Models of Helping

Professional preparation programs are often structured according to two basic approaches. In the first option, you may be studying helping skills before you take a course in theory. It is reasoned that these professional behaviors are so universal among practitioners that it is not necessary to understand their theoretical base before you begin practicing them. Because they take considerable time to learn well and become part of your interpersonal repertoire, the idea is that you should have as much time as possible to master them. Although some of the skills may be learned proficiently in a matter of weeks, mastery of others will take you the rest of your life.

A second training approach requires you to study theories before you learn applied skills. In this approach you postpone learning how to do counseling and therapy until you are fully exposed to the conceptual base that supports practice. Of course, other possibilities are that you are taking both classes concurrently or as part of an integrated unit in which theory and skills are linked.

In any of the scenarios, the outcome is the same: It is necessary to master both the underlying conceptual base of the profession, including the major theoretical approaches (see Corey, 2006; Ivey, D’Andrea, Ivey, & Simek-Morgan, 2006; Seligman, 2005) and the applied interventions that emerged from these models (see, e.g., De Jong & Berg, 2007). There are distinct advantages and disadvantages to each preparation method and no clear consensus as to which is best.

The purpose of this chapter is to help you understand the ways that theory influences and shapes the application of therapeutic skills. This relates not only to choice of which skills are considered most potent and useful, but also when and how they provide optimal effectiveness.

Historically, the evolution of theory in our field has emerged in three movements (Dryden & Mytton, 1999). You would easily guess that Sigmund Freud’s contributions to developing psychoanalytic theory form the first stage. Freud and his collaborators developed the first comprehensive treatment model that explored unconscious motives, instinctual urges, defense mechanisms, and experiences from the past that continue to have an impact on present behavior.

Some of Freud’s contemporaries, like Alfred Adler, helped to shape the second wave of psychological theory, which took the form of humanism, an approach later developed by Carl Rogers and others. These theorists emphasized the importance of the relationship in helping encounters, especially the kind of relationship that is
characterized by empathy, caring, and respect. Emotional expression is often valued and encouraged in this second set of theories.

The third movement focused more on how current thinking (rather than past experiences or feelings) impacts behavior. These theories value the exploration of thoughts and values that can be changed in order to help clients more easily alter negative emotions.

There is a fourth movement currently growing that is primarily focused on contextual factors that influence the process of working with clients, such as taking ethnic culture, social class background, and gender into consideration, to name a few (Enns & Sinacore, 2005). This new approach to theory is influenced by those who seek cultural sensitivity and awareness of social factors that may inhibit a client’s ability to feel well. Corollary theorists who are also becoming increasingly influential identify strongly as “postmodern,” “constructivist” (Neimyer & Mahoney, 2000), “feminist” (Hill & Ballou, 2005; Worrell & Remer, 2002), or “relational” (Jordan, Walker, & Harling, 2004; Miller & Stiver, 1998; Walker & Rosen, 2004) therapists. All of them share an interest in issues related to marginalization, oppression, social justice, language, and culture as they impact client experiences.

As you increase your exposure to theories, you will find that most practitioners use techniques and skills from all of these theories since they all have something useful to offer. For example, it is reasonable to assume that you might use active listening skills from humanistic theory, challenging and disputing from cognitive theory, reframing from solution-focused theory, re-storying from narrative theory, interpretation from psychoanalytic theory, realigning coalitions from systemic theory, empowerment from feminist theory, and so on. The wonderful thing about a skills training experience is that you will be exposed to all the most important therapeutic interventions that are accepted as being most useful.

Theories and Their Offspring

Theories of counseling and psychotherapy provide several distinct uses for practitioners. First, they give you a foundation for understanding what you are doing. Second, they provide an organized framework for diagnosis and treatment. Third, theories help you to articulate your values about why clients come to therapy and how clients change. Table 3.1 provides a list of some theories and their major goals. You should understand that trying to state a general goal in a single sentence is difficult, at best. You should also be aware that each author who studies a theory may differ subtly in his or her understanding of the theory. All this is to say that the stated goals are subjective interpretations of each of these theories.

Finally, every theory supplies an inventory of techniques, skills, and interventions that become the means by which the model is applied. For instance, you have probably heard that psychoanalytic theory stresses that it is important to help clients uncover their unconscious desires and repressed wishes (Freud, 1936). This means essentially that the therapist’s job is to increase client awareness, especially of things in the past that have been buried, as well as internal thoughts and feelings that are not currently accessible. It is reasoned that bringing such material into view will help
people to come to terms with the unresolved issues of the past that are disrupting current functioning and producing annoying symptoms.

It is one thing for Freud and his disciples to present what they believe are the best ways to practice therapy, and it is quite another when they provide specific methods and skills by which this plan can be carried out. In the case of psychoanalysis, Freud (1936) did introduce certain techniques like dream analysis and specific skills like the use of interpretation to increase client awareness of hidden patterns. Most of the other theories you have studied, or will study, have also spawned particular skills; many of these have now become integrated into mainstream practice and are not restricted to practitioners of that one theory. Many therapists and counselors, coming from a variety of schools, now use the skills of interpretation in their work even if they don’t apply the skills in the way that Freud first preferred. Interpretation can be used for a variety of other purposes, such as to offer alternative explanations for patterns or behaviors that may seem puzzling to the client.

Although we used a skill from psychoanalysis as an example, be aware that many of the other theories have generated skills that have migrated beyond their original territory.
Many counseling skills did not emerge from a single theory, but rather resulted from observing what therapists actually do with their clients in sessions. It is one of the paradoxes of our profession that it is often difficult to tell which theory a clinician is using just by watching what is going on; often, a theory is more an organizing set of assumptions rather than a blueprint for how to behave. Examples of these universal skills include open-ended questions in which you might elicit information, or summarizations in which you tie things together.

What Using a Theory Looks Like

Throughout your studies, you will probably hear how important it is to align yourself with one theoretical orientation. This may seem like a challenging task because so many theories have clear strengths. In addition, you may think that being eclectic can serve you just as well. A theory, however, provides you with a structure, a foundation that explains why people do what they do and how people change. Each theory will offer something useful, and you can actually use any technique in any theory.

For example, people often assume that Gestalt theory is primarily about focusing on emotions and works only in the here and now. Some practitioners, however, also work with the client’s thoughts and may have clients reflect on the past. Clients who are particularly emotional but do not have a good understanding of why a feeling is particularly intense or seems disproportionate to the situation are encouraged to think back to the first time they first remembered feeling this way. Clients and therapist may explore the beliefs that underlie the feelings as well as the origins of those beliefs. Because this is based on exploring the past, it might sound psychoanalytical. This could also seem to be cognitive since it’s based on the exploration of beliefs. A Gestalt therapist, however, would encourage the client to bring that moment into the present and then speak from that experience to gain this knowledge. In Gestalt therapy, the therapist assumes that unfinished business creates an incomplete gestalt. Unless you have studied Gestalt therapy, you might not follow the language, but you still could get the point that techniques from any theory can be used to help your clients.

What your professors are advocating when they want you to use a theory (and by the way, many state licensure exams also expect you to align with one) is that you
have a direction in therapy. Everything you say directs the session. When a client
tells you a story that includes many different important facets, which one do you
focus on? Your theory may help you answer this.

To further illustrate the use of theories, we’ll conceptualize several models from
the perspective of a character that almost everyone will be familiar with: Anakin
Skywalker, also known as Darth Vader, from *Star Wars*. As you may recall, Darth
Vader was the villain in the original trilogy of these movies. The more recent *Star
Wars* films portray him during his younger years, before he “went over to the Dark
Side.” We look at Darth Vader’s life through the lenses of three very different the-
oretical orientations: psychoanalytic, person-centered, and cognitive. These are by
no means the only theories we could have selected, but they are ones that have had
a great deal of historical influence.

**Darth Vader: A Brief Biography**

Many of you may know Darth Vader from *Star Wars*, but that was only after his
“transformation.” Before he became Darth Vader, Anakin Skywalker was raised by
his single mother in an implied immaculate conception. During his formative years
he lived in slavery, but had a loving mother who fostered his interests and natural
ability to become a talented pilot. At age 9, he was given the opportunity to fulfill
his dream of becoming a Jedi warrior, but had to leave his mother behind in order
to undergo rigorous training. He left his home and mother in great sorrow, relieved
at having escaped his own fate as a slave but still feeling guilty that his mother had
been left behind. As you probably realize, 9 years old would have been a rather trau-
matic time to be separated from your only living parent.

We see Anakin again when he is 19 and still mourning the loss of his mother.
In the past 10 years he has found love in the arms of a woman senator, and also
found a mentor and father figure in Obi-Wan Kenobi. As much as he loved and
respected his mentor, Anakin became rebellious (typical of later adolescence), feel-
ing that Obi-Wan did not appreciate his abilities as a Jedi knight. Meanwhile, Lord
Sith capitalized on Anakin’s rebellion by convincing him of how powerful he could
be if he followed Lord Sith. Anakin’s rebellion evolved more deeply into anger after
the death of his mother, where we see, for the first time, his rage take control of
him. He eventually suffered a traumatic physical injury in a battle against his men-
tor, Obi-Wan, that resulted in the loss of his arms and legs.

Just before the battle, the love of his life became his wife, and became pregnant
shortly thereafter; Anakin was thrilled with the idea of being a father. His wife tried
to connect with Anakin, but found him pulling farther and farther away because of
fears of intimacy as well as influence from Lord Sith, who felt threatened by
Anakin’s attachment to another. His wife felt extremely stressed by his erratic behav-
ior. While Anakin was having surgery for his prosthetic arms and legs, he learned
that the love of his life had died giving birth. This was too much pain and suffering
for him.

Anakin eventually suffered a number of other experiences that moved him far-
ther toward the “Dark Side.” He became embittered, filled with rage, vengeful, and
in the course of time sustained additional injuries that required mechanical parts. At
some point he became more cyborg than man. Anakin eventually “died,” and Darth
Vader was born, complete with the trademark black mask, cape, labored breathing, and voice of James Earl Jones.

Darth Vader was influenced by his own greed and a hunger for greater power and control. Together with Lord Sith, he attempted to take over the universe for his personal gain.

With that brief synopsis of his history, let’s conceptualize his case within the languages of three very different theories.

**Freud’s Psychoanalytic Theory**

**Conceptualization of Darth Vader**

According to Freud’s (1936) theory, Anakin experienced a strong *oedipal complex* consisting of unconscious incestuous desires toward his mother, especially without a father to guide him. These unresolved feelings caused him to be *fixed* in the *phallic* stage of his development. His father figure, Obi-Wan, was considered the enemy, starting with unconscious *wishes* for Obi-Wan’s death that eventually became conscious and acted upon. His mother contributed to his *narcissism* by indulging him as much as possible during his childhood, enhancing his feelings of grandiosity. Thus, his *ego* was unable to inhibit his strong *id impulses*, enhancing his narcissistic personality.

Anakin/Darth exhibits many of the classic psychoanalytic *defense mechanisms* from the traumas in his life. First, he evidenced *denial* that he could have done something to prevent his mother’s death. He *displaced* much of this anger onto the Jedi Council, and especially toward his mentor, Obi-Wan. Furthermore, he *projected* his own undesirable arrogance onto Obi-Wan, completely denying his own inflated arrogance. Anakin *rationalized* his conversion from being good to giving over to the Dark Side because the Dark Side provided him more perceived power, when actually he was trying to *compensate* for his weaknesses. Once transitioning to the Dark Side as Darth Vader, he *introjected* the value of power over good and *identified* with Emperor Palpatine, the creature symbolizing the Dark Side.

If Freud had seen Anakin, he would have had him lie on a couch and *free associate* to make his unconscious *wishes* conscious. Freud would have interpreted his free associations, evaluating his *psychosexual stages of development*. He would have helped Anakin identify his *id impulses* (especially aggression and sexual repression) and helped him develop a stronger *ego*. Eventually, Anakin would have *projected* his issues with his father onto Freud (instead of Lord Sith) so that the therapist could use this *transference relationship* to work on Anakin’s *Oedipal complex*.

**Rogers’s Person-Centered Theory**

**Conceptualization of Darth Vader**

Rogers (1951) would have conceptualized Anakin’s case very differently: Anakin was held in *high regard* because of his ability as a pilot, creating a *condition of worth*. Anakin believed that being a good pilot made him a worthy person. In addition, when he worked under his mentor, Obi-Wan, his conditions of worth increased because he had to behave according to the Jedi standards. This may have
been further complicated by the fact that Obi-Wan was someone he respected early in their relationship so much that he perceived Obi-Wan as a father figure. His need to please his mentor/father figure was incongruent with his own wants and needs, enhancing the gap between his ideal self and his self-concept. Thus, his organismic valuing process was externally driven, causing him to have a regard complex. As a result, Anakin was unable to symbolize positive experiences accurately, causing a breakdown and dis-organization in his self-structure, and eventually leading him to feel confused and anxious. This anxiety and confusion consequently made the Dark Side more tempting with its lure of enhancing his perceived self-worth.

If Anakin had been able to express his feelings in a trusting relationship where he experienced unconditional positive regard, warmth, genuineness, and empathy, he might have been able to cope with the loss of his mother and his body image in a more fully functioning way, releasing his natural self-actualizing tendency to support good, rather than dark forces.

As a result, if Rogers had seen Anakin, he would have provided him the optimal conditions of therapy, providing empathy, caring, respect, and unconditional positive regard in a genuine way. He would have developed trust with Anakin (admittedly a very challenging goal) and exhibited warmth to enhance the relationship. By providing these conditions, the conditions of worth would lead to greater congruence between his ideal self and his self-concept. This, in turn, would release a greater actualizing tendency allowing Anakin to become a more fully functioning person and to be drawn to good instead of to the Dark Side.

Beck’s Cognitive Therapy Conceptualization of Darth Vader

Beck (1976) might have conceptualized Anakin as having several cognitive distortions. First, Anakin made an arbitrary inference that he could have prevented his mother’s death. In addition, he made another arbitrary inference that Obi-Wan’s intentions were not in his, Anakin’s, best interest. Anakin overgeneralized his negative experience of his mother’s death and the loss of his arms and legs, believing that the world was a bad place where he must become powerful in order prevent feeling hurt. He magnified Emperor Palpatine’s position and minimized the power of the Jedi Council, especially his mentor, Obi-Wan. Furthermore, he personalized Obi-Wan’s criticisms as trying to decrease his personal value rather than seeing Obi-Wan’s influence as educational and helpful. He evidenced dichotomous thinking by seeing people in one of two ways: powerless or powerful. Thus, wanting to be powerful, he aligned with the Dark Side. After the death of his mother and the loss of his arms and legs, he probably was clinically depressed. His probable automatic thoughts with regard to his cognitive triad were that he was worthless without power; that the world was out to get him; and that the future would be bleak unless he aligned with the Dark Side. These beliefs in his triad and his cognitive distortions were probably related to a dysfunctional underlying schema that he must be all-powerful to be worthy of love.

Beck might have started his work with Anakin by developing a trusting relationship through empathic listening. While Anakin shared his story, Beck probably would have listened for cognitive distortions, and would have identified them as Anakin was speaking. He would have amplified Anakin’s distorted thinking by repeating what he was hearing, and giving Anakin new, more functional language. For example, if
Anakin said that he “had to become all-powerful,” Beck might have said, “you want to become all-powerful.” This clarity of language would empower Anakin to take responsibility for his choices and decisions in life. Concurrently, Beck would have attempted to identify the underlying schemas that contributed to Anakin’s distorted cognitions. He would have worked with Anakin to help him to be more objective about how he viewed himself, the world, and the future.

You may notice a difference in the use of language. You may also observe some commonalities. In all three scenarios, Anakin’s negative experiences (mom’s death and his own physical injuries) contributed to his angst. Furthermore, he was unable to or not given the right conditions to cope with these losses in a healthier way, leading him to make the poor decision to join the Dark Side. We believe that if he had undergone counseling, Anakin might never have needed to become Darth Vader. But if that had happened, there would have been no Star Wars movies, and what fun is there in that?

You may also notice how each of these theories provides a direction for the therapist’s work with Anakin. Each practitioner would focus on different aspects of the presenting issue, whether this was the transference and id impulses, the conditions of worth and self-concept, or cognitive distortions and schemas. If you were to watch contemporary therapists use these theoretical orientations as they have developed, you would notice a lot of empathic responses, questioning, and clarity of language. They would be thinking in the language of their theory, but, ultimately, they would probably look fairly similar and arrive at similar outcomes.

You can see that although these three theories are quite different in language and what they emphasize, they also use common sense to determine what went wrong with this client, Anakin Skywalker, aka Darth Vader. We hope this encourages you to find a theory or two that emphasize what you think are important contributors to behavior, and we hope that you will become familiar with them so they can help guide you in conceptualization and treatment planning as you work with clients.

The Limitations of Some Theories

In Chapter 2, we discussed some of the major cultural constructs that must be taken into consideration when working with clients. One of the challenges when choosing a theory is that not all theories are culturally sensitive. Many of the older theories (the ones we used with Anakin) were developed by Western-European/American men who were raised in privileged backgrounds. If you study their personal histories, you’ll realize that much of their theories come from their own experiences, which also include the values of the times. For instance, Freud lived during the Victorian era, which valued the inhibition of sexuality—and all behavior, for that matter. In contrast, some of Rogers’s work was developed from the early 1960s to the 1970s, when society’s inhibitions and limitations were being challenged. In addition, some of Rogers’s theory was in reaction to Freud’s work. Add their personal backgrounds to the formula, and you have theories constructed within sets of cultural assumptions. It would be nearly impossible to develop a theory that would work for everyone.

This is why so many of the classical theories may fit privileged individuals—or at least middle-class individuals who are from the dominant American/Western European culture—very well, especially men. This is the foundation of the fourth
wave of psychotherapy mentioned earlier that takes into consideration contextual differences in clients. If you choose one of the more classic theories, you would want to be careful not to pathologize a client’s behavior or way of being based on the theory. Instead, modify certain concepts to fit the client.

**Exercise in Beginning Your Theory of Choice**

Get into small groups and answer the following questions:

1. Do you believe that you need to focus on the past in order to help most clients, or do you believe that the past is irrelevant and only the present matters?

2. Do you believe that people/clients are driven by their past, are pulled toward a future goal, or have only the present moment in which to make decisions?

3. Do you believe in a structure of personality, or that we are whole and no aspect of ourselves can be separated out?

4. What type of relationship should you have with your client? Are you equal? Do you have more expertise than your client and act in the role of a coach or advisor? Or does the client have the greatest amount of expertise about himself or herself?

5. How active should you be in therapy? Does the client do most of the talking or do you do most of the talking to provide the client with feedback and information?

**Theoretical Frameworks and Models of Practice**

Not only are different theoretical orientations adopted by practitioners, but there are several different views on how to apply them even within these schools of thought (Mobly & Gazda, 2006). If we temporarily put aside the notion that there are more than a dozen major theories currently in use (it has been estimated that there are actually several hundred of them), we can concentrate instead on what clinicians do rather than on their underlying conceptual paradigms. Other courses examine the philosophies and theoretical assumptions that guide therapeutic practice, whereas our job is to focus on skills and interventions.

During the past few decades, a number of authors have developed generic models of practice that formed the basis for the instructional methods. Each of these approaches attempted to integrate what is known about “good practices” and then constructed a systematic method for applying the skills (Greenberg, 2004). The goal of these endeavors is essentially to provide beginners with most of what they might need to conduct a helpful interview when a client walks in the door.
In one of the first systematic attempts to teach counseling skills in a sequential, problem-solving way, Robert Carkhuff (1969) combined the skills that emerged from Carl Rogers's person-centered approach with a series of studies undertaken to identify the behaviors most often associated with positive therapeutic outcomes (Carkhuff & Berenson, 1967). The model that emerged from these efforts is one in which helpers were taught a very structured problem-solving approach that moved from one stage to the next, with each stage composed of a series of steps and related skills (Carkhuff & Anthony, 1979).

Thomas Gordon took much of the same material and in 1970 developed a system for teaching parents and later, in 1974, a system for teaching teachers the major skills of helping. Parent effectiveness training and teacher effectiveness training thus introduced a whole generation of nonprofessional “therapists” to the value of active listening and reflecting skills. Students were taught the basics of several specific interventions:

- **Active listening.** This set of skills involves learning how to listen effectively, “decode” underlying affective messages, and then reflect back to the client what was heard. The goal is to promote deeper exploration of issues and lead clients to solve their own problems.

- **“I” messages.** If active listening works well when the client “owns” the problem, then using the pronoun “I” is appropriate when it is the teacher, therapist, or parent who has a problem with what others are doing. If a student is carving his initials in a desk, for example, the teacher might first try saying something like this in a rather stern, scolding voice: “Young man, do you have a problem?”

### Exercise in Active Listening

For each of the following statements made by a client, try to decode the message by finishing the sentence, “You feel . . .”

1. “My mother is always telling me what to do! Does she think I’m stupid or something?!?!?!?”
2. “My son is using drugs, and he won’t listen to me.” (with tears in her eyes)
3. “I really do like this guy, but I’m not sure I can handle that he dates other people.”
4. “I didn’t get much sleep last night; I kept thinking about the exam I have to take today.”

The student, of course, doesn’t have a problem at all. He **likes** defacing the desk with his initials. About the only problem that he has is that the teacher is in his face. In fact, it is the teacher who has a problem. And until the teacher is willing to recognize that, any intervention is not likely to be very useful. The teacher can punish
the child, send him to the office, make him clean up his mess, but there are consider-
able side effects of this way of “solving” the problem. Instead, the teacher might
have used an “I” message sounding something like this: “Excuse me. I have a prob-
lem with what you are doing to that desk. I appreciate that you are expressing your
artistic talents, but I am the one responsible for this property. So we have a problem
that we need to work out.”

This may not sound much different to you from the first statement, but its
approach clarifies who owns the problem. If it is the student’s problem, then active
listening is indicated; on the other hand, if it is the teacher’s or parent’s problem,
then active listening is not going to be particularly helpful.

Note the use of both skills in the conversation that follows between a father
and his 9-year-old daughter:

 Daughter: No I won’t get dressed! I hate this dress. And I hate these shoes. And
 besides, you said I could stay home and I didn’t have to go.

 Father: I can see you’re really upset right now. You’re mad at me for making you
do something that you’d rather not do. [Active listening]

 Daughter: Well, you told me before that if I didn’t want to go, I didn’t have to. And
 I sure don’t want to go. So that’s the end of it.

 Father: So, if I understand what you’re saying, this argument isn’t really about
which dress to wear, but our disagreement about whether you have to
go to dinner or not. [Active listening]

 Daughter: That’s right! I don’t want to go. And that’s it.

 Father: Okay. I’m in a bit of a bind and I need your help. I did tell you that you
didn’t have to go if you didn’t want to. You’re right. But if you don’t go
to dinner, then I can’t go either. And then your mother and brother will
be pretty disappointed. So, I wonder if there is something we can do to
help me with my problem? [“I” message]

You can see in this brief interaction that the father starts out by resisting the
urge to scold, to use power and discipline to enforce his will over his daughter.
Instead, he decides to listen carefully and compassionately to her, trying to sort out
what is really going on. He reflects back to her what he hears her saying. Once he
thinks he has a handle on what might be going on (since this is only a tentative
hypothesis, it must be checked out), he then “owns” his share of the problem.
Notice he does not become defensive or accusatory. He does not argue with his
daughter. He does not yell at her. He simply maintains an active listening stance until
the point that he realizes that he is the one with the problem, and until he articulates
this reality, he isn’t going to get much cooperation from his daughter.

The models introduced by Carkhuff and Gordon revolutionized the ways that
counseling skills could be taught. A very complex process was reduced to a few basic
skills and a half dozen progressive stages. This made it possible to teach a method
previously restricted to psychiatrists and psychologists to a host of other helping
professionals: nurses, crisis intervention workers, supervisors, teachers, parents, and
more. It also made it possible to take a similar systematic approach to teaching skills
for therapists and counselors.
Among the predominant models for training counseling skills that are currently in use, perhaps the most popular was developed by Gerard Egan (2007). His text on helping skills, now in its eighth edition, presents a very detailed problem-solving method that includes a series of successive steps. This “flow-chart” model follows a tradition first introduced by Gottman and Lieblum (1974) in a manual primarily for behavior therapists that described a series of clinical decisions to be made, such as decide whom to see, negotiate a therapeutic contract, or find the source of client resistance.

Although not to everyone’s taste, there is a certain comfort to a structure like Egan’s that prescribes for Stage I, Step I-B—help clients to become aware of their blind spots—or for Stage II, Step II-A—help clients to explore possibilities for the future.

Some models are slanted toward a particular theoretical orientation. For instance, Cormier and Nurius (2003) introduce a system for conducting interviews heavily steeped in the principles of cognitive therapy, Watts and Carlson (1999) favor an Adlerian approach, and Ivey and Ivey (2006) use a constructivist orientation. Watts and Pietrzak (2000) combined the Adlerian construct of encouragement to integrate with solution-focused therapy. Still other models for learning helping skills have tried to be more integrative and synthesizing (see Mikulas, 2002; Okun, 2007; Stricker & Gold, 2006; Young, 2004).

The present text is both similar to its predecessors and also quite different. We have followed the trails blazed by the aforementioned models but also included a number of unique features that we hope will make the learning experience more fun, interesting, and engaging.

**Exercise in Who Owns the Problem**

In each of the following statements made by a student to a teacher, who "owns" the problem?

1. “I’m just so angry at my mother. I can’t believe she won’t listen to me.”
2. “Teacher, you gave me the wrong grade on my exam. I know I did better than this.”
3. “You want me to clean up this mess? No way! I didn’t do it.”
4. “But I was standing in line. Are you blind?”

**Stages in the Process**

Stage theory has dominated the fields of psychology and education ever since Sigmund Freud first proposed an integrated theory of psychosexual development (remember the oral, anal, genital, and phallic stages?). Others jumped on the bandwagon and introduced their own stage theories to account for some facet of human behavior. Jean Piaget (1967) described stages of cognitive development. He was followed by a disciple, Laurence Kohlberg (1976), who used a similar template to...
account for the development of moral thinking. Erik Erikson's (1950) influential theory of psychosocial development was organized around a series of struggles between polar opposites (i.e., trust vs. mistrust, or integrity vs. despair). Following the “golden age” of stage theory, several more stage theories were developed to describe career development, gender development, sexual development, and cultural identity development. It will therefore come as no surprise to you that counseling and therapy have also been organized according to stages.

An Integrated Model

We have synthesized many of the different models that have been used over the past few decades into a generic outline that we believe most practitioners could live with. What you need most at this point in your development is a framework that helps you accomplish several critical tasks:

1. **Assess what is going on with your clients.** This includes but is not limited to their presenting complaints, other symptomology that is operating behind the scenes, family history and background, cultural identities and personal values, and anything else that helps you to understand their worlds.

2. **Formulate a diagnosis and treatment plan.** This becomes the outline for organizing the work you will do. Diagnoses can be developed according to a number of different models, which might concentrate on personality attributes, behavioral descriptions, developmental functioning, systemic patterns, or other factors. The treatment plan addresses systematically whatever you identified as clinically significant in the diagnosis.

3. **Establish a solid working alliance.** This is the therapeutic relationship that allows you to develop trust and reach treatment goals. The relationship may be structured differently depending on client needs and preferences, the nature of the presenting complaint, the length of the treatment, and the particular stage in which you might be operating. Therapeutic relationships evolve over time according to what is needed.

4. **Make good choices about which skills and interventions to use in which situations.** As we have said before, the major problem you will face is not a scarcity of choices but far too many to sort out in the time you have available. A client says or does something and you must respond—immediately. You need some way to simplify and organize your choice efforts.

5. **Figure out where you are in relationship to where you wish to be.** Regardless of which model you are following, you still will need some way to assess accurately the impact of your interventions. In any given moment you must have at least a rough idea of the stage you are operating in and what your goals are. It is also a very good idea to have a defensible rationale for anything you do or say, one that you can explain if called on by a client or supervisor.

Of course, the kind of model you use to organize your work depends on your own stage of development as a professional. These stages are represented in a series of questions related to a beginner's fear of failure (Kottler & Blau, 1989):
1. **Stage 1: What if I don’t have what it takes to be a therapist?** Hopefully, you are now past the point where you question constantly whether you have the stuff it takes to make it in this profession. You may have some doubts and insecurities about how good you will be as a practitioner, especially when you compare yourself to others who seem more poised, confident, and experienced, but deep in your heart you trust that with sufficient training, practice, and hard work, eventually you will reach a point where you can do somebody some good. On a good day, you will notice a few things you do very well; on a not-so-good day, you will question all over again whether you made the right career choice.

If you are still feeling stuck in this very first stage because you are having serious reservations about whether being a therapist is a good fit for you, then the helping model you choose should be one that is very basic and simple to operate. You already have enough to worry about without adding to your stress by making things unnecessarily complicated.

2. **Stage 2: What if I don’t know what to do with a client?** Once you are comfortable with your ability to function as a relatively skilled practitioner, you’ll reach the stage of being afraid of making a mistake. The usual fantasy is that you will say or do the wrong thing, resulting in the client becoming so distraught by your ineptitude that he or she immediately jumps out the window, cursing your name all the way down. As a beginner, of course you won’t know what to do with a client. We [Jeffrey and Leah] have been doing this work for many decades and we often still don’t know what to do a lot of the time. Doing therapy means living continuously with ambiguity, complexity, and uncertainty. Just when you think you might be helping someone, you discover later that the effects didn’t last, or that the person was just deceiving you and himself. Other times you will be sure that you have screwed up big-time only to discover later that what you thought were misguided efforts turned out to be a brilliant strategy. Then there will be other times when the client thanks you profusely for your masterful interventions—only you will have no recall whatsoever of what you supposedly did. The question is not whether you will feel uncertain at times, but rather how you will handle these doubts.

3. **Stage 3: What if my treatment harms a client?** If in the previous stage you are wracked with doubts about not knowing what to do in a given situation, in this stage you are concerned more with the consequences—most of them negative—of making a huge mistake. At this point you recognize the awesome power of what you have learned; your concern is how to harness this power.

If you get inside the head of a therapist at this stage, you might hear something like the following:

**Therapist:** Where would you like to begin? [What a stupid way to say that. I should have just asked what he wants to talk about today.]

**Client:** Um. I don’t know.

**Therapist:** You don’t know? [What am I, a parrot? All I can think of to say is to repeat what he says?]

**Client:** Remember last time what I was talking about things my supervisor said?

**Therapist:** Sure. You were talking about how angry you were feeling because she wasn’t being fair to you. [Oh no. I’m putting words in his mouth. I don’t think he was saying that at all; rather, that was where I wanted to lead him.]
Client: I was?

Therapist: Um, so what would you like to talk about then? [I’m such an idiot! Now what did I do?]

This therapist is obviously being unnecessarily hard on herself but it gives you a sample of how concerned any of us can be with making mistakes. If there is an overriding fear of failure, the clinician is going to proceed in a way to minimize risks and errors.

4. **Stage 4: What if I'm not really doing anything?** More experienced therapists, who have been practicing for some time, eventually reach this stage. Once you have mastered the basics and become comfortable with the major skills, you have time to wonder about the relative value of your work. Are your clients really changing, or maybe just pretending to change?

One of the most challenging, and at times frustrating, aspects of our work is that we can never be certain about the impact of our helping efforts. Clients lie about what they report in sessions. Sometimes they tell you that things are going great when nothing really has changed in their lives. Other times they will complain that the therapy isn’t working even though they really are making significant changes. Even when clients do appear to have profited from the therapy, the effects often don’t last long—clients relapse without ongoing support.

Therapists who have been in the field for many years, especially those who work with the most intractable problems (personality disorders, substance abuse, impulse disorders, psychotic disorders), often wonder if they are really having much of an impact on their clients. Without good supervision, collegial support, and an ongoing commitment to personal growth, burnout can easily ensue.

5. **Stage 5: What if my life’s work doesn’t really matter?** Here you are trying to transform lives, but perhaps none of this really matters.

Given the stage of development in which most readers might be currently operating (somewhere in the first three stages), we have organized the process of helping (and this text) according to four basic stages. We believe that this outline for understanding the therapeutic process is neither needlessly complicated nor simplistic. It represents our best efforts to preserve the wonderful complexity of what we do, yet does not (yet) burden you with things you probably don’t need at this stage.

**The Beginning Stage**

Think through this logically and analytically. A new client walks in the door. What are the first things you need to do and the first tasks you must accomplish in order to get any productive work done?

This is not rocket science. It isn’t a lengthy, hidden formula that needs the combined efforts of brilliant minds to figure out; it is all quite obvious: Unless you can get clients to respect you and like what you are doing, they won’t come back, and that makes it very difficult to help them. So your first task is to inspire some sort of trust and confidence. You must establish rapport and a working relationship that is designed to elicit the information you need and that also helps the client feel comfortable and safe enough to talk about some very threatening and personal issues.
You have four main tasks to accomplish in this first stage:

1. Establish a working alliance.
2. Complete an assessment and formulate a diagnosis.
3. Conduct a treatment plan.
4. Negotiate a contract and mutual goals.

The major skills that you will be learning and using that are linked to this stage include questioning and reflective listening. These are behaviors that are specifically designed to elicit information efficiently, as well as to develop relationships with clients that build trust, intimacy, and respect.

This is what the beginning stage looks and sounds like in the middle of the first session with a new client, about 20 minutes into the interview.

Therapist: When did you first begin to notice that you were having difficulty sleeping? [Open-ended question to elicit more information on the symptoms of anxiety]

Client: I can't really recall. It seems like it's always been like this.

Therapist: So your sleep has been disrupted for some time. [Restatement]

Client: I guess so. I don't really know. All of this is just so overwhelming that I can't remember things anymore. I don't even know what I'm doing here.

Therapist: You're having some doubts about your decision to come for help and you're feeling like things may be hopeless for you. [Reflection of client's most terrifying feelings]

Client: (nods head) So, what do you think I should do? Can you help me or not?

Therapist: I think that your decision to seek help at this time is a sign of your resilience and strength. [Reassurance and support] You have been feeling so alone and already you will notice that some of that has diminished. [Instilling confidence and planting favorable expectations] Yes, I can help you. I've worked with issues like this many times before. Before we proceed further, I'd like to ask you: What would you like to have happen as a result of our work together? [Question about expectations and treatment goals]

The therapist is trying to accomplish several things simultaneously. At the same time, he or she is learning as much as possible about the client's symptoms and when they occur, while also offering support and reassurance. There is a lot more the therapist will want to explore: what the anxiety feels like, when it first occurred, what has worked and not worked in dealing with it, whether these symptoms have occurred before, whether there is a history of this disorder in the family, what the consequences are of having these symptoms, and so on. Yet gathering all this important information to satisfy the therapist's curiosity and needs is worthless unless the client feels heard and understood. It is absolutely crucial that the initial exploration of the problem is balanced with sufficient efforts to build a good working relationship.
Building a good working relationship involves reflecting—reflecting not only the content and the feelings expressed by the client, but the meaning and emotions beneath what is presented. We are not the only people who believe that a good working alliance is a necessary condition of therapy. All of the primary theorists believe it is the foundation of therapy (Planalp, 2003). As stated before, if clients do not like you or have confidence in what you do, why would they be motivated to return for more sessions? It is difficult enough for most clients to make it to the first session. If they can find an excuse not to return, they may not. This means you have to create a strong working alliance and maintain this relationship throughout the therapeutic process.

Exercise in Building the Relationship

Get into pairs and have one person talk for 5 minutes about an emotionally charged issue, either positive or negative (client role). The other person (therapist role) is to reflect a feeling and some content, in a single sentence, of what is most essential about what the “client” said. Have the client respond with agreement or a correction, and repeat until the reflection is accurate. When complete, switch roles.

Exploring and Understanding

What you began in the first stage is continued as things develop. The relationship is deepened. More and more data are collected about the client’s presenting complaints and annoying symptoms, preexisting conditions, relevant family and cultural background, and other important areas of personal functioning. Essentially, you are exploring what is going on now and what has been going on in the past. This is not an activity that is taken solely for the therapist’s comfort and curiosity; rather, the very process of getting significant background information is also related to helping promote greater awareness and understanding in the client.

Just as you might expect, there are as many ways of promoting this understanding as there are approaches to therapy. Some systems—like behavior therapy or brief treatments—minimize this stage, believing that insight is at best needlessly time-consuming and irrelevant, and at worst is downright dangerous. We would certainly agree that the realities of contemporary practice sometimes require us to shorten treatment to a few sessions. However, we also find that when it is feasible to include some component of insight, even such efforts often help clients to generalize what they learned to other areas of their lives.

Insight can be promoted in a number of different ways, depending on your own therapeutic style and theoretical allegiances. Cognitive therapists concentrate on helping clients understand that problems are the result of distorted and irrational thinking patterns. Insight work is focused on helping clients identify the dysfunctional beliefs that are getting in the way and teaching them to substitute alternative perceptions that are more reality based (Beck, 1976; Laposa & Rector, 2006; Tarrier, 2006).
Once a strong working alliance is established and maintained, many therapists help clients explore the current problem by looking for patterns of behavior that were established in childhood. Once an awareness of where the patterns originated is reached, the client can choose to see self, others, or the world in a more realistic way and act accordingly. Insight is not reached until awareness, cognitive change, and behavioral change occur (Adler, 1963).

A classical psychoanalytic therapist might encourage the client to free associate in hopes of bringing about a catharsis. This process allows the client to bring unconscious material into consciousness, enhancing his or her insight into what has driven the client unconsciously in the past (Freud, 1936).

In Gestalt therapy, one of the assumptions about what brings people to therapy is that they have not fully experienced something. They feel resistant and fearful of going deeper into a certain experience, such as pain or despair. They are stuck, at an impasse. A Gestalt therapist, then, would help the client move into those feelings (or thoughts) in a way that allows a deep immersion into those experiences and the freedom to express what the client has previously feared to release. Once the client has moved through the impasse and experienced and expressed what was lying underneath, an insight usually occurs that helps the client understand what has kept him or her stuck (Perls, 1969).

The type of insight that is promoted depends not only on therapist preferences but also on client needs and time parameters. One of the first questions we like to ask in the early stages of treatment is: How much time do we have together to work this out? Obviously, you would structure therapy differently with a client who was coming for only one meeting versus another who was committed to attending sessions for several years. So if the first question you ask is, “How can I help you?”—one of the next things you will wonder about, if not ask aloud, is, “How much time do we have?”

Compare the different ways you would manage the Insight Stage according to these client responses:

- “Look, I’m kind of in a hurry. I’d prefer that we finish this thing today, but if you really think it’s necessary, maybe I could come back another time.”
- “I understand that therapy takes a long time, maybe years. I’m not looking for a quick fix. I really want to get to the bottom of things and I’m prepared to do whatever it takes to make this happen.”
- “My kids are both sick. I’m out of money. I’ve got nowhere else to turn. I just think that I might as well give up. I think everyone would just be better off if I wasn’t around anymore.”
- “I’ve been sent here by my probation officer. I’m here to serve my six sessions and then get on with things.”
- “I keep getting myself into these awful relationships. I dump one loser and then end up living with another one who is worse than the one before. It’s almost like I can’t help myself.”
- “I’m really not satisfied with my life. I’m in my mid-thirties and I can’t keep a steady job. I don’t have a career, a family, or anything to show for myself. I feel like a loser.”
- “Look, my parents think I need to be here just because my grades aren’t perfect in school. I don’t have a problem; they do. I’m just busy with hockey. That’s all.”
Exercise in Insight

With partners or on your own, develop a plan for the kinds of insight that you might promote for each of the clients presented in the above scenarios. Role-play each scenario.

We don't wish to give the impression that we are “selling” you insight as a necessary and sufficient condition for change to take place. The phrase necessary and sufficient was exactly the wording Rogers (1961) used in his research, where he believed that it was quite enough to help clients access, understand, and express their feelings (i.e., insight). However, like Rogers, many of the great theorists believe that insight is an important condition of therapy. For example, Freud (1936) proposed that “good” therapy helps people to understand their pasts as a way to free them from dysfunctional behavior in the present. Rogers believed that most of the action took place in the realm of feelings, while Freud was far more concerned with understanding unconscious and repressed desires. Cognitive therapists also subscribe to the philosophy that insight is critical for change, but, as we mentioned, they are concentrating on underlying belief structures (Beck, 1976). Existential therapists also place high value on insight, but they are interested in uncovering the meanings of life (May, 1953; Yalom, 1980). Gestalt therapists are interested in enhancing awareness so that clients can fully experience an incomplete gestalt, creating an insight not only at a cognitive level, but at a full mind, body, and spirit level (Perls, 1969). Within individual psychology, insight is the final stage of therapy where a change occurs not only in awareness, but also in the way a person thinks and behaves externally (Adler, 1963).

It is our position, and the one we take throughout this book, that insight is important and valuable but it is often not sufficient to promote lasting changes. You probably know several people who have been in therapy for a long time, may understand perfectly why they are so screwed up, but still persist in their self-defeating behavior. It is therefore entirely possible to understand what is going on but still be unable to do much to change the situation. A particularly good example of this has to do with addiction. A substance abuser knows that doing drugs or drinking all the time is not a good thing to do, but he or she is still unable to stop. An even more common example has to do with smoking. Every smoker today understands all too well the health risks of continuing to engage in this behavior. Most people would love to break this habit, but they still can’t stop.

When there is time to foster some kind of insight, this stage offers a number of advantages:

1. It satisfies the human urge to make sense of life.
2. It helps people to generalize what they learn to other areas of their life.
3. It teaches skills for working systematically to deal with problems in the future.
4. It can sometimes foster change.
Given the variety of ways that different therapeutic systems use insight and understanding, you can appreciate that there is a wide variety in the skills that are used most often. If the skills in the previous stage are centered around exploration, then the ones at this juncture are designed to increase awareness and help move clients to a different level of understanding of themselves and the world. This means that people often must be provoked and challenged before they will give up comfortable but ineffective coping strategies in favor of others that are more fully functioning. The major skills employed include confrontation, challenging, reflecting discrepancies, and information giving.

In the following vignette, some of the major features of the insight stage are evident.

Client: I guess the anxiety that I’ve been feeling is nothing new for me. When I was much younger—I think when I was in elementary school—I had problems going to school. And my parents tell me I was always afraid of strangers.

Therapist: So what you are experiencing right now is part of an ongoing pattern in your life that began when you were quite young. The risks that you avoid at work, and in your most important relationships, represent your best efforts to protect yourself from being hurt.

Client: Yeah. I’d say that is probably true.

Therapist: You think of yourself as rather fragile, as if you can’t take much stress or you’d fall apart.

Client: (nods head)

Therapist: But if that was really the case then how could you possibly have learned to live with your anxiety for so long?

Client: What do you mean?

Therapist: I think you are a lot tougher than you give yourself credit for. You are amazingly resourceful in the ways you have learned to live with your fears. Somehow you’ve managed to keep your job and your friendships. You strike me as pretty competent in a lot of areas—in spite of your handicap.

Client: You really think so?

Therapist: Well, what do you think? Let’s look at the evidence.

This gentle confrontation is intended to help the client examine alternative ways of looking at his or her situation. The therapist is introducing another way of viewing the situation: Instead of weakness, things have been reframed as a kind of strength. The client has not yet agreed to this interpretation, but this conversation is typical of the negotiations that take place in therapy. In part, our job is to teach clients alternative ways of looking at their lives. We do this through an assortment of different skills that are all designed to challenge thinking, clarify feelings, and provoke people to consider alternative viewpoints that are more helpful. And all of this must be accomplished while still being mindful of the relationship with the client.
Exercise in Exploring the Limitations of Insight

In pairs, talk about something in your life that isn’t working. Maybe you need to quit smoking or maybe you drink too much. You may eat unhealthy food, or may need to exercise. Perhaps you need to end that unhealthy relationship. You could want to be nicer to someone important in your life.

Think of at least one or two of your life habits. Discuss what you believe you should do, and what you believe keeps you from doing it. This may help you to appreciate the limitations of understanding in making a change.

Action Stage

This component of the process is more about how clients may act than about how they think or feel. The bottom line for clients is the question: “Based on what you now understand, what are you going to do?”

Like the previous stages, this part of the process is interpreted according to the practitioner’s favored theoretical orientation. One therapist might explicitly ask each client about structured homework assignments after sessions, each of which is designed to build specific behaviors and work toward established goals. Another therapist might interpret action to include things that the client will think about between sessions.

Although some of your clients will be less interested in making specific changes in their lives than in just spending some time understanding themselves better, the vast majority of your caseload will have rather annoying symptoms they wish to eliminate. Your job is to help them to do so by making continual small steps toward their preferred goals.

An adolescent boy has been talking for several weeks about his interest in making more friends. The counselor helped him to look at the origins of this problem, how being a loner became an established pattern when his younger brother was hospitalized and his older sister went away to college. He was also helped to look at his fears of rejection and the consequences of this protective strategy. In this fourth meeting with his school counselor, he is pressed to translate what he now understands into some form of action.

Client: So, what I was telling you is . . .
Therapist: Excuse me but I see we’re almost out of time today.
Client: Oh. Sorry.
Therapist: No problem. I just wanted to bring that to your attention so we could save some time to think of some ways that you could apply what we have been talking about to your life.
Client: I’m not sure what you mean.
Therapist: Just that we could talk about this stuff on and on, but unless you make some changes in the way you do things, nothing much is going to be different. You're still not going to have many friends.

Client: So, what do you want me to do?

Therapist: The question isn’t what I want you to do, but rather what you would be prepared to do.

Client: Go on.

Therapist: That’s just it. Talk is great but my question for you is what you intend to do about the things we’ve been discussing.

Client: You mean I should just go up to people and ask them to be my friends.

Therapist: You could try that, of course, but it isn’t likely to work very well. I had in mind that you start out with something that might be a small step in that direction. What could you do between now and next week when we next talk? Ideally, this would be something small but important, something that would make you feel like you are making definite progress in the right direction.

The major skills used in the action stage are those designed to increase client motivation and momentum, as well as provide structure for reaching goals. Although some theories—such as psychoanalytic, person-centered, and existential—pay less attention to an action stage, many of the theories specifically address this process. In individual psychology, the final stage of therapy is insight (as stated earlier), but insight is not only an understanding of the problem, it’s practicing new ways to be in the world or with others. With Gestalt therapy, the client frequently experiences the action stage in a therapy session aimed at enhancing awareness, such as the empty chair technique, where a client might imagine speaking to her father. In cognitive therapy, action is seen in the homework that might be assigned to clients to increase their awareness of how they think and react in certain situations, and then finally how to change the thoughts or cognitive distortion in the moment. Behavioral therapists might challenge the client to make changes in session and, subsequently, out in the world once a certain level of confidence is built. Both cognitive and behavioral changes are expected to occur within reality therapy and rational emotive behavior therapy.

One primary challenge at this stage is that the client has to be ready, the relationship has to be solid, and the way in which you invite change must be done so that the client doesn’t feel invalidated. In the above example, if the therapist had been this confrontive before the relationship was fully established, or before the client was ready, the client may have felt that the therapist didn’t really understand. He may have felt hurt and scolded, as if his parents were telling him to do something. So, as they say, timing is everything. If, by chance, you take a risk like this and it goes sour, then you use this opportunity to help your client work through conflict. The session might look like this:

Client: I don’t think you fully appreciate how terrified I feel. You don’t get me at all!

Therapist: You’re angry with me.
Client: Yes, I’m angry with you. How could you push me like this? Aren’t you listening? I’m scared.

Therapist: You’re angry because you feel like I don’t understand your fear of people. You’re not ready to take this type of action, yet.

Client: Exactly. Thank you.

Therapist: Since our time is running short, maybe we could talk about how angry and hurt you feel because of my eagerness to help. I imagine that your feeling misunderstood by me is part of what you’re afraid of in developing new friendships.

In this way, the therapist can use the conflict and misunderstanding as a metaphor for what happens in the client’s life. This example is a different way of taking action, by using the relationship between the therapist and the client as a model for how to be outside the session.

The reality of being a therapist is that you will be accountable not only to yourself and your client for evidencing change, but also to the agency you work for and any insurance company or health maintenance organization (HMO) that might be helping to pay for your client’s sessions. Although insight can be wonderful, actual change in the client’s behavior or experience must occur in order for therapy to be deemed successful in the opinion of most agencies and insurance companies/HMOs. Sadly, we have also heard that many insurance companies are less interested in healing than in getting clients to a level of functioning that does not interfere with their work. The behavior change is to “be better,” not necessarily well. Therefore, regardless of your theoretical orientation, you will need to define goals and have some sort of evidence of reaching those goals in order to proceed with therapy. In the above example, the goal may simply be for the client to accept his fear of making friends without believing that eliminating that fear is necessary. We have to be careful not to impose our own goals on clients, even if we feel absolutely confident that we have the answers. Of course, there is an exception to this rule of setting goals. If you have the luxury of working with a client in a private practice and the client is self-paying, then you can do whatever is comfortable for you and your client. You will find, however, that as you gain more experience as a therapist, you will want to see evidence of change as confirmation that your interventions are helpful to your client. After all, that’s what you came to this field to do: transform lives.

Exercise in Action

Using the scenarios role-played earlier, see if you can generate specific goals for each and role-play a technique that might move the client toward that goal.

Integration

As things move toward closure, clients are helped to prepare for the end of treatment. Concerns and apprehensions are addressed. An assessment is made to determine the extent to which original goals were met. Clients are taught to apply
what they have learned to other areas of their lives. They are encouraged to have relapses so they can practice recovering from them. They are prepared in every way possible to be their own therapists in the future.

In the following conversation you can see the integration stage in action:

Client: That’s about it for now. So where do we go next?

Therapist: It sounds like we are moving to a point where you can imagine a time when these sessions will no longer be needed. You’ve been making some solid progress and we’re almost done with our work, or at least the goals that we originally established.

Client: Are you kicking me out? (laughs)

Therapist: No, not at all. We can keep talking as long as this is helpful to you. I just want you to be able to do more and more of the stuff we’ve been doing on your own. All along, you’ve been learning how to be your own therapist.

Client: I guess that’s so. But I’m just worried that once we stop I’ll revert back to the way things were.

Therapist: That’s not only possible but highly likely.

Client: Excuse me?

Therapist: Of course you will have slip-ups. I can see how anxious you look even thinking about that possibility, but consider that when you do have setbacks you can simply apply what you’ve already learned. In fact, I think that a good place for us to go next would be to arrange for you to mess up deliberately so we can see how you handle that kind of situation.

The therapist is implementing a strategy in which he or she is prescribing a relapse in order to improve the client’s confidence and ability to resist deterioration once the therapy ends. This client’s fears are entirely reasonable. During this final stage, the therapist’s job is to help the client handle whatever might come up in the future. Even after the treatment ends, follow-up sessions can be scheduled on a monthly basis to make sure that the momentum continues. Frequently, therapists see clients over the course of years. The client may come for six or eight sessions, terminate for a year, and then reappear when a new challenge occurs. Therapy does not have to be something static with a single beginning, middle, and end; rather, therapy can be something dynamic that’s taken when needed, like aspirin for a headache.

So when does therapy end? That’s a good question. If you are in training, it could end at the end of the semester. It could end when the HMO or insurance company stops paying, which is sometimes after six sessions. Therapy could end once a concrete goal is reached. However, the ending is usually more vague and nebulous. Termination is something that is agreed on between the client and therapist and should always include an invitation to return, if needed, in the future.

A Note About Stages

As we stated earlier in this section, stage theories have developed in myriad ways. Many were developed with the assumption that when one stage was completed, the
client would move into the next stage. While that is a possibility, it is more likely that stages are rough estimates of how things flow. You may start in the beginning stage with a strong relationship, but find that the relationship becomes compromised and must be repaired. This can happen at any time; you have to go back and reestablish the relationship. You may have an assessment of what’s going on with the client, but then after six sessions, the client finally feels safe enough to disclose the real issue, which is much different from the presenting problem. You may even get as far as the action stage, where the client experiments with new behaviors, and find that this experience brings up some repressed information that must be understood in order for the client to continue the new behavior. In addition, you are always working on the relationship, always assessing and diagnosing as the client changes, and always shifting and adjusting goals. The point is this: The stages aren’t clearly delineated, and many stages must be reexperienced, massaged, or readjusted completely. Keep this in mind as you work with clients. The process is not linear; it is more like a spiral—each time you touch back on a particular stage, you do so from a better understanding and with greater clarity. No two clients work in the exact same way. No two therapists work in the same way, either, even if they are using the same theoretical orientation. Individual differences often make therapy a messy and complex experience. Yet, we believe that the process of working with clients is a most rewarding experience once we let go of our preconceived notions.

Applications to Self: Choosing and Using a Theory

Many programs require that you choose a theory to use before you begin working with clients. Some state licensure boards require proficiency in at least one theory, and most licensure exams require some familiarity with all of the primary theories. The question is: How do you choose a theory?

Before discussing how to choose, let’s start with your resistance to this process. One common response from many students is that they like several theories and find many techniques useful from all theories. They feel frustrated that they must choose one and prefer, instead, to be eclectic. The problem is, in order to provide good therapy, you must have a rationale for applying certain interventions, an underlying structure that motivates the direction of mutually negotiated goals. Without that structure, you will have difficulty justifying what you do. Even if you choose to be eclectic, you are likely to have some beliefs about how to treat each client, a foundation from which to work (Feltham & Horton, 2006). Thus, you are still using a theory, a theory of eclecticism (Slife & Williams, 1995). It’s difficult to escape the fact that using an underlying structure or theory is necessary.

The good news is that research indicates that which theory you choose is far less important in determining therapeutic outcomes than your ability to use it effectively. Therefore, choosing a theory to learn well is what’s most essential, because there is no right or wrong theoretical approach; rather, the best theory is the one you feel most comfortable with (for now). Remember, you can always change if it doesn’t fit. You aren’t stuck with it for life.

In addition, we have found that good therapists all look basically the same, but differ in how they explain what they do. Most theories essentially focus on the same task—finding underlying causes of behavior that must, usually, be understood and then consciously changed. That’s why we presented our eclectic stage theory as a
way to provide a structure for what you do. The primary theorists give the motivations for why you do what you do.

Okay, let’s assume you have, reluctantly or not, agreed to choose a theory. Let’s talk about how you choose, before discussing the best way to use your theory. First, you must think about what brings people to therapy and how people change.

If you believe that clients come to therapy because of unconscious drives and can change once those drives are made conscious, then psychoanalysis might be the theory for you. On the other hand, if you believe people feel discouraged because their feelings of inferiority are overcome in socially useless ways that inhibit their ability to feel a sense of belonging, and that learning socially useful ways of striving for significance is the key, then individual psychology (Adler) might be your theory. Existential therapy might be more your cup of tea if you believe that people come to therapy because they lack meaning in their life, and change can occur once they realize they have the freedom to choose meaning and take responsibility for their lives. Or you may be attracted to person-centered therapy, which focuses on how the client’s ideal self and perceived self are incongruent due to conditions of worth; and once the appropriate conditions of warmth, empathy, genuineness, and unconditional positive regard are provided to the client, the client will be able to realize his or her actualizing tendency to become a more fully functioning person.

If you believe that individuals get stuck at an impasse because they feel fearful of fully experiencing something painful, and by fully experiencing that pain through some sort of expression they could increase their awareness and change how that pain is experienced, then Gestalt therapy might be more interesting to you. Another possible paradigm that might parallel your belief system is cognitive-behavioral therapy, where people come for help because they have cognitive distortions, and once the schemas that hold those distortions are confronted and changed, clients’ affect and behavior also change. Finally, if you believe that all of our problems are contained within a system and can be changed only by working within that system to reveal alliances, then family systems therapy might be more appropriate for you.

You may have noticed that in each of the descriptions just given, a special language was used to say that the client comes to counseling because of some problem (i.e., unconscious drive, discouragement, lack of meaning, conditions of worth, impasse, cognitive distortions, or systemic dysfunction), that an exploration must occur to gain insight into that problem (i.e., the techniques of each of these theories), and finally, that some kind of change will occur once a shift takes place (i.e., unconscious material made conscious; courage and belonging; responsibility; fully experiencing; changing schemas; or change in a system). And the beauty of it is that you can use any technique you want as long as you can rationalize how you are using this process within your theoretical framework. So the hard part is exploring your value system, and then studying each of the theories that you think might best align with your values. After learning the top two or three really well (we’re talking about reading more than what your theory textbook describes), you are more prepared to choose one and learn to use it. In addition, we recommend talking with practitioners or professors who align with the theories that interest you to gain a deeper understanding. This brings us back to how best to use your theory of choice.

Once you master (if that’s possible) the basic counseling skills, especially of building a solid relationship with the client, you will need to do other things with most clients to bring about change. Your theory helps you to understand why your client is experiencing this problem. Once you are able to conceptualize your client’s
problem and identify the consequent goal, you use your theory to help explain why
you say what you say to the client, why you apply certain interventions with the
client, or why you suggest a certain homework assignment. Your theory provides
you with a rationale and direction for therapy. Theory is one of your best tools for
understanding the therapeutic process, which you must usually share with your
supervisor(s), teacher(s), or HMO/insurance company in the form of case notes
and other paperwork. Therefore, although identifying your own values and studying
the theory that matches you best is a daunting task, you will be better prepared to
serve your clients effectively.
In this chapter, we have discussed how skills and theory work together within the therapeutic process. We talked about the fact that many theories have specific stages in their process, and that several writers have worked to create an eclectic model for working with clients. Finally, we examined our own model for conceptualizing the therapeutic process with four primary stages: beginning, conceptualization and understanding, action, and integration. These stages are broken down in the following chapters, which give more detail to help you work with clients more effectively.

**Skills in Action: The Phobia**

*Therapist:* Where would you like to start today? Shall we pick up with talking about your mom? [The beginning stage]

*Client:* As I told you before, I’m going on a trip, and I’m really excited about it, but I’m also really scared. I’m, well, I’m embarrassed to tell you, but I’m afraid to fly. It’s a new thing! I’ve flown many times, but only recently have I had this fear. I don’t know where it comes from. I meant to come here to talk about my mom’s illness, but I’m losing sleep over this. I don’t understand it.

*Therapist:* You sound surprised and ashamed to fly. You sound like your mind is obsessing over it. What do you imagine will happen? [Empathy; exploring and understanding]

*Client:* I’m flying with the other passengers, and all a sudden, the turbulence gets out of control. Then I hear the engines shut down, one by one. People are screaming. I know it’s going to be a long and painful death. We have several minutes as we nosedive to our deaths. I’m helpless, I can do nothing.

*Therapist:* You’re helpless. [Empathy]

*Client:* Yes! I can’t protect my wife. I can’t save my own life. I just have to wait for my death and feel the fear of pain and dying.

*Therapist:* You’re afraid to die. [Empathy]

*Client:* I suppose everyone is, but it’s that I’m sure that I’ll die in a plane crash. What’s wrong with me? Am I going crazy?

*Therapist:* Let’s see if we can figure this out, since you’re worried you might be going crazy. I’m aware that you are afraid of a plane crash even though I assume you know it’s safer than driving. [Instilling hope; empathy; exploring and understanding]

*Client:* I’m not going to die driving. I have control. There are lots of ways to die, but if a plane crashes, then I can’t do anything about that! If I’m sick, I get help. You know what I mean?
Therapist: Control. Now you have said that twice, in a way. You feel helpless to protect your wife; you have no control. Tell me about the last time you flew and were comfortable, and then the first time you flew that you were uncomfortable. [Exploration and understanding]

Client: Okay. When I was in college, I flew all the time. I went to school here and would fly home to Oregon to see my folks every few months. The last time I flew and wasn’t worried about it was six years ago. Then, the next time I flew, for a delayed honeymoon, about four years ago, I was terrified. We went to Fiji, and the vacation was wonderful, but the flight was like a horror movie in my mind. Since then, I have worked really, really hard to avoid flying. But this is an awesome opportunity to fly to New Zealand, and I don’t want to pass it up.

Therapist: I’m struck that there was a two-year window between flights. I wonder if there was anything that happened during that time where it was important for you to be in control. [Exploring]

Client: I got married. That happened. Control? Well, I guess I feel responsible for my wife, to protect her.

Therapist: Protect your wife. From what in particular? [Probing]

Client: From everything. She is my responsibility now. I need to care for her, make sure she’s safe, help her get her needs met.

Therapist: That sounds like quite a responsibility. Any ideas where you might have gotten that belief? [Probing]

Client: No, not really. It’s true, isn’t it?

Therapist: It sounds like you believe that. I wonder if you see her being equally responsible for you. [Probing]

Client: No. Not really.

Therapist: Okay, now we’re getting somewhere. [Instilling hope]

Client: Really? I’m lost. Weren’t we talking about my phobia?

Therapist: I can’t help but think there might be some connection. Indulge me for a moment and tell me about your parents’ roles with each other. [Exploring]

Client: I’m not sure how this will help since I’ve worked on my past, but I’ll answer. My dad is addicted to pain killers and my mom is a saint. She took care of us and him. I never understood why she didn’t leave him.

Therapist: Your dad wasn’t the kind of dad you wanted. In fact, I imagine your dad still isn’t the kind of dad you deserve. [Facilitating insight]

Client: True, but I understand. He’s an addict. I’ve studied addiction, and when I look at his past, I’m surprised he doesn’t do worse. He did the best he could.

Therapist: A part of you knows he did the best he could and feels understanding. Another part of you is angry that he wasn’t the father you needed. [Reflecting discrepancy]
Client: That's true. He wasn't there for any of us.

Therapist: When I bring that into the present situation, I can imagine that you feel responsible for your wife because the worst thing you could do is be the kind of husband and father your father was. [Interpretation; intuition]

Client: I have to admit that. I don’t want to be anything like him.

Therapist: Now, I’m really going to take a guess. Please feel free to tell me if any part of this or the whole thing doesn’t fit for you. I think that you feel a strong sense of responsibility as a married man to care for your wife, your family. The most horrible thing you could do is not follow through on this responsibility. And when you fly, you have no power to save her life or help her. You like having control. I say this not only because of what you said before, but also because of how you dress and hold yourself. You’re also very careful with your words. You like control. Is that accurate or is there any part that doesn’t resonate with you? [Interpretation; intuition]

Client: Um (long pause) I think that does fit, really well actually. I do like control. It’s a good thing.

Therapist: It must be helping you in some way, to have control. [Exploring]

Client: Well, yeah. I’m not like my dad. I keep a job. I take care of my responsibilities.

Therapist: And control can be really helpful. At the same time, you don’t want to face that you can’t control everything. So much of life has chaos that’s beyond you. When I say that, what’s that like for you to hear? [Preparing for action]

Client: I feel anxious (pause) lots of anxiety.

Therapist: Yeah. It’s almost as if by acknowledging any lack of control, you resemble your father. [Interpretation; intuition]

Client: That makes a lot of sense. Now, I don’t feel quite so crazy.

Therapist: Now when you think about flying, how is it? [Assessment]

Client: (long pause) There’s still some anxiety, but not nearly as bad. I don’t think that fixes it, but it sure helps.

Therapist: I wish this insight were enough to get you over your fear of flying, but you also have to make some changes. I would like you to think about taking a risk in the near future. Go to a movie without knowing what’s playing. Or go to your favorite restaurant and let your wife or if you’re really feeling brave, let the chef choose your meal. [Action]

Client: Whoa! That sounds really scary.

Therapist: What might a little risky for you? Let’s take it one step at a time. In our past conversation, you seemed to really care about not looking like a fool. I wonder if you would have any difficulty going to a playground with your wife and swinging on a swing set. My thought is that maybe the care-free child in you could come out and play. I imagine he’s been hidden for a while. [Action]
Client: That would be really weird, but I’d be willing to do it. How will this help me?

Therapist: I think if you can begin to let go of control of some little things, that eventually you may not need to control so much. I’d also like to teach you some deep breathing before you go. That way, when you begin to feel anxious, you can practice your breathing and talk yourself down. [Action; integration; homework]

Client: Sounds good to me. I’ll do anything I can.

Therapist: Great, and by the way, I will follow up on how the swinging went. (smiling) Now let’s get started on your breathing . . .

References and Resources


Skills to Use With Individuals

PART II