-ORIENTED HYPNOSIS

In contrast to traditional uses of hypnosis, the SF therapist uses this technique to summon skills that support solutions. This unique approach to hypnosis apparently originated with therapists of the "Ericksonian" school, who used it to "access unconscious resources" (O'Hanlon & Weiner-Davis, 2003, p. 139). The implication is that the resources evoked are those that are thought to be beyond the client's conscious control.

Mary hypnotizes Kelly and asks him to see himself responding to his parents calmly. He sees himself doing so and even cracking jokes about how they care so much about him that he can't stand it.

MyCounselingLab

Video Example 14.5 Watch Insoo Kim Berg using scaling.



EVALUATION OF THE THEORY

SF therapy is a relative newcomer to the psychotherapy scene. SF authors are prolific, fun to read, and for the most part very good at arguing their cases. Because many are practicing counselors, their writings are filled with case studies that illustrate the practical applications of their theory.

Further, they attempt to collect data on their approach, and the results of these efforts are promising. The SF approach is appealing to many because of its brevity.

On the other hand, S. D. Miller (1994), in a very entertaining critique of SF counseling, pointed out that its claims of being different (quicker and better) are not supported by a review of the psychotherapy research. He pointed out that the average number of sessions for clients in any type of counseling is around five. Further, very little evidence exists that demonstrates that any one theoretical approach produces better outcomes than the others. The wise sage in Miller's (1994) article, Brief Throat, concludes, "The main impact of the solution-focused model—and any model of therapy, for that matter—is on the therapists that adhere to and practice the model's theoretical tenets and techniques and *not* on their clients!" (p. 29; emphasis in original). By saying this, Miller was pointing primarily to two issues: that the therapist's belief in her system boosts her effectiveness, and that across approaches, common factors produce client change. Claims that something special is happening in SF counseling therefore are simply ways to keep folks interested and invested in the approach.

SF therapy can be criticized as being superficial; it lacks a theoretical structure through which client complaints can be understood. Those who choose other theoretical orientations that are concerned with underlying causal structures (e.g., psychoanalytic, existential) are likely to see SF therapy as shallow. Proponents of the view that symptoms serve functions (i.e., proponents of almost all of the other counseling theories) would suggest that simple symptom relief would not last unless the function were replaced by some other means.

Piercy, Lipchik, and Kiser (2000) suggested that SF theory should attend more to emotion and that its practitioners should be more flexible in their approaches to their clients. De Shazer and Dolan (2007) contended that an emphasis on emotions stems from traditional views of therapy in which such inner states are privileged over external or social states and made into mystical, problematic things. They reply that SF therapy "does not view emotions as problems to be solved but rather views them as some of the many resources that clients have for constructing something 'better.' In other words, helping clients construct situations where they 'feel better' and where they can remember that they feel better is one part of successfully constructing and 'reinforcing' solutions. By paying attention to the context in which emotions happen, [solution-focused brief therapy] keeps them in their proper home, which is the client's everyday life, rather than making them an esoteric, mysterious phenomenon inside of the individual" (de Shazer & Dolan, 2007, p. 149; quotes in original).

QUALITIES OF THE THEORY

Precision and Testability. Because there is so little actual theory in SF therapy, theory-testing research is difficult to find. However, a manual has been developed for individual applications of SF counseling, which will facilitate outcome research.

Empirical Support. In earlier editions of this book, I contended that SF therapy did not have strong empirical support. However, research has been building (as you will see in the next section), and I tentatively conclude that support for the effectiveness of this approach is evident. In fact, SF therapy is recognized by the Substance Abuse Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices.

Research Support

Because SF therapy doesn't have much theory to test, I have bypassed my usual division of this section into outcome and theory-testing research.

From a historical perspective it is interesting that, much to their credit, de Shazer and the therapists at the BFTC collected outcome data on some of their clients (De Jong & Berg, 2013; de Shazer, 1985, 1991). For example, a study of 275 clients who presented for therapy at the BFTC in 1992 and 1993 found that 7 to 9 months after therapy, 45% of the 136 clients who could be contacted reported that their goals had been met in therapy, 32% reported some progress, and 23% reported that they had made no progress in meeting their goals. Keep in mind that these are informal survey data—helpful, but subject to many potential pitfalls in terms of experimental design.

Turning to more recent research, meta-analytic studies of the outcomes of SF therapy have yielded mixed results. At least three meta-analyses have been conducted on studies of SF counseling. Corcoran and Pillai (2009), using rigorous criteria (studies had to be experimental or quasi-experimental), meta-analyzed 10 studies of SF interventions, finding that about half of the studies showed positive results. J. S. Kim's (2008) meta-analysis of 22 studies found small effect sizes that favored SF therapy. However, these effects were statistically significant only for internalizing problems (e.g., depression, anxiety). When compared with control treatments, SF therapy was not significantly more effective when externalizing issues (e.g., conduct problems) or family/relationship issues were the outcome measures. J. S. Kim and Franklin (2009) meta-analyzed seven studies of SF therapy used in school settings. The quality of the studies included was variable, and the results were mixed.

Two fairly recent qualitative reviews have appeared. Bond, Woods, Humphrey, Symes, and Green (2013) focused on the effectiveness of SF therapy with young people (ages 0–18 years) and their families. Reviewing 38 studies, Bond et al. concluded there was good support for SF interventions, particularly for internalizing and externalizing behavior problems. Gingerich and Peterson (2012) presented a qualitative review of 43 studies of SF therapy, including only studies that included comparison groups and intensive single-subject studies. They reported that 74% of the studies showed significant benefits for clients in SF therapy; when only the results of studies in which random assignment to treatment were considered, 83% of the studies showed positive effects. Gingerich and Peterson concluded that there was strong support for the effectiveness of SF therapy, particularly for adult clients who were experiencing depression. Similarly, Gingerich, Kim, Geert, Stams, and Macdonald (2012), after reviewing 48 studies, concluded that SF therapy produced moderate effect sizes and outcomes comparable to other approaches.

Randomized controlled trials of SF therapy are beginning to appear, with positive results. As part of the Helsinki Psychotherapy Study, the effectiveness of SF therapy was compared with that of psychoanalysis and short- and long-term psychodynamic therapies (Knekt et al., 2011). This well-conducted study randomly assigned 626 clients to one of three treatments and used a comparison group that was assigned to psychoanalysis. Clients in psychoanalysis averaged 56 months of treatment. Those clients assigned to long-term psychodynamic treatments averaged 31 months (averaging 232 sessions), short-term psychodynamic 5.7 months (average 18.5 sessions), and solution-focused 7.5 months (averaging 9.8 sessions). All groups showed significant reductions in symptoms at follow-up, with symptom change happening fastest in the

short-term therapy groups. However, although all of the groups maintained significant levels of change at a 5-year follow-up measurement, long-term psychodynamic therapy was the most effective. Similar results were reported by Marttunen, Välikoski, Lindfors, Laaksonen, and Knekt (2008), who compared the long-term outcomes of depressed inpatients who received either SF therapy or short-term psychodynamic therapy. The two approaches did not differ in effectiveness at a 1-year follow-up assessment. Smock et al. (2008) found that SF group therapy outperformed traditional psychoeducational group intervention for substance abuse. After six sessions of treatment, the SF clients showed decreases in general distress and depressive symptoms, but the psychoeducational group did not.

Zhang, Yan, Du, and Liu (2014) were interested in the effects of SF therapy conducted in groups with mothers of children diagnosed with autism. They randomly assigned these women to one of two SF treatment groups or to a control group. Taking a positive perspective (as compared to symptoms based) on outcomes, a measure of post-traumatic growth was used, which included subscales such as appreciation for life, personal strength, and relationships with others. At the end of six group sessions, the mothers in the groups fared better than those in the control group, although the differences were not as pronounced at a 6-month follow-up assessment. However, these results must be viewed with caution because of issues involving statistical testing (i.e., multiple tests that may produce significant results by chance alone).

Studying older adults in Mexico, Seidel and Hedley (2008) randomly assigned 20 participants to either three sessions of SF therapy or a wait-list control group. Their results indicated that at post-test, participants in the SF condition showed significant changes in positive directions on a number of measures (symptom distress, problem severity ratings, and goal achievement), whereas the control group showed no changes pre- to post-test. Although this study had a very small number of participants, it is notable that the researchers developed a treatment protocol and used well-known measures with a sample of Latino/Latina origin.

Jakes and Rhodes (2003) reported on an interesting study of SF and cognitive-behavioral (CB) strategies with clients who had delusions. Five clients were intensively studied at baseline (no treatment), and then when they were treated with one SF and two CB interventions (schema-focused cognitive therapy and cognitive therapy focused on challenging the delusion), in that order. They observed that two of these clients (who were diagnosed with chronic psychosis as well as delusion for at least 1 year) responded positively (in terms of decreasing belief in their delusions) when they were treated with SF. All clients decreased their negative views about their selves, and Jakes and Rhodes indicated that this effect was seen mostly in the SF phase of treatment. However, because this was a multiple case study design, we must be cautious in generalizing its results to a wide range of clients.

McKeel (2012) presented a review of change processes in SF therapy. He focused on SF techniques such as asking about pretreatment change, presuppositional questions, the first session task, and the miracle question. The findings were mixed. For instance, several studies indicated that clients were confused by the miracle question (Estrada & Beyebach, 2007; Lloyd & Dallos, 2008). However, these same studies indicated that clients responded positively to scaling questions. Much of the research reviewed relied on small samples and simple client reports about outcomes. Concluding that the existing research was insufficient to confidently link techniques to outcomes, McKeel called for replication of existing research and suggested a number of ways to increase the effectiveness of process research on SF therapy.

Wettersten, Lichtenberg, and Mallinckrodt (2005) explored the relationship between the working alliance and outcome in SF therapy and brief interpersonal therapy (BIT). Reasoning that the alliance should be more important in BIT than in SF therapy, Wettersten et al. compared a sample of 26 clients who received SF therapy with an archival sample who had completed BIT. Interestingly, the results showed that the alliance scores of the two groups were similar when measured early in treatment and at termination. However, levels of symptom change, which overall were similar in the two groups, were correlated with the alliance only for the BIT group. Wettersten et al. suggested that these findings indicate that, although an alliance is necessary in SF therapy, it is not a mechanism of change. This conclusion would be acceptable to proponents of SF therapy, who would be pleased with the results for symptom change and also for client satisfaction, which was similar for the two groups.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Because de Shazer and his colleagues maintained that they construct the view of the problem along with the client, they argued that they enter the client's world, avoiding any imposition of the counselor's perspective on the client (de Shazer, 1994). Great care is taken to accept the client's presentation at face value and initially to work within the client's perceptual framework. Thus, these theorists would probably argue that their approach is, in fact, culturally bound, but to the culture of the client rather than to that of the theory or counselor. According to J. S. Kim (2014), many SF theorists have pointed to a potential for stereotyping linked to attending to cultural factors, advocating instead for a *not knowing* stance that avoids such bias. However, Kim concluded that attention to cultural competency is warranted to increase counselors' understanding of cultural barriers and to reduce the risk of culturally linked misunderstandings.

SF proponents have explored the use of this approach with a wide range of clients and presentations, including male cross-dressing (Dzelme & Jones, 2001), Muslim-American clients (Chaudhry & Li, 2011), and religious/spiritual concerns (Guterman & Leite, 2006). Bliss and Bray (2009) discussed using SF therapy with individuals who have cognitive limitations (e.g., as a result of stroke, developmental disability, or autism), noting that using the miracle question could be problematic because they may have difficulty imagining a preferred future due to neurological factors.

Bigler (2014) reviewed the use of SF therapy with African-American clients, concluding that sensitive use of this approach may be helpful for these clients. Noting that some African-Americans have unfavorable perceptions of helping professionals and counseling, she wrote that "often, these interactions for many African Americans fall into three categories: businesslike, neutral, or negative. Providing compliments to an African American client can be particularly aligning for the therapeutic relationship" (p. 80). Also, the focus on intently listening to and accepting the client's story in SF therapy might make African-American clients feel validated and heard, "talked to rather than talked *at*" (p. 79, emphasis in original). Similarly, Lehman, Jordan, and Masharef (2014) found value in using SF therapy with Hispanic and Latino clients. Advocates of using SF counseling with Native American clients have suggested that the term *miracle* be replaced with *vision* because the former may be perceived as having a Christian undertone (Blakeslee & Jordan, 2014).

Berg and Miller (1992) and Chang and Yeh (1999) specifically evaluated the utility of SF therapy for clients who are of Asian origin. Although these authors warned that to act on stereotypes of Asians or Asian-Americans alone is risky, they maintained that certain aspects of SF counseling

are very consistent with these clients' ideologies. They pointed out that, because Asian-Americans tend to seek counseling as a last resort, they are often in crisis, which leads to a desire to focus on problems. Indeed, in general, individuals of Asian heritage are thought to be more comfortable problem solving than addressing emotional content (Berg & Miller, 1992). SF counseling would seem to be a good match for these clients because of its emphasis on rapid change as a result of an intense problem (solution) focus. Berg and Miller also noted that when therapists focus on exceptions, they are helping the Asian client "save face," an important cultural process.

Nonetheless, some of the same criticisms can be directed at this approach that are commonly directed at other theories of counseling. From a broad perspective, the notion of solutions may be culturally linked. For example, the search for exceptions is often behaviorally oriented and typically results in prescriptions for behavioral change. This individualistic focus may neglect the needs of individuals from more relationship-oriented cultures such as Latino/Latina or Native American clients. However, SF counseling is frequently offered in formats other than the individual (i.e., couples, family, and group therapy), and Berg and Miller (1992) pointed out that SF counselors often help clients explore exceptions by asking about how important others view the situation, thereby acknowledging the critical nature of these relationships. Lutz's (2014) recommendations concerning clients' VIPs would certainly fit here. Individuals who have experienced oppression and discrimination (e.g., the physically challenged; African-Americans; gay, lesbian, and bisexual individuals; and Latinos/Latinas) may find it difficult to focus narrowly on solutions when so many social and cultural factors influence their daily lives. S. A. S. Jordan (2014), however, asserted that the SF emphasis on client strengths and respect for the client's perspectives is helpful with clients who are of other than heterosexual orientations.

SF therapy is very focused and directive, which may clash with the values of clients from cultures that are less problem oriented in their approaches to living. Women may find that the focus on problems and solutions neglects relationship themes that are important to them and de-emphasizes cultural factors that restrict their ability to directly problem solve. At the extreme, SF counselors tend to follow almost a formula in dealing with clients, leading to very specific prescribed questions or tasks. For example, techniques such as scaling that reflect the pragmatic Western ideology may be foreign to clients from cultures other than Western cultures.

Dermer, Hemesath, and Russell (1998) pointed out that SF therapy's emphasis on a collaborative relationship between client and counselor is consistent with feminist perspectives on counseling. However, they also asserted that SF theorists overlook the power of stereotypic roles and that the neutral stances of SF therapists may reinforce the (patriarchal) status quo. This neutral stance may also lead to the failure to assign responsibility for problems such as domestic violence even though the violence itself is condemned.

Rossiter (2000) noted that the SF therapist's eschewal of the past can potentially be problematic, particularly when working with clients from groups who have historically been oppressed or have experienced physical or sexual abuse. Encouraging clients to testify about injustices they have experienced is an important political event, according to Rossiter. Discouraging talk about the past is a serious mistake that potentially aligns the therapist with the historically privileged and powerful:

> It is chilling to contemplate therapy being used widely to conspire with silence by rendering history invisible and trivializing the symptoms (forms of telling) of injustice by managing them as "complaints." In such circumstances, the culture that therapy helps to create is invested in denial, repression, and abuse of power. (Rossiter, 2000, p. 158; quotes in original)

THE CASE STUDY

Understanding Kelly's presentation from the SF perspective is at first a little daunting. He speaks in problem language and labels himself as "an angry person" and "a perfectionist." It is somewhat difficult to find exceptions in his initial description, although they are not difficult to imagine. He is clearly a customer open to change, which makes it easy to use the SF approach. He identifies clear goals and has a number of strengths upon which the SF counselor, Mary, can draw. Because Kelly is a White male, potential issues of cultural bias are reduced. In summary, SF theory seems to fit well with Kelly's presentation.

Summary

SF counselors approach counseling with a model that focuses on client strengths and resources. It is a constructivist approach and is presented as a radical alternative to traditional models of counseling. Instead of spending a lot of time dissecting the client's (customer's) problem, attention is directed toward times when the complaint does not happen, or exceptions. Solutions are emphasized in this approach, and great care is taken to use language and techniques that emphasize exceptions rather than problem occurrences.

SF therapists do not use formal assessment, and they see the therapy relationship as collaborative. The SF counselor is an expert on change, but the client is the expert on how and what to change. The goals of therapy are set by the client, and the SF counselor's job is to redefine the problem so that it is solvable. The SF counselor helps the client avoid doing more of the same and increase the performance of exceptions to the problem.

Outcome research is building in support of SF therapy, and it includes meta-analyses and well-designed clinical trials. The constructivist approach of SF counseling may be beneficial for clients of diverse backgrounds, but the individualistic, solve-your-problem focus of SF counseling may neglect environmental factors that influence client presentations.

MyCounselingLab

Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy*, Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 19.

CHAPTER 15

Narrative Therapy



Michael White

The Kennedy family comes to counseling in hopes of helping the eldest daughter, Rachael (17 years old), in her struggle with anorexia. David and Melanie, the parents, have been divorced for 4 years. Rachael's problems developed when she was 13 years old, around the time her parents separated. There are two other children in the family, Jeff (age 12) and Jessica (age 15).

David and Melanie report that their marriage ended because David "came out." Another factor in the couple's history was Melanie's drinking—she was apparently physically abusive to the children when she was drinking, resulting in frequent conflict with David as well. Melanie reports that she has been sober for 4 years.

Rachael, according to her mother, just could not handle her parents' breakup, the news that her father was gay, and her mother's entry into alcohol rehabilitation. In addition, Rachael reports that she was almost raped by an uncle when she was 15 years old. Rachael says that when the family lived together, her father was perfectionistic and demanding, insisting that she perform at the highest levels in schoolwork and athletics. When she did not meet these standards, he would tell her that she was going nowhere with her life. Rachael readily admits that her anorexia is a form of "passive suicide."

Rachael has been hospitalized three times for her problems and the family is referred to counseling by the psychiatrist with whom she has most recently been working. Multiple forms of treatment have been attempted, including hypnosis, antidepressant medication, individual psychotherapy, music therapy, and Eating Disorders Anonymous. Rachael reported that until about a year ago she used laxatives, diuretics, and diet pills to maintain a low body weight. She currently weighs about 105 pounds and is considered severely underweight for her height. She restricts her food intake and exercises several times a day.

For the most part, the family is coming to therapy to see if they can help Rachael. However, David does not see how family therapy can help—he sees the problem as Rachael's and states that she just needs to get her act together and start eating.

BACKGROUND

Essentially, narrative therapists see life as a process of storytelling. Narrative therapy (NT) is a relatively recent development and it is firmly situated in the social constructionist approach to psychotherapy. For some, what is disconcerting about this approach is that there is no one True Story. I will have more to say on this issue later.

The names most commonly associated with the NT approach are Michael White and David Epston. The "bible" of the theory is White and Epston's (1990) book *Narrative Means to Therapeutic Ends*. Sadly, Michael White died in 2008, but his memory lives on in his writing, such as in his 2007 book, *Maps of Narrative Practice*. In Box 15.1 you'll find a selection of Michael White's writing that will give you a sense of how he thinks about his work.

Box 15.1

Michael White on How Narrative Therapy Works

I believe that this is very significantly what the skills of therapeutic practice are about. In the context of narrative practice, a small percentage of the ever-present but otherwise neglected initiatives of people's lives are identified, characterized, acknowledged, honored, and taken into the development of storylines that have been subordinated by the dominant and often problem-saturated stories of people's lives. I am using the term *initiative* as a substitute for the terms *exception* and *unique outcome*, because this term evokes a sense of personal agency, that is, a sense that one has the capacity to play a part in the shaping of one's own actions and the sense that, in some way, the world is responsive to the fact of one's existence.

There are many ways of contributing to the characterization and acknowledgment of these neglected initiatives. One option is to support people in the development of a rich account of the foundation of these initiatives. This is a foundation that features specific knowledge about life and skills of living that people have developed in the history of their lives. What people give value to in their lives, and what they intend for their lives, is also part of the foundation of these initiatives. The development of a rich account of these types of knowledge and skills, of what people accord value to, and of what they intend for their lives is achieved through the careful scaffolding of the therapeutic conversation.

This term *scaffolding* is drawn principally from the work of the followers of the Russian psychology, Lev Vygotsky, and is related to the metaphor of "construction." When taken up as a concept of therapeutic practice, scaffolding refers to the therapist's contribution in providing a context for people to separate from what is known and familiar to them about their lives and to arrive at what might be possible for them to know about their lives, and to do. In contributing this scaffolding, the therapist does not engage in "pointing out positives," "giving affirmations," "illustrating strengths and resources," "reframing" the difficult experiences of people's lives, "making hypotheses," or "delivering interventions." Rather, the therapist initiates the sort of inquiry that makes it possible for people to traverse the gap between what is known and familiar to them and what it is possible for them to know and to do. This scaffolding provides people with support in the incremental and progressive distancing from the known and familiar toward what is possible for them to know and to do. Without the assistance of this scaffolding, this gap between the known and familiar and what it is possible to know and to do represents the impassable chasm or gulf.

Source: White, Michael. Scaffolding a Therapeutic Conversation, pp. 122–123. In *Masters of Narrative and Collaborative Therapies* edited by Malinen et al. Used with permission.

Beels (2001) provides a history of White and Epston's collaboration in creating NT, and the following section draws significantly from his work. White and Epston were trained as social workers, a professional background that often tilts more toward family than individual therapy. As an undergraduate, Epston majored in anthropology and also worked for Australia's Northern Territory Department of Aboriginal Welfare. According to Beels, he held many diverse jobs and then "dropped out into the hippie world of Vancouver, Canada" (p. 166) in the late 1960s or early 1970s. Epston eventually returned to New Zealand in the late 1970s and began to work with children and families.

A native of Adelaide, White worked for the Department of Welfare while working on his degree in social work and then in a children's hospital. An interesting tidbit about his training: The first therapy approach he learned was person-centered theory.

White and Epston reportedly met at the First Australian Family Therapy conference in 1980 and found a mutual interest in anthropology as a basis for family therapy. The influence of this foundation can be clearly seen in the NT commitment to grounding individuals' stories in cultural and historical contexts. This emphasis, along with the genesis of NT in Australia and New Zealand, probably led to the interest among these therapists in community-level interventions such as the Dulwich Centre's consultations with Aboriginal peoples' councils. Both White and Epston's thoughts were strongly influenced by the cultural transformation of the 1960s, which encouraged questions about everything (Beels 2001; Duvall & Young, 2009). Thus, NT was informed by feminism, LGBT issues, race/cultural analysis, and values of social justice (Madigan, 2011).

Currently, NT has a sizable international following. One hotbed of NT is the Dulwich Centre in Adelaide, Australia, directed by Cheryl White, found on the web at www.dulwichcentre.com.au. Check out www.narrativeapproaches.com for the website founded and maintained by David Epston and colleagues. Other important writers in the NT family are Jill Freedman and Gene Combs of Evanston, Illinois (www.narrativetherapychicago.com), and Stephen Madigan, of Vancouver, British Columbia, Canada (www.stephenmadigan.ca). If you are interested in a narrative take on eating disorders, check out David Epston and colleagues' book *Biting the Hand that Starves You: Inspiring Resistance to Anorexia/Bulimia* (Maisel, Epston, & Borden, 2004). Another engaging resource is *Narrative Practice: Continuing the Conversations*, a compilation of previously unpublished writings of Michael White (White & Denborough, 2011). You can see a really good example of narrative therapy on MyCounselingLab™, featuring therapist Jim Kreider with the client Helen.

MyCounselingLab

Video Example 15.1 Watch narrative therapist Jim Kreider work with Helen.



BASIC PHILOSOPHY

NT, as noted earlier, is rooted in social constructionist philosophy. Pure social constructionists believe that there is no objective social reality; instead, the way we view ourselves, others, and the entire social world in which we live is created (constructed) by social processes, and most significantly through our interactions with others. The conversations that we have with others about ourselves and the world around us are particularly powerful in determining reality, but so

are social institutions and norms. Another way of describing the philosophical basis of NT is that it adopts the narrative metaphor, or the idea that we create social reality, including our views of our self, through the stories we tell (Combs & Freedman, 2012). However, it is important to keep in mind that NT theorists are also very much aware of the influence of contextual factors, such as cultural norms and values, that influence our lives.

NT theorists are also interested in the workings of social power, drawing from the ideas of the French philosopher Michel Foucault (White & Epston, 1990). In this view, power is seen as determining the truths by which society operates, which in turn strongly influence the stories individuals create and tell about their lives. You may see similarities with a feminist ideology in this NT perspective, which is not accidental. Both approaches are considered political stances as much as they are ways of helping. A narrative therapist would be very comfortable with the phrase "the personal is political."

Power and knowledge (that accepted by the dominant culture) are inseparable. However, it is difficult to see the relationship because the workings of power are disguised under the notion of "truth." Those who have the truth have power in society and vice versa. For example, Western European culture generally accepts the notion of an objective reality (outside of us) that can be known by all and studied with scientific method. One who departs from this version of reality is usually known by those around her as "crazy" and is rendered powerless (think of how folks talk about psychic advisors, for example).

Because therapy is part of the domains of knowledge/power it is possible for it to become a form of social control. If one accepts this stance, then, a critical evaluation of our actions as counselors in terms of power is in order. Further, because NT often supports and encourages clients to question the dominant stories of their cultures, the NT counselor is aware that therapy is a form of social/political action (White & Epston, 1990). White (2011) opined "it is never a matter of whether or not we bring politics into the therapy room, but whether or not we are *prepared to acknowledge* the existence of these politics and the degree to which we are prepared to be complicit in the reproduction of these politics" (p. 49; emphasis in original). There is a distinct sense of social activism in this approach, nicely captured by Doan (1998): "Narrative therapy concerns itself with the deliverance of clients from the weight of oppressive and totalizing stories via liberating the client's voice and preferences" (p. 219).

NT counselors approach clients from a perspective that emphasizes health and strengths (Semmler & Williams, 2000). This stance, combined with NT's insistence that reality is socially created, leads to a questioning of traditional psychological perspectives. Traditional diagnosis is seen as locating the problem within the person and thereby obscuring the historical and political forces at work (White, 2011). The idea of diagnosis supports a notion of expert knowledge about people that is foreign to NT. Narrative therapists don't particularly like the term *client*, and the term *patient* is even worse. Although White did refer to therapy, he consistently wrote about "persons who consult us" and about narrative practices rather than techniques. Other important values in NT are accountability of the therapist to clients and, like feminism, the commitment to make therapy as transparent to clients as possible (recall the feminist value of demystifying therapy).

Here is a bit of Michael White's writing to give you a flavor of his position on therapy and politics:

> In therapy, I have participated with persons in challenging various practices of power, including those that relate to: (a) the technologies of the self—the subjugation of the self through the discipline of bodies, soul, thoughts, and conduct according to specified ways of being (including

> the various operations that are shaping of bodies according to the gender-specific knowledges); (b) the technologies of power—the subjugation of others through techniques such as isolation and surveillance, and through perceptual evaluation and comparison. (1993, p. 54)

Deepa is the narrative therapist who has agreed to work with the Kennedy family. She is 30 years old and of Asian Indian descent, an important influence on her choice of NT; her ethnicity is a constant point of reference in her work. Approaching Rachael's family with the knowledge of her own background and the awareness that historical and cultural influences affect their lives, Deepa is particularly attentive to the power differential that is inherent in the therapeutic relationship, traditional views of anorexia, and cultural discourses that demand that women maintain a slim figure to be considered attractive.

HUMAN MOTIVATION

NT theorists don't spend a lot of time talking about what motivates people, probably because they are so intently focused on an individual client's story. Further, taking a stance in this area might be seen as limiting the possibilities of individuals to create their own versions of a meaningful life. Given the emphasis on personally constructed meaning in this approach, however, it would probably be safe to say that NTs would view the tendency to create meaning as a central feature of human existence (Morgan, 2000).

Deepa considers that Rachael and her family are struggling to create meaning out of the various life events in their experiences. Rachael is likely struggling with the meaning of sexuality and womanhood. Deepa guesses that in listening to their accounts of how the present came to be, she will understand this family's perspectives and how they make sense of the current situation.

CENTRAL CONSTRUCTS

STORIES

Human life, according to the NT tradition, is a series of stories. These stories are created over time through our attempts to connect events in our experience and, in this way, derive meaning from them. Morgan (2000) writes that "for narrative therapists, stories consist of events linked in sequence across time according to plot" (p. 5). The process begins when we start connecting a number of events into a plot or the beginnings of a story. Once these first connections are made, it begins to be easy to gather more events that are consistent with the story line; in the words of the NT theorists—some events become "privileged" over other events and are included in what becomes the *dominant* story for the individual (Morgan, 2000). For example, I learn the tango, and then salsa. I begin to create a story about myself that I like to dance. I begin to live this story, and it creates meaning for me in my life. I then take up tap dancing. I now have a story of myself as Nancy the dancer.

In contrast to dominant stories are *alternate stories* (White & Epston, 1990). We all live such complex lives that invariably there are aspects of our experience that do not get included in or are hidden by dominant stories. These aspects are known as alternate stories and are often important in helping our clients.

Stories, however, are not created in isolation; they are created through the interactions we have with others. Stories are also heavily influenced by the culture in which the person participates.

In fact, NT theorists use the terms *cultural discourse* or *dominant discourse* to refer to culturally based systems of "truths" that influence our lives (Combs & Freedman, 2012). Those who comply or accept these discourses are in the "in" group and those who don't are marginalized. What's worse is that the reality of these discourses is taken for granted and their operation is often invisible to those in the culture. An example of a Western European cultural discourse is individualism—the idea that a person should develop a strong sense of self separate from others. Other cultural discourses that operate in Western European cultures involve gender roles, cultural stereotypes, and ideas about science and "real" knowledge.

One special type of story is a *problem-saturated story*, which is what people bring to counseling (Payne, 2006). For most clients, the problem-saturated story is the dominant story of their lives at that time—it is what prompts them to come to counseling. It is often heavily influenced by cultural discourses.

Rachael's family brings the problem-saturated story about Rachael's anorexia to counseling, seeking Deepa's help. Currently, it is the dominant story for this family and is heavily situated in cultural discourses about acceptable roles and appearances for women. The family also tells the story of Melanie's journey from alcoholism to sobriety and David's coming out process.

Thinness and Thickness

These adjectives refer to the qualities of the stories people tell. Thin stories contain few events and are relatively sparse in detail. Thick stories, on the other hand, are very elaborate and rich in nature. Stories get thick because they are told again and again, and they are usually embellished upon with each telling. More detail and description is added to the original, sparse story, making the retold story more vivid and complete. Dominant stories are rich and thick; alternate stories tend to be sparse and thin.

How one views the problem-saturated stories that people bring to counseling is a matter of perspective. From the perspective of the dominant culture, forms of "psychopathology" carry rich, detailed stories that serve to reinforce the existing power structure. However, when thinking about the individual who is burdened by the dominant story, one can also see the problem-saturated story as relatively thin and unitary, because it contains a label and cultural discourse; it obscures the uniqueness of the individual and the power politics inherent in the label. That is, the social power and oppression embedded in the cultural discourse are unrecognized and simply go unquestioned. Problem-saturated stories are also very restricted views of the person that don't include details about her strengths and competence.

The Kennedy family has a rich, thick story about Rachael's problems that is highly connected to the dominant discourses of society about "anorexia." They describe her refusal to eat, her hospitalizations, therapy—it is clear to Deepa that they see her troubles as a sickness that resides inside of her. At the same time, her father thinks that Rachael needs to get her act together—this may be her last chance. Deepa thinks that this description of Rachael is very influenced by power and politics and represents a very thin view of who Rachael really is as a person. It seems that the dominant story reads that Rachael is the carrier of a disease but is also found to be responsible for it. Cultural discourse around being female and the value of physical appearance is not recognized by Rachael or her family as being involved in the current situation.

UNIQUE OUTCOMES

Unique outcomes are events that are not part of the dominant, problem-saturated story (White & Epston, 1990). They are the exceptions to the problem's rule and are very important in helping clients consider new possibilities. White also used the term *initiatives* for these occurrences, to better emphasize the personal agency involved in them (White, 2012). Often found in alternate stories, unique outcomes usually become part of the *preferred story* (here read "therapy goals") for the client. The NT therapist is very interested in unique outcomes and spends a lot of time asking detailed questions about them, getting the client to expand upon her description.

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Video Example 15.2 Watch Jim and Helen explore Helen's resistance to Nagging Dissatisfaction (unique outcomes).



Gonçalves, Matos, and Santos (2009) identified five different types of unique outcomes: action, reflection, protest, reconceptualization, and new experiences. The first three types refer to simple actions or verbalizations that relate to the problem. Gonçalves et al. argue that reconcepualization unique outcomes are critical to change, for they allow the person to distance herself from the problem, give meaning to the unique outcomes, and take a position as the author of change, which is then extended with new experiences.

Deepa sees a glimmer of hope in the family reports that Rachael no longer uses laxatives or diuretics. She has also managed to stop purging, and Deepa sees these as potential examples of unique outcomes. Deepa will remember these things as she begins to talk with Rachael and her family and will search for further instances that are counter to the family's dominant story.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

NT counselors don't have much use for traditional, stage-oriented theories of development. Although these are sometimes seen as helpful (C. Smith 1997), NT therapists are usually more interested in the client's unique trajectory through life, cultural context, and her personal understanding of the current situation.

In his latest writings, White had begun to explore the usefulness of Lev Vygotsky's developmental theory, which emphasizes that development occurs in relation to others (Duvall & Young, 2009; White, 2011). White drew from this theory the concept of *scaffolding*, which he interprets as the process by which adults help children distance from their lived experience so that they can learn the relationships between events and behaviors, thereby developing a more sophisticated sense of self. Scaffolding involves lots of questions for the child, like "what happens if you remove that block from your block sculpture?" The child learns that the sculpture will come crashing down—the result of the connectedness of the blocks as well as the connections of her actions with the outcome of loud noise and a mess. Further, these kinds of conversations progress to evaluation of outcomes and plans for future behavior. The kid who crashes the

block sculpture may decide that crash and noise is fun and plan to repeat the behavior in the future. White maintained that many who consult therapists have had little of this kind of experience, which leads to deficits in knowledge of the self. It is the counselor's job to help the client develop scaffolding so that they can distance, or separate from the old, dominant story and begin to consider new possibilities (Duvall & Young, 2009; White, 2011).

In some ways, NT therapists see people as having multiple personality disorder (in case you didn't notice, that's a joke; as I noted earlier, narrative therapists don't really like traditional diagnosis). We are all multiversioned or multistoried (Crocket, 2013). How we behave in a given situation depends upon which story has the most influence at that point in time. For example, J. L. Zimmerman and Dickerson (2001) suggest that "under the influence of patriarchy a man might be inclined to dominance and overentitlement. However, the same person, under the influence of compassion (as a way of being) might respond quite differently" (p. 419).

Thus, the NT counselor sees humans as having multiple selves, the expressions of which are situationally determined. However, because mainstream Western society is so individualistic, we cling to the idea that we have one self and experience others in the same way (J. L. Zimmerman & Beaudoin, 2002). The notion of a single self is deeply ingrained in Western European culture—so much so that it rarely occurs to us to think differently. So Sarah, who would rather climb trees than play with Barbie dolls, is labeled a tomboy because she violates the cultural discourse about girls, and despite the fact that she also likes other activities that are considered gender neutral (such as reading), she and those around her get stuck on the story of Sarah the tomboy. Narrative theorists, in contrast, reject the individualistic model in favor of a view of the self as relational, multistoried, and situated in a context of politics and power (Madigan, 2011). However, there is a "trace" of self that runs through all of our stories across time (Combs & Freedman, 2012).

Deepa recognizes that Rachael is in the general developmental period termed adolescence *but makes no assumptions about what this experience means to Rachael. Deepa does see Rachael as struggling to define herself, and after listening to Rachael understands that currently, for Rachael, self is anorexia.*

HEALTH AND DYSFUNCTION

Narrative counselors believe that individuals come to therapy because the stories by which they are living do not sufficiently represent their life experiences (White & Epston, 1990). Something about the story doesn't fit with the client's view of how things are or should be. They become very focused on this particular story and the client's presentation is said to be problem saturated. As White and Epston noted: "persons organize their lives around specific meanings and . . . in so doing, they inadvertently contribute to the "survival" of, or what is often called the "career" of, the problem" (1990, p. 3, quotes in original).

Several authors have attempted to identify commonalities across clients in terms of problem stories. Doan (1998) suggested that it is possible that two central narratives are common to all people: Fear and Love. He maintains that it is inherent in the human condition that we can choose life stories that are saturated by one of these two themes, the consequences of which I am sure you can imagine. An amusing and informative reference is Doan's interviews with these two entities. Investigative reporters were hired to conduct the interviews in unbiased manners, because although it was possible for therapists to interview Love, when they tried to interview Fear they tended to try

somehow to change it. These influence attempts invariably resulted in Fear prematurely terminating the interview and being labeled "suspicious" and "resistant" by the therapists (p. 220).

Madigan (2011) identifies "internalized conversational problem habits" that we learn as we evaluate ourselves by the standards of the culture around us. He labels eight of these: Self-Surveillance, Illegitimacy, Fear, Negative Imagination/Invidious Comparison, Internalized Bickering, Hopelessness, Perfection, and Guilt (2011, pp. 96–113).

The term *preferred narrative* is probably the closest thing to *healthy person* in this approach. We can deduce that healthy people are aware of their multistoried nature and how they are connected to others, and are comfortable with this situation. They are aware of what they value and do not let cultural pressures affect their enactments. A sense of personal agency is evident in the healthy person (Combs & Freedman, 2012).

Deepa thinks that Rachael is somehow not happy with the current story of her life and her family generally agrees. They are contributing to the story of anorexia by focusing heavily on it and defining Rachael almost solely on the basis of this story. Although it is not entirely clear yet to Deepa, she thinks that perhaps another way to see this story is that it is partially one of Rachael feeling Not Appreciated or Unloved. Deepa hopes to understand this story more deeply and to help Rachael and her family find a preferred story that better suits them.

NATURE OF THERAPY

ASSESSMENT

NT practitioners are not very likely to use formal assessment; the assumptions behind such systems are generally inconsistent with NT philosophy. First, traditional models of assessment assume a single reality to which the therapist has access. Second, these processes tend to be pathology oriented and may ignore cultural or other contextual factors. They tend to "totalize" the person because they result in a label that takes over the identity of the client.

The narrative therapist is simply intent on understanding clients' perspectives on their lives. Particular attention is paid to the cultural and other contexts of the client's experiences. Multiple perspectives are honored such that "the initial focus of therapy is on trying to grasp the local meanings and understandings of everyone involved" (C. Smith, 1997, p. 29).

A thorough exploration of the problem is what interests the NT counselor. Morgan (2000) recommends examining the problem's tricks, intentions, plans, motives, and deceits and lies, among other things (p. 25).

As members of the Kennedy family tell their stories, Deepa listens to each one closely, acknowledging their perspectives. As she listens, Deepa affirms the various views of the problem, but she generally refers to Rachael's situation as "her problems with eating" or her "problems with anorexia" rather than as Anorexia *(as a formal diagnosis). She asks about Anorexia's ways of operating, how it "tricks" Rachael into exercising a lot and not eating. What does Anorexia tell Rachael about herself and who she should be?*

OVERVIEW OF THE THERAPEUTIC ATMOSPHERE

The collaborative nature of the therapeutic relationship leads to a therapeutic process that proceeds at the pace of the client (Carr, 1998). The client's language is used, or privileged, rather

than the therapist's. It is common for the narrative counselor to overtly check with the client to see if it is OK to proceed and also to see if the therapist understands her story accurately and is on the right track (White, 2007). Typically, narrative therapists take notes so that they can use clients' actual words and phrasings as a way of being sure they are fully understanding and also in service of documenting unique outcomes (Crocket, 2013).

Deepa begins with the Kennedy family by asking if it is OK for her to ask them some questions so that she can understand them and the influence of Anorexia in their lives. She suggests that they will work together to find out what the family thinks might be better ways to live.

Roles of Client and Counselor

In NT, the therapist is a collaborator or consultant; clients are the true experts on their lives (Monk & Gehart, 2003). M. Weber, Davis, and McPhie (2006) put it well when they wrote "[n]arrative therapy challenges the idea that expert knowledge belongs to the world of therapists and the medical model" (p. 393). Respectful curiosity would accurately describe the narrative therapist's attitude, a "not knowing" stance that allows room for alternate stories to emerge (Monk & Gehart, 2003). White (2007) adopted the metaphor of investigative reporter for both client and counselor, particularly when they are collaborating on externalizing conversations (more on these follows). The reporter doesn't try to engage the problem, but rather to conduct an exposé of its character, operations, and motives (p. 28). The investigative reporter client can then "transcend the 'playing field' of the problem—that is, address the problem in a territory that is not the home territory of the problem" (p. 29, quotes in original). Moving to this position allows the client to feel less vulnerable and stressed.

The accountability of the therapist to the client is of great importance in NT. White (2011) wrote that therapists had "a commitment to establish therapy as a context in which we are accountable to those persons who seek our help; accountable for how we think, for what we do, and for the real effects or consequences of our interactions and with those persons who seek our help" (p. 63). Sometimes NT counselors turn the tables on clients and ask them to interview the therapist on how they are conducting the counseling (J. L. Zimmerman & Dickerson, 2001).

Finally, the therapist in NT is something of a political activist. She will be alert for oppressive dominant cultural discourses that might be related to the client's life and will initiate conversations about these.

Deepa's orientation to Rachael and her family is one of not knowing—she makes no assumptions about how the problem gained its life and energy and how things will proceed in this consultation. She recognizes the Kennedy family members as the experts in this discussion and works hard to understand their points of view. Deepa occasionally checks with the Kennedy family about how they think the therapy is going and her work with them. Because he was initially pessimistic, she interviews David about how he thinks therapy is progressing and respectfully asks him to evaluate her performance. However, Deepa makes sure that everyone in the family has a voice in this evaluation process.

Deepa also considers cultural discourses about femininity and attractiveness that seem very relevant to Rachael's situation. She tentatively brings these up with the family to see if they resonate to these stories as being connected to their experience.

GOALS

What NT counselors want is new, more satisfying, stories for their clients. More formally stated, the goal of NT is to deconstruct problem-saturated stories and to re-author narratives that support preferred outcomes (West & Bubenzer, 2002, p. 366). Therapist and client work together to deconstruct the dominant, problem-saturated story and thicken the plots about unique outcomes so that they can be woven into a new storyline that is more satisfying to the client.

Deepa hopes that she can work collaboratively with the Kennedy family to help them define new stories, or preferred outcomes, in their experiences. It is likely that the preferred outcome of this family is to get out from under the tyranny of Anorexia and begin to tell stories about themselves as a loving, caring family. This process will require deconstruction of the story of Rachael the Anorexic.

PROCESS OF THERAPY

Most simply put, NT is a place where the client tells the therapist a story, the therapist listens, and the two make what they can out of it. These discussions are also called *re-authoring conversations*, which are those that help clients find stories that have been obscured by the problem-saturated story (Madigan, 2011).

Several writers have identified stages of NT counseling. Vromans and Schweitzer (2010), in creating a manual for NT (see the research section for more information on their work), identified five stages of NT: (a) establishing relationship, (b) eliciting problem stories, (c) deconstructing dominant stories, (d) embracing preferred stories, and (e) living enriched stories (p. 4). They point out, however, that these stages are overlapping and probably should be thought of as principles as much as rigidly sequenced phases.

Beels (2001, pp. 177–178) identified three stages of NT. First, through listening to the story of the problem, it is recast as an affliction of the client. To do this, the therapist and client concentrate on the effects rather than the causes of the problem. These efforts help in the process of externalizing the problem. Next, alternatives to the problem are explored, and an alternate story is created through focusing on *unique outcomes*, or times when the problem was not manifest. Care is taken to elaborate on these experiences, resulting in a thick, rich account of the unique outcome.

The client is asked to decide if the story of the unique outcome is the *preferred story*—if her actions or situation are more consistent with her experiences and more acceptable to her than was the problem-saturated story. As it begins to develop, this story will include plans and strategies to strengthen the story line and describe opportunities for the new story to take place. The preferred story characterizes the client as capable rather than downtrodden—as able to stand up to the problem. This process is sometimes called *re-authoring*, *re-storying,* or *re-membering* (White & Epston, 1990) and is described as "relocating a person/family's experience in new narratives, such that the previously dominant story becomes obsolete. In the course of these activities, people's own lives, relationships, and relationships to their problems are redescribed" (White & Epston, 1990, p. 127).

Finally, and in Beels's view most importantly, the therapist and client build a support group to help the client continue the new story. The support group is chosen by the client and can be family, friends, or entire communities (such as the community found through the Archive of Resistance: Anti-Anorexia/Anti-Bulimia; see the description under "Taking It Back Practices"). The support group believes in the preferred story and helps to create this "new" reality for the client.

An important process in NT is the *externalizing conversation* (Combs & Freedman, 2012; White, 2007). In externalizing, the NT therapist helps the client recast the problem as something outside of her by carefully listening to the client's story and asking a lot of questions about it, particularly about the effects of the problem on the client and the people around her. This kind of questioning is called *relative influence questioning*. In effect, the "problem becomes the problem, and then the person's relationship with the problem becomes the problem" (White & Epston, 1990, p. 40). Usually, but not always, the problem is given a name to emphasize its separateness from the person. Some examples include Trouble, Worry, Tantrums, Guilt, and Bad Habits.

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Video Example 15.3 Watch Jim and Helen discuss "Nagging Dissatisfaction."



Externalizing the problem is thought to help clients take a stand against it (J. L. Zimmerman & Dickerson, 2001). It is often considered a political activity in which client and therapist expose the problem as the oppressive agent of the power structure of the dominant culture. An NT counselor, might, for example, see a depressed client as under the influence of Sadness. She asks, What are the effects of Sadness? How does Sadness influence your relationships with others? What does Sadness tell you about yourself? Sadness tells the client she is not meeting someone's (society's) standards; it is oppressive and dictatorial. Together, therapist and client can find ways it can be resisted and overthrown. You can read about a good example of problem naming in Box 15.2, "The Story of Sneaky Poo."

Box 15.2

The Story of Sneaky Poo

An interesting and engaging case described by White and Epston is that of "sneaky poo," the story of a 6-year-old encopretic boy. Nick, the boy, had "accidents" nearly daily, and even more traumatizing for the family was his tendency to play with the poo, smearing walls, creating balls with it, and secreting it in clothes, corners of the house, and bathroom drains. Relative influence questioning of Nick and his family revealed that "the poo was making a mess of Nick's life by isolating him from other children and by interfering with his school work. By coating his life, the poo was taking the shine off his future and was making it impossible for him and others to see what he was really like as a person" (White & Epston, 1990, p. 44). His mother was at her wits' end, ready to give up, and saw herself as a failure as a parent. His father was very embarrassed about the poo, and this shame was driving him to isolate himself from relatives and friends. All of the relationships in the family were affected by the poo; "it was wedged between Nick and his parents, Sue and Ron. The relationship between him and Sue had become somewhat stressed, and much of the fun had been driven out of it. And the relationship between Nick and Ron (the father) had suffered considerably under the reign of

(continued)

Box 15.2 *(continued)*

tyranny perpetrated by the poo. Also, since their frustrations with Nick's problems always took center stage in their discussions, the poo had been highly influential in the relationship between Sue (the mother) and Ron, making it difficult for them to focus their attention on each other" (p. 44).

White and Epston helped Nick and his parents identify instances where Nick was able to outwit Sneaky Poo—when he resisted smearing or playing with it in other ways. Sue identified situations where she did not feel overwhelmed and miserable. Ron could not recall *not* being embarrassed by the poo, but was open to revealing his terrible secret to a work colleague. How could they re-author their story?

The narrative therapist helped this family identify their resources that could be used to quit being ruled by Sneaky Poo. Nick decided that he would no longer be "tricked" into being Sneaky Poo's playmate. Ron decided that he could reveal his problem to others, and Sue had some notions about how to refuse Sneaky Poo's invitations to misery.

After three sessions, this family had conquered Sneaky Poo. Nick was making more friends, and Sue and Ron talked to other parents, finding that they were not alone in their worry about parenting skills. By taking Sneaky Poo out of Nick and renaming it as the enemy, this family was able to unite and defeat it. They did this by revising their relationships with the problem. Nick was awarded the Breaking the Grip of Sneaky Poo certificate for his efforts.

Source: Based on White, M. & Epston, D. (1990). *Narrative Means to Therapeutic Ends.* NY: W. W. Norton & Company.

Externalizing conversations have a special character. By giving the problem a name, it is given a life of its own, and is often cast as "recruiting" the client to its cause (White & Epston, 1990). Often, problems are situated in dominant discourses, which calls for a special kind of *deconstruction:* the examination of the influences of cultural truths in the genesis of the problem (J. L. Zimmerman & Dickerson, 2001).

White (2007) identified four general categories of inquiry that are used in externalizing conversations: (a) negotiating a particular, experience-near definition of the problem; (b) mapping the effects of the problem; (c) evaluating the effects of the problem's activities; and (d) justifying the evaluation (pp. 40–48). The experience-near definition is one that is couched in the client's life and culture, and is particular because no two problems are ever the same. Mapping and evaluating the problem involve asking a lot of questions about what it is and what it does, and then justifying, the last step, is asking the client why she evaluates the problem and its operations in the way that she does. Justifying is perhaps the most complicated and confusing part of the inquiry—it requires the client to answer "why" questions about her evaluation of the problem and is intended to further explore the client's values and develop positive perceptions of herself. Sometimes clients are surprised by this last tactic of the counselor; they expect the counselor to immediately condemn the problem, not ask them how they feel about it and why.

NT therapists are quick to point out, however, that in cases of violence or other abuse, perpetrators are not let off the hook. Externalizing the problem does not mean that the person escapes

responsibility for his or her contribution to its existence. However, it is recognized that the person perpetrating abuse is not the originator of the abusive practices, but rather was recruited into them by cultural means (White, 2011). They are accomplices, but this conceptualization does not excuse them from the responsibility to expose the culturally embedded discourses of power, make reparation to their victims, and find ways of being that are not exploitive and abusive (White, 2011).

There is some concern about externalizing conversations becoming overemphasized in NT. White (2007), while acknowledging the value of these conversations, maintained that they were not always present in his work with clients. Externalizing is only the beginning of the journey—the focus must next turn to the exploration of unique outcomes.

White (2007, 2011, 2012), in adopting Vygotsky's ideas about learning, emphasized the idea of the scaffolding conversation in NT. The therapist, through the questions she asks, contributes to the cognitive structure necessary for the client to distance herself from the problem according to the dominant story so that she can see what else is possible and enact it (or strengthen initiatives already happening that have been obscured by the dominant story). Scaffolding is erected by asking questions in the same domains of inquiry used in externalizing, only the questions are asked about unique outcomes or initiatives. Together, therapist and client (a) create a rich, personal description of the initiative; (b) create a detailed description of the effects of the unique outcome; (c) evaluate the effects of the outcome; and (d) the client justifies the evaluation.

Dominant stories are often supported by lots of plot and don't go away easily. They are therefore sometimes difficult to deconstruct. This perspective is one way in which NT counselors would view "resistance" on the part of the client. There are several other sources of client resistance in NT theory. In social constructionist approaches, client resistance is seen as the client's attempt to protect the view of self and world if these are threatened by the prospect of change (Richert, 2003). White (2007, 2011) also noted that resistance resulted when the therapist did not provide the right relationship—one that was collaborative and offered the scaffolding the client needed to step beyond old ways of thinking. Finally, the failure of the counselor to fully understand the client through imposing theoretical understandings or insensitivity to local politics or cultural/ethnic contexts can lead to client protest (White, 2011).

Deepa engages Rachael and her family in detailed discussions of Anorexia. How does Anorexia manage to get the upper hand with Rachael? What does Anorexia tell Rachael about herself? Is Perfection a friend of Anorexia or its child? Anorexia is seen as taking charge of this family, and in particular, running Rachael's life. It is a tyrant that interferes with the family's mission. Deepa asks how it does this. Who is most affected other than Rachael? Are there times when Anorexia does not get the upper hand?

Deepa finds that the story of Anorexia is very detailed and complex. It is intertwined with the stories of Divorce and Alcohol or Drinking. There is also the issue of the sexual abuse of Rachael by her uncle, and it is not clear to Deepa how this story plays out in relation to the others. It is clear to Deepa that Anorexia is a sneaky and powerful entity that tells Rachael that she is fat and unworthy. She is not perfect and also weak, for Anorexia manages to outwit her; it carries with it the force of society's judgments about women and their appearances.

THERAPEUTIC TECHNIQUES

QUESTIONING

The major technique in NT is asking questions. They are so important that Madigan (2011) admits to using them at least 99% of the time in therapy (p. 93). Questions are critical in helping the client deconstruct the dominant story and are a major vehicle in the process of externalizing the problem. NT counselors believe that the questions asked of clients generate experience; that is, questions can bring about new ways of seeing things (Freedman & Combs, 1996).

One very important kind of questioning is *relative influence questioning* (Madigan, 2011). These questions help the client explore two critical sets of information: (a) the influence of the problem in her life, most importantly, in her relationships with others; and (b) her influence on the problem.

The first set of questions includes some like these:

Who was in charge at that moment, you or the problem?
Who sides with the problem?
What has Trouble tried to get you to do lately that you didn't want to do?
How does Guilt get between you and your husband?

The second kind of questions are intended to help the individual see what influence she has on the problem and usually involve a focus on times when she is able to resist the influence of the problem. Examples of this second sort include the following:

This is a pretty powerful problem. How have you managed to keep it from getting even more difficult?
How did you avoid Trouble when it wanted you to come out and play?
How did you act to make Anger take a break from bothering you?

Questions are also important in reinforcing alternate stories that contain unique outcomes. Here are some examples of these:

How did you manage to do this? Can you give me some idea of what it took?
Did you almost chicken out? How did you keep going?
Were there things going on in other areas of your life that helped you take these steps?

Another way of categorizing questioning is in terms of *Landscape of Action* and *Landscape of Identity* (White, 2007). These are used in both examining the dominant and alternate (preferred) stories. Landscape of action questions require the client to situate outcomes in a sequence across time. Landscape of Identity questions are used to help the client reflect on the material gleaned from action questions and to give it meaning, including implications of re-storying for the client's identity (in fact, White originally used the term *consciousness* to refer to these questions, but later changed it to *identity* to emphasize this aspect; White, 2007).

Deepa asks many questions of Rachael and her family, listening closely and checking frequently to make sure she understands what they are telling her. How does Anorexia influence relationships in the family? What has been the pattern of Anorexia's influence over time? How does Anorexia trick Rachael into thinking she is incompetent, weak, fat, ugly, and so forth? She thinks about a similar series of questions on Divorce, Drinking, and Abuse, but because the family is so focused on Anorexia, she decides to stay with their dominant story for now.

Deepa is very interested in times when Rachael has been able to escape the influence of Anorexia. How did Rachael manage to defy Anorexia and stop binging, purging, and taking laxatives? Who is on Rachael's side against Anorexia? Have there been any times recently when Rachael has been able to resist Anorexia's commands? How did she do this? What does this resistance mean about Rachael as a person?

Double Listening

Double listening is a practice adopted by NT counselors to help clients explore unverbalized values and meanings. The basis for double listening is White's (2000) notion of the *absent but implicit*—that we only know about something by contrasting it with something else. For example, one can know loneliness only if she has some experience with being connected with others (Aman, 2014). Double listening helps clients explore the unspoken and also develop alternate stories that challenge the negative stories about identity that result from oppression or marginalization.

Deepa reflects on Anorexia's accusations that Rachael is lazy and incompetent. What is absent is the meanings of these words to Rachael, so she asks Rachael about times when she has experienced herself as energetic and capable. Deepa also looks for recollections of Rachael and her family members that speak to Rachael's energy and initiative.

Outsider Witness Practices

As the name implies, the outsider witness practice involves inviting a special person or group of people to participate in therapy conversations (Russell & Carey, 2004; White, 2007). This practice is also sometimes called a *definitional ceremony*. White (2004) described this technique as rooted in the tradition of acknowledgment. Its primary purpose is to develop a rich, thick story line for the client in a very public way (Chang & Nylund, 2013). White (2007) was particularly concerned that you don't take the term *acknowledgment* as it is typically used, as in telling the client "hey, great job"; witnesses should not in any way evaluate, interpret, or judge the client's telling. Instead, the best outsider witnesses describe the impact of the client's telling on *themselves* (more on this later). Another goal of outsider witness practices is to assist the client in firmly establishing the preferred story; people who are identified by the client as the most likely to believe in the client's ability to change can be invited to hear the client tell the preferred story and react to it. They might also become allies of the client in establishing the preferred story.

This technique involves the client(s) and an outsider witness group. The witness(es) can be the other partner in a couple, family members, friends—anyone who is deemed relevant by the client(s). Influenced by T. Anderson's (1987) work with reflecting teams, White and colleagues also sometimes use other professionals as outsider witnesses (White, 2007).

The ceremony begins with the client telling a story of her choosing and the witnesses listening carefully. At some point (determined by the therapist) the witnesses are invited to recount what was most salient for them in the client's story. White (2007, pp. 190–192) established four areas of inquiry that he used with outsider witnesses: expression, image, resonance, and transport. Witnesses are asked to identify which elements in the client's story they were most drawn to (expression), any images that emerged as they listened, and to explain why they were most engaged by these elements of the client's story, locating this last part in the witnesses'

personal history (resonance). Lastly, witnesses are asked to describe how they are personally transformed through listening; in White's (2007) words, the witness tells how her "life has been touched in ways that have contributed to your becoming someone other than who you were before you witnessed the person's expressions and had the opportunity to respond to them" (p. 192). White used the term *katharsis* for this latter phenomenon, to distinguish it from the typical notion of catharsis as the release of emotions. He also added that in the best therapeutic conversations, therapists should experience katharsis, too.

Following the witnesses' retelling, the therapist then interviews the client, asking some of the same questions: what stood out in the witnesses' retelling, what images emerged for the client about her life in this process, and what meanings were salient for the client. Again, it is important for the client to reflect on how the witnesses' expressions had affected her view of self and problem. In this process, the therapist takes charge, giving structure to the interview by the questions asked and managing the interaction. Those who are reflecting are not to directly address the witnessing individuals (White, 2007).

The choice of outsider witnesses depends on the needs of the client. Sometimes the witnesses are members of the client's family or immediate friends. In other instances the witnesses are former clients who have dealt with similar problems or a team or group of counselors. For example, Russell and Carey (2004) describe a situation in which women who were formerly in abusive relationships attended a client's therapy session. These women listened and then respectfully responded to the client's description of her relationship with her brother, who helped her survive the abuse.

Deepa thinks that outsider witness practices may be very useful to Rachael and her family. Because she has worked with a number of clients who struggled with eating, Deepa considers bringing in a group of them as witnesses. Rachael could tell them how she managed to stop binging, purging, and using laxatives. The witnesses could listen and then comment on what was most important to them in what they heard. Rachael could also describe her dreams for her future as someone who has escaped the clutches of Anorexia. An alternative might be for Rachael to identify critical individuals to serve at witnesses, which might include her immediate or extended family and friends.

Deepa considers that she has several colleagues who are accustomed to serving on reflecting teams, at least one of whom is familiar with struggles with anorexia. She decides to invite these colleagues to serve as a reflecting team, after ascertaining that this procedure is acceptable to the Kennedy family. Three NT colleagues observe the family as Deepa interviews them about recent developments in their lives and Rachael's progress in outwitting Anorexia. The team members then emerge from behind the one-way mirror and convey their impressions to the family. One comments on the obvious caring and concern among the family members, despite the hardships they have suffered. Another remarks that she was touched by Melanie's description of how she defeated Alcohol and wonders what this means to Rachael. Deepa then interviews the family about their reactions to the witnesses' observations.

TAKING IT BACK PRACTICES

This term applies to both therapists and clients in NT and refers to giving back what one has learned through NT. For therapists, the philosophy of NT counselors suggests that the therapist (or a reflecting team) tell the client how she (or they) have been influenced by the client (J. L. Zimmerman & Dickerson, 2001). What is in other approaches deemed a negative event, that is,

influence of the therapist by the client, is seen in NT as a positive. NT counselors acknowledge that therapy changes both client and counselor (White, 2011).

Taking it back is also seen when clients are given the opportunity to share their experiences with others, such as when they help other clients by revealing their struggles and triumphs with similar problems (Carr, 1998). A good example of this type of campaign is seen in The Archive of Resistance: Anti-Anorexia/Anti-Bulimia, found on the Narrative Approaches website (narrativeapproaches.com). The Archive contains art, writings, and scholarship; many of the contributors have survived anorexia or bulimia and they offer their stories, poetry, and art in the interest of helping others do the same. According to Epston and Maisel (2006), 200–300 people have contributed to the archive, motivated to express their protest of and disobedience to anorexia and bulimia.

Deepa will certainly alert Rachael to the existence of The Archive of Resistance and ask if she wishes to contribute or participate in any way. Deepa conveys her respect for Rachael's struggles and remarks that others may be able to learn from her. Rachael thinks that she might learn a great deal from studying the archives and seems encouraged to learn that others have struggled in ways similar to hers and found satisfactory new stories.

Written Artifacts

NT counselors often use written documents as ways of thickening preferred stories, both for the client and for important others in her life (Combs & Freedman, 2012). Because the written word is considered more powerful than the spoken, these artifacts are important evidence for the client and others of the client's new story. These artifacts can be letters, certificates, memos, lists—virtually anything that is dreamed up by the therapist and client (Payne, 2006). For example, White and Epston (1990) describe the "Certificate of Concentration" and the "Escape from Tantrums Certificate" (pp. 196–197) given to commemorate therapeutic success stories. They refer to these items as *counterdocuments* because they oppose the oppressive dominant discourse that has been influencing the client's life.

NT therapists sometimes send clients letters in between sessions. Used to reinforce events in therapy, letters sometimes summarize session content and are often used to comment on unique outcomes or offer new perspectives on the problem-saturated stories of clients. "Readiness letters" can be composed for clients who are reluctant about therapy to acknowledge the client's choice and control in her life. An interesting example is one written by Jim, the narrative therapist in the *Theories in Action* videos found on MyCounselingLab, in Box 15.3. The letter also includes Jim's comments (in parentheses) on his theoretical intentions as he wrote.

Deepa decides to send a summary letter to the Kennedy family after the first counseling session. In this letter, she describes her perceptions of the family and compliments them on their persistence in the face of great challenges from the two As—Alcohol and Anorexia. She wonders what Rachael has observed over the years in Melanie that allowed her to defeat Alcohol and if Rachael sees any of these strengths in herself. Rachael replies that her mother's determination and never-give-up attitude has been inspirational. She is determined to get in touch with these qualities within herself.

Box 15.3

Jim's Letter to Helen

Dear Helen,
As I mentioned at the end of our meeting yesterday, I often write letters to people after meeting with them to offer additional ideas that come to mind. Since one idea often leads to another, these letters often help people form their own thoughts for further discussion at our next meeting. *(Describing our conversation as being about "ideas," which have various interpretations and negotiable meanings, as opposed to directives informed by "objective reality")*

First of all, I want to say how very much I enjoyed meeting you and learning about this new story you are writing for your life. *(Introducing the idea of "story" where both social "reality" and "identity" are subjective and consequently open to storying and re-storying)* It is clear that the old story where Nagging Dissatisfaction had trapped you so you couldn't move forward or backward is a story you are no longer willing to put up with. *(Describing the problem as she sees it as "The Problem," and externalizing to separate "The Problem" from the person. Mapping a central plot of "The Problem" story and its influence on the person)* I suspect that Nagging Dissatisfaction may have to find a different job than stirring up those disquieting feelings for you, or pushing you to the point that you feel out of control and behave toward your children in ways that don't reflect what you love most about being a mother. *(Contrasting the unidimensional problem-saturated story with a story of possibility based on meaning, values, and purpose)*

When you asked if I thought you'd need to be in therapy for the rest of your life, I said I doubted it since most people in this country find what they are looking for in six or fewer therapy sessions. *(Countering privilege by sharing "professional" knowledge)* After talking with you, I am even more confident that you are unlikely to be in therapy for a long time. *("Spending" my privilege to counter the demoralizing influence of "The Problem's" story)* I base my opinion on how you have already begun realizing how passionate you are about the significant role you play in your children's lives as a "stay-at-home-mom," and how much you love that role. You beautifully described the great importance of your role in shaping their lives: You are dedicated to helping them discover who they are, what they are passionate about, and what dreams they have for their futures. *(Privileging a story of conscious purpose rather than of unconscious or systemic pathological motives)* As a parent myself, I can think of no job that is more significant than this one in which you have clearly invested so much of yourself. *(Spending my privilege as an older "professional" male to privilege her local meaning as a means to counter the marginalization and subjugation of dominant discourses about women)*

I am very impressed that your dedication to your children's current and future lives has made it possible to prevent Nagging Dissatisfaction's scare tactics and lies from further intimidating and confusing you. *(Privileging the emerging story of the person's influence on "The Problem" by retelling the story of the subdominant plot of personal agency found in this unique outcome)* As I thought about this, I realized how remarkable this is given three things that you mentioned:

1. You were not "seen" in your family as you grew up, which can plant the seeds of doubt about one's abilities and worth.
2. Your marriage "is not life giving" in terms of recognizing what is fulfilling for you, creating doubts about how much you can hope for in life.
3. Your mother appeared to be happy with her life story, which made it seem like you should also be happy with your life story, despite your dissatisfaction.

(Situating "The Problem" in the social and historical context that covertly contributes to the construction of "The Problem" story with a unitary as opposed to multistoried description)

Not giving in to Nagging Dissatisfaction seems even more remarkable when I consider how our culture insinuates that being a stay-at-home-mom is "never enough: you should be more." *(Politicizing "The Problem" by exposing an oppressive dominant discourse whose essentialist, individualizing context helps construct "The Problem's" story)* It looks to me like Nagging Dissatisfaction used these three sensitive areas in your life, teamed up with society's message, and tried to deceive and discourage you. It appears that Nagging Dissatisfaction almost had you bullied into believing that "whatever I do, it is never enough." *(Elaborating the externalization to open space for her to act against "The Problem" without acting against herself)* But you took away one of Nagging Dissatisfaction's most important tricks when you correctly noted that what may have been satisfying for your mother as a woman born in 1929 is not necessarily going to be satisfying for you as a woman facing today's challenges and opportunities. *(Making transparent a thin description that will lead to thin conclusions, and instead honoring and privileging the story of the person's influence on "The Problem")*

Now that you have stalled Nagging Dissatisfaction's initiative, I can't help but wonder how your realization about the significance of your role in helping your children move forward in their own lives is likely to also help you rediscover your own passions and dreams. *(Opening space for a story with future possibilities based on a plot of hope and competence)* I'm also wondering how this, in turn, is likely to help you move forward in your life as well. (*Speculating about a richer and thicker narrative based on personal purpose and meaning)* However, doing so may stir up more of those disquieting feelings like the troubling anger, fear, and longing you mentioned. As a mother, I am sure you know that stirred emotions are to be expected with any transition. *(Normalizing to counter the culture of pathology that pervades professional conversations)* But I am concerned that Nagging Dissatisfaction may try to use these feelings as a way of frightening you into "going asleep" again, as it had in the past, so you won't pay attention to what really matters in your life. *(Mobilizing opposition to the problem-saturated story with its "universal truths" that obscure "local truths")*

On the other hand, the "hope" you mentioned which brought tears to your eyes at the end of our meeting suggests to me that you are indeed staying awake and already beginning to rewrite this story with more possibilities than Nagging Dissatisfaction would write for you. *(Celebrating the new identity in the emerging story and re-envisioning a future with space for various possibilities for action)* Having heard the beginning of this new story that is so different than the one Nagging Dissatisfaction had in mind, I have been wondering who in your life would not be surprised that you've been able to break Nagging Dissatisfaction's spell and

(continued)

Box 15.3 *(continued)*

instead remember what really matters most to you. *(Eliciting discourses about possible audiences for change to re-member with communities supportive of her re-description as a person able to change her relationship with "The Problem")* I mentioned how I thought catching on to Nagging Dissatisfaction's tricks may help you move forward: I have also been wondering how this change is likely to benefit your children's futures as well. *(Thickening a plot of personal meaning and conscious purpose by bolstering a unique re-description of her as someone with an identity of competence)*

Something I wish I'd asked you during our meeting was how our conversation was going for you. In particular, I wondered if the conversation was going in a useful direction and if there was anything I could have done that would have been more useful for you. I welcome any thoughts you have about this, since my best guesses about what may be helpful may or may not really fit for you. *(Flattening the hierarchy, privileging her voice as a counter-oppressive action)* You understand your life story as only a woman and a mother can; being a man, I can only understand your story as an outsider. *(Exposing the politics of power inherent with patriarchy and hierarchy)* I would very much appreciate your guidance in how I can be most helpful to you as you learn to keep Nagging Dissatisfaction from interfering with this new story that you are writing for yourself and for your children. *(Situating myself as a co-author of this progressive narrative rather than as an "expert," which would invite colonization and subjugation of her indigenous knowledge and wisdom)*

I'll be interested in hearing your thoughts about these ideas I've offered, as well as any ideas you have had about your changing story. I look forward to seeing you next week to dialogue with you further. *(Situating myself as a collaborator around the evolving meanings that story her as one with personal agency. Consequently, this new plot storys her as one with the ability to influence her own lived experience toward her preferred future, which is crucial to co-constructing a story of hope)*

Warm regards,

Jim
(Expressing interest and caring in a personal, nontechnical and non-"professional" way to reduce the privilege afforded to males in authority roles)

Source: Courtesy of Jim Kreider.

EVALUATION OF THE THEORY

Perhaps the most common criticism of NT (and of social constructionist approaches more generally) is that it is difficult to read and understand. Partly, this difficultly is due to the language used—terms such as *discourse*, *languaging*, and *privileging* are not typically found in your average theory of counseling. Hayward (2003), a proponent of NT, argued that to really convey the new ideas of NT, the unfamiliar is necessary to convey the uniqueness of the approach. He says, "If we accept that language creates our perspectives as well as reflects them, then different language practices will be required to access different perspectives and to think outside of what is routinely taught" (p. 186).

Minuchin (1998) criticized the NT approach for "losing the family." He pointed out that although NT theorists emphasize the socially embedded nature of reality, they in practice ignore the relationships between people because they do not attend to the relationship patterns and structures in their clients' families. Essentially, he is disappointed that NT does not include a more defined theoretical structure when he writes "I began to ask myself whether this metatheory concerning the construction of reality had a theory about families at all. How would this theory explain bonding? Or the affiliations between family members that create subgroups, and sometimes scapegoating? How does it explain the way conflict between parents affects their children's views of themselves? How does it frame the complexities of divorce and remarriage, or the way individual family members select certain family functions and certain styles of interpersonal transactions?" (p. 398). He contends that NT practitioners, who are not adverse to working with individual family members, unduly privilege the individual voice and then skip the family context in their practice of relating individual stories to cultural discourses.

Efran and Clarfield (1992) came to the defense of social constructivist therapies (in the general sense), pointing out that the label does not automatically mean that "anything goes." Essentially, they argued that constructivism is simply another metaphor or descriptive device and that too often advocates of this position obscure matters by weaving "a virtually impenetrable fog of abstraction" (p. 202). Further, they urged constructivist therapists to accept their expertise and to take positions, opining that "we regret that some constructivists feel inclined to deny that they are in this sort of 'influence' business" (p. 202; quotes in original).

Qualities of the Theory

Precision and Testability. You will generally not find hoardes of hard-core NT advocates out there doing empirical research. The postmodern approach adopted by the NT camp recognizes two types of knowledge: the "expert" knowledge of traditional science and the "local" knowledge of individuals and communities. They are very suspicious of generalizations, and thus tend to see the products of traditional science (i.e., expert knowledge) as merely hypotheses that can be subjected to local tests (Madigan, 2011). Still, some clear, testable predictions can be derived from NT theory; you will see some of these in the research sections that follow.

Empirical Support. Despite the reservations of NT proponents when it comes to traditional research, it appears that data are starting to accumulate on the NT approach. Many of the studies are qualitative (which fits well with the spirit of NT), but some quantitative research is beginning to emerge and, in sum, the research is supportive of NT. That manuals have been developed is a good sign that traditional quantitative research will begin to accumulate (although they evidently remain unpublished; Gonçalves & Bento, 2008; Vromans & Schweitzer, 2011).

Because most of the high-quality research on NT is relatively new (and sparse), the question of empirical support is perhaps a qualified yes. At the same time, proponents of this approach argue that the issue of empirical validity is rooted in the traditional, expert knowledge–based view of science and is therefore not very relevant to the verification of NT. Local knowledge (i.e., client and therapist stories of therapy) is considered to be more legitimate and useful, and there is plenty of that. Finally, Lock, Epston, Maisel, and de Faria (2005) remind us to remember that accessing expert knowledge (via the traditional system of scientific verification) can legitimize dominant cultural stories that emphasize the location of health and dysfunction as properties of individuals, not problems to be re-storied.

RESEARCH SUPPORT

Outcome Research. Probably because of the NT philosophy about sources of knowledge, supportive rigorous outcome research has been slow to accumulate. Early on, Etchison and Kleist (2000) reviewed outcome research on NT. Although they found that NT was useful in working with families, they cautioned that the limited research base precluded general statements about the efficacy of this approach with any specific family issue.

However, more recently research using traditional methods has begun to appear in support of NT. Lopes et al. (2014) reported on their trial of NT in comparison to cognitive-behavior therapy (CBT) for moderate depression. Both treatments were manual based, and clients were assigned in an alternating fashion to treatments as they appeared for intake at a university clinic. Forty clients completed treatment, with 24 receiving 20 sessions (the complete treatment) and the remaining clients terminating between 8 and 19 sessions. At the end of treatment, clients who completed either treatment showed statistically significant improvement on all measures and change seemed to occur at the same rate for both groups. However, comparing the effect size for NT (a measure of pre to post change) to established benchmarks revealed that it was weaker than could be desired and smaller than that found for the CBT group, so Lopes et al. recommended caution in adopting their results as evidence for the equivalence of NT to CBT in treating moderate depression.

An earlier trial conducted by Vromans and Sweitzer (2011), also using a treatment manual, examined the effects of eight sessions of NT on depression and interpersonal relatedness in a sample of 38 adult clients. Providing strong support for NT, Vromans and Schweitzer reported that almost 75% of the clients showed reliable improvement in depression scores (measured by the Beck Depression Inventory). Smaller percentages showed improved interpersonal relatedness, but overall the results compared favorably to improvements documented in the highly regarded NIMH treatment of depression study, which compared interpersonal and cognitive-behavioral therapy (see Chapter 1 for more on this study). An interesting feature of Vromans and Schweitzer's research was the use of the NIMH study data as a benchmark comparison rather than any sort of control group. Ethical, methodological, and practical concerns led to this decision, but the absence of a control or comparison group nonetheless decreases the confidence with which conclusions can be drawn from the study.

Looyeh and colleagues have tested the effectiveness of group NT with children presenting with learning disabilities, depression, social phobia, and diagnoses such as oppositional defiant disorder and attention deficit/hyperactivity disorder (ADHD; Looyeh, Kamali, Ghasemi, & Tonawanik, 2014; Looyeh, Kamali, & Shafieian, 2012; Looyea & Matin, 2006; Sheibani, Looyeh, & Delvar, 2007). These investigations generally find supportive results but vary in terms of methodological sophistication, so some degree of caution should be observed in reviewing their results. For example, Sheibani et al. (2007) did not use a control group in their study of 10- and 11-year-old girls presenting with depression. In contrast, Looyeh et al. (2012) randomly assigned a small sample of girls diagnosed with ADHD into NT group intervention or a wait-list control condition. At the conclusion of treatment and 30 days afterward, the young women in the treatment group showed decreases in symptoms of ADHD, whereas those in the control group did not. Similarly, Looyeh et al. (2014) assigned 24 boys into either wait-list or NT group therapy and found differences in symptoms of social phobia when the treatment group was compared with the control group after 14 weeks. Both parents and teachers of these children reported

observing decreased symptoms of social phobia among the children receiving NT, whereas no such decrease was observed among wait-list kids.

A number of other studies of NT have appeared in the literature, but again they are of varying degrees of methodological quality. Many of these studies used very small samples, which leaves us questioning the generalizability of results. I will briefly review only a few of these. The effectiveness of NT as a group intervention for eating problems was investigated by M. Weber, Davis, and McPhie (2006). You might notice the use of the term eating *problem* rather than eating *disorder*. This was a deliberate choice that stems from the NT dislike of language that pathologizes clients. Seven women displaying a range of problems reported favorable outcomes at the conclusion of 10 weeks of group NT. Cashin, Browne, Bradbury, and Mulder (2013) found that emotional symptoms of autism decreased among 10 young people (ages 10–16 years) with autism following a series of five sessions of NT conducted over 10 weeks.

St. James-O'Connor, Meakes, Pickering, and Schuman (1997) used ethnographic methods to study clients' experiences in NT. Eight families who were clients of the researchers participated in semistructured interviews situated in a university hospital outpatient clinic. They reported that six overall themes appeared in their qualitative analysis of the data: externalizing conversations, unique outcomes and alternate stories, developing personal agency, consulting and reflecting teams, building the audience, and helpful/unhelpful aspects of therapy. All of the families reported a reduction in the severity of the problem over the course of therapy, although those who had been in therapy longer reported greater gains than those who had been in for only a short time. St. James-O'Connor et al. also noted two themes that clients most often recognized in therapy: increasing feelings of personal agency and issues around reflecting teams (both positive and negative impressions of these). To the surprise of the researchers, discussions of externalizing conversations were much rarer than the other themes.

Theory-Testing Research. A series of studies by Gonçalves and colleagues combine elements of outcome and theory-testing research. Gonçalves, Matos, and Santos (2008) developed a coding system for unique outcomes, which they call innovative moments (IM), and several subsequent studies using this system have investigated important NT phenomena. In a single case study, Santos, Gonçalves, Matos, and Salvatore (2009) used the coding system to identify five types of IMs: action, reflection, protest, reconceptualization, and performing change. Over 12 sessions of NT, action and reflection IMs tended to appear early, whereas reconceptualization and performing change IMs were identified more in the final sessions of counseling. Matos, Santos, Gonçalves, and Martins (2009) further clarified that reconceptualization and performing change IMs were the most important in signifying client change. Poor outcome in NT was found to be associated with the absence of reconceptualization IMs. Reflection and protest IMs, while about equal in the two groups, tended to be associated with a return to the problem story. Following up on Matos et al.'s (2009) study, Gonçalves et al. (2011) studied IMs in five good and five poor outcome NT cases, verifying that returning to the problem is associated with poor outcomes. Cuhna, Spinola, and Gonçalves (2012) looked at the role of the therapist in IMs in two cases of NT, one with poor outcome and one with good outcome. Their results demonstrated that IMs generated by the therapist (i.e., the therapist noticed a unique outcome and pointed it out to the client) were observed more than expected in the poor outcome case, whereas those prompted by the therapist (e.g., the therapist asks the client if there were changes over the week) were seen more often than expected in the good outcome case. IMs generated completely

by the client were observed to occur roughly equally in both cases. Although this research is interesting and supportive of NT, the small number of cases used should be noted.

Ramey, Young, and Tarulli (2012) directly tested White's (2007) ideas about scaffolding conversations using sequential analysis of NT sessions with children. By assigning categorical codes to each verbalization in the sessions, they looked to see if children and their therapists would progress from naming the problem, to connecting and evaluating consequences, to forming intentions and plans for the future, and further, to see if the therapist led in the process, as expected in NT, with children responding by using the scaffolding provided by the therapist. Their results were very supportive of NT theory in that most of the talk in the sessions was identifiable as scaffolding conversation and that children responded as expected, following the lead of the therapists. Interestingly, almost half of the statements in the sessions were naming statements, although the other kinds of expected statements were observed, too. This last finding supports the notion that externalizing (naming) conversations are an important part of NT.

Piran and Cormier (2005) offered a study that could be construed as testing the theoretical propositions underlying NT. In a study of 394 women, they examined the relationships between eating-disordered behaviors and attitudes and three internalized social expectations: (a) silencing the self in relationships in favor of the wants and needs of others, (b) anger suppression (hypothesized to be in response to cultural norms), and (c) objectification of their bodies. Consistent with their predictions (and those that could be derived from NT theory), they found that all three of these qualities were significantly related to eating-disordered characteristics. On the basis of these results, Piran and Cormier argued that deconstruction of these social discourses would be particularly important in helping young women fight anorexia and bulimia.

As I noted earlier, many studies of NT use qualitative methods, seeing this approach as more collaborative and less entrenched in authoritative models of knowing than traditional quantitative methods. A good example of this kind of philosophy is seen in what was called the "Narrative Therapy Re-visiting Project" (Young & Cooper, 2008). In this study, a small sample of clients who participated in one-session of NT reviewed videotapes of their sessions and identified what was most meaningful to them. Researchers then classified these remembrances into four themes: posture (or the respectful, nonjudgmental attitude of the therapist), giving people back their words (or summarizing), externalizing conversations, and learning from the revisiting (p. 73). That these categories, consistent with NT theory, could be identified can be considered support for NT theory. Similarly, Keeling and Bermudez (2006) used a qualitative approach to assess the effects of externalizing problems in the form of creating sculptures of them. Participants in this research wrote journals responding to questions about the externalization, the influence of the problem in their lives, and unique outcomes they could identify. The results were generally supportive of NT—participants were able to externalize and showed evidence of experiencing unique outcomes and developed new stories consistent with the unique outcomes.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Proponents of NT argue that this approach is perfect for use with individuals from diverse backgrounds. To first state the obvious: NT counselors are likely to be sensitive to and to initiate conversation about oppressive cultural discourses that potentially relate to client problems (Chang & Nylund, 2013). Kamya (2012) noted that "narrative practice seeks to deconstruct taken-for-granted norms, with an eye toward building an appreciation of diversity in a rapidly

evolving context" (p. 234). Payne (2006) opined that even though he assumes that most current psychotherapy approaches are anti-isms (e.g., racism, sexism, classism, heterosexism), "the emphasis in narrative therapy on the need for continual vigilance against the more subtle manifestations of these elements is particularly consistent and emphatic" (p. 31). In sum, the examination of cultural influences is inherent to NT, making it an excellent approach for use with individuals from diverse backgrounds.

NT counselors, however, warn that as with any approach to therapy NT can't just be blindly applied in cultures other than the ones in which it originated (see the Dulwich Centre website at www.dulwichcentre.com.au). Differences in traditions across cultures (such as reliance on written or oral traditions, acceptability of asking direct questions) may influence the applicability of the approach. Ideally, according to the Dulwich Centre website, the therapist should be of the same culture as the client.

The values of NT are consistent with those of feminist therapy, proponents of which would heartily support the ideas about collaboration with clients and the demystification of the therapy process. NT's stance against oppressive practice would also seem to promote the growth of female clients and, indeed, clients from any group that has been the target of such practices in the past or present. Feminists celebrate NT's emphasis on deconstructing cultural discourses about women that have supported male dominance (C. G. Brown, Weber, & Ali, 2008; Nylund & Nylund, 2003).

The NT perspective on sexual orientation is to recognize the influence of the dominant cultural discourse about sexuality that privileges heterosexuality over homosexuality (White, 2009; Yarhouse, 2008). Thus, NT is also considered a good approach for working with those whose sexual orientations are other than heterosexual. B. Logan (2002) described such work and maintained that "coming out is a process in which a person 'rewrites' the story they have about themself [*sic*]" (p. 140, quotes in original).

THE CASE STUDY

Conceptualizing the case of Rachael was relatively easy from the NT perspective. NT proponents are very interested in anorexia/bulimia and write extensively on this topic (e.g., Maisel, Epston, & Borden, 2004). However, my opinion is that although it is easy to discuss the conceptualization of anorexia from an NT approach, actualizing this in practice might be more difficult. It might be quite difficult for clients to perceive anorexia as something external to the identified client. The same might be true for conceptualizing drinking/alcohol.

Summary

Narrative therapy is a constructivist approach in which counselors and clients collaborate to create new life stories. NT therapists recognize that we create our realities through our language and, further, that cultures have dominant discourses that determine who gets power and control and who doesn't. Thus, NT therapists are very attuned to issues of social justice and power. People and problems are always viewed with an awareness of the cultural context in which they are embedded.

Clients come to NT because the stories that are dominant in their lives do not fit some aspects of their experiences. The NT counselor listens closely to the client's story, attempting to understand the dominant themes but also looking for alternate stories or unique outcomes—cases in

which the problem-saturated story does not hold. The goal of NT counseling is to help the client deconstruct the problem-saturated dominant story and thereby create opportunities to choose among other, more preferred outcomes.

Questioning is a major technique in this approach, and it is often aimed at externalizing the problem, which means that the person is separated from the problem and the problem becomes the person's relationship with it rather than part of the person. It is important that therapist and client examine all the influences in the life of the problem and their sources, but most importantly the client and therapist examine times when the client is able to resist the problem and focus on how this happened. A new story can then be created based upon the deconstructed version of the client's story. In the words of our NT therapist on the video *Theories in Action*, the client and counselor engage in a process of "collaborative co-construction of a unique re-description" of the client's life (Jim Krieder, personal communication, March 30, 2007).

Other techniques of NT involve engaging important individuals or groups of individuals in the client's struggle with the problem. Outsider witness practices, in which carefully selected others listen to the client's story and then reveal their reactions to it, are often employed. Written artifacts such as letters and certificates of achievement are also used to reinforce clients' process and progress in therapy.

Because of NT's philosophical basis in the constructivist camp, many of its practitioners do not welcome traditional scientific approaches to testing it. Proponents of NT are critical of dominant discourses that emphasize the existence of one true reality that can be explained only through a culturally approved set of scientific methods that are the province of "experts." Despite this distrust, a small but supportive body of research has emerged in support of NT.

Issues of cultural and individual diversity seem to be handled well in an NT perspective. Advocates of NT emphasize local and cultural influences in the stories lived by clients and also the deconstruction of dominant (culturally based) narratives that seem to negatively affect clients.

MyCounselingLab

Visit the MyCounselingLab site for *Theories of Counseling and Psychotherapy*, Fourth Edition, to enhance your understanding of the concepts covered in this chapter. You will have the opportunity to practice your skills through video- and case-based exercises. There is also a Video Library that includes videos of counseling sessions, ethical scenarios, and interviews with helpers and clients. Start with Topic 13.

CHAPTER 16

Mindfulness Approaches



Marsha Linehan

Annika is a 27-year-old, single White female who presents with relationship issues and problems at work. She reports alternating bouts of depression, anxiety, and anger and is seeking help to "calm down" and regain her life.

Annika was an only child, and her parents divorced when she was 12 years old. Her mother, a former fashion model, had significant psychological difficulties most of the time Annika was growing up and was hospitalized repeatedly for depression and suicide attempts. Her father was not around much; as a highly successful international fashion photographer, he traveled extensively. When he was home, he doted on Annika at times, but was also often distant and cold.

Annika works as a feature reporter for a local TV station and was closely involved in the station's coverage of the disappearance, sexual abuse, and murder of a 4-year-old girl. She stopped eating and sleeping, became erratic, and was unable to function at work. Her performance deteriorated to the point where 6 weeks ago Annika was put on leave and asked to see a psychologist. During the past year, she also had a short affair with a married news director, which Annika reports has resulted in a hostile work relationship with this man. Annika has a close relationship with a female anchor and admitted to sexual fantasies about her. Currently, Annika is in a relationship of 8 months with her cameraman, who is doggedly devoted to her. However, she is not particularly devoted to him. She comes for help, saying, "My life is a mess and I don't know what to do about it. I want a decent, healthy relationship and a little peace of mind." Annika wants to keep her job; ultimately, she wants to become a news anchor in a major market like New York or Los Angeles.

BACKGROUND

Over the years, as creative counselors work, they borrow elements from various approaches, invent unique twists on existing systems, or integrate knowledge from other disciplines. The resulting creations, typically resting on or reacting to existing theories of psychotherapy, are novel approaches, and they are sometimes tailored to a particular client presentation. This chapter describes two such approaches, which share two common elements: their origins in cognitive and behavior therapies and their integration of mindfulness and acceptance principles and practices. An essential component of both Christian contemplation and Zen Buddhist practice, the concept of mindfulness has been around for a really long time (Lynch, Chapman, Rosenthal,

Kuo, & Linehan, 2006). Only relatively recently (as far as counseling theories go) has mindfulness been incorporated systematically (dare I say mindfully?) into approaches to intervention. However, it seems nowadays you see mindfulness wherever you go; even mindful grocery shopping is a distinct possibility.

Mindfulness approaches have been called the third wave of behavior and cognitive therapies (S. C. Hayes, 2004). The first wave would be what you would know as behavior therapy (see Chapter 8), a reaction to the opinion that traditional psychotherapeutic approaches (particularly psychoanalysis) were unscientific. As S. C. Hayes (2004) put it, "Behavior therapists poked fun at the complexity of psychoanalytic theorizing by showing experimentally that simple contingencies could readily produce behavior that would occasion bizarre psychoanalytic interpretations" (p. 641). Even though orthodox behavior therapy (also known as applied behavioral analysis) was successful, it left out some things that seemed important to people, like cognition, emotion, language, and existential concerns such as meaning in life. Neglect of these issues and processes and the rise of experimental cognitive psychology led to the second wave of behavior therapy, cognitive (or cognitive-behavioral) approaches (see Chapters 9 and 10). However, problems with the cognitive conception of behavior (e.g., findings that the cognitive model does not always hold up under empirical scrutiny) along with the emergence of social constructivist and postmodern thought prompted the third wave of behavior therapy, which keeps some of the old (cognitive and behavioral elements) and adds new things and ways of thinking.

The two approaches in this chapter—acceptance and commitment therapy (ACT, said as *one word*, not letters) and dialectical behavior therapy (DBT)—represent the third wave. Another approach, mindfulness-based cognitive therapy, is highlighted in Box 16.1. Although ACT and DBT are similar in that they both address mindfulness and contain aspects of cognitive and behavior therapies, their origins and philosophies, I would say, are different. You can judge for yourself.

Box 16.1

Mindfulness-Based Cognitive Therapy

Mindfulness-based cognitive therapy (MBCT), initially developed to prevent relapse of depression, combines techniques and principles of cognitive-behavioral therapy with mindfulness practices (Segal, Williams, & Teasdale, 2012). According to MBCT theorists, relapse of depression is associated with the recurrence of negative ways of thinking and feeling, which eventually leads back to a depressive episode. The manual for MBCT is the book *Mindfulness-Based Cognitive Therapy for Depression* (Segal et al., 2012).

MBCT theorists posit that old habits of thinking are motivated by the goal of avoiding or escaping depression and are based on well-practiced, ruminative, cognitive routines that are not useful. Despite their ineffectiveness, these routines are maintained because the individual becomes stuck and goes on "automatic pilot," focusing intently on discrepancies between what is and what is desired. We go round and round trying to avoid or change the discrepancy, and the inability to do so reinforces negative feelings about the self (Segal et al., 2012).

The core theme of MBCT is learning how to stay away from old patterns of thinking by being mindful and letting go. MBCT practitioners emphasize *experiential learning*, in which the required skills and knowledge are acquired via actual experience and not simply cognitive or "book" knowledge. This experiential learning should be based on the client's own experiences; the assumption that the client is the expert on herself serves to *empower* the client (Segal et al., 2012).

MBCT is delivered in classes, which should be large enough to prevent falling into "therapy" mode (around 12 people; Segal et al., 2012, p. 83). A number of skills are taught by MBCT therapists. First is *concentration*, or the ability to focus attention on one thing at a time instead of trying to multitask. The second is *awareness/mindfulness* of thoughts, feelings, emotions, and bodily sensations. Awareness is essential to letting go of unhealthy patterns because one cannot let go of those patterns until one is aware of them. *Being in the moment* is the third skill and involves being able to experience the present on a moment-by-moment basis. Fourth is the ability to *let go* of, or stop engaging in, old unhelpful patterns of thinking. *"Being" rather than "doing"* is important in allowing oneself to mindfully be in the moment, without worry or concern about what has to happen next. Finally, *bringing awareness to bodily manifestations of a problem* is when the client is aware of sensations in her body that result from a difficulty she may be facing. Becoming aware of these bodily sensations is the first step in letting go of unhealthy patterns of thinking and feeling (Segal et al., 2012, pp. 91–93).

MBCT counselors encourage clients to practice techniques learned during the active phase of treatment on a daily basis so that they will not forget these techniques once they experience a new way of being in their lives. The 8-week treatment is broken down into two basic parts: *learning mindfulness* (sessions 1–4) and *handling mood shifts* (sessions 5–8). Before an individual begins the classes, she participates in an individual interview, in which the MBCT practitioner explores her experiences with depression and teaches her about MBCT and how it can be helpful, emphasizing that MBCT will involve hard work.

Sessions 1 through 4 consist of three basic tasks. First, clients become more aware (mindful) of daily life, learning how quickly the mind can shift from one topic to another, through exercises aimed at allowing the client to learn by experiencing. The next focus is to gently bring the mind back to a specific topic once clients notice it drifting away. Finally, clients discover that negative thoughts or feelings are likely to surface and escalate when the mind wanders. Essential to all of MBCT is learning to address the self with kindness and compassion (Segal et al., 2012).

In sessions 5 through 8, clients learn first to allow a negative thought or feeling to just be and to explore it before deliberately taking a break from it by attending to breathing for a few minutes and then expanding awareness to the whole body. The taking a break part is called the *breathing space* (Segal et al., 2012, p. 84). Various avenues can be taken after using the breathing space: simply returning to typical experiencing in a more grounded way, more fully exploring the physical experience, inspecting how negative thoughts are associated with negative mood and their effects, or engaging in mastery or pleasure activities. Instead of dwelling on depressive symptoms or problems and asking "Why me?" and other similar questions that contribute to the downward spiral of depression, clients learn to meet negative, distressing thoughts, cognitions, and emotions with empathy, patience, and kindness.

A number of empirical studies have been conducted that examine the efficacy of MBCT in preventing relapse of depression (e.g., Kuyken et al., 2010) as well as in addressing

(continued)

Box 16.1 *(continued)*

problems other than depression, including panic disorder (B. Kim et al., 2010), social-emotional resiliency in children (Semple, Lee, Rosa, & Miller, 2010), and bipolar disorder (B. Weber et al., 2010). In general, MBCT is more effective than treatment as usual or no treatment in preventing relapse of depression, particularly for individuals who have experienced more than three episodes of major depression (Coelho, Canter, & Ernst, 2013; Metcalf & Dimidjian, 2014). There is no good evidence that it is more effective than other approaches in treating depression.

As for how MBCT works, Metcalf and Dimidjian (2014) concluded that "the degree to which mindfulness practice is an active ingredient of MBCT is unknown" (p. 275). Research on disorders other than depression is still in the early stages, and the overall consensus of that body of literature is that MBCT has the potential to be a helpful addition to pharmacotherapy, but most reviewers call for further research using randomized control trials.

Source: Used with permission of Romana C. Bresin.

ACCEPTANCE AND COMMITMENT THERAPY

OVERVIEW

The originator of ACT is Steven Hayes, currently a professor of psychology at the University of Nevada–Reno. When Hayes began his undergraduate studies, he was interested in Eastern thought as part of what he acknowledges as his membership in the "hippie" subculture (HappinessTrap, n.d.). At the same time, he began to explore behavioral approaches to psychology, finding B. F. Skinner's (1976) *Walden Two* fascinating. Then it was on to graduate school, where Hayes eventually received his doctorate and began to teach psychology—and here's where the story gets really interesting. One day in 1978, Hayes was beset by a panic attack in the middle of a faculty meeting (Cloud, 2006). Before he knew it, anxiety had taken over his life, and his traditional training in cognitive-behavioral therapy was of no help. He went back to his hippie roots and began to explore Eastern ideas and humanistic principles as avenues to heal himself. Out of this process came ACT (HappinessTrap, n.d.).

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Video Example 16.1 Listen to Steven Hayes describe how he found his way to ACT.



https://www.youtube.com/watch?v=VYht-guymF4

Hayes is a prolific writer and scientist. The recipient of numerous awards for his work (including the Lifetime Achievement Award from the Association for Behavioral and Cognitive Therapy), he has written a treatment manual for ACT (Luoma, Hayes, & Walser, 2007) and an ACT self-help book, *Get Out of Your Mind and into Your Life* (S. C. Hayes, 2005). A recent publication is a collection of Hayes's writings that describes the journey to ACT entitled *The Act in Context: The Canonical Papers of Steven C. Hayes* (2016). The website for ACT, the Association for

Contextual Behavioral Science, is found at www.contextualscience.org. You can read the ACT take on stereotypical masculinity in Box 16.2.

Central Constructs

ACT specifies a clinical theory, which identifies six critical processes of human functioning: acceptance, being present, cognitive defusion, self as perspective, values, and committed action (S. C. Hayes, Strosahl, & Wilson, 2012). The flip side of each of these processes describes dysfunction, in the ACT view, so as I describe each process you will get a flavor for both the dysfunctional and the functional aspects of these constructs. I will then add a brief description of mindfulness, a key process in ACT.

Box 16.2

The ACT Perspective on Stereotypically Male Behavior

[Relational frame theory] researchers have developed a body of evidence that shows the utility of casting symbolic and verbal behavior as a matter of a contextually situated and learned ability to relate events arbitrarily. As children become verbal, a wide variety of verbal relations are trained, such as similarity, opposition, distinction, or comparisons. These relations are applicable by social whim, rather than determined solely by the form of related events. For example, a nickel can be "smaller than" a dime because a relational context, not the events themselves, specifies nickels and dimes relate one to the other.

Once such relational abilities are established the verbal community can readily create relational networks that may be so extensive that they restrict behavioral repertoires and, thereby, promote negative psychological outcomes for the individual and society. A verbal rule such as "a man should be masculine" establishes a complex relational network that extends far beyond the relations in the sentence itself. For example, the verbally constructed coordination between manhood and "masculine behaviors" (e.g., emotional suppression, risk-taking) will very likely impact the listener's views of women by derivation of the frames of opposition between manhood and "feminine behaviors" (e.g., emotional expression, help-seeking). Consider, for example, how the rule "a man should be masculine" may reduce behavioral variability or extend the rule beyond contexts in which such learning has occurred. The verbal community demands construction of a consistent self-concept from a history full of inconsistent behavior. The need to conform one's behavior to this conceptualized self narrows the person's behavioral repertoire and begins to exclude even behaviors that may be effective (e.g., help-seeking in the context of psychological distress). For example, if *help-seeking* is in a frame of coordination with *femininity*, and *maleness* and *femininity* are in a frame of opposition, the derived relation is that *help-seeking* is in a frame of opposition to *maleness*. It is easy to imagine how such verbal processes could pit, through derived relational responding, the biological fact of being a male in opposition to help-seeking. It is clearly absurd to state that men who seek help are not men in a biological sense, though this is exactly what normal verbal processes can lead toward.

Source: From Sylvester, M., & Hayes, S.C. (2010). Unpacking masculinity as a construct: Ontology, pragmatism, and an analysis of language. P*sychology of Men & Masculinity*, 11, p. 95.

Acceptance. Surprise! One of the most basic ideas in ACT is acceptance. In ACT theory, acceptance means an active, deliberative process of accepting our thoughts or emotions without trying to change them (S. C. Hayes, Pistorello, & Levin, 2012). It does not mean wanting or desiring our experiences (Bach & Moran, 2008). Terms such as *willingness* and *letting go* are also used to describe this attitude. Further, acceptance involves taking a "gentle, loving posture toward yourself, your history, and your programming so that it becomes more likely for you to simply be aware of your own experience" (S. C. Hayes, 2005, p. 45). The opposite, or dysfunctional process, is experiential avoidance, or our tendency to evade experience—mainly that which makes us uncomfortable.

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Video Example 16.2 Watch this story about acceptance in the service of achieving valued goals.



https://www.youtube.com/watch?v=O-Ith3X1x9k

Gloria is Annika's ACT therapist. She looks for signs of acceptance in her new client. As Annika begins to speak, Gloria notices that Annika seems quite uncomfortable with herself. She says she wants to get rid of her erratic emotions and to calm down and have a more peaceful life. Annika's struggles indicate that she is not very accepting of her thoughts and feelings, but that she would like to find a way to a more tranquil existence.

Being Present. To function optimally, we need to be in contact with what is going on around us now—not caught in the past, future, or our own convoluted thoughts. This attention to the moment should be flexible, voluntary, and focused (S. C. Hayes, Pistorello, & Levin, 2012). Being present allows us to focus on our values mindfully so that we can actively seek to fulfill them. Dysfunctional individuals attend rigidly to the past or future rather than being present.

Annika seems focused on the past or on the future. She is depressed, anxious, and angry, ruminating over the mistakes she has made (like the affair with the news director), and she says she is reliving her chaotic childhood through the recent investigation of the abused child who was murdered. Gloria observes that Annika often seems to live in the fantasies of her relationship with her friend, the anchor, and in her dreams for her future. Overall, Annika does not seem very attentive to the now.

Cognitive Defusion. Cognitive defusion refers to learning to perceive thoughts as only thoughts (S. C. Hayes, Strosahl, & Wilson, 2012). Human beings have a tendency to forget this simple principle and see our cognitions as truth, which can cause us problems, a state known as *cognitive fusion* (see the discussion of relational frame theory in the section on "Theory of the Person and Development of the Individual"). However, it is possible to separate thoughts from relationships with other things, including our sense of self, and by doing so diminish the power of language in our psychological lives; this is cognitive defusion.

Gloria thinks that Annika is probably very attached to her thoughts, as indicated by her anger, anxiety, and depression. She reports that she can't sleep because she obsesses over her past, current life, and future. When she is anxious, her thoughts seem to "run away with her," and then she finds herself

getting depressed. She is carrying her anger around with her and periodically explodes at what seems to be relatively minor provocation. All of these qualities seem to indicate to Gloria that Annika has a low level of cognitive defusion.

Self as Context. This idea is probably one of the most difficult in ACT for us to understand. According to ACT theorists, the self should not be viewed as a static conceptualization (such as a limited set of roles and characteristics, which make up the *conceptualized* self), but rather should be seen as "the context where life events unfold" (Waltz & Hayes, 2010, p. 162). The term *self as process* is also used to describe this way of experiencing, which encourages us to be observers of what happens around and in us, without judging or justifying (S. C. Hayes, Strosahl, & Wilson, 2012, p. 223). Westrup (2014) emphasizes the distinction between self as *process* and self as *context*, pointing out that process is the ongoing noticing of experience, whereas context is being aware that we are noticing.

Annika wants to be a calm, capable individual who deeply values relationships with others. However, her recent (and past) experiences are inconsistent with this view; she has learned that she is an awful, angry, anxious, depressed person who fails in relationships and in her work. Her anger, anxiety, sadness, and troubles with others are scary, so she is struggling to avoid them along with thoughts about herself and these events. She finds explanations for these events in her rough childhood and becomes even sadder and angrier thinking about how her parents failed her.

Values. In ACT theory, values are consciously chosen thoughts and behaviors. Acting in alignment with our values is rewarding to us (S. C. Hayes, Strosahl, & Wilson, 2012).

Annika has only a vague sense of her values. She wants to value her relationships with others, but somehow they never seem to go quite right. Work seems to be an important value, but Annika is struggling in this realm as well. Gloria wonders if Annika's confusion is leading her at the moment to value not so much the work, but the attention she receives for it. Perhaps she is trying to satisfy her relationship values through this means. Gloria guesses that Annika's troubles with work are a blow to her value system and her sense of self as a committed, competent worker.

Commitment. The goal of ACT is to help us behave in ways that are consistent with our values despite the inevitable suffering we humans experience (S. C. Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013). When our values are not clear to us, we are like ships without rudders or even stuck aground. When we adopt (or pretend to) the values of others, we are not being true to ourselves, and the inconsistent information we receive is troubling to our sense of self.

Because she can't get a clear sense of Annika's true values, Gloria thinks that Annika is not really committing to action furthering them. Annika seems to be living her life in reaction to her internal experiences, so Gloria guesses that she is stuck in confusion.

Mindfulness. Mindfulness is tricky to describe other than in very simplistic ways. On the most basic level, it means that you are deliberately paying attention to your experience in the present moment and accepting it; it is the state attained, not the practices that get you there (Herbert & Forman, 2014). Many definitions have been offered that add elements such as curiosity, acceptance, and a nonjudgmental attitude. It is the opposite of being on automatic pilot (Sauer & Baer, 2010).

In ACT theory, mindfulness is seen as resulting from the combination of four of the key processes of human functioning: acceptance, cognitive defusion, being present, and self as perspective (S. C. Hayes, Pistorello, & Levin, 2012).

Gloria notes that Annika seems to be running from her experience or struggling to change it. As a result, she is not exactly on automatic pilot, but she is also not really attending to her experience.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Hayes (2005) doesn't mince words; he will simply tell you that "people suffer" (p. 1). Suffering is a universal human condition. Yet Hayes also acknowledges the courage and determination of human beings, pointing out that we often persevere and succeed even in the most difficult conditions. In his self-help book, he writes eloquently that "knowing they can be hurt, humans still love others. Knowing they will die, humans still care about the future. Facing the draw of meaninglessness, humans still embrace ideals" (2005, p. 1). The ACT philosophy is therefore that humans can live meaningful, productive lives even though they will inevitably experience pain, sadness, and other undesirable emotions, memories, and experiences. So a basic motivation of human beings is to find meaning and live a productive life.

The philosophy behind ACT is known as *functional contextualism* (S. C. Hayes, Strosahl, & Wilson, 2012). Functional contextualism is distinguished from other approaches by three underlying values: (a) It is holistic, (b) the role of context is central in understanding events, and (c) the criterion for truth is pragmatic (S. C. Hayes, Strosahl, & Wilson, 2012). Loosely translated, these principles mean that the person can't be separated from her parts or her surroundings (both physical and psychological, present and past). Also, the value of explanations for events is judged by the extent to which they work for the person (this is the pragmatism part). There is a behavioral flair to this approach, in which antecedents and consequences of actions are evaluated, but always in context, with an eye toward the function of the behavior (Bach & Moran, 2008).

ACT is based on the theoretical foundation of relational frame theory (RFT), developed by Hayes (S. C. Hayes, Strosahl, & Wilson, 2012). With roots in radical behaviorism (see Chapter 8), RFT starts with the premise that language and cognition are learned, along with a set of relationships between phenomena, called *relational frames*. An example of a relational frame is the comparative and evaluative frame, which links things together with terms such as *better than, bigger than*, and *prettier than* (S. C. Hayes, 2005, p. 18). Although they are first learned in a specific context, these relations can be established and generalized even without direct experience; that is, humans can learn by observing or through language (such as when I watch someone slip on ice or when Jeremy's mom tells him not to touch the hot burner on the stove because it will burn him). We can also transfer this learning to other situations or, in ACT language, contexts (I learn that ice is slick and can be found on sidewalks and ponds and, for goodness' sakes, can hide under snow). We begin to learn these relationships as tiny babies, and we never stop learning such associations. We accumulate relations like a miser collects money.

More importantly, behavior research demonstrates that behavior, including linguistic relations, is never really unlearned (S. C. Hayes et al., 2012). So the sometimes strange relations we learn (my boyfriend left me, so I am unlovable) stick with us, and worse, messing with them in the way that traditional cognitive approaches do ("let's examine this thought carefully") may only elaborate them and make them stronger. Also, trying not to think of these thoughts is not effective; it may work for a while, but then the avoided thoughts come back (see Box 16.3,

Box 16.3

The Purple Unicorn

Get as physically comfortable as you are able, and try to clear your mind of everyday thoughts, worries, and so forth. Take several relaxed breaths, focusing on the air as it enters and leaves your lungs. When you feel as relaxed as possible, imagine a purple unicorn. Take your time, and see all of the details. Is it male or female? How long is its horn? See its dainty little hooves and flowing mane. Watch as it bounds from cloud to cloud in a clear, blue sky.

Once you have a clear vision of your unicorn, I want you to *stop thinking about it*. Try as hard as you can to *not* think about that unicorn.

What happened?

"The Purple Unicorn," for a demonstration of this effect). According to Hayes, these principles apply to behavioral dispositions and emotions, too. I will have more to say about the importance of this issue in the following section, "Health and Dysfunction."

Gloria thinks that Annika has learned a number of relations that are not helping her in the present. Probably the most critical one is that she sees herself as broken, locating the cause of this dysfunction in her early upbringing, which she can't change. Annika also has probably learned a relation about relationships: They are always difficult and stormy and that she always fails in them. Yet Annika struggles to avoid these thoughts, wanting to see herself as competent and whole. This relational frame is not working for her, nor is her unwillingness to accept the good and bad of life.

Health and Dysfunction

ACT therapists take a health rather than a disease model of psychological dysfunction (S. C. Hayes, Pistorello, & Levin, 2012). The first lesson of ACT is that healthy folks are those who accept their humanness, with all of its good and bad, and work toward a life informed by personal values. Because we are all going to suffer and also be happy, we need to simply go with the flow. As Hayes, Strosahl, and Wilson (1999) put it, "The goal of healthy living is not so much to feel *good*, but rather to *feel* good" (p. 77; emphasis in original).

Specifically, health in ACT terms is *cognitive flexibility* (S. C. Hayes, Pistorello, & Levin, 2012); we don't let our current thoughts and feelings get in the way of working toward our valued long-term life goals. All of the other processes specified in ACT theory (acceptance, cognitive defusion, being present, noticing self, values, and commitment) contribute to cognitive flexibility, which is why it is in the center of Figure 16.1. Notice that the basic ACT processes can be classified into mindfulness and acceptance processes and commitment and change processes, which presents another way to look at psychological health from this perspective.

In terms of the ACT processes, healthy means that we should be open to our experience, particularly our feelings, but it doesn't rule our world. We mindfully accept our experience, but avoid our natural tendency to regard our thoughts and associated feelings as truth—a process that, as I noted earlier, is called *cognitive fusion* (S. C. Hayes et al., 2013). Healthy people know that thoughts are just thoughts, and no more than that. They might be interesting. They are

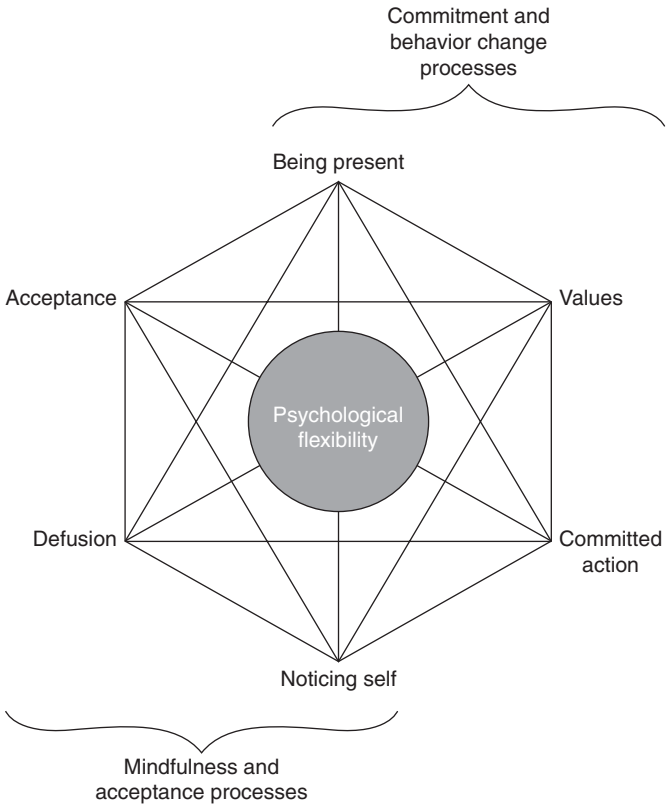


FIGURE 16.1. The ACT Model.

Source: The ACT model of behavior change from "Acceptance and Commitment Therapy as a Unified Model of Behavior Change" Steven C. Hayes; Jacqueline Pistorello; Michael Levin. Used with permission.

likely to be important sometimes. However, healthy people see thoughts as thoughts—they are to be reviewed for their workability, not as truths. Healthy thinking is *defused*. For example, I am hungry right now. I notice this thought, but I don't let it lead me to jump up from my computer and rush to McD's. I simply observe it and decide that progress in my writing is more important (and workable because I am way behind schedule) than eating at this moment.

In contrast, folks who are experiencing psychological dysfunction are likely to be fused with their thoughts; they are immersed in them, take them as *Truth*, and believe that they *always* cause their behavior. Psychological dysfunction is seen as the result of language barging into places where it doesn't work for us. Where people go wrong is when they try to respond to, control, or avoid parts of their inner lives—specifically, those thoughts or feelings that we find aversive (Arch & Craske, 2008). Devoting ourselves to obsessively managing our experience limits our options to act in ways consistent with our values (assuming we are clear about these). The classic example of this is what happens when we discover anxiety. Typically, we respond by avoiding anxious feelings, struggling to change thoughts associated with feared entities, or bypassing the anxiety-provoking situation altogether. We use methods such as suppressing thoughts or feelings by medicating ourselves with various substances or experiences (e.g., drugs, sex, rock and roll; Luoma & LeJeune, 2006). The

formal name for this process is *experiential avoidance*, and it is at the root of many of our human woes. According to ACT theory, this doesn't work because these relations can't be unlearned.

Another feature of dysfunction in the ACT model is the *conceptualized self*, seen when the individual is stuck on one version of self ("I am unworthy of attention" or "I am good at what I do") and can't unhook across the various life contexts she experiences. Sometimes this conceptualized self is helpful, such as when it helps us describe ourselves to others. At other times these conceptualizations can get us into trouble, such as when we receive contradictory information, which can cause unwelcome emotions and spark experiential avoidance (Hayes, Pistorello, & Levin, 2012). Also, rigidly holding negative conceptualizations is associated with relational frames that are invested with truth and associated with negative emotions that the individual wants to banish.

Annika is clearly struggling with her thoughts, trying to avoid or change them when they lead to uncomfortable emotions. When she notices her anxiety, she immediately tries to avoid it and suppress the associated thoughts (e.g., "I will never get back to work"). Her anxiety hangs around because she perceives her thoughts as truth, but they are inconsistent with her desired view of herself (I am a competent worker). Her "uncontrollable" anger surfaces in relationships or when she obsesses about them ("Why is this other treating me badly? I am a failure and broken. I can't stand my life!"). When Annika receives feedback from others that is contrary to what she wants it to be, old relations emerge, such as her ideas that she is damaged from her childhood, and she believes these words and becomes depressed.

Nature of Therapy

Assessment. Assessment can take many forms in ACT. On a very basic level, the ACT counselor tries to understand the client and see where she might be stuck (conceptualized self) or avoiding experience. ACT theorists acknowledge that sometimes formal assessment tools can be helpful, but caution that standard inventories (e.g., symptom assessments) most often register the presence of the symptoms, not their function (i.e., how they are related to the client's language system). S. C. Hayes, Strosahl, and Wilson (2012) recommended a "Work–Love–Play" assessment be completed, which means that the therapist attempts to understand the client's functioning across valued aspects of life (p. 107). There are also specific ACT measures, such as the Acceptance and Action Questionnaire (Bond et al., 2011).

Gloria talks with Annika, trying to clearly identify Annika's way of being in the world, noting that she seems pretty inflexible, yet she has intense, changeable emotions. Annika reports that she wants to work on being more comfortable in her life, which Gloria sees as a good sign. Annika seems motivated to change her world. Gloria also explores the specific situations and thoughts that lead to Annika's feelings, noting that Annika presents as if these are unarguable and she can't resist responding to them.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. Although many sources bypass the issue, the core conditions of warmth and genuineness are important in ACT (Strosahl, Hayes, Wilson, & Gifford, 2010). Strosahl et al. (2010) noted that "when we see our clients trapped by language, we see ourselves and the traps which generate our own pain" (pp. 52–53). Counselor and client are equals in ACT, and the belief that the client can change is emphasized. Part of being equal is that the ACT therapist is willing to self-disclose when doing so facilitates the client's progress (Strosahl et al., 2010).

The ACT therapist is also a witness, holding the client accountable for choosing and following through with valued action (Waltz & Hayes, 2010). However, counselor and client must be careful to view this process as a living one; it is a journey that will surely take different paths than anticipated, and the outcomes must be viewed flexibly. Getting stuck on particular ways of getting there or on particular goals can be seen as a form of fusion, so the process is one of trial and error, guided by the values identified by the client. In ACT language, clients are expected to "commit and slip" (Waltz & Hayes, 2010, pp. 165–166).

The person of the therapist is important in ACT. Counselors must apply the principles of ACT to themselves. For example, the ACT therapist must be aware that her own thoughts are simply verbal events entwined in context (Bach & Moran, 2008). Accepting her own experience makes it more likely that the therapist can accept the client's. Therapists must not get stuck on what "should be" in therapy, avoid certain paths of exploration or experience, or choose actions that are not consistent with their values as therapists (Vilardaga, Villatte, & Hayes, 2015, p. 40).

Gloria begins by simply trying to establish a trusting connection with Annika. She engages Annika in a discussion about what has been happening in her life with the awareness that she, Gloria, has experienced similar thoughts and experiences. Knowing that she herself will need to be flexible in this relationship, Gloria tries to be genuine and understanding.

Goals. The primary goal of ACT is to help clients behave in ways that are consistent with their values, even when uncomfortable, unwanted private experience tells them to do otherwise (Waltz & Hayes, 2010). It is not enough to think about doing this; ACT requires *committed action*. A necessary prerequisite to committed action is psychological flexibility (Sauer & Baer, 2010).

Another way to look at ACT goals is through the concept of *willingness*, defined as "being open to one's whole experience while also actively and intentionally choosing to move in a valued life direction" (Luoma et al., 2007, p. 24). This term is sometimes used interchangeably with acceptance because some clients may interpret acceptance as giving up, but that is not what acceptance and willingness are all about.

From a narrower perspective, the ACT therapist tries to help clients change the functions of experiences (mainly thoughts), not their form. When clients seek help, it is because they are frozen; their inner experience is dictating their behavior rigidly (this is the "function" part). What the ACT counselor wants to do is change the social and verbal meanings of these relations. After all, if a thought is not "true," it doesn't need to drive our behavior.

Gloria thinks that Annika really needs to identify her goals and values so that she can proceed to make choices to move toward them. However, aware of the need for flexibility in her work with Annika, Gloria thinks that they will first need to discover the thoughts that are plaguing Annika so that she can help her disconnect from them. For example, Annika says, "I am awful in relationships. See how I always mess them up?" Gloria notes this thought for further attention.

PROCESS OF THERAPY

The acronym ACT can also spell out its therapeutic approach: Accept, Choose, Take Action (S. C. Hayes et al., 1999, p. 77). Figure 16.1 shows the six core processes in ACT: acceptance, cognitive defusion, being present, self as perspective, value, and commitment (S. C. Hayes, Strosahl, & Wilson, 2012). The ACT counselor tries to help the client get in contact with her

experience in the present and tailors interventions to the client's presentation, with attention to the qualities of the client, such as culture, ethnicity, and social or language practices (Strosahl et al., 2010). Admonished not to argue with the client, the ACT therapist is to recognize experiential processes relevant in the therapeutic situation and build metaphors and design interventions based on this recognition.

The process of therapy is to move from FEAR to ACT (Strosahl et al., 2010). The acronym FEAR stands for fusion, evaluation, avoidance, and reason giving. Most of these terms are self-evident, except perhaps *reason giving*, which refers to the tendency to rely on what seem to be logical and culturally sanctioned justifications "that 'explain' and 'rationalize' the use of unworkable coping strategies that make the individual less responsive to real contingencies in the environment" (Strosahl et al., 2010, p. 32; quotes in original).

To achieve ACT, the therapist must first foster a sense of *creative hopelessness* in the client. Although this may sound injurious, it simply means that the counselor helps the client see that the culturally supported change strategies that she has been endlessly trying (e.g., the idea that one needs to get rid of negative experiences by fixing their causes, which are usually deficits in the client) are not working. The criterion of workability is the yardstick used to evaluate the client's efforts, with the therapist asking three questions: (a) "What does the client want, (b) what has the client tried, and (c) how has that worked?" (Hayes et al., 1999, p. 89). The ACT therapist wants the client to know that she is not broken or hopeless, but that the tactics she has been using (trying to control the problem) are (Strosahl et al., 2010). Here lies the doorway into defusion, acceptance, and committed action, according to ACT.

Gloria helps Annika review her experiences by asking detailed questions about her thoughts and behavior. She explores what Annika has done to try to solve her problems and gently tries to lead Annika to see that these attempts (trying to suppress her anger, avoiding anxiety or the painful thoughts that lead to depression) don't work very well. Seeing the growing creative hopelessness in Annika, Gloria is truly hopeful that Annika can identify her values, make plans to move toward them, and live a more satisfying life.

Therapeutic Techniques

There are tons of techniques that can be used in ACT, so the following is a general discussion with a few specific techniques used as examples. Good sources for more exploration of interventions are Luoma et al. (2007), S. C. Hayes (2005), and the website of the Association for Contextual Behavioral Science (http://contextualscience.org).

Metaphor. Acceptance and commitment therapists often use metaphors to get points across to clients. A commonly used metaphor is the chessboard, used to separate the self from thoughts (i.e., to promote the self as context). The client's self (the context) is the board; it doesn't care what the chess pieces (the client's thoughts) do, even if they are fighting (which is the case with most clients). The counselor can even note that, while the queen may be dead set on murdering the knight, in the end there will be no harm done to the chessboard. "Passengers on the bus" is another commonly used metaphor: Clients are encouraged to make their unwanted, uncomfortable experiences passengers on the bus life, even to the point of giving them pet names (Vilardaga et al., 2015, p. 40). The client's relationship with each rider is examined, and how the passengers influence the direction in which the client is driving is considered: toward or away from a meaningful life.

Gloria considers metaphors she could use with Annika. The chessboard is her favorite, so she explains it to Annika, showing how her angry, anxious, and sad thoughts are the chess pieces. She asks Annika which thought is the king ("I am broken") and the queen ("I can't do anything right in relationships"), gently joking with her about these images. Annika begins to understand that the king and queen can't really hurt the board in any way and also begins the process of practicing mindful observation of her experience.

The Willingness Dial. Sometimes called the two scales metaphor, this technique is used to illustrate the futility of trying to control negative personal experience (Hayes et al., 1999). The therapist has the client imagine one dial that represents negative personal experience. For example, a common target is anxiety. The anxiety dial goes from low to high and, of course, the client is trying to keep it low. The counselor then reveals another dial, which the client can't see—the willingness dial, which also can be high or low and represents the client's willingness to *experience* anxiety. If the willingness dial is low, the client spends a lot of energy trying to get the anxiety dial to register zero. However, the attempt to control anxiety only creates more anxiety, guaranteeing that the anxiety dial will be stuck on high. So the client needs to fool with the willingness dial, because she can choose the level at which it set. If she sets the willingness dial high, then anxiety will be either high or low, but she is released from the struggle and can pursue valued life goals.

Teaching Annika about the two dials, Gloria explains that Annika can control one (her willingness) and not the other (her anxiety). Annika struggles with these ideas because she has always experienced anxiety as something that should be fixed, not experienced. "If only I were a better person, then I wouldn't have this anxiety," she tells Gloria. Gloria assures Annika that this is just a thought and that Annika can adjust the dial so that it becomes only that—so that Annika can get on with her life.

Mindfulness Techniques. Achieving mindfulness takes lots of practice. The idea is to learn to access experience without judging, but instead observing and accepting what is going on. Various meditation and body awareness exercises are used for this purpose. Other interventions can take the form of mindfully doing something, such as eating a raisin (Luoma et al., 2007). In this exercise, the client carefully examines raisins, comparing their size and wrinkle patterns and how they feel on her fingers. Then she eats several raisins, very carefully, maybe slowly, all the while paying the utmost attention to the raisins.

Because Annika reports difficulty eating, Gloria decides to have her do the raisin exercise three times this week at home. Annika reports that she isn't often hungry, but Gloria points out that it won't do any harm for Annika to eat one raisin when she is not hungry. She also suggests that Annika begin a yoga class to help her calm her mind. At the end of her sessions with Annika, they practice a breathing exercise, where they both spend 10 minutes trying to quiet their minds by focusing on breath.

Cognitive Defusion Techniques. A wide variety of interventions are directed at helping clients separate their thoughts from themselves. In contrast to traditional cognitive-behavioral intervention, the idea is to change the function of a thought, not its form (as is the goal of cognitive restructuring). In essence, the goal is to make a thought just a thought and nothing else, disconnecting it from the prior dysfunctional feelings or behaviors (Arch & Craske, 2008).

One way to do that is to unhook words from their meanings, which are often powerful in determining how we structure our worlds. The most basic intervention is to simply ask the client to "notice that thought" (Luoma et al., 2007) and then let it go instead of obsessing about it or acting on it.

A well-known ACT exercise is "Milk, Milk, Milk," in which the client is first asked to think a whole lot about milk—what it looks, tastes, and feels like. Then the client is instructed to say the word *milk* over and over again (for maybe a minute or two). What happens is that the word begins to lose its meaning. Then the client is asked to do the same thing with a negative thought she has about herself (Luoma et al., 2007). The client can also be asked to say her thoughts in funny voices or sing them, with the same effects.

Gloria considers Milk, but then decides to wait awhile to introduce that exercise to Annika. Instead, when Annika reports a troublesome thought, Gloria asks Annika to visualize the thought floating by her, perched on a cloud in a bright blue sky. Annika is learning how to simply observe that thought without trying to kick the cloud.

Values Work. Helping clients clarify values is essential to ACT. One exercise that can be used is "What Do You Want Your Life to Stand For?" (S. C. Hayes, Strosahl, & Wilson, 2012). In this rather intense intervention, the client is asked to relax and then to visualize her funeral. The therapist then asks the client to report what she would like to hear various witnesses saying about her—what do her family, friends, and other important folks remember her for? Once the visualization ends, client and therapist can talk about the values revealed by this exercise and also how the client's problems may seem less significant as a result.

On the lighter side is the "Values Shopping Mall" (LeJeune, 2007, pp. 139–141). In the mall are 17 stores, with names like Leisure and Learning Lane, the Family and Friends Store, and the Spirituality Shop. Items within the stores have prices, and the client has $100 to spend. Core values are often seen in how the client spends her money. Once the core values are identified, the client and counselor make plans for committed action toward reaching these goals.

When Annika first started counseling, she said that what she wanted was a peaceful life. Gloria asks her to describe what that would be like. Annika replies that she would have meaningful relationships and would be mostly happy with her work and do it well most of the time. Gloria asks Annika if she could be OK with these things even if her life were not peaceful. After many discussions, Annika agrees that she could be partly satisfied with that state of affairs. Gloria then proposes that she and Annika go shopping at a different kind of mall. They work together to discover what other things Annika truly values in her life. As therapy progresses, Gloria may help Annika explore her sexual orientation as part of establishing life values, but only if this seems to be a problematic issue for Annika.

DIALECTICAL BEHAVIOR THERAPY

Overview

DBT was conceived by Marsha Linehan to treat a very specific client group: the highly suicidal (Linehan & Wilks, 2015). Many of the clients that displayed self-harming behaviors met the criteria for the diagnosis borderline personality disorder (BPD) in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V; American Psychiatric Association, 2013), so DBT has

become known as an approach directed at this specific diagnostic category. These individuals (mostly women) are considered very difficult to help. You can read some of what Linehan has to say about DBT in Box 16.4.

Box 16.4

Marsha Linehan on Acceptance and Change

Over the past 20 years, I have been developing and evaluating an approach to treatment designed specifically for suicidal individuals, particularly those who are chronically suicidal. Although the treatment, Dialectical Behavior Therapy (DBT), is now considered by many to be a general treatment approach applicable to many populations, its origins as a treatment for seriously suicidal clients had much to do with its current form. As the name suggests, DBT is firmly anchored in behavior therapy; the change strategies at its center are standard cognitive and behavioral treatment approaches. In attempting to apply standard behavior therapy to severely and chronically suicidal individuals, however, I noticed two things become immediately apparent. First, focusing on client change, either of motivation or by enhancing capabilities, is often experienced as invalidating by clients who are in intense emotional pain. In many clients, it precipitates noncompliance, withdrawal, and at times, early drop out from treatment, in other clients extreme anger and aggressive attacks on the therapist, and in still others both patterns of behavior. Second, focusing treatment on exploration and understanding, in the absence of a clear focusing of efforts to help the client change, is often experienced by these same clients as invalidating because it does not recognize the unendurability and, therefore, necessity for immediate change of the present unremitting pain. Thus, therapy approaches that focus on acceptance of the client (rather than change) also risk client withdrawal, attack, or both. Either of these client responses, attack in an attempt to change the therapist or passive withdrawal in an attempt to avoid unwanted therapist behavior, typically have a reciprocal invalidating effect on the therapist in turn. The therapist then may unwittingly respond with, at times, almost imperceptible, but none-the-less real, attack or withdrawal from the client. Although unavoidable at times, client or therapist attack or withdrawal interfere with the collaborative working relationship necessary for therapeutic progress.

It was the tension and ultimate resolution of this essential conflict between focusing on client change this very moment versus acceptance of the client as he or she is in the moment that led to the use of dialectics in the title of the treatment and to the overriding emphasis in the treatment on reconciliation of opposites in a continual process of synthesis. The most fundamental dialectic is the necessity of accepting clients just as they are within a context (and, indeed, therapy's *raison d'être*) of trying to help them to change. The emphasis on acceptance as a balance to change flows directly from the integration of a perspective drawn from Eastern mindfulness (primarily Zen) practice with Western psychological (primarily cognitive-behavioral) practice. Although acceptance and change cannot really be as clearly distinguished as I am portraying it here, for reasons of exposition, acceptance of the client in DBT is described under the rubric of three fundamental treatment-strategy groups: validation, reciprocal communication (including warmth, genuineness, and responsiveness), and environmental intervention (i.e., influencing or making changes in the environment to assist the client).

These acceptance strategies are balanced by corresponding "change" strategies of problem solving (including behavioral analyses, analyses of alternative behaviors and solutions, commitment and psychoeducational strategies, basic change procedures of skills training, exposure-based procedures, cognitive modification, and contingency-based procedures), irreverent and confrontational communication, and the stance of consultant to the client (rather than to the client's personal or professional network) when interacting with the community outside of the therapeutic dyad. All strategies are applied within a context of overarching dialectical strategies and stance.

It would be difficult to overestimate the importance of validation in DBT. Together with dialectical and problem-solving strategies, it forms the triadic core of the treatment. Although validation encompasses and requires empathy, it is more than empathy.

Source: Linehan, M. M. (1997) Validation and Psychotherapy. In Bohart, Arthur C., and Leslie S. Greenberg, *Empathy reconsidered: New directions in psychotherapy* (pp. 535–392). American Psychological Association, Washington, D.C., © 1997. Reprinted with permission.

Linehan began her theoretical journey attempting to use cognitive-behavioral therapy with these clients, but soon realized that she was adding elements of acceptance of feelings and emotions and, oddly, confrontational and somewhat paradoxical interventions that seemed more like those used in family systems theory (see Chapter 13). She noticed a tension between validating the client (acceptance) and addressing the very real need for change in these clients, a phenomenon that evolved into the dialectical philosophy of DBT (T. R. Lynch et al., 2006).

DBT has exploded in popularity over the years since it was introduced. Linehan is a very busy woman, researching DBT and traveling extensively to present her work. She has obtained many grants to study the outcomes of DBT and oversees a set of clinics at the University of Washington that apply DBT to various client problems. Linehan has established a training organization, called The Linehan Institute (www.linehaninstitute.org). The treatment manual for DBT is Linehan's (1993a) book *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, so you will see a great deal of information drawn from this source as you read this part of the chapter. Linehan has just updated the *DBT® Skills Training Manual* (Linehan, 2015), so if you are aspiring to do DBT this reference would be a must read. An interesting side note is that in 2011 Linehan disclosed her own struggles with the issues she studies and treats in an article published in the *New York Times*; you will find a link to this very poignant story at www.linehaninstitute.org/news.php.

CENTRAL CONSTRUCTS

Dialectics. The *D* in DBT refers to a philosophy and also to strategies used in this approach (Linehan, 2015). Philosophically, a dialectic standpoint is similar to the philosophy of ACT; it refers to a holistic perspective in which context is critical. In this view, reality is fluid and is composed of opposing forces, or *polarities*, the synthesis of which creates a new set of opposing forces. Lest you get too lost here, let's take an example from Linehan (2015). A basic opposition in our helping profession is the tension between helping a client change versus helping her accept herself. If you get stuck in either extreme, you are probably not going to be an effective counselor.

So the trick is to move back and forth and to view life as an ever-changing balancing act. With regard to strategies, DBT recognizes the balancing act of, for example, working directly with the client for change versus changing the environment (Linehan, 2015). The core DBT strategy is conceptualized as the tension between problem solving and validation of the client's perspective.

Oberon, Annika's DBT therapist, begins by noticing that Annika seems to be stuck at one end of the change–accept polarity. She passionately wants to get rid of her emotions, change her existence, and thus have a peaceful life.

Emotion Regulation. In traditional cognitive therapy, emotion is conceptualized as largely resulting from thought; in contrast, in DBT emotion stands on its own as a critical factor in psychological functioning (Swales & Heard, 2009). Emotion regulation refers to the ability to pay attention to emotional experience but not let it carry you away, self-soothe any accompanying physiological arousal, and the ability to act deliberately in the presence of strong emotion (Linehan, 2015). Advocates of DBT are more likely to discuss emotion dysregulation than regulation, but we can infer that healthy regulation leads to adaptive behavior instead of the extreme shifts seen in emotionally vulnerable individuals who don't have such skills.

Oberon notices that Annika is having difficulties regulating her emotions, particularly anger. Her changing emotions seem to be driving her behavior.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

Because the theoretical structure of DBT emerged in the context of helping individuals diagnosed with BPD, the conceptions of human development and personality are focused on understanding this presentation. Linehan (1993a) proposed a biosocial theory of development that points to the failure of the emotional regulation system in combination with a dysfunctional environment as the primary cause of BPD.

The roots of DBT in the principles of behavioral and cognitive approaches lead to a basic assumption that the individual's behavior is strongly influenced by environmental contingencies (i.e., reinforcement and punishment). Yet at the same time, another important factor in development is the ability to regulate emotion. This ability to deal with emotion is thought to be biologically based (Linehan, 2015). By "biologically based," Linehan doesn't necessarily mean genetic (although genes can be one factor). Other factors such as intrauterine events and environmental events that affect nervous system development are possibilities, too. Children are thus born with different sensitivities to emotion; some are so reactive that they seem to have "no emotional skin" (Linehan, 1993a, p. 69). When such a child is raised in an invalidating environment (see the following section on "Health and Dysfunction"), emotional experience is not validated, and the child is not taught to modulate emotion. In healthy family environments, parents and others help children identify an emotional experience, express it, and take action, if appropriate.

Childhood experience is therefore critical in the DBT model of individual development. Kids, according to Linehan (1993a), need validation of their experiences from parental figures. When a child expresses her inner experience—such as when a baby cries because it is hungry—caretakers must respond to, not ignore, the child. For example, when the little boy cries because he's stubbed his toe, the healthy parent kisses it to make it all better.

Oberon wonders if Annika is more vulnerable to her emotions than are other people. Certainly, she is showing some difficulties with emotional regulation at present. He reviews Annika's case history, evaluating the nature of her early experience.

Health and Dysfunction

Healthy people, in the DBT model, do not have specific vulnerability to emotion and are able to regulate their emotions. They likely have grown up around important others who allowed them to experience and express their inner lives and responded to their needs in appropriate ways. To continue our earlier example, when the hungry baby cries, the parent feeds her. Equally important, when the baby cries because it wants cuddling, the parent does not feed the baby; rather, the parent cuddles.

Based on her biosocial theory, Linehan (1993a) proposed that the biological tendency to emotional vulnerability combined with an invalidating rearing environment produces psychological dysfunction. Emotional vulnerability is defined as high sensitivity and intense response to emotional events and a slow return to the nonemotional, or baseline, state (Linehan, 2015).

In invalidating environments, the expression of experience (particularly emotion) is not supported by caretakers or, if it is, such support is inconsistent. In fact, the expression of inner experience is often punished or ignored, according to Linehan (1993a). The child is told that she is not hungry, hurt, or scared, or in other instances she is told that what she believes or wants is not really true. This invalidation seems to particularly apply to negative emotional states, such as anger. The tendencies of the environment and the individual interact in a pattern of reciprocal influence (T. R. Lynch & Cuper, 2010). For example, the emotionally vulnerable child expresses a strong emotion and is dismissed by individuals in the invalidating environment, leading to further (louder) expression of the emotion and further intensification (and perhaps a sense of justification) of the dismissing reaction of the individuals around her.

The consistent invalidation of experience leads to the child never learning how to process emotion. Further, she does not learn how to tolerate distress. Worse, the child learns not to trust her own view of life—she is constantly being told that her feelings, views, and experiences are wrong. Invalidation also leads to deficits in problem-solving skills because the child is not taught ways in which emotional states can be addressed. Instead, the child may learn dysfunctional ways of regulating emotion, such as self-harming, suicide attempts, or maladaptive eating patterns (T. R. Lynch & Cuper, 2010). The inability to adaptively process and respond on the basis of emotion is called *emotional dysregulation*, which is considered to be a core characteristic of BPD (Neacsiu, Ward-Ciesielski, & Linehan, 2012).

Oberon, listening to Annika's presenting concerns and recent experiences, is observing signs of emotional dysregulation. She bounces among anger, anxiety, and depression. Her life story suggests an invalidating environment—her father was away a lot, and her mother seemed to be experiencing significant psychological distress. It seems likely that neither had time to attend much to Annika. However, that her father sometimes doted on Annika when he was around is a good sign. He may have provided some much needed validation of her feelings. Still, Annika seems to be showing intolerance, poor regulation of her feelings and experiences, and some faulty ways of addressing her changing emotions, such as not sleeping and not eating.

NATURE OF THERAPY

Assessment. Linehan (1993a) asserted that a thorough assessment includes a diagnostic interview, which is used to obtain a detailed history and the client's previous counseling experiences. She recommended the use of the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 2002; now available as the SCID-5; www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5) and the Diagnostic Interview for Borderlines (Zanarini, Gunderson, Frankenburg, & Chauncey, 1989).

In DBT, a distinction is made between primary and secondary behavioral targets (Linehan, 1993a). Primary targets are life- or therapy-threatening behaviors, such as suicide attempts, self-harming, or other behaviors that seriously detract from the client's quality of life or the therapeutic work. Secondary targets are emotional regulation, problem solving, self-validation, and other life skills. Assessment, then, in DBT consists of reviewing the client's presentation in these categories. In order to proceed, primary targets are addressed first.

The counselor assigns the client the task of completing diary cards to track progress from week to week. The primary purpose of the cards is to track critical behavior such as suicidal ideation, drug use, and client mood so that the DBT counselor can intervene if primary target behavior surfaces (Linehan, 1993a).

Oberon interviews Annika, finding out about her family history and current circumstances. He notes that although she is not actively suicidal at present, some of her behaviors are problematic, such as her difficulty eating, and could be classified as primary targets. She doesn't seem to display any therapy-threatening behaviors at present. Oberon notes Annika's current emotional regulation and the strategies she uses to address her troublesome feelings. Issues of self-validation are evident in Annika's description of herself as "broken" and always having problems with relationships. Oberon shows Annika DBT diary cards and asks her to track her emotions, sleep patterns, and success in eating regular, healthy meals.

Overview of the Therapeutic Atmosphere and Roles of Client and Counselor. DBT therapists assume that clients want to get better and that they "are doing the best they can" (Linehan, 1993a, p. 106). Although they may not be responsible for their problems, they are responsible for solving them, and they must work hard to do so. The DBT therapist also takes the position that clients can't fail—only the therapy or therapist can. A particularly interesting principle of DBT is that the counselor needs support to deal with the difficult clients with whom they work (Linehan, 1993a).

The counselor's first job is to conduct an extensive orientation with the client, beginning with the assessment described above, followed by the presentation of the biosocial theory on which it is based (Linehan, 1993a). During the orientation (which can last multiple sessions), the therapist and client typically agree to a length and format of treatment. In full-scale DBT, this means a commitment of 1 year, and it includes attendance at individual therapy and skills-training groups. In these sessions, it is very important that the therapist establish a strong alliance with the client, so validation is used liberally (Rizvi, 2011). Rizvi (2011) suggested the metaphor of a client who does not know how to swim plunging courageously into a rough ocean because she "should." The therapist is a swim coach (p. 262).

In Linehan's words, "Stylistically, DBT blends a matter-of-fact, somewhat irreverent, and at times outrageous attitude about current and previous parasuicidal and other dysfunctional

behaviors with therapist warmth, flexibility, responsiveness to the client, and strategic self-disclosure" (1993b, p. 5). She contended that the therapeutic relationship is critical to success in DBT and identified validation of the client as an essential component of the approach (Linehan, 1993a). Validation is considered a core therapeutic strategy that is described by six different levels (Linehan, 1993a; Swales & Heard, 2009). The first level involves accurately listening to the client and demonstrating interest in her experiences. Level 2 is accurate reflection, or letting the client know that she is understood. In level 3, the counselor verbalizes aspects of the client's experiences that the client has not overtly described. Validating the connection between the past and the client's current feelings or behaviors is the essence of level 4. Communicating that the client's current behaviors or feelings are reasonable or functional constitutes level 5. Finally, level 6 is radical genuineness, or validating the inherent strengths of the client; the therapist conveys that he believes the client has the capacity to behave in effective ways and overcome her troubles (while maintaining basic empathy for her).

MyCounselingLab

Video Example 16.3 Watch Marsha Linehan conduct DBT. How would you describe her manner?



https://www.youtube.com/watch?v=S4Ccpqh6giM

Oberon conducts a thorough initial assessment with Annika. He explains DBT theory to her and asks her to commit to 1 year of therapy, with individual and group sessions weekly. Sensitive to Annika's reactions, Oberon attempts to be as supportive and validating as possible.

Goals. According to Linehan (1993a), the goals of DBT are to teach clients to (a) modulate intense emotions and reduce or eliminate maladaptive behaviors associated with these and (b) trust in the self, thoughts, feelings, and behaviors (p. 62). Ultimately, these changes are in the service of achieving a life worth living (Linehan, 1993a).

Oberon discusses therapy goals with Annika, and she indicates that what she wants is to be less depressed, anxious, and angry. She admits that, although she projects a sense of confidence at times, inside she questions herself and feels that she can't control her feelings, which lead her to unproductive behavior. Annika and Oberon agree that she is not reaching valued life goals, like having a satisfying, lasting relationship and being productive at work. They set specific goals to help Annika work toward these larger goals, such as increasing her ability to manage emotions that get in the way of reaching them.

Process of Therapy

DBT is based on principles derived from three underlying theories: DBT's biosocial theory, behavior theory, and dialectical philosophy (Rizvi, 2011). An intensive approach, DBT has four treatment modes: individual therapy, group skills training, telephone consultation, and therapist consultation groups (the last, of course, is for the DBT therapist, not for the client; Neacsiu et al., 2012).

Individual therapy in DBT has four stages (Neacsiu et al., 2012). Stage I is concerned with addressing life-threatening behaviors along with those that disrupt the client's quality of life or

the therapeutic process in significant ways. Stage II is concerned with helping the client experience distressing emotions. In stage III, the client is helped to make greater connection with the world and increase self-respect, while also decreasing behaviors that are still in the way of achieving desired life goals. Finally, stage IV addresses any leftover feelings of incompleteness. I am guessing that you will want to know more about *therapy-interfering behaviors*. These are actions of the client *or* the therapist that disrupt therapeutic progress. Some obvious examples are suicide attempts or other self-harming actions, failure to attend sessions, not completing homework assignments, and negative therapist reactions to the client.

The DBT practitioner uses a structured approach with careful attention to balancing the opposites of problem solving and validation, change and acceptance (Bedics, Korslund, Sayrs & McFarr, 2013). Linehan (1993a) admitted that the DBT counselor "first develops a strong positive relationship and then uses it to 'blackmail' the patient into making targeted, but excruciatingly difficult, changes in her behavior" (p. 296; quotes in original). It is recognized that both the therapist and the client are influenced by contingencies. The client will reinforce or punish the counselor's behaviors—and sometimes these contingencies are problematic (such as when the client becomes energetic and invested when the therapist moves away from undesirable topics such as suicide attempts and therapy-interfering behaviors).

Telephone consultations with clients serve several purposes in DBT. Ben-Porath (2014) identified three functions of telephone consultations: (a) decrease self-injurious behavior, (b) help clients learn to generalize skills learned in therapy across situations, and (c) address any problems in the therapy relationship (p. 2). Also, these calls help teach clients appropriate ways to ask for help because they tend to not ask or they ask in demanding, inappropriate ways (Linehan, 1993a). These very specific uses of telephone coaching should be explained to clients at the very beginning of treatment; phone calls are to be brief discussions of how to solve or tolerate a problem (Ben-Porath, 2014). DBT counselors are expected to explore their own limits with respect to phone calls and other client behaviors. Will phone calls be accepted at any hour, or only until 8 P.M.? These limits should be clearly communicated to clients and carefully maintained by the therapist, which is easier said than done, according to Linehan.

Critical to the success of DBT is the therapist consultation team (Linehan, 1993a). Because clients diagnosed with BPD are known to evoke negative reactions among psychotherapists, this team of dialectical behavior therapists meets weekly and focuses on counselor motivation and skills (McMain & Wiebe, 2013). Clients may be discussed at this meeting, but the more important topic is how the therapists are doing with the difficult scenarios often encountered in DBT. The same kind of support and validation offered to clients in DBT is an important element of the consultation team. Therapists are also encouraged to practice their DBT skills as a way of managing negative reactions and increasing compassion for their clients (McMain & Wiebe, 2013).

Oberon asks Annika if she has any thoughts about harming herself or committing suicide. Annika replies that she has thought about suicide at times, but currently is not serious about it. After questioning her closely about these thoughts, Oberon concludes that Annika is not in danger now, but that he should monitor her status as therapy progresses. He decides to focus on Annika's ability to tolerate her feelings without acting out. Oberon checks in with his consultation team, and the team members validate his plan. He also tells Annika about the possibility of phone consultations and emphasizes the importance of attending individual and group therapy sessions every week.

Therapeutic Techniques

Many specific techniques are available to counselors using DBT. In addition to traditional cognitive and behavioral techniques such as exposure, thought modification, and the manipulation of contingencies that maintain behaviors (see Chapters 8 and 10 for further description of these), techniques more specific to DBT are added. First, I describe a set of essential skills that are taught to the client in the early phases of therapy and in skills-training groups. Descriptions of these skills are necessarily brief; for more information, you should consult Linehan's (2015) skills-training manual. Following the description of skills, I describe a selection of other strategies used by DBT therapists.

Core Mindfulness Skills. DBT is going to teach you (and your clients) a critical skill: mindfulness. The reason I am choosing to speak directly to you here is that it is important that therapists learn DBT skills, too. These skills are typically taught very early in therapy, in the skills-training group, although they can be taught in individual therapy as well. Mindfulness simply means that you notice what is going on in the here and now, without judging, a more difficult skill than you might think (Linehan, 2015). There are three sets of mindfulness skills: *wise mind* skill, the *whats*, and the *hows* (Linehan, 2015).

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Video Example 16.4 Mindfulness



https://www.youtube.com/watch?v=5d46amlJEkI

Wise mind involves teaching clients about three primary states of mind: reasonable mind, emotion mind, and wise mind. The first two exclude each other (i.e., reasonable mind is logical and in emotion mind affect dominates), and wise mind is an integration of the two (Linehan, 2015). It also includes the client's inner wisdom or the ability to mobilize resources to address a situation to attain valued outcomes. Clients learn that reasonable mind and emotion mind can interfere with using wise mind. In these skills sessions, clients evaluate the benefits and drawbacks of reasonable and emotion mind and explore fusing them into wise mind.

What skills involve learning to observe, describe, and participate in experience. Even if the experience is painful, the client is taught to observe and describe it. Experience is to be talked about rather than reacted to or avoided. Here's where ACT and DBT seem to be saying similar things: Linehan (1993a) asserted that learning to describe means that you learn that thoughts and emotions are just thoughts and emotions, not facts or truth. However, Linehan goes one step further, indicating that thoughts and emotions must be tested against facts, thereby aligning with more traditional principles of cognitive therapy. Participating is to be done without self-consciousness, which may sound a little contradictory at first. What is meant here is that you fully engage in the moment in a spontaneous way. You are aware and alert and not fretting about the self-relevant aspects of the experience.

Adopting a stance of not judging, focusing on one thing at a time, and doing what is effective are the three *how* skills (Linehan, 1993a, p. 146). Nonjudgment means things are neither good nor bad; it does *not* mean making something negative into a positive. In fact, Linehan suggested that it might be best to stop judging altogether and simply evaluate the consequences of

behaviors and events. Looking at the consequences of an act can suggest changes that might be made, but does not make the act itself bad.

The second *how* involves controlling attention to focus on the moment. We often multitask in our minds, allowing thoughts or worries that are not relevant to participating in the current situation to creep in—this is not mindful, according to DBT theory.

Finally, being effective is just that—doing what needs doing in a situation regardless of what you might think is "right." This does not mean you can't have principles, but that sometimes you need to bend in the interest of effectiveness. You need to trust your own perception, judgment, and decision-making ability to achieve effectiveness.

Oberon and Annika work on the whats *and* hows. *Annika struggles to observe and not judge her emotional experience. Oberon helps her focus on one thing at a time and decide what is most important for her right now. They determine that her problems eating and sleeping are the first to be addressed, and these tend to be connected to her ruminating about life events, which provoke anxiety. Oberon helps Annika view the ruminations as just thoughts, which she can mindfully observe. He also helps Annika describe these experiences as fully as possible and figure out how to deal with the thoughts and anxiety when they arise.*

Distress Tolerance Skills. Marsha Linehan agrees with Steven Hayes that life is painful and distressing. Thinking that life must always be happy and peaceful is just going to lead to more suffering. One must accept that what is is what is and not judge or try to change it, yourself, your behavior, or your thoughts. Distress tolerance skills are mainly concerned with getting through crisis situations, although there are other times when acting for change is important. Remember, the dialectical nature of DBT means that there is always a balance of acceptance and change.

There are a number of distress tolerance skills, but the major ones are distracting, self-soothing, improving the moment, and thinking of pros and cons (Linehan, 1993a, pp. 147–148). Linehan (1993a) added to this group three acceptance skills: radical acceptance, turning the mind to acceptance, and willingness (p. 148). Distracting involves taking your mind off of your situation—for example, by engaging in some other activity or thinking of something else. Engaging in calming activities is the essence of self-soothing: a bubble bath may be just the thing for some people. Using imagery, prayer, self-encouragement, and so on can help improve the moment, and thinking of pros and cons is just what it says it is.

Radical acceptance refers to a genuine, deep acceptance, and turning toward it means choosing it. As Linehan (2015) put it, "it involves acknowledging facts that are true and letting go of a fight with reality" (p. 417). Willingness is an existential idea: knowing that we are a part of the cosmos and participating in it, while giving up a dogmatic sense of one's separateness (Linehan, 1993a).

Oberon thinks that distress tolerance is a very important skill for Annika to learn. He asks Annika what calming activities work for her (going for a run). This strategy might work during the day, but because she tends to get anxious late at night when trying to sleep, Annika needs other options. They discuss ways Annika can distract herself from troubling thoughts or simply accept them as thoughts and let them float away. Annika decides that she can distract herself from her anxious thoughts by having music on when she goes to bed.

Emotion Regulation Skills. Because individuals diagnosed with BPD are known to be emotionally intense and labile, emotional regulation is a key skill. To help clients regulate emotion,

DBT therapists teach them how to identify and label affect, identify things that prevent them from changing their emotions, and increase positive emotional events. Attention is also given to factors that make clients susceptible to "emotion mind"—that is, the tendency to react emotionally (Linehan, 1993a, p. 150). Here the therapist helps the client address physical and emotional stressors, such as nutrition, exercise, and living conditions. The official term for this skill is *taking care of your mind by taking care of your body*, and the acronym PLEASE is introduced: treat PhysicaL illness, balance Eating, avoid mood-Altering substances, balance Sleep, and get Exercise (Linehan, 2015). Other important emotion regulation skills are increasing mindfulness (discussed previously) to current emotion and taking *opposite action*. In the latter, the client is asked to identify an unhelpful emotion and then to genuinely act in a way that is inconsistent with the tendency prompted by the emotion. An example might be doing a good deed for someone with whom you are angry (Linehan, 2015).

Oberon and Annika work on eating more regularly and getting exercise. Oberon thinks that, if Annika exercises almost every day, her appetite will improve. However, it seems useful to set up some environmental cues to help Annika eat regular meals, so he asks her to go shopping and buy some food that she particularly likes to eat. Annika will also set a timer that will sound an hour before the times she prefers to eat so that she can begin preparing her meal.

Annika and Oberon also work on tolerating distressing emotions when they occur. Oberon encourages Annika not to try to turn her emotions off, but to watch for and observe them. He assures Annika that she can handle her feelings. Oberon also wants to know what activities Annika would enjoy; she indicates running and listening to music. He encourages her to do these things and also wonders whether she would like to do some volunteer work or approach going back to work.

Four Categories of Treatment Strategies. In the official manual for DBT, Linehan (1993a) identified four categories of essential strategies: core, dialectical, stylistic, and case management (p. 199). In the following section, I will define each of these general strategies and give a few examples of representative techniques. This section is largely drawn from Linehan's manual, so if you want to learn more about these strategies and techniques you should start there.

Core strategies. The core strategies of DBT are validation and problem solving. Validation of the client can take different forms, and Linehan (1993a) described emotional, behavioral, cognitive, and "cheerleading" validation strategies. The essence of validation is to let the client know, in no uncertain terms, that her behavior is understandable, given her current circumstances (p. 221). *Emotional validation* takes the form of encouraging emotional expression, helping the client identify and name emotions, empathizing so well that barely recognized feelings emerge, and simply telling the client that her feelings are valid. *Behavioral validation* involves helping the client identify and counter "shoulds" that are driving behavior and accepting her behavior. *Cognitive* strategies include helping the client separate events from her interpretation of them, finding the nugget of truth in the client's perceptions, and acknowledging "wise mind," which refers to the validity of intuitive understanding that the client may have (Linehan, 1993a, p. 241). In all this, the dialectical behavior counselor is careful to acknowledge that his values are different from the client's (if they are), but not necessarily the absolute truth. Finally, *cheerleading* includes communicating the belief that the client is doing her very best, expressing hope, focusing on client strengths, praising, being on the client's side, and sticking with the client when she is in crisis (Linehan, 1993a, p. 245).

Problem-solving strategies in DBT mostly look a lot like standard cognitive-behavioral interventions. For example, *chain analysis* is a technique borrowed directly from traditional behavior therapy (Rizvi & Ritschel, 2014). It can be used with a variety of problems, but is always used when the client reports parasuicidal or suicidal behavior. The target behavior is clearly identified, and then the counselor and client work together to determine what triggers it and its consequences (essentially this is a contingency analysis). Conditions that make the client more susceptible to the trigger(s) are also determined. With this information in hand, the counselor and client then devise ways to reduce vulnerability factors and find ways to avoid the trigger (Safer, Telch, & Chen, 2009). An interesting aspect of chain analysis is that it is sometimes deliberately used as an aversive consequence imposed by the therapist when the client engages in life-threatening behavior (Linehan, 1993a). Chain analyses are followed by solution analyses, in which the client and therapist work to manage the antecedents or consequences of the problem behavior to reduce its likelihood (Rizvi & Ritschel, 2014).

Other problem-solving strategies are also fairly behavioral in nature, such as generating solutions and evaluating them. Cognitive and behavioral rehearsal are also used. Essential to all problem-solving strategies is commitment, and Linehan (1993a) outlined a set of interventions to obtain and reinforce it, such as emphasizing freedom of choice and the absence of viable alternatives (p. 289).

Annika and Oberon work on problem-solving strategies relevant to her current situation. They have already worked on sleeping and eating, so examining Annika's thoughts about her current relationship might help her determine what she wants to do about it. Oberon also decides that a chain analysis of Annika's depressive episodes might be helpful. He asks careful, detailed questions about the last time she got depressed. Through all of this work, Oberon is empathic and validating of Annika and is certain that she can change.

Dialectical strategies. The essence of DBT is the core strategies combined with the dialectical strategies. Dialectical strategies are born of the essential tensions inherent in therapy that arise out of the constantly changing nature of existence, the contradictions between acceptance and change, and the recognition that "truth" or "reality" is not static, but ever evolving and full of oppositions (Linehan, 1993a). The following are a couple of dialectical strategies.

Making lemonade out of lemons. As its name implies, this technique requires that the therapist help the client make the bad (the lemons) into the good (the lemonade). If the client didn't have problems, then the therapist could not be helpful to her. Sadness and pain lead to greater understandings of self and others. The most troublesome experiences in our lives are great opportunities to practice new skills. Reading the preceding sentences, you might have figured out that using this technique is a bit tricky; the therapist must *not* invalidate the client by seeming to disregard her problems. A solid therapeutic relationship is the prerequisite for this approach, which is often used with light humor.

Oberon considers using the making lemonade technique, but wonders if he has established a strong enough relationship with Annika. Later he might talk about how being put on leave has given her the

opportunity to really examine her life and decide what she wants to do. Troubles in relationships teach us what we don't appreciate so that we can avoid or head these aspects off in the future.

Entering the paradox. In this technique, the counselor emphasizes the contradictory aspects of the client's situation. Essentially, the counselor lets the client know that there are many sides to a story, that things can be true and not true at the same time (Linehan, 1993a). The classic example is the therapeutic paradox: that, while the counselor is validating the client's experience, he is also pushing for change. Acknowledging that more than one session a week might be good for a client, the counselor can still set limits and not provide them.

Oberon thinks that the paradox of asking Annika to simply accept herself may be helpful. If Annika makes this commitment, she will have to accept the troublesome emotions that are a very real part of her—and of life. However, if she can just tolerate them, rather than trying to banish them, she will have made great progress and perhaps can operate more from her wise mind.

Stylistic strategies. These strategies are concerned with how the counselor relates to the client. Linehan (1993a) advocated the dialectic use of reciprocal and irreverent styles. Reciprocal communications are things like responsiveness, genuineness, warmth, and self-disclosure. Irreverent strategies are the other pole of the dialectic, unexpected and used to get the client to pay attention or to see things from a new perspective. These strategies are a little scary at first glance and include taking a confrontational attitude, calling the client's bluff, using unusual reframing, and expressing omnipotence or impotence (Linehan, 1993a).

A particularly provocative irreverent strategy is plunging in where angels fear to tread (Linehan, 1993a). In this approach, the therapist directly and clearly addresses issues, such as when he openly acknowledges that the client could kill herself (adding that this would clearly inhibit therapy). Linehan likened these strategies to the tactics used by a firefighter throwing someone out the window of a burning building to be caught by a net below. Needless to say, these kinds of interventions need to be couched in a strong relationship built on validation.

Oberon's style as a therapist is warm and genuine. He has not self-disclosed to her yet, but is willing to do so when the time is right. Considering the irreverent strategies, he thinks that they may be of some use, but is uncertain at this point.

Case management strategies. The counselor's relationship with things outside of the therapy relationship is the focus of case management strategies (Linehan, 1993a). The therapist helps the client manage her environment to promote health and also attends to how well he is providing DBT. Of concern here are things like deciding when to intervene on behalf of the client (when the outcome is extremely important and the client is not able to act), observing limits, and consulting or coaching with the client about dealing with other providers, friends, and family members. The absolute dictate that the therapist have supervision and consultation resources falls under this category, too.

Oberon has a supervisor and his case consultation team who help him manage his work with Annika. He does not consider intervening on Annika's behalf, and so far she has not tested his limits. He does work with her on how to approach her employer about going back to work and how to manage her relationships with her parents.

EVALUATION OF MINDFULNESS APPROACHES

Although these approaches are relatively new on the psychotherapy scene and their proponents go to great lengths to elaborate on their innovativeness, other writers are skeptical of these claims. S. G. Hoffman and Asmundson (2008), for example, asserted that the only really new thing about ACT (and other "third wave" approaches) is that it offers some strategies for emotion regulation that may be helpful to clients. Leahy (2008) makes the case that cognitive therapy (CT) and ACT are actually doing the same things: Cognitive therapists are, like ACT practitioners, helping clients reduce the believability of unhelpful thoughts rather than encouraging them not to think those thoughts, as ACT theorists sometimes claim. Leahy does acknowledge that mindfulness interventions are a unique contribution of ACT and other such approaches and that many CT practitioners are drawing upon these. David and Hofmann (2013) questioned the validity of ACT's underlying model (RFT). In evaluating these arguments, we should probably note that these writers are proponents of CT and rational emotive behavior therapy. Both ACT and DBT have attracted much attention over the last few years and are generally considered to be excellent contributions to the psychotherapy enterprise (Murdock, Duan, & Nilsson, 2012).

QUALITIES OF THE THEORY

DBT can be faulted for being too narrow, given its origin with and focus on clients who are diagnosed with BPD. It is mainly a theory of dysfunction. However, both formal and informal reports suggest that elements of DBT are effective for clients with other types of presentations, including eating disorders (Lenz, Taylor, Fleming, & Serman, 2014; S. Fischer & Peterson, 2015) and trauma reactions (Fiorillo & Fruzzetti, 2015). At the same time, DBT was specifically developed for the BPD diagnostic picture, and some caution that care must be taken in applying beyond this type of presentation (Bedics et al., 2013).

One also must be mindful of the criticisms of the diagnosis of BPD (e.g., that it is not clear or reliable or that it is unduly pessimistic; Crowell, Beauchaine, & Linehan, 2009) when thinking about DBT. Swales, Heard, and Williams (2000) suggested that this diagnosis may not be acceptable to therapists and clients in cultures other than that of the United States.

ACT presents a broader base of theory, given its foundational relational frame theory. However, it is my experience that counselors learning ACT struggle a great deal to understand RFT and want to quickly jump to ACT's clinical theory. ACT also was originally developed to address anxiety, but seems to have grown far beyond that syndrome in its application.

RESEARCH SUPPORT

Steven Hayes would like to claim that ACT has a good deal of research support, both for RFT and for ACT as a treatment approach. According to Hayes et al. (2006), over 70 published studies have examined RFT, resulting in good support for the theory. Meta-analytic studies of the research support for ACT generally find that although it is effective, it is not more effective than other approaches. For example, Öst (2014) meta-analyzed 60 studies, all of which were randomly controlled trials (RCTs) that compared ACT to other treatments or control groups for a wide range of psychological distress (e.g., depression, psychotic symptoms, somatic disorders, stress at work). Generally, only small effects were found relative to other active treatments, and comparisons to other behavioral or cognitive treatments produced nonsignificant differences. These results and a number of methodological concerns led Öst to conclude that "ACT is not yet

a well-established treatment for any disorder. ACT is *probably efficacious* for chronic pain and tinnitus, whereas it is *possibly efficacious* for depression, psychotic symptoms, OCD, mixed anxiety, drug abuse, and stress at work. Finally, ACT is *experimental* for nicotine dependence, borderline personality disorder, trichotillomania, epilepsy, overweight/obesity, diabetes, multiple sclerosis, and ovarian cancer" (p. 115; italics in original). A recent meta-analysis supported Öst's conclusions: Hacker, Stone, and MacBeth's (2016) meta-analysis of 46 studies led to the conclusion that the evidence was not sufficient to declare ACT more effective than other treatments for depression or anxiety.

In contrast, Smout, Hayes, Atkins, Klausen, and Duguid (2012), using traditional qualitative review, found ACT generally to create outcomes that were superior to treatment as usual (TAU) across a wide range of client presentations. They noted, however, that most of these studies did not control for the amount of contact and attention received by participants or their engagement in other treatments during the studies. Several studies reviewed by Smout et al. did evidence appropriate controls, and in these ACT was observed to outperform TAU.

In a meta-analysis of 39 RCTs, A-Tjak et al. (2015) came to similar conclusions: ACT was superior to control groups and TAU, and it was equivalent to other established treatments across a wide range of dysfunction and for measures of quality of life. Of particular interest, given the arguments over whether ACT is really new wave, was Ruiz's (2012) meta-analysis comparing ACT and CBT. This study found some overall evidence that ACT was significantly more effective than CBT, but the effect sizes for the differences were small to medium in size. The two approaches were deemed equivalent for the treatment of depression and anxiety.

Hayes also claims support for the specific therapy model of ACT; for example, Hayes et al. (2006) described a meta-analysis of 32 studies that included correlations between ACT components or processes and outcomes (e.g., stress, depression, anxiety). An average effect size of 0.4 was found across all of these studies, indicating a small or moderate relationship. Bluett, Homan, Morrison, Levin, and Twohig (2014) examined the effectiveness of ACT for anxiety and obsessive-compulsive disorders (finding it as effective as other well-tested theoretical approaches) but also analyzed data in support of ACT's theoretical model. Modest evidence was found for the explanatory processes specified in ACT (e.g., that changes in psychological flexibility and acceptance were related to client outcome).

Further, component studies have supported the proposed mechanisms of change from an ACT perspective. For instance, Niles et al. (2014) looked at mediators of change in CBT and ACT for social anxiety disorder. Results were supportive of ACT's clinical model in that decreases in experiential avoidance significantly predicted change for clients receiving ACT but not for those in CBT. In both conditions, decrease in negative thoughts at the beginning of treatment predicted change. In a laboratory analog study, Yovel, Mor, and Shakarov (2014) tested cognitive restructuring (CR) and cognitive defusion (CD) interventions among participants induced to ruminate on a negative life experience. Consistent with the theoretical assumptions of both CBT and ACT, Yovel et al. reported that in the CR group improvements in mood were associated with reappraisal but not with acceptance, and the reverse was true for the CD group. A meta-analysis of 66 similar (laboratory analog) studies was supportive of ACT hypotheses: Acceptance, defusion, being in the present, awareness of values, and mindfulness conditions were associated with both behavioral (e.g., academic grades, errors in tasks) and cognitive (e.g., believability of thoughts) outcomes in expected directions (Levin, Hildebrandt, Lillis, & Hayes, 2012).

Because it is such a unique ACT intervention, you might be interested to know that Masuda, Hayes, Sackett, and Twohig (2004) compared a CD task (similar to the "Milk, Milk, Milk" exercise, but using participant negative self-reference talk instead of milk), a distraction task (reading unrelated material), and a thought control task (based on breathing techniques). They found that the defusion task was superior to the others in reducing discomfort with and the believability of negative self-talk. So, we can conclude that much of the research on ACT produces evidence that confirms its theoretical predictions and the efficacy of its interventions, but we should note that (a) Hayes is a very frequent author on these studies, raising the question of allegiance bias (see Chapter 1) and (b) the effects are generally small to moderate.

DBT also has significant research support. A meta-analysis of 18 studies of DBT with clients diagnosed with BPD found a moderate effect size for DBT when compared to treatment as usual, treatment by community experts, or 12-step approaches (Kliem, Kröger, & Kosfelder, 2010). However, effect sizes were smaller when DBT was compared to intervention approaches specific to BPD. Panos, Jackson, Hasan, and Panos (2014) meta-analyzed five studies that met the following criteria: (a) randomly controlled trials; (b) clients diagnosed with BPD; (c) assessed suicidal attempts, parasuicidal behavior, attrition from therapy, and levels of depression; and (d) compared DBT to treatment as usual or an alternative therapy provided by the same facility (p. 215). Of the five studies, four compared DBT to TAU and only 2% of the clients in the trials were male. Overall, DBT appeared to reduce suicidal and self-harming behaviors, and several of the studies indicated that decreased attrition was seen among clients receiving DBT. However, no differences in depression were observed across treatment groups. Bendit (2014), using a qualitative strategy, reviewed five major studies of DBT with clients diagnosed with BPD and found mixed results; DBT did not outperform comparison treatments and in comparison to TAU, differences were inconsistent.

Because the full DBT package is time intensive (and therefore expensive), there has been interest in using DBT skills-training groups as a stand-alone intervention. In an attempt to assess the effectiveness of this tactic, Valentine, Bankoff, Poulin, Reidler, and Pantalone (2015) located 17 studies that offered skills training without the other DBT modalities. Although some evidence emerged in support of using skills training alone, Valentine et al. urged great caution in accepting this conclusion due to methodological problems in the studies reviewed.

Linehan and her colleagues have conducted a number of clinical trials of DBT. Harned et al. (2008) reported on a 2-year study in which clients diagnosed with BPD received either a year of DBT or a year of community treatment by experts. These clients, who also had other diagnoses (e.g., substance dependence, major depression, eating disorders) were followed for a year afterward. Significant decreases in substance dependence were found among the clients in the DBT group compared to clients receiving community treatment. However, no differences were found for the other disorders, and this study did not examine changes in symptoms of BPD. Fleming, McMahon, Moran, Peterson, and Dreessen (2015) tested DBT group skills training as an intervention for college students with ADHD. Compared to a control group that received skills handouts, the group receiving DBT training showed superior outcomes.

Feldman, Harley, Kerrigan, Jacobo, and Fava (2009) presented evidence in support of the DBT hypothesis that experiencing emotions in functional, skillful ways leads to positive psychological functioning and also that DBT is useful for clients with diagnoses other than BPD. In a small study (19 participants), they compared clients who had been diagnosed with major depression who were assigned to either a 16-week DBT skills-training group or a wait-list

control group. Results of this study showed that when emotional processing increased among the treatment group, depression decreased. In contrast, for the wait-list clients, increased emotional processing led to more depressive symptoms. Although this pattern lends some support for the DBT hypothesis, it was assumed (rather than verified) that the clients in the DBT intervention group were using adaptive emotional processing tactics whereas those in the wait-list control were not. Also, an important piece of evidence (in terms of testing DBT) was missing—whether the processing resulted in acceptance of emotions for the treatment group.

As you have read, a cornerstone of DBT is teaching emotional regulation, particularly of negative emotion. Neacsiu, Lungu, Harned, Rizvi, and Linehan (2014) tested the hypothesis that DBT would result in decreased negative affect when compared to community treatment by expert therapists (CTBE). Although the DBT group decreased in the expression of anger and experiential avoidance in comparison to the CTBE group, no differences were found for other negative emotions (e.g., trait anger, shame, guilt, anxiety). Using an experimental emotion induction procedure, Feliu-Soler et al. (2014) attempted to assess whether adding DBT mindfulness training to general psychiatric management would decrease emotional reactivity among clients diagnosed with BPD. They found no differences between groups on emotional regulation after treatment but did document greater improvement in clinical symptoms among clients in the mindfulness treatment condition.

In reviewing research relevant to DBT, it is important to remember that full-scale DBT (individual therapy, skills training, telephone consultation) is an intensive form of treatment. In my opinion, making comparisons to TAU or CTBE are somewhat slanted in favor of DBT because these interventions (which are typically not described) are, at a minimum, probably less time intensive than DBT. Also, much of the really good research involving DBT comes from Linehan's labs, which leads to the possibility of investigator bias effects (see Chapter 1).

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Both ACT and DBT emphasize client values, so in this sense they can be seen as friendly to clients from cultures other than Western European cultures. The emphasis on a life worth living (DBT) and value-driven committed action (ACT) creates situations where clients from diverse backgrounds can determine culturally consistent goals. The integration of Eastern practices such as mindfulness and acceptance in both ACT and DBT might be particularly helpful for clients from these cultures. These theoretical systems would seem to pose no inherent difficulties for individuals of diverse sexual orientations as well. Stitt (2014) noted that for individuals who identify as LGBT, acceptance in ACT means not accepting bigotry or homophobia, but it does mean accepting fear, anger, and shock in reaction to it (p. 284). ACT may be particularly well suited to working with diverse individuals because of the theory's emphasis on the principle that context is always important in determining the meaning of events.

Interestingly, Linehan (1993a) discussed how the holistic emphasis in DBT is consistent with feminist views in that it calls into question the Westernized values of individualism, independence, and separation. DBT assumes that identity is relational, and Linehan (1993a) wrote that women and individuals with little social power are likely to have identities that are social/relational rather than individuated. To her credit, Linehan (1993a) did point out that women are given a diagnosis of BPD more often than are men and examined the influence of sexism in the development of the disorder.

THE CASE STUDY

The case of Annika contained some features that were consistent with DBT's theoretical structure, such as strong, shifting emotions; stormy relationships; and an invalidating early environment. ACT theory is less specific about the qualities of the client presentation, but Annika's anxiety and general discomfort with her emotions and thoughts are easily conceptualized from an ACT perspective. Annika is not clear about her life values; both DBT and ACT lend themselves well to addressing this issue. Mindfulness techniques seem to be helpful for Annika, so were easily applied in both of the theoretical conceptualizations. The greatest difficulty I found in conceptualizing the case of Annika was related to the complexity of ACT theory—some of the constructs (e.g., self as perspective) are relatively difficult to understand and apply. In contrast, DBT seemed a little more straightforward and easier to use.

Summary

ACT and DBT are theoretical systems that are rooted in cognitive and behavioral theory but add elements of mindfulness and acceptance to the mix. ACT is based in relational frame theory and focuses on inflexible thinking as the root of psychological dysfunction. The function of unwanted experience is to be changed rather than its form.

DBT was developed for a specific client group: those with borderline personality disorder. Linehan proposed a biosocial theory of BPD that locates the root of this diagnosis in faulty emotional regulation paired with a behavioral environment.

Both approaches include cognitive and behavioral interventions, but also use interventions that teach clients to live mindfully, with the goal of leading lives that matter. To different extents, both ACT and DBT are relativistic in that they propose that there are no absolute truths—what matters is how client behaviors relate to valued life goals.

ACT and DBT have solid theoretical systems and good research support. They both seem to be applicable with clients from diverse cultural backgrounds and sexual orientations and with both men and women. One caution in this arena is that DBT was developed for a diagnosis that is applied more often to women than men.

CHAPTER 17

Conclusion



Consider the following scenarios:

1. *Scarlett's therapist believes that the current disarray in her relationship with Rhett is the result of unconscious forces that stem from her childhood. Rhett is simultaneously the father that Scarlett desires and a forbidden object. Scarlett is transferring her anger at her father's rejection to Rhett and will eventually interact with her therapist in similar ways.*
2. *Irrational beliefs are the problem behind Scarlett's current distress. She believes that everyone must love her and the world must treat her kindly or life is unacceptable. Scarlett's counselor resolves to teach her the ABCs so that she will adopt rational beliefs such as "It's too bad that Rhett left; I'd rather he hadn't, but that doesn't make me a worthless worm."*
3. *Scarlett is coming to counseling because she is hurting in the area of belonging needs. She experiences a problematic relationship and has placed both Rhett and Bonnie in her quality world. However, she has persisted in attempting to control their behaviors and abdicated responsibility for her own. She is anxietying, angering, and depressing because she is attempting to meet her need for love in the best way she can.*
4. *Scarlett is clearly in need of interventions to change her behavior. Her therapist will focus on the anxiety attacks that seem to lead to her fainting. Cognitive and behavioral techniques will be used to intervene when Scarlett begins to feel anxious. Exposure therapy will be most helpful for her.*
5. *Scarlett seems to be having problems with her efforts to avoid her personal experience. She views her thoughts as truth, so the relations that she has established are plaguing her (e.g., I am terrible and Rhett will never take me back). She is living in the past or the future and, when she feels anxiety as a result, tries to banish it. Her counselor thinks that Scarlett is so stuck that she is not living her life in accordance with cherished values.*
6. *Unfinished business is clearly getting in the way of Scarlett's creative adaptation to the world. She has an unmet need for love that has become figure; as a result, she can't freely experience her feelings.*
7. *Scarlett is not successful in the life tasks of love, work, and society. She is discouraged and pursuing a socially useless lifestyle. Clearly, she needs to find ways to achieve power that don't involve selfish motives such as winning the battle with Rhett. Her selfish ways of getting attention need to be seen for what they are.*
8. *Rhett and Scarlett's relationship had been stabilized by the triangulation with their daughter, Bonnie. Rhett and Bonnie appear to have formed a cross-generational coalition. Now that Bonnie is gone, these parents are confronted with mourning the death of their child along with the conflict in their relationship. Rhett responds by emotionally distancing from Scarlett, and she is tempted to pursue him.*
9. *Scarlett has been oppressed by society in that the rules say that she can't experience her personal power because she is a woman. She has met with a good deal of rejection over the course of her life because she displayed qualities that*

are not ladylike, such as starting her own business and freely speaking her mind. Rhett left partly because her anger over being oppressed by White men became directed at him.

10. *Scarlett is clearly having problems with emotional regulation. She bounces around her intense emotions, sometimes acting on them. Her therapist guesses that she experienced little support for her thoughts and feelings in her early upbringing.*
11. *It is not important why Scarlett behaves as she does. She and her counselor need to decide exactly what the problem is and reconsider it. Scarlett is lonely and afraid. Examining times when she is not lonely and afraid, she and her counselor work to make these events happen more frequently.*
12. *Activation of the loss and threat modes are behind Scarlett's current distress. She shows depressive schematic functioning ("things will never get better") and anxiety-generating thoughts ("I am inadequate to handle the world by myself"). These constellations of thoughts are bringing on Scarlett's dysfunctional emotions and behavior.*
13. *Scarlett is clearly experiencing an existential crisis. The loss of Bonnie has brought her face to face with her own mortality, causing her to question her life's meaning. She is using the hope of Rhett as the ultimate rescuer to ward off existential anxiety and terror, but this defense has failed because Rhett, confronted with his own mortality, has run away (probably exercising the defense of specialness).*
14. *Scarlett is experiencing incongruence between her self and experience. Her need for positive regard from self and others has led her to avoid experiences that are inconsistent with her vision of herself, which is a sweet, feminine, Southern lady. Her anger at her circumstances is not consistent with this self-image, so she attempts to deny it. She becomes depressed, but the anger erupts at times because her defenses are weak.*
15. *Scarlett seems to have a fragmented sense of herself. Her recent losses are stressing her, making it difficult for her to relate to others on an even keel. This is why she's been distant all these years with Rhett; something about him activates feelings that she can't understand or control. Early dysfunction in the relationship with her parents (her father's drinking is likely to be a sign of this) is likely to be the source of these dynamics.*
16. *Something about Scarlett's current version of her life is terribly at odds with how she'd like it to be. She is trapped and oppressed by the power structure embedded in her current life story and is desperately seeking a different outcome. She is an independent woman, yet feels caught between social pressure to return to stereotypic ways (settle down with Rhett) and the desire to be herself and live her own story.*

Key to Scarlett's therapists: 1. Psychoanalysis; 2. Rational emotive behavior therapy; 3. Reality therapy; 4. Behavior therapy; 5. Acceptance and commitment therapy; 6. Gestalt therapy; 7. Individual psychology; 8. Family systems therapy; 9. Feminist therapy; 10. Dialectical behavior therapy; 11. Solution-focused therapy; 12. Cognitive therapy; 13. Existential theory; 14. Person-centered therapy; 15. Neoanalytic theory; 16. Narrative therapy.

What do you think about the various descriptions of Scarlett? You undoubtedly have recognized that each paragraph is a very brief conceptualization derived from each of the theories reviewed in this text (if you are puzzled about any of them, check the key at the end of the descriptions). Which one do you think makes the most sense? Will one vision help Scarlett more than the others? The answers to these questions should help guide you in your search for the right theoretical orientation for you at this stage of your career.

Now that you've worked your way through 15 theories of counseling and psychotherapy, you may be a little overwhelmed. It may seem to you that there are just too many interesting approaches—too many roads on the map or too many kinds of cars in which to travel. The approaches covered in this text all have some form of empirical support, they make sense, and most of them have been around for a while. You probably like parts of all of them. You may hate parts of some of them. You may be somewhere between the extremes. However, I've rarely seen

anyone emerge from a basic theory course absolutely certain that one of the major approaches is the perfect fit. More commonly, students are a little bewildered and still wondering how to choose among all of the theories.

In Chapter 1, I outlined some considerations that I believe are important in examining theories. As you now know, theories vary widely on these dimensions, and you are probably wondering which of these dimensions is the most important. If I were pressed to answer, I'd probably say empirical support. That answer may not seem helpful to you, though, because all of the theoretical systems I presented have empirical support to some degree or another. One way out of this dilemma might be to choose the theory with the "best" (meaning most) empirical support—probably behavior or cognitive therapy.

However, there is another way of looking at the situation. Given that the research evidence demonstrates that the major approaches to counseling produce client change relative to no treatment, empirical support does not have to be the sole criterion in selecting your orientation. The other factors I discussed in Chapter 1 are helpful, too. In essence, you need to find an approach that fits with who you are, what your philosophical assumptions are, and how you understand human existence. It is not my intent in this last chapter to exhaustively compare the theories along these dimensions. However, I will attempt to provide some examples of how the approaches differ on what I believe to be some key dimensions. I invite you to answer the following questions as I present them.

IS THIS A GOOD THEORY?

What do you think of the research evidence presented in support of this theory?
Is the theory testable?
Are the predictions derived from the theory precise?
Is the approach practical?

One way to progress in the dilemma of theory choice is to evaluate the approaches we have studied along the dimensions of "good theory." In the preceding chapters, I evaluated each theoretical perspective on the dimensions of precision/testability and empirical support. The various approaches fell out along a continuum on these two dimensions. In the sections that follow, I will briefly compare the theories on these qualities.

EMPIRICAL SUPPORT

To some extent or another, all of the theoretical systems reviewed have outcome data to support their efficacy. The quality of these data varies, however, with the behavior and cognitive approaches at the forefront of the group in terms of amount of empirical study. Less-rigorous outcome support is found for other perspectives (e.g., rational emotive behavior therapy, individual psychology, person-centered therapy, Gestalt therapy). Empirical verification can be found for aspects of family systems therapy, feminist therapy, the mindfulness approaches, and individual psychology. Probably the least evidence for empirical verifiability is found for reality therapy, narrative therapy, and solution-focused therapy, although the support for narrative and solution-focused therapy is growing. Gestalt therapy receives indirect support from the work of Greenberg and colleagues in emotion-focused psychotherapy. The status of person-centered therapy is also mixed, with good evidence for Rogers's ideas about the importance of the therapeutic relationship in support of the theory. The data are less convincing regarding the specific

predictions of person-centered therapy. Psychoanalytic theory in the broadest sense is supported by research that seems to confirm the existence and influence of unconscious processes; recent research supports both short-term and more time-intensive forms of psychoanalytic psychotherapy. There is also direct evidence for the efficacy of psychoanalytic and neoanalytic approaches.

STIMULATING

As I noted in Chapter 1 , all of the approaches that I chose to present are stimulating in one way or another. Judging by the surveys of counselors' theoretical orientations, some are more popular than others. Cognitive and behavioral approaches, for example, seem to have the most adherents. In terms of stimulating thought, psychoanalysis seems to have cornered the market. Newer approaches such as narrative therapy and solution-focused therapy have been receiving a lot of attention in the practice community, as have dialectical behavior therapy and acceptance and commitment therapy. Many counselors adopt a feminist therapy philosophical approach or consider existential questions within the structure of one or more other theories if they don't adopt these approaches in total.

PRACTICAL

Many theories (e.g., behavior, cognitive, family systems) have a large number of specific techniques that are applied to problems presented by the client. Person-centered, existential, and feminist therapies tend to be a little more vague or global in their techniques. Narrative therapists seem a little mystifying at times, at least in the way they write and talk about their approach.

Some would argue that psychoanalysis is not very practical anymore because it just takes too long to do a real analysis. Solution-focused therapy is at the opposite end of the spectrum; its proponents claim very quick "cures," sometimes in a single session. However, there really are therapists out there doing classic analysis, complete with a couch (as you observed in Chapter 2), so for a certain group of clients this approach is viable. Students are often impatient with the unfolding process of person-centered therapy because they want to help the client right away. To these students, it seems impractical to sit back and wait for the client to grow.

A focus on the problem as defined by the client might be seen as the most practical route to helping. In other words, take the client's word for it—the problem is not the result of early childhood experiences or irrational beliefs. If you take this position, then behavior, family systems, or solution-focused therapy might be for you. However, I think it would be naïve to assume that these approaches do absolutely no translation of the client problem presentation. For example, the solution-focused therapist must develop a solvable problem, and the family systems theorist has to help clients see the problem as living in relationships, not the individual.

YOUR PHILOSOPHICAL ASSUMPTIONS

Considering your assumptions about people is critical to choosing your theory because, for the most part, these broad statements about human nature are not testable. Take a minute and think about the following questions:

Do you think humans are mostly inherently good, neutral, or evil?

Do you think that there is one concrete reality out there that we can access? Or do you believe that multiple views of reality exist?

Is human behavior the result of biology, learning, or the influence of others (i.e., social relationships)?

Is it important to look at the person as a whole, or should a specific behavior be the target of observation?

In the basic philosophy section of the chapters, I attempted to describe theories along these dimensions. To begin with the obvious, psychoanalysis seems to offer a rather gloomy picture of humanity, whereas person-centered folks have been accused of wearing rose-colored glasses. Other theories are not as explicit about the basic character of human nature, so they could fit with a position of neutrality on this dimension.

What do you think about the idea that anatomy is destiny? Some theorists (e.g., the behaviorists and the feminists) insist that behavior is socially determined, whereas others place much more weight on inherent or biological factors. Even Albert Ellis thought that irrationality is an innate human characteristic (as is rationality).

If you believe in an objective reality (i.e., one real, true reality), you might find behavior therapy most compatible with your leanings or, oddly enough, psychoanalysis, with its certainty about the origins of behavior. Reality therapists would seem to be the ultimate in objectivity. The constructivist approaches—such as narrative therapy, solution-focused therapy, Gestalt therapy, and person-centered therapy—are much more concerned with how the individual interprets the world.

Think about your goals for counseling. Are they focused on specific behavior change or overall global well-being? Is your client to be happy or symptomless? Do you think human functioning is connected to family, work, and environmental cues, or is it the result of specific thoughts or needs?

YOUR BELIEFS ABOUT HUMAN BEHAVIOR

Some experts would say that we shouldn't even be talking about *beliefs* here—we should stick to the scientific evidence in understanding human behavior. If you are close to this position, recognize that and choose an approach with a lot of empirical support that has a treatment manual tested in randomly controlled trials. However, you may want to take a more moderate position. In that case, choosing an approach that is consistent with your ideas about human functioning (provided it has some empirical support) is probably the best route to becoming a good therapist. Consider the following questions, which are loosely derived from my system for case conceptualization that you can find on MyCounselingLab:

- *What do you believe motivates human behavior?*
  Table 17.1 contrasts the views of human motivation presented in this book. Do you buy the notion of the unconscious as the prime mover of human activity? Psychoanalysts do, and cognitive therapists seem to be proposing unconscious influence in the forms of protoschemas or modes; certainly automatic thoughts are often not immediately accessible. Behavior therapists are less vocal on this issue. We can infer that they see behavior as stemming from a motivation to survive and adapt to the environment. More narrowly, for behaviorists, humans move toward positive stimuli and away from aversive ones. They would attend little to unconscious processes, even if they believed in them. Systems theorists would probably acknowledge influences outside of our awareness (i.e., the family system), but those things are very different from the influences proposed by psychoanalysis or even person-centered therapy, which would also acknowledge unconscious activity.

TABLE 17.1
VIEWS OF HUMAN MOTIVATION

Psychoanalysis	Pessimistic; humans are motivated by instinctual drives of sex, aggression
Neoanalytic Approaches	Pessimistic, but maybe less so than psychoanalysis; instinctual drives are recognized, but so is the power of the ego
Individual Psychology	Optimistic; humans are motivated by striving for superiority and feelings of community
Person-Centered Therapy	Optimistic; humans are motivated to actualize their potential
Existential Therapy	Depends on which approach; some are optimistic, some pessimistic (the only certainty is death); humans search for meaning
Gestalt Therapy	Optimistic; humans are motivated to grow (meet needs), but also to attain harmony with the environment (homeostasis)
Behavior Therapy	Neutral; humans are motivated to adapt to the environment and obtain resources to survive; immediate behavior is controlled by environmental sources—the consequences of behavior
Rational Emotive Behavior Therapy	Neutral; humans are human, rational and irrational
Cognitive Therapy	Neutral; humans are motivated to adapt to the environment and obtain resources to survive; cognition is primary in producing behavior; some versions recognize unconscious structures/processes in generating behavior
Reality Therapy	Optimistic; humans are motivated by basic needs, but most important, the need for love and belonging
Feminist Therapy	No clear statement, but power and intimacy are important
Family Systems Therapy	Varies with approach: Bowen is neutral, the tension between individuality and togetherness drives behavior; Satir is optimistic, humans are motivated to grow and love; strategic and structural approaches do not closely consider motivation
Solution-Focused Therapy	Neutral; no real statements on motivation
Narrative Therapy	Optimistic; humans are motivated to seek meaning
Mindfulness	Varies according to approach: In acceptance and commitment therapy (ACT), individuals are motivated to make meaning (relations); dialectical behavior therapy (DBT) is less clear

- *What are the principal constructs that help to explain experience?*
  Table 17.2 reviews some of the major theoretical constructs of the 15 theories covered in this text. Are "deep" psychological constructs such as modes, lifestyle, and needs essential to understanding our clients? Do we need to critically examine the effects of patriarchy? Can we help a client by simply focusing on what she would like to have happen, the times when things are going well? Do we really carry around a mental picture of our ideal self or mental representations of those who satisfy our needs? Is the content of the client's belief influential in determining her behavior? Is our fear of being alone a major consideration?

TABLE 17.2
MAJOR THEORETICAL CONSTRUCTS

Psychoanalysis	Id, ego, superego; psychosexual stages of development
Neoanalytic Approaches	Internalized representations of others; defenses; relational matrix
Individual Psychology	Striving for superiority; basic tasks; lifestyle; social interest; family constellation
Person-Centered Therapy	Actualizing tendencies; self and experience; congruence and incongruence
Existential Therapy	Modes of being; ultimate concerns (death, freedom, meaning, aloneness); anxiety; defenses
Gestalt Therapy	Contact; needs; cycle of awareness; polarities
Behavior Therapy	Classical conditioning; operant conditioning; social learning
Rational Emotive Behavior Therapy	Beliefs, rational and irrational
Cognitive Therapy	Beliefs; schemas; modes
Reality Therapy	Basic needs; quality world; total behavior; choice theory
Feminist Therapy	Gender; personal is political
Family Systems Therapy	Family as a system; communication; subsystems and boundaries; triangles; family hierarchy; differentiation of self; chronic anxiety
Solution-Focused Therapy	Exceptions; solutions; client strengths and resources
Narrative Therapy	Stories; unique outcomes
Mindfulness	Dialectics; emotional regulation; acceptance; mindfulness; cognitive defusion; being present; self as perspective; values; commitment

- *How do you see the process of human development? Is it important in determining current behavior, or can we bypass this theoretical step?*
  Developmental aspects of the 15 approaches are shown in Table 17.3. Although they may not address it specifically, all of these theories would acknowledge the biological/physiological processes of growth associated with human development. How the physiological processes interact with the psychological processes of development is described differently across the various theories. To help your client, do you need some structure that describes psychological development? Does the past live in the present, or is the past irrelevant?
- *List the characteristics of a healthy person. Which approach fits best with your ideas?*
  What factors are the most important in psychological health? Do you focus on thoughts? Do you focus on creative, growth-oriented behavior or whether the individual is making good choices that do not violate the rights of others and the rules of social groups? What about our thoughts about our finiteness? Do these play a role? Does the individual require a healthy family or rational society to be healthy? Table 17.4 sketches the versions of healthy individuals presented by the theories covered in this text.

TABLE 17.3
VIEWS OF HUMAN DEVELOPMENT

Psychoanalysis	Psychosexual stages are innate; early experience paramount
Neoanalytic Approaches	Early experience critical; instinctual drives
Individual Psychology	Family environment influences development along with innate creative processes and the drive for superiority
Person-Centered Therapy	Development is toward maximization of potential; influenced by family, other significant individuals
Existential Therapy	No specific model
Gestalt Therapy	Humans progress from environmental to self-support; need satisfaction is affected by the surrounding environment and individuals in it
Behavior Therapy	Development is the process of learning
Rational Emotive Behavior Therapy	Innate biological and psychological tendencies interact with social influences
Cognitive Therapy	Early life experience influences development of schemas; modal functioning is largely innate
Reality Therapy	Strength of basic needs is innate; development is influenced by individuals around the person
Feminist Therapy	Emphasizes the influences of gender and power
Family Systems Therapy	Varies across approaches, but all emphasize family influences
Solution-Focused Therapy	No formal statements
Narrative Therapy	No specific statement
Mindfulness	Learning is critical; in DBT, quality of the early environment is important

TABLE 17.4
VIEWS OF PSYCHOLOGICAL HEALTH

Psychoanalysis	Low levels of repressed urges; healthy defenses; mature ego
Neoanalytic Approaches	Coherent sense of self; adapted ego
Individual Psychology	Socially useful strivings for superiority; successful at basic tasks; acceptance of self as human and therefore fallible
Person-Centered Therapy	Congruence between self and experience; self-acceptance; authentic expression of experience
Existential Therapy	Authenticity; awareness of ultimate concerns
Gestalt Therapy	Satisfaction of needs; awareness of experience; authenticity
Behavior Therapy	Adaptive behavior
Rational Emotive Behavior Therapy	Mostly rational beliefs; rational life philosophy
Cognitive Therapy	Adaptive beliefs leading to adaptive behavior
Reality Therapy	Basic needs relatively satisfied; healthy relationships

Feminist Therapy	Aware of social influences on experience; able to set and reach life goals unencumbered by social constraints
Family Systems Therapy	Healthy family structures and communication patterns
Solution-Focused Therapy	Complaints do not exist
Narrative Therapy	Preferred outcomes; new fulfilling story
Mindfulness	For ACT, being healthy involves seeing self as perspective, cognitive flexibility, living in accordance with important values; in DBT, healthy refers to the ability to regulate emotion and live a life worth living

- *What is the relative importance of family, intimate others, friends, and so on in a person's functioning?* Can you help a client by working with that person as an individual? With the exception of some family systems approaches, the answer is yes. However, the relative influence of family members and events varies among approaches. Individual psychology would see family as a critical influence, whereas many other theories would see family as a source of learning only in a very general way. Of course, family influences are pivotal in psychoanalytic theory.

  Feminist therapy sees relationships as critical, particularly those between men and women, and a woman's relationships with other women are a key source of support. Existential therapists see authentic relationships with others as very important.
- *Relatively speaking, how important are behavior, cognition, and affect in the ways we function?* Do you think that attention to emotion is the most important thing that happens in counseling? If so, you may want to consider psychoanalysis, Gestalt therapy, or person-centered therapy. If you see thoughts as relatively more important than feelings or behaviors in terms of functioning, your choice might fall in the cognitive therapy camp (cognitive therapy or rational emotive behavioral therapy). If behavior is of most interest, then behavior or reality therapy seems right, but so might solution-focused or family systems therapy. If you think social influences are critical, try narrative therapy or feminist therapy.

YOUR PERSONAL STYLE: APPROACH AND TECHNIQUE

Are you an active type, or are you more able to sit back and wait?
Do you think the client or the therapist should lead in determining what happens in sessions?
Do you think the client or the therapist should take responsibility for what happens in counseling?
Are you a problem solver?

Different theories naturally lead to different ways of doing counseling. Some approaches rely heavily on formal assessment, for example. Recall that formal assessment refers to ritualized kinds of procedures, such as giving tests (such as the Rorschach or the Beck Depression Inventory) or administering structured techniques (such as Adlerian early recollections). Informal assessment means talking with the client or simply observing the client's behavior during the counseling session.

Table 17.5 presents the ways in which each of the 15 theories approaches assessment. Qualities of the therapeutic approach and the relationship between client and therapist are summarized in Table 17.6. Table 17.7 compares the goals of the various counseling theories, and Table 17.8 lists common techniques associated with each approach.

TABLE 17.5
ORIENTATIONS TO ASSESSMENT

Psychoanalysis	Both formal and informal assessment are used; therapist's observations initially determine the appropriateness of therapy; projective techniques are considered useful; target is unconscious processes
Neoanalytic Approaches	Observation of the client's ways of relating to the therapist
Individual Psychology	Formal and informal assessment are considered useful; counselor's observations are important; target is means of achieving power/superiority; family constellation and early recollections are significant
Person-Centered Therapy	Not appropriate; creates distance between counselor and client
Existential Therapy	Not appropriate; could interfere with the authenticity of the therapeutic relationship
Gestalt Therapy	Formal assessment is generally not used; informal assessment focuses on client experiencing, particularly emotional functioning
Behavior Therapy	Formal assessment is critical; normally behavioral observation by the therapist or significant other, or self-observation; paper-and-pencil objective measures are sometimes used
Rational Emotive Behavior Therapy	Formal and informal assessment are acceptable; primary target is belief(s)
Cognitive Therapy	Formal, objective, symptom-focused measures are frequently used; critical to assess thoughts, often using paper-and-pencil surveys; targets are thoughts, beliefs
Reality Therapy	Informal assessment; target is needs, particularly belonging/love
Feminist Therapy	No assessment is advocated; therapist observation of social/environmental influences is important
Family Systems Therapy	Formal assessment is not used; therapist observation of family patterns is critical
Solution-Focused Therapy	No assessment is used; client determines the problem; focus is on exceptions to the problem
Narrative Therapy	Not appropriate; limits the story of the client and the therapist
Mindfulness	In ACT, assessment and diagnosis focus on understanding where the client is stuck or avoiding experience; formal assessment and diagnosis are used in DBT

In Box 1.3 of Chapter 1, I presented some research evidence that suggested that philosophical assumptions and interpersonal tendencies may be factors in the choice of theoretical orientations. Those philosophical assumptions are included in a previous section, "Your Philosophical Assumptions" (e.g., objective versus subjective, emphasis on physical versus psychological causation, holism versus elementarism).

Interpersonal dominance was the interpersonal dimension that emerged from our data. Those who endorsed a psychoanalytic orientation appeared to see themselves as more interpersonally

TABLE 17.6
General Qualities of the Approach to Therapy

Psychoanalysis	Formal; doctor–patient relationship; long-term process
Neoanalytic Approaches	Formal; depending on variant, can be doctor–patient; long term
Individual Psychology	Collaborative; therapist is educator and model; therapist is human, fallible; relatively long term
Person-Centered Therapy	Authentic therapist in equal, genuine relationship with client; can be long term
Existential Therapy	Authentic unknowing therapist, client as fellow-traveler; long term
Gestalt Therapy	Counseling is an authentic encounter between therapist and client; length of therapy varies
Behavior Therapy	Therapist is teacher/consultant, client is learner; generally short term
Rational Emotive Behavior Therapy	Therapist is teacher/consultant, client is student; generally short term
Cognitive Therapy	Therapist is teacher/consultant, client is student; elements of doctor–patient relationship; generally short term
Reality Therapy	Therapist is genuine and direct; short-term approach
Feminist Therapy	Egalitarian relationship is essential; client is empowered; length of therapy varies
Family Systems Therapy	Therapist is an expert who joins the family as an honorary member; generally short term
Solution-Focused Therapy	Therapist is a consultant to the client who determines the goals; considered a brief therapy approach
Narrative Therapy	Collaborative, equal relationship is essential; length varies
Mindfulness	In both approaches, counselor is warm, genuine, and an expert on theoretical views of problems; DBT is year-long (or longer), whereas ACT theorists are less specific on length of treatment

dominant compared to those who endorsed the other orientations. Do not be put off by the use of the term *dominant*; yes, it has some negative connotations in our culture, but the way it is used technically is a little different. First, the degree of dominance observed in behavior spans a continuum, and in fact extreme dominance is problematic. A therapist displaying rigid and extreme levels of dominant behavior would not be a very good therapist. In considering dominance in the context of theoretical orientation, we could see it as the willingness to take charge of the counseling enterprise or the general activity level of the therapist. However, these two forms of dominant behavior are not exactly the same thing in therapy. The degree to which the therapist takes charge of the session is related to the level of activity observed to some degree, but not totally. For instance, in psychoanalysis the therapist is clearly in charge (setting the rules for free association, making interpretations of behavior—the doctor role), yet relatively passive behaviorally (letting the client free associate). In person-centered therapy, the therapist is active, but the directiveness of this approach is less obvious.

TABLE 17.7
GOALS OF COUNSELING/THERAPY

Psychoanalysis	Resolve unconscious conflict; insight; healthy defenses
Neoanalytic Approaches	Integrated self; adapted ego; insight
Individual Psychology	Convert selfish lifestyle into socially useful one; correct basic mistakes; insight
Person-Centered Therapy	Resolve incongruence between self and experience
Existential Therapy	Understanding of life; authenticity; freedom
Gestalt Therapy	Awareness; self-support; harmony with the environment leading to growth
Behavior Therapy	Adaptive behavior
Rational Emotive Behavior Therapy	Rational thoughts; rational life philosophy, including knowledge of ABCs
Cognitive Therapy	Modify distorted thought patterns; knowledge of the cognitive model
Reality Therapy	Healthy choices that satisfy basic needs, especially belonging/love needs
Feminist Therapy	Empower client to reach life goals; understand, resist, and subvert oppressive influences
Family Systems Therapy	Satir: increase self-esteem of family members; release blocked potential of family members; clear communication. Structural: change the family structure, thereby resolving the presenting problem. Strategic: resolve the presenting problem; modify dysfunctional hierarchies. Bowen: increase the level of differentiation of self from family of origin
Solution-Focused Therapy	Resolve the complaint; increase exceptions to the complaint
Narrative Therapy	Re-author preferred narratives
Mindfulness	ACT: free the client from problematic language in order to live a life consistent with cherished values; DBT: teach emotional regulation and trust in the self so the client can live a life worth living

TABLE 17.8
TECHNIQUES

Psychoanalysis	Free association; interpretation of transference; dream analysis
Neoanalytic Approaches	Free association; interpretation of transference; dream analysis
Individual Psychology	Interpretation; encouragement; natural and logical consequences; acting as if; pushing the button; catching oneself; creating images; pleasing someone; paradoxical intention
Person-Centered Therapy	No techniques; therapist provides conditions of empathy, unconditional positive regard, and genuineness (congruence)

Existential Therapy	Self-disclosure; dream analysis; paradox; bracketing; guided fantasy
Gestalt Therapy	Therapist self-disclosure; dialogues; playing the projection; working with polarities; making the rounds; taking responsibility; exaggeration; reversals; dream work; bodywork
Behavior Therapy	Relaxation; flooding; exposure and response prevention; systematic desensitization; aversive techniques; paradoxical intention; shaping; reinforcement; extinction; punishment; assertiveness training; stimulus control; covert conditioning; modeling; behavioral self-control
Rational Emotive Behavior Therapy	Disputing; bibliotherapy; proselytizing; recording therapy sessions; reframing; stop and monitor; rational coping strategies and rational emotive imagery; flamboyant therapist actions; humor; forceful coping statements; role playing; dialogues; reinforcement; skills training; in vivo desensitization; shame attacking
Cognitive Therapy	Questioning; downward arrow; thought recording; behavioral experiments; activity scheduling; graded tasks; assertiveness training; problem solving; imagery and role playing
Reality Therapy	Questioning; bibliotherapy; doing the unexpected; humor; therapist self-disclosure; metaphor; physical activity/meditation; allowing or imposing consequences
Feminist Therapy	Gender-role analysis; self-disclosure; assertiveness training
Family Systems Therapy	Satir: family sculpting; family stress ballet; communication analysis; therapist communications; family thermometer; parts party. Structural: enactment; focusing; achieving intensity; boundary making; unbalancing; teaching complementarity. Strategic: directives; reframing; exaggerating the hierarchical problem; pretend directives. Bowen: process questioning; detriangling; coaching; I-position
Solution-Focused Therapy	Questions; asking about the problem; normalizing the problem; compliments; miracle question; scaling questions; prediction tasks; fast-forward questions; first session formula task; generic task; altering the performance of the complaint; surprise task; write, read, and burn; structured fight; doing something different; solution-oriented hypnosis
Narrative Therapy	Externalizing; questioning; visualization; accountability practices; reflection practices; written artifacts
Mindfulness	ACT: metaphor; mindfulness techniques, willingness dial; cognitive defusion techniques; values work. DBT: core mindfulness skills; teaching distress tolerance and emotional regulation; chain analysis and other behavioral techniques; dialectical, stylistic, and case management strategies

Your preference for activity is fairly important in choosing an approach. If you are very active and like to solve puzzles, a theory such as solution-focused therapy, family systems therapy, reality therapy, or one of the cognitive or behavioral approaches may be for you. If you are more laid back, think psychoanalysis or person-centered therapy. Of course, psychoanalysis has its share of puzzles to solve, too.

THE ROLE OF YOUR CLIENTS: DIVERSITY IS HERE TO STAY

The type of clients with whom you expect to work is yet another factor in the theory choice equation. If you are going to work primarily with children, some approaches would seem to fit better than others, but then again, all of the approaches could be modified to work with kids. Because of the need to narrow the focus of this text, at least one approach very popular in working with children, play therapy, is only superficially describedin Chapter 5. You might want to check it out more fully.

Data and experience verify that the world is changing. It is becoming a much more diverse place than it was even 5 years ago. Cultural and ethnic groupings that used to be considered minority are quickly approaching majority status. For both pragmatic and ethical reasons, you have a responsibility to decide if the approach you choose can be used without bias with clients from varying backgrounds.

I have provided evaluations of each of the major theories in terms of their strengths and weaknesses in working with clients who are from other than White, Western European, Protestant, backgrounds. I have considered issues of sex and sexual orientation. You will need to personally evaluate these assertions. Most approaches have a decided bias toward individualism or the notion that independence and separateness are the hallmarks of psychological health. Will person-centered therapy really help a client from a disadvantaged background who is struggling with very basic life support tasks? Does the notion of differentiation embedded in family systems approaches limit your ability to help clients from collectivistic cultures?

I hope that these questions have helped you more clearly settle on the route that you choose to follow in your journeys with your clients. Yet I find myself still returning to these questions: Why choose one approach? Can't we use the best of all or a set of theories as seems appropriate? This question brings us to a consideration of what are known as eclectic or integrative approaches.

ECLECTIC AND INTEGRATIVE APPROACHES TO PSYCHOTHERAPY

As early as 1932, attempts were made to integrate approaches to psychotherapy—namely, the two dominant theories of the time, behaviorism (classical conditioning) and psychoanalysis (Goldfried, Glass, & Arnkoff, 2011). In 1936, Rosenzweig wrote his famous paper on the common factors operating in the different approaches to counseling (Rosenzweig, 1936/2002). These early efforts are recognized as pioneering, but the nature of eclecticism and integrationism is a little different in the 2000s.

We now recognize four general approaches to the thorny problem of eclecticism in psychotherapy: technical eclecticism, theoretical integration, assimilative integration, and common factors (Norcross & Beutler, 2014). However, Norcross (2005) warned that in practice these approaches are not so easily distinguishable, as you will see in the following paragraphs. For purposes of clarity, however, it is useful to discuss them separately, so I will do so.

The eclectic approach is perhaps most clearly articulated by those who assume a stance of *technical eclecticism*. These therapists adopt techniques from various approaches without endorsing the theoretical assumptions behind them. However, there does seem to be an assumption that many technical eclectics have a unifying theoretical system that guides their selection of techniques.

Arnold Lazarus, who developed multimodal therapy (MMT), is probably the best-known proponent of technical eclecticism. A behavioral orientation—specifically, social-cognitive learning theory (Lazarus, 2009)—informs this approach, so it could also be categorized as assimilative integration (here you can see the difficulties with the categories that I mentioned earlier). According to Lazarus (2000), MMT is "predicated on the assumption that most psychological problems are multifaceted, multidetermined, and multilayered, and that comprehensive therapy calls for a careful assessment of seven parameters or 'modalities'—behavior, affect, sensation, imagery, cognition, interpersonal relationships and biological processes" (p. 107). Substituting drugs for biological processes (Lazarus contends that this substitution is appropriate because biological processes are most often treated with drugs), we get the memorable acronym BASIC ID. Once a BASIC ID assessment is completed with a client, techniques appropriate to the modalities most salient in the client's presentation are selected.

A second well-elaborated approach that exemplifies the current status of technical eclecticism (or is it assimilative?) is the transtheoretical approach (Prochaska, 1979; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Norcross, 2014). Initially based on studies of individuals who actually changed addictive behaviors (e.g., cigarette smoking), this approach combines all theories of counseling by postulating generic *processes* of change (initially generated by a conceptual analysis of the major theories of psychotherapy) and identifying common *stages* of change across clients. These stages and processes fit together as shown in Figure 17.1, and Box 17.1 gives a broad summary of the approach.

Theoretical integrationist approaches are a second alternative to traditional theory. In this paradigm, two or more theoretical systems are merged. In essence, these approaches attempt to take the best of all worlds and "smush" them together (Stricker & Gold, 2011). Early attempts to merge psychoanalysis with behaviorism represented this camp; however, these systems never really caught on.

Another important integrative approach is *assimilative integration*. In this model, the therapist is firmly committed to the theoretical assumptions and structures of one model, but adds techniques and assumptions from other theoretical systems in a deliberate way. For example, Stricker and Gold (2005) described assimilative psychodynamic psychotherapy, which has a theoretical basis in relational psychoanalysis (see Chapter 3), but employs techniques from behavioral, experiential, and family systems approaches. In this approach, three tiers of functioning are identified: interpersonal relatedness (tier 1); cognition, perception, and emotion (tier 2); and psychodynamic conflict, self-representations, and object representation (tier 3). Clients are assessed on all three levels, and interventions are then designed that enhance client strengths and address dysfunction on each level. An overall goal is to target issues on tiers 1 and 2 that might impede successful work on tier 3.

Other assimilative approaches include cognitive-behavioral assimilative integration (Castonguay, Newman, Borkovec, Holtforth, & Maramba, 2005) and the interpersonal-cognitive approach proposed by Safran and colleagues (Marcotte & Safran, 2002; Safran, 1998; Safran & Segal, 1990). These approaches would have the drawbacks traditionally associated with the major theories they access and they have varying degrees of empirical support.

A final approach is the *common factors* perspective, which was briefly reviewed in Chapter 1. In closing, I present a common factors model that emphasizes the value of a theoretical structure, or belief system, in the counseling process, but that also recognizes the common factors inherent in the healing relationship.

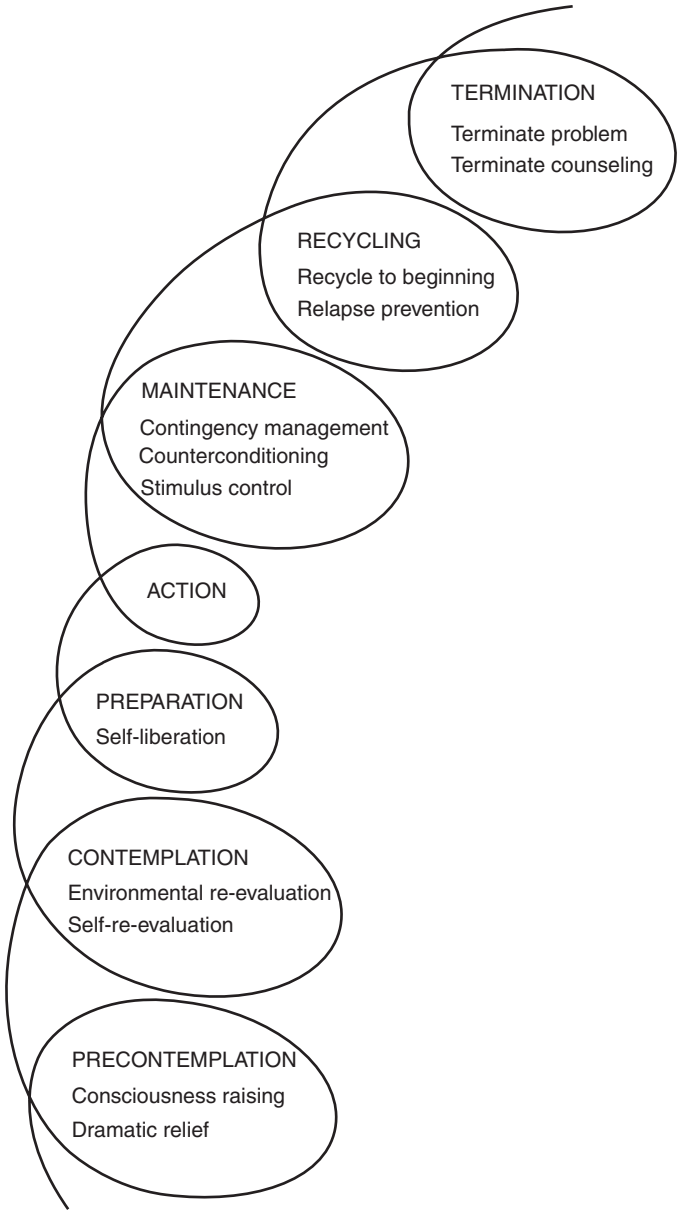


FIGURE 17.1. Stages of Change in Which Change Processes Are Most Emphasized.
Based on Prochaska, J. O., & Norcross, J. C. (2014). *Systems of Psychotherapy: A Transtheoretical Analysis* (7th Ed.). © 2010 Wadsworth, a part of Cengage Learning, Inc.

Box 17.1

Transtheoretical Therapy

Developed in the late 1970s, transtheoretical therapy is based on the assumption that the major approaches to counseling are more similar in how change happens than in the actual material to be changed (Prochaska, 1979; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Norcross, 2014). Prochaska, Norcross, and colleagues proposed a model that integrates elements from many theoretical perspectives, called transtheoretical therapy (TT). TT identifies three basic dimensions of change: *processes*, *stages*, and *levels*.

PROCESSES OF CHANGE

Understanding how people change is partially achieved through understanding what they do when they attempt to change their own behaviors. TT presents 10 basic processes associated with change:

1. Consciousness raising
2. Catharsis/dramatic relief (emotional expression)
3. Self-re-evaluation
4. Environmental re-evaluation
5. Self-liberation
6. Social liberation
7. Contingency management
8. Counterconditioning
9. Stimulus control
10. Helping relationship

STAGES OF CHANGE

Not every client who walks in your door is going to be ready to leap into action. Prochaska and Norcross (2014) identified seven possible stages of change: precontemplation, contemplation, preparation, action, maintenance, recycling, and termination. Understanding these stages is fairly straightforward and helps to shed light on what processes of change might be most useful to clients as they progress through them (see Figure 17.1.) The following material is summarized from Prochaska, DiClemente, and Norcross (1992) and Prochaska and Norcross (2014).

In *precontemplation*, the client is not even thinking about change. Precontemplators who show up for counseling are not likely to be happy because they are probably there because someone else has forced them there (e.g., family, courts). The best a TT counselor can do in this circumstance is try to create some awareness through consciousness-raising techniques or help the client gain emotional release through dramatic relief.

Clients who are in the *contemplation* stage are beginning to think about change; they perceive a problem and are thinking about what to do about it in a serious way. According to TT theorists, clients can stay in the contemplation stage for a very long time. Like those in the precontemplation stage, these individuals will not respond well to traditional, action-based therapeutic approaches.

(continued)

Box 17.1 *(continued)*

The first attempts to change behaviors are seen in the *preparation* phase. For instance, a client who wishes to quit smoking will cut down on the amount of cigarettes she smokes in a day or institute some ritual that must be performed before smoking. However, the person has not reached the full commitment to change that is seen in subsequent stages.

Significant, committed behavior change occurs in the *action* stage. One day of serious change is recognized as action stage status.

After 6 months of change, the individual is considered to be in the *maintenance* stage. During this stage, the individual is working to maintain and consolidate her gains. It is well known that change is very difficult, and for particularly stubborn problems, such as smoking or substance abuse, relapse is common. Thus, for some problems, maintenance may be a lifelong experience.

Recycling refers to the observation that most people don't maintain change on the first attempt—they must recycle to the beginning and try again. Thus, the process of change is seen as a spiral rather than a ramp. Counselors can help by providing some relapse prevention training, which is directed at avoiding relapse and also at recycling after one occurs (which it typically does with addictive behavior within the 3 months of termination of treatment; Prochaska & Norcross, 2014).

Termination is said to occur when the individual no longer has to fight relapse. Termination of counseling and termination of the problem do not always coincide.

TT advocates realize that individuals do not progress through the stages in a simple stage-by-stage fashion. Relapses occur, and the individual cycles back to a preceding stage from either the action or the maintenance stage.

LEVELS OF CHANGE

Levels of change are interrelated areas of functioning in which intervention for change can be made. TT theorists identify five levels of change:

1. Symptom/situational problems
2. Maladaptive cognitions
3. Current interpersonal conflicts
4. Family/systems conflicts
5. Intrapersonal conflicts

(Prochaska & Norcross, 2014, p. 468)

The levels are ordered according to how "deep" the problem is in terms of historical influences and relevance to the individual's sense of self. Different approaches to psychotherapy focus on different levels of change. For example, psychoanalysis is concerned with intrapersonal (within the individual) conflicts. Family systems counselors zero in on family/systems conflicts. According to Prochaska and Norcross (2014), the critical factor is that client and counselor agree on the level or levels to which they attribute the problem.

THERAPY

It is most important for the TT therapist to assess the three constructs identified as essential to the change process. TT therapists assess the *stage* of change of the client, the kind of *processes* the

client is using or has used, and the *problem levels* relevant to the client (Prochaska & Norcross, 2014).

In intervening with clients, TT advocates attempt to put together in one approach their knowledge about stages, levels, and processes of change. As Goldfried and Norcross (1995) put it, "Efficient behavior change depends on doing the right things (processes) at the right time (stages)" (p. 263). Thus, recommended interventions are different for clients in different stages of change. For example, using consciousness-raising techniques with clients in the action stage is a mistake. Clients in this stage benefit from approaches emphasizing behavioral processes such as contingency management (Prochaska & Norcross, 2014). Likewise, using action-oriented techniques with a client in the contemplation or precontemplation stage is not likely to work. As far as level of intervention is concerned, the first preference of a TT counselor is to intervene at the symptom/situational level because the symptom or situation is usually what has brought the client to therapy. Attempting change at the deeper levels is more complicated because some of the problem causes may be out of awareness or intimately tied to the client's sense of self. Change of this kind takes longer (Prochaska & Norcross, 2014).

TT counselors realize that the levels are interconnected, however, so that change at one level can introduce change at other levels, too. Interpersonal conflicts often involve dysfunctional cognition, for example, and changing one may affect the other (Prochaska & Norcross, 2014).

TECHNIQUES

The TT approach does not specify techniques per se; instead, TT theorists outline strategies for intervention. The aim of the strategies is to help the client progress through the stages of change using the processes of change. These processes can be embedded within an existing theory of personality/psychotherapy or independent of a traditional counseling theory.

Shifting levels is one of these strategies; it is used when problems can't be eliminated by working at a given level (Prochaska & Norcross, 2014). For example, consider the client dealing with depression resulting from the loss of a significant relationship. He starts work focusing on his symptoms. However, progress is slow to nonexistent. In response, the therapist might need to shift from the symptom level to the maladaptive cognitive level because cognitions seem to be supporting and exacerbating the symptoms. If the depression involves the loss of a significant relationship, the cognitive focus might not work either. The therapist can then go to any one of the other levels as seems appropriate.

A second strategy is intervening at a *key level* (Prochaska & Norcross, 2014). In the case of some client presentations, the level applicable is fairly obvious, such as with simple phobia. The counselor focuses on the symptom level. In other client presentations, the key level is not all that obvious.

The *maximum impact* strategy is invoked when the problem seems to have elements at multiple levels (Prochaska & Norcross, 2014). Interventions are devised to affect several levels of the client's problem.

SUMMARY AND EVALUATION

TT theorists identify three important elements of the counseling process: processes of change, stages of change, and levels of change. Counselors must first assess where the client

(continued)

Box 17.1 *(continued)*

is in terms of the stages of change before deciding on useful processes and levels. Interventions are directed at a key level of change, and sometimes shifting levels is seen as a useful strategy. Techniques are not specified; all interventions that create the processes of change are acceptable.

The TT approach is relatively new, yet the response to this conceptualization among helping professionals has been positive. The proponents of TT—Prochaska, Norcross, and colleagues—have worked hard to establish empirical support for their approach and have amassed an impressive amount of data in this process. Because this approach was developed on very specific behaviors, however, it is more difficult to apply to more general client presentations. From a diversity viewpoint, this approach seems to adopt the traditional individualistic stance, although the recognition that clients sometimes are not ready to change may allow room for family and social factors that have significant implications in client presentations. Further, the proponents of TT would argue that the approach is broad and flexible enough to be used in ways that are sensitive to individual and cultural diversity.

THE CONTEXTUAL MODEL

In considering how psychotherapy works, Bruce Wampold started where any good scientist-practitioner would: with a comprehensive review of the research on psychotherapy outcome. Along the way, Wampold identified two models of helping: the medical model and the contextual model (Wampold, 2001; Wampold & Imel, 2015).

The *medical* model is based on the premise that different treatments produce treatment-related specific effects that cure the client or patient. It is so named because in medical research the emphasis is on specific biological effects of treatments; "psychological" effects are seen as simply confusing the matter. In classic medical research, using a placebo pill filters out psychological effects. The situation in psychotherapy, however, is a little different: Both the specific and the placebo effects are psychological.

Nonetheless, in psychotherapy research, medical model advocates try to identify the specific effects of therapy and relegate nonspecific effects, such as those associated with the counseling relationship, to a lesser status. So, for instance, the latest advocates of the medical model, the proponents of the empirically supported treatment (EST) approach, say things like this: "We define ESTs as clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population . . . . We suggest that practitioners and research will profit from knowing which treatments are effective for which clients or patients" (Chambless & Hollon, 1998, p. 7).

Yet you will recall from Chapter 1 that there were very few differences between the various theoretical approaches in terms of client outcomes. Even the elaborate client–treatment matching studies such as the National Institute of Mental Health Treatment of Depression and Collaborative Research Program and Project MATCH have failed to uncover specific effects of treatment and client characteristics. Wampold used this information to support a different conception of psychotherapy. After reviewing an amazing amount of psychotherapy outcome research from a common factors perspective, Wampold argued that the most powerful influences

in counseling outcome are the therapeutic relationship and therapist allegiance. Therapist allegiance, in this context, is interpreted as the extent to which the therapist believes her approach is beneficial.

Wampold proposed that the operation of psychotherapy is better captured by what he called the *contextual* model. Derived from Frank and Frank's (1991) work, this model is based on the assumption that "the aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby transforming the meanings of experiences to more favorable ones" (p. 30). People come to therapy because they are demoralized, not because of their symptoms. For these reasons, all successful therapy has the following ingredients:

1. A therapeutic relationship in which the client can confide in the therapist and in which there is a level of emotionality.
2. The relationship is conducted in a setting connected to a healing mission.
3. There is a rationale or conceptual formulation about the client's symptoms and ideas about how to resolve them.
4. The rationale, which need not be "true," must be accepted by client and therapist.
5. The rationale must be consistent with the worldview and values of the client, or the counselor must help the client understand and accept it.
6. The conceptual system leads to a ritual or procedure that requires the active involvement of client and therapist.

(Adapted from Wampold & Imel [2015], p. 48)

Can you see the implications of this model for what you intend to do as a therapist? First, you must establish the right kind of relationship with your client. Further, you and your client must believe in what you are doing, and this belief must lead to active engagement in a process expected to lead to healing.

There are several points I wish to emphasize about the contextual model. First, the conceptual scheme in this instance is not just any scheme—it must be one that is recognized by our profession as legitimate (Wampold calls this a "bona fide" approach). Even better, it should be one that has withstood some empirical testing. Second, sometimes folks interpret the contextual model as saying that it is the therapeutic relationship that creates the change. If you re-read the earlier description of the model, there are important elements beyond the relationship: the setting, emotion, and in my mind the most important, the conceptual system and associated ritual. In fact, Wampold and Imel (2015) have elaborated on the original contextual model to clarify that the "good" therapeutic relationship (characterized by trust and empathy, established with a therapist who is perceived as competent), once established, can lead to increased client well-being. However, there are two other paths to change: expectation on the part of the client (and counselor) that the treatment will work and the specific tasks and behaviors associated with the conceptual scheme. So, the ideal therapeutic process would use all three of these paths.

CONCLUSION

Clients do not come to therapy with a theoretical explanation of what's wrong in their lives. If they do have an explanation, most of the time it is not helping them. Your task as a counselor is to think critically about the helping process. That evaluation can now be based on the large amount of information that I have conveyed to you in this text. The approaches I chose to

present are generally recognized as the major theoretical approaches to counseling (give or take a few, depending on whom you ask) and would seem to be a good starting point for your exploration of the counseling process. You could do worse than adopting one of these theories as you begin to work with clients.

If you consider Wampold's perspective, in some ways it really doesn't matter whether you are an advocate of the medical or the contextual model. In essence, what you need is a theory in which you can believe. Again, I suggest that your belief is best placed in one of the major approaches to counseling rather than in more obscure, relatively untested models. Further, trying to create your own eclectic approach at this stage of your career would likely result in a less-than-coherent system that would be hard to communicate to your client.

For now, I think I have said what I can. I leave to you the ultimate decision about your commitment to a theoretical stance. I wish you the best in your journey and would welcome your feedback on my thoughts.

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