

CHAPTER 1

INTRODUCTION AND OVERVIEW

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LEARNING OBJECTIVES

After reading this chapter, each student should be able to:

- 1 Compare the similarities and differences between the concepts “psychotherapy” and “counseling.”
- 2 Sketch the history of contemporary therapy and theory.
- 3 Appraise therapy’s relationship to theory.
- 4 Critique attributes used to judge the soundness of a theory.
- 5 Evaluate the strategies to assess the effectiveness of therapy.
- 6 Explain the authors’ approach to writing this textbook.

Two key terms found in the title of this textbook are *psychotherapy* and *counseling*. In the traditional sense of the term, *psychotherapy* was used to identify professionals who were trained to deal with serious mental or emotional disorders primarily through some form of psychological treatment; these professionals included clinically trained psychiatrists, clinical psychologists, and psychiatric social workers. The term *counseling* was used to identify professionals who worked with others to help them accomplish various outcomes, such as establishing vocational or career goals, learning needed skills (e.g., parenting), promoting changes that would allow them to overcome obstacles in academic and work settings, and assisting with less disruptive mental health-related issues. Psychotherapy and counseling started to acquire definite forms toward the end of the 1800s and the beginning of the 1900s, but after more than

100 years, the distinctions between the two had weakened considerably, and the crossover between each territory of work caused the distinctiveness of the two practice areas to disappear essentially. Even though the areas of psychotherapy and counseling are relatively recent, development from a historical perspective, including interest in promoting mental health, dates back eons. Because of such early occurrences, it is correct to state that psychotherapy and counseling have a long past but a short history.

Throughout history many notable occurrences have clearly represented forward thinking in the providing of mental health assistance. One example of such forward thinking occurred with the Muslim scholar Abu Zayd Ahmad ibn Sahl al-Balkhi, who wrote *Sustenance for Body and Soul*, a thesis that addressed what constitutes mental health, why various forms of mental illness occur, and procedures that would enable a suffering person to gain mental health.

Al-Balkhi provided a surprisingly contemporary view of what would be recognizable today as a form of cognitive therapy. Haque (2004) summarized al-Balkhi’s basic treatment approach in these words, “He suggested that just as a healthy person keeps some drugs and First Aid medicine nearby for unexpected physical emergencies, he should also keep *healthy thoughts and feelings in his mind* [italics added] for unexpected emotional outbursts” (p. 362). Like many others, al-Balkhi understood that from time to time, everyone experiences the pain and disappointment that is associated with life’s inevitable misfortunes, but al-Balkhi differed from others because he gave us a means to prevent such misfortunes from escalating into mental illness. His message was simple: We need to maintain a realistic and balanced perspective whenever we encounter the serrated edges of life.

In *Sustenance for Body and Soul*, al-Balkhi distinguished between neuroses and psychoses and also explained the interaction of physiological mechanisms that led to psychosomatic illnesses. Furthermore, al-Balkhi designated four diagnostic categories with connections to identifiable symptoms: (1) anger and aggression, (2) anxiety and fear (i.e., phobias), (3) obsession (i.e., obsessive-compulsive disorders), and (4) sadness

and depression (Badri, 2013; Edson & Savage-Smith, 2004; Pickren, 2014). Al-Balkhi wrote extensively about this last diagnostic category. He asserted that disturbances in the area of sadness and depression take one of three forms (Haque, 2004). One form is normal depression that represents a *normal reaction* to daily life's struggles. Another form, *reactive depression*, originates from outside the person, for instance, when a person fails to fulfill a very important personal goal or when an individual suffers a significant loss of property or personal status. The, final type, *endogenous depression*, originates within the person and is marked by symptoms of incessant distress, profound unhappiness, and significant withdrawal from daily activities. Al-Balkhi believed endogenous depression has a strong body connection that requires a combination of medical and cognitive and/or affective-based treatment.

Clearly an interest in mental illness and its treatment can be traced back through human history, which predates al-Balkhi by centuries. The lay psychoanalyst Sudhir Kakar (1991), for example, showed that India's earliest societies practiced shamanistic healing rituals that were applied to both physical and psychological problems. While we (the authors of this textbook) earnestly believe that the roots of psychotherapy and counseling extend deep into humanity's past, we also believe such prophetic thinkers as al-Balkhi were more the exception than the rule in terms of explaining key causes and viable treatments for mental illness. Such thinkers were often simply the victim of being in the wrong place at the wrong time.

The Start of Contemporary Therapy and Theory

Although various historical documents and practices of ancient cultures might seem synonymous with contemporary mental health practice, not until the 19th century did a persistent and significant shift in understanding mental disorders occur. This type of understanding, which had authentic focus, depth, and scope, had found its right time and place. In contrast to earlier times, we only have to look back approximately 200 years to appreciate the magnitude of this major shift in thinking. During the 18th century, the hospital-prison called Bedlam was regarded by the social vanguard of England as imbued with high amusement value and well worth the penny fee charged to enter this human zoo, so visitors could safely observe the mysteriously acting inmates who were placed on public display (Pickren, 2014). The 19th century marked the dividing line between rare and fleeting occurrences of humane treatment of people with mental illness and an explosion of widespread and sustained efforts to develop comprehensive approaches to help these people. The second half of this remarkable century is especially notable for a series of events that led to what we know today as psychotherapy.

During the 19th century, a cadre of European healers and theorists emerged with a strong disdain for how mental problems had previously been handled and conceptualized. One measure of the fundamental change in approach to mental illness was the rise of the term *alienist* (an archaic term generally attributed to early practitioners of psychiatry). These professionals were called *alienists* because of the generally held opinion that those who suffered from mental disorders were basically alienated from themselves and from others. The term *alienist* can still be found in works of fiction, such as Caleb Carr's 1994 crime novel, *The Alienist*, in which the author used the term to contextualize the story shortly after the turn of the century.

Establishing a Foundation for New Theories and Therapies

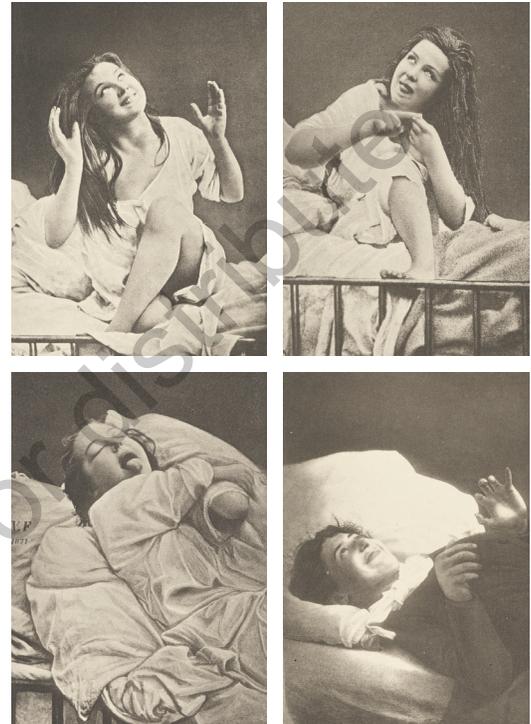
The original group of “psychological” healers and theorists who are covered in this textbook can be thought of as frame-breakers. These individuals departed from the theoretical frameworks and approaches to treat mental disorders that dominated during their time. They accomplished this departure by presenting new discoveries and revolutionary ideas that provided the requisite support to make important advances in theory and practice. Two such frame-breakers who departed from the prominent, unquestioned beliefs of 19th century were Jean-Martin Charcot and Sigmund Freud. Charcot was a renowned French neurologist who established the first neurology clinic at the Pitié-Salpêtrière Hospital, Paris, France. The existence of this hospital allowed for the removal and isolation from society those individuals who were suffering from mental illness. Charcot used the controversial procedure of hypnosis to study and manipulate symptoms of hysteria, which was a common mental disorder in the late 1800s and was considered to be confined solely to women until Charcot argued otherwise (see Figure 1.1). During Charcot’s time, hysteria manifested in an array of conditions, including amnesia that was limited to forgetting specific events; emotional outbursts that could change rapidly and unpredictably; overdramatic displays of behavior and narcissistic monologues; and displays of anxiety or depression that were converted into some form of pseudo-illness, such as paralysis that did not match any known patterns of genuine paralysis (Oxford University, 1971).

Upon learning of Charcot’s work, Sigmund Freud traveled to Paris to observe and study his work. These pioneers not only significantly contributed to what would become contemporary forms of therapy, but their efforts eventually led to new methods of conceptualizing and treating mental disorders. This process did not progress easily or without complications. Such difficulties were reflected in Freud’s years of concerted efforts to establish what was to become psychoanalysis. Although Freud’s effort would eventually garner him worldwide recognition, he initially received considerable resistance and experienced years of isolation from Vienna’s medical establishment. This was the case even among those professionals who were initially attracted to Freud’s new treatment approach and became affiliated with him, for example, Carl Jung and Alfred Adler, among others, who eventually broke with Freud because of disagreements. These disagreements were often rooted in a difference of theoretical opinion, but in some cases they led to acrimony and a partisan type of contentious quarreling that persisted for decades between members of each theoretical camp (e.g., Jungian and Adlerian practitioners).

Freud tended to categorize such departures and the resulting therapeutic approaches as misdirection that at best added little significance to the understanding of or treatment

▼ FIGURE 1.1

Nineteenth Century Photographs of Women Diagnosed With Hysteria



Source: Photographs from *Iconographie Photographique de la Salpêtrière*.

of mental disturbance; at worse, he felt these departures led to theoretical dead ends. In fact, the stories that surround the creation of psychoanalysis or the reasons for Carl Jung's break with Sigmund Freud have all the necessary ingredients to portray great literary or cinematic drama. (To appreciate the true nature of these stories of conflict or contrast of character, read Jean-Paul Sartre's screenplay *The Freud Scenario* [1984/2013], portions of which were used by the film director John Huston for his 1962 movie *Freud*, or watch David Cronenberg's 2011 movie *A Dangerous Method*, which vividly portrays the intense relationship that developed between Carl Jung and Sigmund Freud.) The various streams of thinking that led to the current forms of therapy represent fascinating endeavors that cannot be appreciated by reading a brief summary of a particular theory.

Therapy's Relationship to Theory

Since contemporary therapy's roots can be traced to the late 19th and early 20th century, one would assume sufficient time has elapsed for a single theory to arise that can explain the etiology and best means to treat mental disorders. However, a single explanation for why mental disorders occur has not emerged, nor has a single, best therapeutic approach emerged. In fact, Corsini and Wedding (2000) asserted that the term *therapy* cannot be defined to everyone's satisfaction because the word itself lacks the necessary exactness. These editors added that it is probable that more than 400 different therapies exist. Is it possible to tally what we cannot define? When these two seemingly contrary assertions are simultaneously considered, one may experience the sensation of having fallen into a bottomless pit.

The authors of this textbook acknowledge the inherent difficulties in determining what should and should not be included in a representative list of therapeutic approaches, but we also feel that the task is feasible. Our starting point does not consider all of what might fall within the realm of the term *therapy*; the approach we take starts with the following question. Of the present therapies, which are the most likely to be encountered by today's clients? The answer is tied to what might be referred to as "major approaches," which is a much more manageable number than the hundreds of "therapies" identified by some professionals.

Furthermore, we believe that to start the discussion by delineating the various types of available treatments is placing the proverbial carriage before the horse because all three authors of this textbook agree with the following statement: *Therapy cannot exist without theory*. This statement is consistent with the position held by Murray Bowen, a well-known family therapy practitioner who foremost regarded himself as a theorist: "Therapy and theory are part of the same fabric" (see Gladding, 2002, p. 127). Thus, before the widely used therapies can be understood, we must momentarily sidestep the issue of what is and is not therapy and focus our attention on determining what constitutes a viable major theory of therapy (keeping in mind that each major theoretical approach defines what is and is not therapy).

Each theory provides a therapist with a set of interconnected ideas that possess enough explanatory power to enable a therapist to hypothesize causes for a client's

problem. Theory provides a springboard from which to decide the therapeutic course to take so that specific theory-forged techniques can be strategically enacted in ways to achieve a meaningful closure to the therapeutic process. A theory is a road map of sorts that gives direction from the start to the end of therapy.

Even though we have significantly reduced the number of theories that will be covered in this textbook by narrowing our focus, it should be obvious at this point that having more than one major theory to consider means that the psychological territory presented by any one client can be traversed by using a number of different theoretical maps. In fact, the particular map selected by a therapist will determine to a large extent whether a client is perceived, for instance, as suffering from a mental disorder or in the midst of a developmental challenge, and if the client is even diagnosed as experiencing a mental disorder, and whether an appropriate diagnostic label should be applied.

This process can be illustrated by contrasting the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* with the theoretical positions known as psychoanalysis and reality therapy. The fifth edition of the *DSM (DSM-5, 2014)* uses the term *psychosis* but not *neurosis* even though psychoanalysis relies upon a diagnostic continuum that includes the term *neurotic* (McWilliams, 2011), which is a term used in the 2015 version of the *International Classification of Diseases (ICD)* of the World Health Organization. Furthermore, although the *DSM's* current and previous editions have recognized schizophrenia as a form of mental illness, William Glasser, who created reality therapy, rejected this assertion. Glasser shares company with several other prominent thinkers who also criticized the value or purpose of certain labels, such as Michel Foucault, who wrote *Madness and Civilization*. (Foucault argued that the label “madness” has been misused throughout history by powerful groups to isolate society’s outcasts, misfits, and deviants; the label was used to “imprison” society’s undesirables while the groups responsible maintained, at best, only a tepid interest in treating genuine mental illnesses.)

Finally, the map analogy also serves to remind us that whatever theoretical chart we ultimately decide to rely upon, we should avoid becoming so enamored of a particular map that we mistake it for the actual territory; in other words, no map (or label) can capture the complete complexity and subtle nature of any client. The map analogy also helps us to remember that just like printed or GPS-generated road maps, maps can lose accuracy when they are not updated to reflect changes. Similarly, a therapist’s theoretical map’s accuracy is likely to change over time in light of new findings and advances in the field.

Certain qualities typically characterize the major theories presented in this textbook; these qualities include robust concepts, consistency of treatment outcomes, and good applicability for the range of problems that individuals confront today, including a range from the relatively common relationship problems that can wreak havoc on a family’s day-to-day existence to the less frequent but significant disturbances rendered by psychoses. Regrettably, instances have occurred in which a so-called theoretically based approach used to treat mental illness has not been adequately tested to determine the soundness of its conceptually derived assumptions, degree of outcome certainty, or level

of treatment applicability—even in modern times. One case in point is the *transorbital lobotomy*, which is a form of psychosurgery that was introduced by Dr. Walter Freeman. The procedure was used as a remedy for conditions, such as aggressive tendencies, mild learning difficulties, delinquency, schizophrenia, postnatal depression, and unruliness—applications that could not be unequivocally justified.

Freeman was a psychiatrist with no formal surgical training who created the procedure commonly referred to as the “ice pick lobotomy” because of the surgery instrument used, an orbitoclast, which resembled an ice pick. Freedman would insert an orbitoclast above a patient’s eyeball, hammer it through the bone of the orbit into the frontal lobe (an area of the brain associated with the control and regulation of behavior and various abilities associated with executive functioning such as planning and retrieving memories), and move the orbitoclast in a manner to sever brain tissue. He then performed the same surgical procedure on the opposite frontal lobe.

Considering that Freedman did not conduct animal studies to ascertain the effects of a transorbital lobotomy, nor was he interested in doing so, he essentially introduced an extremely invasive procedure that was based on personally held beliefs that lacked evidence of validity. In addition, as evidence shows, the outcomes of this form of psychosurgery were not always predictable; scores of patients died, and others (such as President John F. Kennedy’s sister, Rosemary Kennedy) became incapacitated for life.

Amazingly, Freeman performed 2,500 transorbital lobotomies in 23 states at 55 different psychiatric hospitals. One of Freeman’s patients, Howard Dully, was misdiagnosed by Freeman as suffering from schizophrenia (Dully & Fleming, 2008; National Public Radio, 2014). Other medical and psychiatric professionals, who had seen Dully prior to Dr. Freeman, had not detected a mental disorder. Based on available information, Dully was most likely reacting to both the death of his mother and the remarriage of his father a year later to a woman who had rejected Dully as a stepson (he described his stepmother as a person who “hated me”).

Freeman performed a transorbital lobotomy on Dully at 12 years of age in 1960, years after the procedure had been discredited and replaced with breakthroughs in pharmacological treatments, such as the introduction of the antipsychotic drug chlorpromazine (brand name Thorazine). Dully described coming out of the surgery feeling as if he had been “zombified.” Figure 1.2 shows Freeman performing Dully’s psychosurgery. Specifically, Freeman is demonstrating the procedure he used to perform a transorbital lobotomy.

Attributes Used to Judge the Soundness of a Theory

What qualities make a particular major theory solid and strong? In addition to the need for factually based assumptions, reliable outcomes, and wide applicability, referential integrity is also extremely important to judging whether a theory is sound. Although no major theory completely fulfills all these qualities to the fullest degree, a major theory should be sufficiently strong in each area to justify its status as representing a major theory. These four qualities are defined and illustrated with references to psychoanalytic theory.

- *Structural Integrity*: Components of the theory are complete, coherent, and internally consistent. Structural integrity provides the conceptual glue that binds ideas and assumptions to form a unified whole. Such an explanation can be illustrated through Freud's theory of the dynamic unconscious. According to Freud, disturbing desires, feelings, and thoughts may be made to disappear from awareness through a mental process he termed *repression*, but he also asserted that what was repressed is likely to have a dynamic nature; that is, repressed experiences will continue to affect a person's behavior in various ways, such as when psychological symptoms develop. Freud spent decades forming a tightly constructed and elaborate theory of mental functioning that was based on his concept of the dynamic unconscious.
- *Explanatory Power*: The extent to which a theory can effectively explain the subject matter it encompasses (i.e., explanatory power) provides explanations for a wide array of mental processes and behaviors. Freudian *defense mechanisms* can be thought of as habitual strategies that are unconsciously activated for the purpose of distorting reality to protect us from any anxiety-provoking desires, feelings, or thoughts. If these occurrences were not controlled (which prevents us from consciously dwelling on them), our benignant self-image would reveal a repugnant brutish self.
- *Therapeutic Scope*: This quality specifically pertains to the degree that a theory's concepts and techniques are relevant for treating a range of mental disorders. Whereas Freud focused on treating conditions that fell under the umbrella term *neuroses* (e.g., anxiety disorders and dissociative disorders), contemporary versions of psychoanalysis have been developed that are designed to treat *borderline personality disorders* (serious conditions marked by unstable moods, behaviors, and relationships that are problematic) and psychoses (e.g., schizophrenia).
- *Referential Integrity*: This quality hinges upon establishing a correspondence between what the theory claims and what has been termed *bias-free objective reality*. Thus, regardless of how well Freud's theory explains human problems, holds together conceptually, or can be widely applied, ultimately the theory must be shown to match real-life situations; that is, reasonable proof for the existence of dynamic unconscious processes must be provided. One means for testing the quality of referential integrity is through

▼ FIGURE 1.2

Dr. Walter Freeman Performs a Lobotomy Using the "Ice Pick" Instrument He Created



Beitmann/Getty Images

empirical investigations. For example, in 2012, university-based researchers reported that empirical support had been found for the psychoanalytic assertion that a connection exists between unconscious conflicts and the conscious symptoms experienced by individuals diagnosed with an anxiety disorder (University of Michigan Health System, 2012).

These four qualities are closely related and even though they influence each other, each quality introduces an aspect about theories that none of the others fully addresses.

Interestingly, pseudoscientific approaches to therapy continued to appear despite the establishment of standards to judge the soundness of such newly introduced “therapeutic approaches.” In the book *Alternative Psychotherapies: Evaluating Unconventional Mental Health Treatments*, Mercer (2014) critiques various regression therapies along with other questionable therapies. According to Mercer, regression therapies focus on having someone drop back to an earlier time in their lives (literally becoming their former adolescent or child self again) that supposedly positions the person to overcome deeply disturbing early experiences. Mercer discussed how *adulthoodomorphism* (the belief that infants and children share adult characteristics) can cloud the thinking of regression advocates, some of whom have asserted that birth itself is traumatic enough to cause psychological problems. Mercer referred to evidence that infants experience neither agitation nor distress during birth; nor do they make a physical effort to escape the experience. In fact, an infant’s movement is inhibited by a paralysis reflex. Mercer further stated that “certainly an experience resembling birth would be agonizing for an adult, with fully developed, unbending skeleton, tight tendons, and fully formed skull, but the soft bones and malleable skull of the newborn ease the passage” (Mercer, 2014, p. 51). Mercer has reviewed a number of alternative therapies (e.g., energy therapies such as qigong and reiki; holding and attachment therapies; and *le packing*, which treats autistic children by tightly wrapping them in wet, chilled sheets for up to 6 hours) and has cogently argued that these alternative therapies are not in accordance with scientific views and lack sufficient evidentiary support for claims made by their advocates.

Assessing Effectiveness

Historically, theorists and researchers were curious about the effectiveness of therapy, with the earliest studies appearing in the literature in the 1920s (Lambert, 2011). Luminaries such as Sigmund Freud observed clients carefully and recorded notes about similarities and differences in patterns in clients’ behaviors and their responses to treatment. Through qualitative methods reported by groups such as the Berlin Psychoanalytic Institute (Fenichel, 1930), various conceptualizations or diagnoses about individuals’ psychological functioning were formed, and specific intervention strategies were introduced and employed. In addition, successful prototypical cases were shared with relevant professional communities as evidence of the effectiveness of psychotherapy.

In the late 1940s, Carl Rogers, founder of the client-centered (person-centered) approach, introduced the new technology of audiotaping of therapy sessions, which allowed Rogers and others to review the interactions between a therapist and client.

From this innovation (i.e., the utilization of systematic procedures to capture and assess clients' behaviors during a therapy session), an interest increased in tracking client–therapist interactions from the first session through the point of therapy's termination (Rogers & Dymond, 1954). Such attention also contributed directly to a new way of educating and supervising aspiring therapists who were interested in learning client-centered therapy. Like Freud and his colleagues, Rogers and his followers relied on a qualitative method to extract themes that they noticed in the audiotapes, and they modified their theories and strategies accordingly and also shared their case examples with the professional community.

In the 1950s, a quantitative procedure was employed to investigate the effectiveness of therapy. Since then, a growing number of researchers have relied on a randomized control design to investigate the process and outcome of various therapy approaches. Hans Eysenck, a highly recognized scholar, reviewed many outcome studies and reported that therapy is not beneficial and potentially even harmful (Eysenck, 1952, 1961, 1966). Based on their review of the literature, other investigators arrived at a different conclusion and stated that therapy is effective (Bergin, 1971; Luborsky, Singer, & Luborsky, 1975). In addition, in a seminal meta-analysis of the effectiveness of psychotherapy, two other researchers found strong support for the effectiveness of therapy (Smith & Glass, 1977). Finally, since the 1970s, other individuals have argued that certain theoretically inspired approaches are best suited for certain types of client problems. On the other hand, Wampold et al. (1997) conducted a meta-analysis investigation and concluded that no evidence supports the claim that some forms of therapy are better than others.

Other scholars found interesting results that have brought us to a much deeper level of understanding of what exactly contributes to the effectiveness of therapy. This realization was accomplished by changing the focus from comparing various approaches to investigating the specific characteristics of three components of successful therapeutic outcomes; that is, the characteristics associated with the therapist, the client, and how the intervention approach is applied. Researchers found that regardless of the particular therapy approach, the effective therapist is aligned with other effective practitioners and appears to display what the researchers called common factors that are curative in nature (Norcross, 2002). Some of the common factors that were linked to effective therapists include exhibiting warmth, showing respect, possessing a capacity for empathy, displaying unconditional positive regard, presenting themselves in a genuine manner, and offering the client encouragement. Common factors associated with clients believed to be linked with successful outcomes include attributes such as having hope, being motivated, having a social support system in place, and having an expectation for a positive outcome due to participating in therapy. Common factors reported to be tied to positive outcomes of the therapy process are factors such as establishing a positive working alliance (the connection between the therapist and the client), agreement on treatment goals, and agreement on tasks to be employed during therapy (Horvath & Bedi, 2002; Wampold, 2001).

Various professional organizations also have made concerted efforts to address factors that surround therapy's effectiveness. One such professional organization is the American Psychological Association (APA). The debate about the effectiveness

of therapy reached a new level in 1995 when APA introduced the concept of empirically validated treatment (Task Force on Promotion and Dissemination, 1995). The APA Task Force on Promotion and Dissemination of Psychological Procedures was charged with identifying scientifically validated therapy approaches for specific problems, as determined by a particular mental disorder diagnosis (Garfield, 1996). In time, approximately 50 of more than 500 treatment approaches were considered effective (Wampold, 2010). As a result of strong criticism about the exclusionary nature of what was considered “validated” treatments (as if no other interventions had any validity), in 1998, the task force agreed to change the validated treatments label to “empirically supported treatments” (ESTs). It is interesting that, since 1996, the task force has not updated its report of ESTs (Wampold, 2010).

More recently, in 2006, another APA task force (i.e., Task Force on Evidence-Based Practice) was formed to once again focus, in part, on the effectiveness of therapy. This committee defined what was termed *evidence-based practice* (EBP) in therapy as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (American Psychological Association, 2006, p. 273). Evidence for the efficacy of an intervention as defined earlier resulted in a designation of a treatment as an EBP (e.g., De Los Reyes & Kazdin, 2008). This task force defined best available research as scientific findings that were connected to assessment and intervention strategies for specific client problems and populations. Whereas the more recent EBP policy of the APA did not endorse ESTs (Wampold, 2010), the APA’s Division of Clinical Psychology has identified what it considers to be the best research evidence available for effective approaches of therapy given a specific client problem, and this group of professionals has made the information that it gathered available at <http://www.div12.org/psychological-treatments>.

Still, EBP and EST are not the same constructs. EBP is a much more comprehensive construct (APA, 2006) that is not confined solely to the profession of psychology. In fact, the original definition and practice of EBP was introduced by the Evidence-Based Medicine Working Group (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000), and, eventually, an official definition of EBP was endorsed by the Institute of Medicine (Institute of Medicine, 2001). In recent years, other health care disciplines (e.g., medicine, nursing, public health, physical, speech, and occupational therapy) also have endorsed the paradigm of evidence-based practice.

Along with the best available research, the EBP approach to determining effectiveness also stresses the importance of clinical expertise (e.g., competencies such as assessment, diagnosis, case formulation, forming and maintaining the therapeutic relationship, treatment planning, clinical decision making, self-reflection) in the promotion of positive outcomes in therapy (APA, 2006). As mentioned earlier, client characteristics (e.g., presentation and severity of problem, personality traits, developmental functioning, gender, race, ethnicity, social class, gender identity, disability status, sexual orientation) and the client’s culture (e.g., values, beliefs, understanding of health and illness, help-seeking behaviors, expectations about therapy) are critical components of EBP as well (APA, 2006).

Since therapeutic approaches were first conceptualized and put into practice during the late 19th century, much has changed, including judging what is and is

not an effective application of theory. Today, therapists are required to obtain a complex understanding of human behavior and develop a keen ability to employ interventions that are suitable and appropriate for a particular individual's present and ongoing concerns. Although it is difficult to predict the direction that the study of therapy's effectiveness will take in the future, Ivey and Zalaquett (2011) argued that the effectiveness of various theory-derived therapies should be examined in ways that consider the link between psychological functioning and new discoveries taking place in modern neuroscience that have led to a greater understanding of the role that the nervous system plays in all forms of disease, which also includes mental illnesses.

The Authors' Approach to Writing This Textbook

Terminology

In writing this book, we sought clarity over relying on unnecessary terminology and, when possible, avoided using jargon in ways that might make a topic area needlessly difficult, if not unintelligible, for readers who are new to the field. Using specialized words or expressions to explain other specialized words or expressions does little more than create a theoretical quagmire that muddles understanding and drowns readers in enough confusion to extinguish their interest. Our primary aim in writing this textbook was to expose readers to the amount of conceptual terminology that would both allow them to differentiate among various theoretical approaches to therapy and grasp the unique contribution made by each of these approaches to the practice of therapy. In addition, we sought to use terminology in a consistent manner throughout the textbook when referring to practitioners and the client recipients of what practitioners have to offer. Thus, a decision was made to use the terms *therapist* and *therapy* (or *psychotherapist* and *psychotherapy*) and *client* in a generic manner throughout this textbook rather than alternating between terms, such as *client* or *patient*; *counselor*, *psychologist*, *psychiatrist*, *social worker*, or *therapist* (or its synonym *psychotherapist*); and *counseling*, *psychology*, *psychiatry*, *social work*. (Exceptions to this decision occur when, for the sake of clarity, another term is deemed more appropriate, such as in Chapter 2, where professional counseling and counseling psychology are discussed.)

As mentioned at the beginning of this chapter, the terms *psychotherapy* and *counseling* were originally used to differentiate forms of treatment. For example, therapy was used to indicate the use of a long-term treatment approach designed to assist a person overcoming some form of a serious psychological disorder by fostering changes in the person's personality. Counseling was used to define short-term treatments that were much less intrusive in nature and sought a solution for what were generally thought of as everyday sorts of problems or concerns, such as the selection of a meaningful career path. As alluded to earlier, over time the distinctions that once existed began to blur when therapists developed and utilized short-term applications of their approaches, and counselors started to work with the full range of problem situations, including various mental disorders. One factor that contributed significantly to this melding of therapy and counseling was the contribution made by Carl Rogers. Rogers's client-centered

approach was adopted by many counselors in training and is a good example of the movement toward the growing similarity of clients' needs. In 1962, Eugene T. Gendlin reported on how he had adapted Rogers's approach to assist individuals who suffered from schizophrenia. Eventually, the approach originally developed by Rogers was being used to treat a number of serious concerns, such as depression, alcohol abuse, cognitive dysfunction, and personality disorders.

Target Audiences

This textbook was designed to provide a comprehensive overview of those therapeutic approaches that emerged from what was to become a multitheoretical system whose origin could be traced back to the late 1800s. This textbook was also designed for readers who seek an introduction to the world of therapy, especially those enrolled in introductory undergraduate courses offered through counselor education, psychology, social work, and criminal justice departments or programs. Further, this textbook is appropriate for advanced curriculums, which reacquaint students with previously studied theories. In addition, certain paraprofessionals who have earned bachelor's degrees and plan to complete a training program that will certify them to work in mental health, for example, as a paraprofessional substance abuse counselor, may benefit from this textbook. Many such trained paraprofessionals will also find this textbook suitable for their area of practice, broadening their understanding of how certain treatment approaches might interface with their treatment responsibilities, such as family therapy, which can make an invaluable contribution to the healing process for family members adversely affected by a family member's addiction. In addition, to the aforementioned audiences, numerous training programs exist outside the United States, programs that expect their students to be familiar with the theoretical approaches in this textbook. We believe the information contained in subsequent chapters can help such students in training to obtain a general foundation of knowledge that they can build upon as they advance in their specific areas of expertise. Even though differences exist in the training programs found among different countries and the theories and strategies employed in the therapeutic relationship, globalization is a force that affects much more than the exchange of consumable goods and has increasingly affected intangibles, such as ideas, world views, and other aspects of different cultures that are increasingly being "imported" and "exported" around the world. Such exchanges include important aspects of what comprises the ingredients for effective therapy. Bergin, Bigham, Ginter, and Scalise (2013), for instance, used stratified random sampling of marriage and family therapy practitioners who resided in either the United States or Canada and found an exceptionally high degree of similarity in the responses given by participants in both countries to more than 350 survey items that measured six categories of performance: the practice of systematic therapy; assessing, hypothesizing, and diagnosis; designing and conducting treatment; evaluating ongoing process and terminating treatment; managing crisis situations; and maintaining ethical, legal, and professional services. The globalization of knowledge is helping to spread and shape what therapy is today and what therapy will become in the future.

Foci of the 12 Theory Chapters

In addition to the current chapter, Chapter 2 covers topics such as the therapist as a person and a professional, and Chapter 15 summarizes commonalities and practice-related considerations. Other than Chapters 1, 2, and 15, the majority of chapters are devoted to examining the various theoretical foundations that support contemporary forms of therapy. Furthermore, the 12 theories or approaches reviewed were christened with names that are now widely known—psychoanalysis, Adlerian, existential, client-centered, gestalt, behavioral, cognitive-behavioral, reality, feminist, family systems, multicultural, and post-modern. Various other descriptors are also found throughout this textbook, including the identification of Albert Ellis’s form of therapy as “rational-emotive behavior therapy,” which can be logically paired with several other versions of what has generally become known as cognitive-behavioral approaches to therapy.

The theories covered in this book span three centuries from the late 1800s to the present. Even though differences in the organization and content can be found among the 12 chapters of this textbook, each theory chapter was structured to encourage comparisons of theories. We used a rubric that organized each chapter into sections that provide the following information about a theoretical approach: biographical background on major proponent(s), basic theoretical concepts and assumptions, components of the therapeutic process (e.g., role of therapist and client, nature of the therapeutic relationship, how goals are established, therapeutic techniques that are commonly linked with the approach), theoretical explanation for client change, the role that assessment plays in therapy, unique ethical concerns, research support for a theory’s approach, relevance to current mental health delivery systems (e.g., how the approach is suited for systems that rely on managed care, time limits, evidence to support its use of the approach in various mental health settings), critique of strengths and identification of shortcomings, client populations generally served, and an example of how the theoretical approach covered might be applied when working with actual clients.

In addition to devoting an entire chapter to examining multiculturalism’s role in today’s therapies, all other theory chapters also contain a multicultural section that specifically calls attention to how multiculturalism interplays with the theory that is being reviewed. Another theoretical aspect that is emphasized is how each theoretical position considers the role of social justice.

Finally, each of the 12 chapters closes with summary comments and critical thinking questions related to the chapter’s content. Also, some recommended publications or websites are provided to enable the reader to acquire additional information and understanding of the key topics covered in each chapter. Each chapter concludes with a list of the resources that were consulted and cited in that chapter.

Connecting the Dots: Seeing the Big Picture

Each theory molds and shapes the therapeutic approach that it has given birth to since each theory determines how a therapist is to explore a client’s problem through maintaining a distinctive style of focus; helps to explain the reason why a therapist relying

upon a certain theoretical approach would tackle a client's problem quite differently from a therapist relying on another theoretical position; motivates a therapist's actions and thoughts during therapy sessions and guides the therapist in ways to gauge the degree of progress made and when it is appropriate to terminate therapy; and provides the necessary raw material to construct and test the accuracy of hypotheses. Thus, an understanding of how various theoretical approaches function toward solving clients' problems lies at the heart of understanding more fully the different forms of therapy practiced today.

An important aspect of every theory that deserves recognition is the philosophical position represented by a theory concerning the *fundamental nature of reality and human existence*. The latter raises a critical question related to whether human existence encompasses the attribute of free will. Specifically, to what degree can humans willfully affect who they become during the course of their lives? If humans lack a sufficient degree of free will, then attempting therapeutic change becomes futile because the power to act without the constraint of fate is impossible, and any changes thought to be the result of free will are an illusion.

Concerning the issue of free will's role in affecting change, Carl Rogers (1951) stated:

I have yet to find the individual who, when he examines his situation deeply, and feels that he perceives it clearly, deliberately chooses dependence. Deliberately chooses to have the integrated direction of himself undertaken by another. When all the elements are clearly perceived, the balance seems invariably in the direction of the painful but ultimately rewarding path of self-actualization or growth. (p. 490)

The power for humans to pursue their unique personal potential and actively construct who they will become without the constraints of fate is the meaning of *free will*. In addition to Carl Rogers's humanistic approach, which stresses a client's dignity and worth and capacity for self-realization, existentialism is another theoretical perspective that also highlights the central role of free will in therapeutic change.

Created by Viktor Frankl, logotherapy (*logos* is Greek for "meaning") rests upon his belief that humans are free to search for a meaningful life (Devoe, 2012). Frankl is best known for his book *Man's Search for Meaning*, in which he outlines his existential position, a position that even the atrocities he encountered in a Nazi concentration camp were unable to alter. By the end of World War II, Frankl had survived a literal hell on earth. Later, he used his concentration camp experiences to further support the importance of free will to facilitate important therapeutic shifts in a client's life.

One of existentialism's strongest advocates was Jean-Paul Sartre, whose work titled *Being and Nothingness* carefully presents the philosophical basis for this framework using terms such as *anguish*, *essence*, *existence*, and *responsibility*. The root phrase that best captures what Sartre was trying to communicate to the world is "Existence precedes essence." Sartre meant that a person's *existence* is a given, an outcome of birth, but that the person we ultimately become is ideally sculpted through meaningful choices we make to reach our potential, which Sartre called *essence*. Choice is an inescapable

quality of living according to Sartre, for even if we consciously decide not to make a meaningful choice, we have still made a choice. Relying upon happenstance rather than our free will to self-determine our essence eventually leads to living a life driven by basic urges or one driven by radically conforming to others' expectations of who we should become. No matter how much we give in to our impulses or try to conform, any happiness that results is fleeting and leaves in its wake a sense of dread and lingering unhappiness. Personal happiness comes with assuming the responsibility that accompanies our becoming aware that we are meant to be the "incontestable author" of our own lives (Sartre, 1956/1974, p. 552).

Providing Greater Understanding by Moving Beyond Words

In keeping with our goal to write with clarity about complex theoretical perspectives and applications, we make use of other creative forms of expression, such as eye-catching symbols or visual illusions, works by painters and sculptors, segments of poems or musical lyrics that convey vivid images or elicit emotional reactions, portions of stage plays, snippets of scenes from movies, photographic images that tell a story, and so forth. There are instances when the proverb "A picture is worth a thousand words" is true with regard to students who are genuinely grasping the meaning of an abstract or even some generic idea generated by a particular theoretical position. An example of how "moving beyond words" can be used to facilitate understanding is provided next by juxtaposing a technical definition for existential anguish with a widely recognized painting by Edvard Munch.

Sartre (1956/1974) defines the term *anguish* this way:

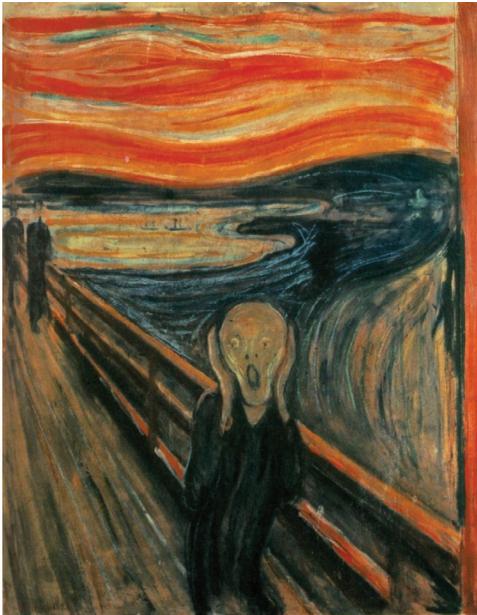
The reflective apprehension of the Self as freedom, the realization that a nothingness slips between my Self and my past and future so that nothing relieves me from the necessity of continually choosing myself and nothing guarantees the validity of the values which I choose. Fear is of something in the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

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

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

▼ FIGURE 1.3

Munch's Painting *The Scream*



Source: The Scream (or The Cry) by Edvard Munch. Wikimedia Commons.

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

Reappearing Case Study Used in Each Theoretical Chapter

Another way we, the authors, have been able to instill a greater appreciation of each theoretical area covered in this textbook is through the provision of case studies that highlight several key components of a particular theoretical approach. The case illustration found at the end of each theory chapter is based on the Case of Miguel Sanchez box on page 17.

▼ FIGURE 1.4

Mask used in the Movie *Scream*



Source: Konrad, C. and Woods, C. (Producer), & Craven, W. (Director). (1996). *Scream* [Motion Picture]. USA: Woods Entertainment.

It should be noted that in some chapters new story elements are introduced into the Sanchez case information for the purpose of better illustrating the type of strategies relied on by a therapist who is affiliated with the theoretical model discussed in the specific chapter. This reexamination of the same case in each of the theory chapters is intended to enable a reader of this textbook to ascertain genuine differences and similarities among various therapeutic approaches.

In addition to returning to the Sanchez case study in each of the 12 theory chapters, each of these chapters begins with a unique case not found in any of the other chapters. These unique cases embrace several different forms. For example, a case may represent an amalgamation of cases that the chapter's author(s)

THE CASE OF MIGUEL SANCHEZ

Miguel Sanchez is a 14-year-old Mexican American male who emigrated from Mexico City to South Los Angeles with his family 6 years ago. His guidance counselor, Mrs. Torres, refers Miguel to receive psychological services and assessment. Mrs. Torres cites a decrease in Miguel's school attendance, a shift in gravitation toward a negative peer group, and potential substance abuse as reasons for her referral. Mrs. Torres reports her being particularly concerned about Miguel's recent negative behavior because he has a history of being a bright student who has been involved with various student organizations. Mrs. Torres calls a local community mental health agency and requests that Miguel be matched with a male clinician, preferably Hispanic. Miguel's mother, Mrs. Sanchez, agrees that it might be in her son's best interest to engage in psychological services and leaves a message at the agency that she would like to schedule an appointment.

Dr. Ramirez is assigned to the case and contacts Mrs. Sanchez to schedule an initial assessment.

Dr. Ramirez explains on the phone how he initially works with a new client and their family by discussing his theoretical orientation, the client's right to confidentiality, cancellation policy, sliding scale to receive reduced fee services, and how he may work collaboratively with the school and other providers.

Mrs. Sanchez confirms that she has recently noticed a negative change in her son and agrees to bring him to see Dr. Ramirez in the following week.

After the initial session, Dr. Ramirez could not help but wonder if the Sanchez family situation were more

complicated than they originally presented. The Sanchez family spent the first session focusing on behaviors and expectations; however, Dr. Ramirez left the session feeling as if there might be underlying unresolved issues. He made a mental note to further explore how acculturation may be affecting the Sanchez family.

In the following session, Dr. Ramirez helps to initiate a conversation between mother and son as to how their experiences of moving to the United States might be different as well as how it might be similar. During this session Mrs. Sanchez tearfully explains how she feels that her son is losing his heritage by wearing baggy clothes, listening to rap music, and refusing to participate in familial and cultural activities that he once enjoyed. In defense, Miguel loudly tells his mother that she embarrasses him because of the traditional clothing that she chooses to wear and by her refusing to learn to read or write in English.

Miguel is noticeably agitated when the conversation moves to his decreased connection to his Mexican heritage. Miguel attempts to explain to his mother, in Spanish, that the only people that he can truly relate to are his new friends. A heated discussion then ensues about Mrs. Sanchez's view of Miguel's new friends' criminal mentality and lack of morals. Miguel shouts, "At least they give me respect" and storms out of the room. Dr. Ramirez is left with Mrs. Sanchez as she sobs in the room with her hands held over her face.

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

At this point we hope that the current chapter piques the interest of the readers in a field of study and practice that has fascinated us throughout our careers. The theories covered in this textbook offer a wide range of therapeutic formulas designed to provide a therapist with the requisite structure and strategies to effectively work with a large array of client concerns, ranging from individuals interested in achieving personal growth to persons who are experiencing the serious ramification of a mental disorder.

Further, we hope that upon reaching the end of this textbook, a reader will become aware of how the theories explored within its pages share divergent characteristics but also certain commonalities. One such commonality is that these theories offer much more than what is solely associated with processes that occur within the confines of a therapy room's four walls. These are theories that have general implications for how we are to live, love, and work. Such wide-ranging implications help to explain why Carl Rogers moved from calling his approach "client-centered" to "person-centered" once he realized that his theoretical position offered transformative possibilities beyond what was taking place in traditional therapy settings (Rogers, 1980). Similar to Carl Rogers, the researcher B. F. Skinner, whose theory was deterministically driven rather than free will driven, also believed that his theory of operant conditioning had implications well beyond what was being applied in and outside his research laboratory; this belief prompted Skinner to write *Walden Two*, a novel that describes how behaviorism can serve as a blueprint for building a modern-day utopia (Skinner, 1962). The point is that the 12 theoretical areas covered in this textbook have much to offer anyone who is willing to immerse himself or herself in what is presented. We believe such immersion coupled with an open mind will allow the reader to reach the end of the last chapter having abstracted from this textbook what will be of greatest benefit in terms of how that reader chooses to live, love, and work in ways that are both meaningful and satisfying.

Ongoing Exercise That Concludes in Chapter 15

By this textbook's conclusion, readers should be able to express clearly what they believe are the elements that would comprise their own personal theoretical approach to therapy. In Chapter 15 we provide a method to achieve this important end goal. Table 1.1 is an example of how such a comparison method is intended to work. Specifically, the six rows in Table 1.1 depict how a reader might have responded when writing a comparison summary (e.g., "1. Theoretical perspective used to understand basic human nature") for each of the four theoretical approaches (i.e., feminist therapy, postmodern therapy, marriage and family therapy, and multicultural/cross-cultural therapy) selected to illustrate how a reader can establish similarities and dissimilarities among theories.

After writing summary statements across all "Six Areas of Comparison" found in Table 1.1 for the four theoretical approaches listed across the top of the table, the reader will have filled 24 cells. The contents of these 24 cells reveal the prominent differences and similarities among the four theoretical approaches. As the reader looks across each row of written summary statements, a means for the reader to review six key points in which the listed theories diverge or converge with one another is presented.

The concluding exercise found in Chapter 15 expects readers of this textbook to isolate from their own written summaries for each of the theoretical chapters read what they consider most meaningful to them for the purpose of constructing their own unique theoretical position. Furthermore, in Chapter 15 a number of important concepts are explained (e.g., syncretism, technique matching, theoretical frames, and common factors) that readers will be required to consider in light of the summaries they wrote. The information in Chapter 15 creates a structure for readers to achieve a critical assessment of the various theories in this textbook, the type of assessment that is necessary before a reader can clearly state what comprises his or her personal theory.

▼ TABLE 1.1

Four Therapies Juxtaposed on Six Areas

Six Areas of Comparison	Feminist Therapy	Postmodern Therapy (Narrative Therapy)	Marriage and Family Therapy	Multicultural/Cross-Cultural Therapy
1. Theoretical perspective used to understand basic human nature	The interplay of male and female perspectives, biological differences, and social expectations related to gender	Personal “stories” are what define an individual’s or group’s understanding of reality and the role they play in that reality	The family represents the fulcrum to understand individuals and various groupings of family members	Factors, such as racial and ethnic diversity, sexual orientation, disabilities, classism, and the history of marginalized groups
2. Mental events, processes, or other attributes focused on	Prejudice in favor of or against one gender in a way considered to be unfair and detrimental to mental health	Cognitively humans are driven to make meaning of the experiences encountered in their lives	What occurs within and between individuals is related to family dynamics	Factors that contribute to beliefs (positive, negative, or unbiased) about other individuals and groups
3. General explanation given for client problems	Thinking that reflects inherent privilege that leads to systemic gender inequalities within a society or culture	The way clients have interpreted and “written out” the events in their lives can create personal problems	Dysfunctional family systems originate in many possible ways, but all have a disruptive impact on family relationships	Attitudes, judgments, and behaviors reflect prejudice, stereotyping, and discrimination
4. Emphasis placed on client’s past, present, or future	Depends on the particular form of feminist therapy referred to because theoretical views overlap and differ	Full range because the past, present, and future can all contribute to the deconstruction and reconstruction of a meaningful narrative	The full range of time periods is utilized, but focus depends largely on the specific family therapy utilized	Full range referred to but can differ as a result of the particular theoretical position and a client’s worldview
5. The role that free agency plays in therapeutic change	Self-determination is a key aspect of feminist-oriented therapies in uncovering possible solutions for client concerns	Individuals, couples, and families possess the ability to rescript their lives through reinterpreting events in their lives	Depends on the particular approach referred to because theoretical views differ concerning amount of free agency possessed	In general, the degree of free agency believed to exist allows for changes in the self, others, and systems to occur
6. Theoretical developments	Other forms include Marxist feminism, radical feminism, ecofeminism, erotic feminism, and lesbian feminism	Postmodern theory encompasses several conceptually important additions that continue to remain influential, such as hyper-reality	Encompasses earlier approaches and newer approaches that operate from a systems perspective	Theoretical developments include cultural identity development theory, integrative life pattern model, and feminist therapy

Table 1.2 is a summary format that readers should use to collect the information they will need to complete the concluding exercise. Readers should photocopy, scan, or create their own version of the guide in Table 1.2 and use it to write summaries for each of the theoretical chapters they complete. Finally, users of this textbook are strongly encouraged to review those pages near the end of Chapter 15, which concern the final exercise discussed here. In reviewing those pages, readers will notice that the concluding exercise has three parts (and subparts) to complete. The last part, Part III, requires readers to write a detailed description of their own personal theoretical position. Their description must also incorporate what they learned by completing Parts I and II, including an explanation of how the knowledge gained from these two parts helped them construct their own unique theoretical approach to therapy.

▼ TABLE 1.2

Guide for Summarizing the 12 Areas

Name of Theoretical Approach Reviewed: _____	
<i>The 12 Areas</i>	<i>Summary Statement for the Corresponding Area (Areas 1–12)</i>
Area 1: Philosophy concerning basic human nature	
Area 2: Role of therapist	
Area 3: Key concepts	
Area 4: Goals of therapy	
Area 5: Therapeutic relationship described	
Area 6: Techniques of therapy	
Area 7: Applications of the approach	
Area 8: Multicultural considerations	
Area 9: Social justice consideration	
Area 10: General contributions to the field	
Area 11: General limitations	
Area 12: General strengths	

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