The Merrill Counseling Series

4TH EDITION

THEORIES OF COUNSELING AND PSYCHOTHERAPY

A Case Approach

NANCY L. MURDOCK

Pearson

Theories of Counseling and Psychotherapy

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.

Brief Contents

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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.

MyCounselingLab

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.

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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,