Third Edition

COUNSELING AND PSYCHOTHERAPY THEORIES IN CONTEXT AND PRACTICE

Skills, Strategies, and Techniques

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Counseling and Psychotherapy Theories in Context and Practice

THIRD EDITION

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Skills, Strategies, and Techniques

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Preface

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

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

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

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

WHAT'S NEW IN THE THIRD EDITION?

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

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

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

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

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

New content is distributed throughout the text. Examples include:

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

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

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

WORDS TO THE WISE

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

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

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

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

ORGANIZATIONAL FEATURES

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

- *Learner Objectives*: Readers can see the roadmap for their learning at the beginning of their journey.

- *Introduction*: Including a definition of key terms and, when appropriate, a short biographical profile of the person(s) who developed the theory.

- *Historical Context*: Every theory has cultural and historical context. In some cases, when needed, an additional history section may be included, for example, Evolution and Development in Psychoanalytic Theory and Practice.

- *Theoretical Principles*: Core theoretical principles are described and explained. As much as possible, concrete and real-life examples are included to help bring abstract theoretical principles to life.

- *The Practice of …*: This section describes the distinct assessment and therapy approaches associated with each theory and ends with two case vignettes to help readers apply the material.

- *Case Presentation*: For every theory there's an extended case presentation that includes (a) a problem (or goal) list, (b) problem (or case) formulation, (c) specific interventions, and (d) outcomes assessment.

- *Evaluations and Applications*: This section provides a review of the evidence-based status of each theory-based approach. In addition, an analysis of how well the approach addresses issues related to culture, gender, sexuality, and spirituality is included.

- *Concluding Comments*: Final quotations and commentary are included.

- *Chapter Summary and Review*: A detailed chapter summary and list of key terms are provided.

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

ACCESS TO ENHANCED FEATURES

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

Videos

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

Psychoanalytic

Adlerian

Existential

Gestalt

Person-Centered

Motivational Interviewing

Behavioral

Cognitive Behavioral

Reality Therapy

Feminist

Solution-Focused

Family Systems

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

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

> You can watch the clip in its entirety and just focus on absorbing what you see as an example of a particular therapy prototype.

> You can watch the chapter in segments, as each video includes an introduction to the specific approach, followed by a video clip of the therapy session, followed by a brief discussion, followed by a final clip from the therapy session.

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

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

Practice Questions

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

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

BEYOND THIS TEXTBOOK

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

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

- A **theories beliefs pre- and post-test** in each chapter.

- An **opening professional development essay** written by a student, practitioner, or faculty member who is active within the counseling or psychology professions.

- A **theory review** section that includes a **glossary of key terms**, **theories crossword puzzle**, and **critical reflections** on each theory.

- A section on **practice activities** designed to help students experience and practice implementation of each theory.

- A section for each chapter titled **Testing Yourself** that includes a **25-item multiple choice practice test** and a comprehensive **short-answer question review**; these materials will help students succeed on even the most difficult examinations.

- **A closing essay** by another student or practitioner who has applied theory-based knowledge in a practice setting.

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

- Sample course syllabi.

- Supplementary lecture outlines and ideas.

- A test bank with 50 multiple choice questions for each chapter.

- Generic PowerPoint slides that can be downloaded and adapted for instructor needs.

ACKNOWLEDGMENTS

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

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

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

About the Authors

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

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

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

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

- *How to Listen so Parents Will Talk and Talk so Parents Will Listen* (2011, Wiley)

- *Tough Kids, Cool Counseling* (2nd ed., 2007, American Counseling Association)

- *Clinical Interviewing* (6th ed., 2017, Wiley)

- *Becoming an Ethical Helping Professional* (2007, Wiley)

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

Psychotherapy and Counseling Essentials
An Introduction

LEARNER OBJECTIVES

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

WHY LEARN THEORIES?

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

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

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

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

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

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

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

****

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

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

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

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

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

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

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

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

Contemporary Theories, Not Pop Psychology

Despite Darrell's argument that traditional theories belong in the dumpster, all the theories in this text—even the old ones—are contemporary and relevant. They're contemporary because they (a) have research support and (b) have been updated or adapted for working with diverse clients. They're relevant because they include specific strategies and techniques that facilitate emotional,
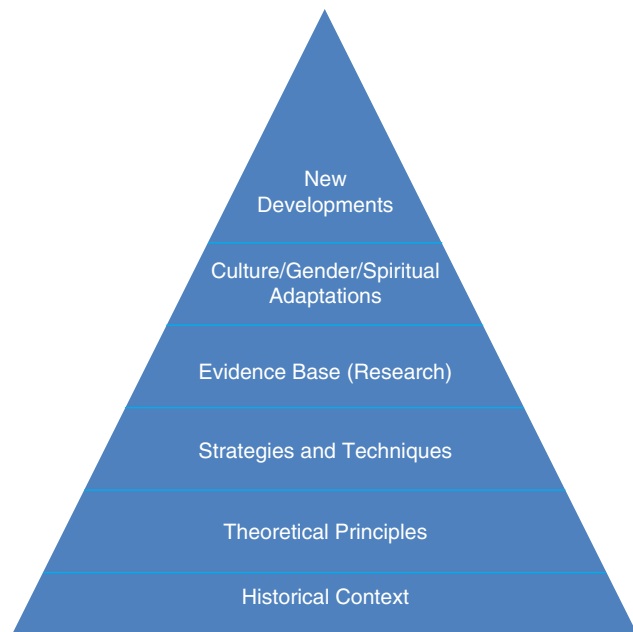
FIGURE 1.1 Counseling and Psychotherapy Theory: Foundations, Principles, and Practice

psychological, and behavioral change (see Figure 1.1). Although some of these theories are more popular than others, they shouldn't be confused with "pop" psychology.

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

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

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

Human Suffering and Hope

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

- Constant worry that he hadn't turned off his kitchen stove.

- Repeated checking to see if he had properly engaged his car's emergency brake … even when parked on level ground.

- Repeated thoughts of contamination. He wondered, "Have I been infected by worms and germs?"

- Hands that were red and chapped from washing 50+ times a day.

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

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

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

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

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

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

What Is a Theory?

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

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

Context

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

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

HISTORICAL CONTEXT

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

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

The Father of Psychotherapy?

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

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

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

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

Bankart (1997) articulated this point about historic discovery:

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

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

Four Historical–Cultural Perspectives

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

The Biomedical Perspective

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

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

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

The Religious/Spiritual Perspective

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

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

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

The Psychosocial Perspective

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

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

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

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

The Feminist/Multicultural Perspective

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

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

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

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

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

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

DEFINITIONS OF COUNSELING AND PSYCHOTHERAPY

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

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

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

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

What Is Psychotherapy?

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

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

We have several favorite psychotherapy definitions:

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

What Is Counseling?

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

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

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

What Are the Differences Between Psychotherapy and Counseling?

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

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

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

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

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

REFLECTIONS

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

A Working Definition of Counseling and Psychotherapy

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

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

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

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

THE SCIENTIFIC CONTEXT OF COUNSELING AND PSYCHOTHERAPY

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

Eysenck's Review

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

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

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

A Psychotherapy Research Boom

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

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

Table 1.1   A Closer Look at Effect Sizes

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

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

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

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

Although Smith and colleagues helped settle the issue of whether psychotherapy is generally efficacious, they didn't clear up the big debate over whether one form of therapy was more effective than others. This is because they found that different theory-based techniques didn't produce significantly different outcomes. Their findings, consistent with previous and later research, lent support to the conclusion that "Everybody has won and all must

have prizes" (a quotation from *Alice in Wonderland*'s Dodo bird). The relative equivalent efficacy of various therapy approaches is now commonly referred to as the **Dodo bird effect** (Luborsky, Singer, & Luborsky, 1975; Marcus, O'Connell, Norris, & Sawaqdeh, 2014).

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

The Great Psychotherapy Debate

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

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

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

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

- *Point*: Research has demonstrated the superiority of specific psychotherapy techniques for specific mental disorders; these techniques should be identified as "empirically supported" or "evidence-based" and should constitute the specific procedures that mental health practitioners employ.

- *Counterpoint*: A broader examination of the research reveals that different therapy approaches include common therapeutic factors. These factors account for most of the positive change that occurs in psychotherapy and so psychotherapists should deliver therapy in ways that emphasize these common factors.

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

Common Therapeutic Factors

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

- A culturally appropriate or sanctioned explanation (or myth) for client distress combined with a similarly sanctioned rationale for the treatment (ritual) procedures.

- A healing setting where the therapy takes place.

- Advice or education.

- An emotionally charged relationship bond between client and therapist.

- Catharsis or emotional expression.

- Exposure to feared stimuli.

- Feedback from the therapist.

- Insight into one's problems.

- Positive expectations (aka hope).

- The working alliance.

- Therapist credibility or expertise.

- Trust in the therapist (this alphabetized list is compiled and adapted from Frank & Frank, 1991; Lambert & Ogles, 2014; Laska, Gurman, & Wampold, 2014).

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

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

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

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

Extratherapeutic Factors 40%
Therapy Relationship 30%
Expectation 15%
Specific Techniques 15%
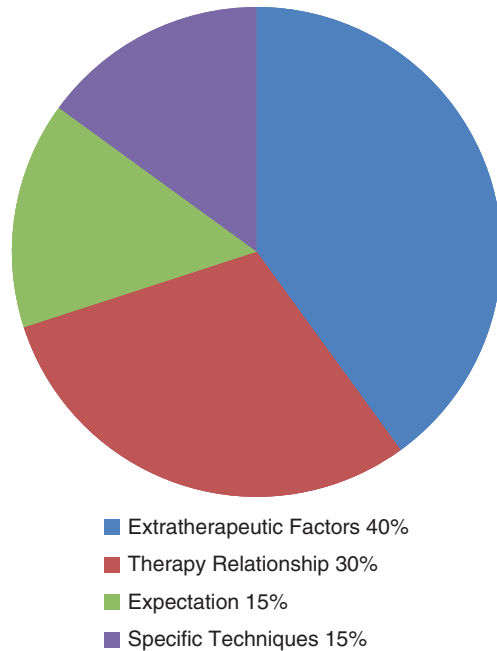
FIGURE 1.2   Lambert's Common Factors

Extratherapeutic Factors

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

Therapeutic Relationship

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

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

1. A positive interpersonal bond between therapists and clients.

2. The identification of agreed-upon therapy goals.

3. Therapists and clients collaboratively working together on therapeutic tasks linked to the identified goals.

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

Expectancy

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

Techniques

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

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

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

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

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

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

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

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

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

Efficacy Research

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

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

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

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

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

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

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

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

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

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

Effectiveness Research

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

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

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

Other Research Models

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

Techniques or Common Factors? The Wrong Question

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

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

Empirically Supported Treatments (ESTs)

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

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

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

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

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

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

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

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

- Help clients activate their extratherapeutic factors.

- Develop a positive working relationship.

- Create expectancy or placebo effects.

- Know how to use many different techniques that fit within your theoretical frame.

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