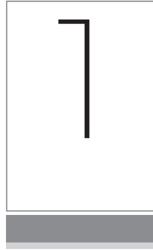
CHAPTER



Overview of Theories and Paradigms of Counseling and Psychotherapy

OBJECTIVES

- To introduce readers to definitions of theories and paradigms of counseling and psychotherapy
- To raise the question "How does psychotherapy work?" in order to address the mechanism of change through talk therapy
- To address whether counseling and psychotherapy are means of deviance control and engineering for social or client benefits
- To differentiate the concept of *mental health* from the concept of *mental disorder*
- To define the role theory plays in the treatment of mental health issues, problematic personalities, or dysfunctional behaviors

Theories of counseling and psychotherapy are foundational to the practice of mental health professions. In fact, it was the development of theories of treatment through *talk* that is at the core of what professional counselors and psychotherapists do. Regardless of whether the professional has trained as a counselor, psychologist, social worker,

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marital/family therapist, or psychiatrist, the idea that client problems can be addressed and solved through interpersonal interaction with a trained professional is at the heart of mental health practice. Sigmund Freud's associate, Josef Breuer, invented the "talking cure" (Freud, 1909/undated, p. 13) and first made use of the technique with the founding patient of psychoanalysis, Anna O., a woman suffering from hysteria. It was actually Anna O. who identified the techniques as the "talking cure." Freud, in his 1909 lectures (First Lecture), stated:

> It soon emerged, as though by chance, that this process of sweeping the mind clean could accomplish more than the merely temporary relief of her ever-recurring mental confusion. It was actually possible to bring about the disappearance of the painful symptoms of her illness. (Freud, 1909/undated, p. 13).

Freud later called the process "catharsis." The idea was new at the time. Literally, a person could be cured (in this case cured of hysteria) by talking to another person. Today, the idea that mental problems, or mental disorders, can be solved or cured by a conversation between a client and a therapist is well understood. It is called ***psychotherapy***. Since the birth of Freud's Psychoanalysis (based initially on the works of Breuer), there has been an explosion of ideas related to the treatment of individuals with talk therapy.

Most people acknowledge the healing that occurs when they are helped by conversation with caring individuals. Psychotherapy stands apart from general or even empathic conversation because it typically addresses serious and unresolved problems using specially designed techniques. Professional ***counseling*** or ***psychotherapy**** (the terms *counseling* and *psychotherapy* are used interchangeably in this text) is not just friendly accepting conversation. It is supposed to be qualitatively different. **It is the process whereby a trained professional uses his or her knowledge of biology, psychology, personality, relationships, and social systems to change behaviors and to solve client problems.** Professionals are paid a fee or salary to change the behavior of clients. In the end, the counselor is typically viewed as an expert and is paid with the expectation that the counselor's interventions produce positive and healthy results for people in need.

The focus of study and ideas about the target for treatment intervention vary significantly across the field. There are a number of *psychotherapy* or *counseling theories*. **A counseling *theory* is an intellectual model that purports certain ideas about underlying factors that affect behavior, thoughts, emotions, interpersonal interactions, or interpersonal interpretations. A theory also must provide a focus of study (e.g., thoughts, behaviors, emotions, relationships, systems of relationships, social agreements) for clinicians using the model. The model outlines the limits of activities used by the clinician to examine and evaluate the client. Once evaluated, it provides specific techniques of intervention that can be used by the clinician to affect the client.** Therefore, a counseling theory is a model of understanding and intervention; it provides the clinician with ways to view and to change a client's behaviors, feelings, thoughts, or interactions. Over the history of mental health treatment, wide variations in the models of treatment have evolved. There are those that are more medically oriented, assuming biological bases for unusual behavior. Some theories purport a psychological nonphysical

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*Noteworthy or new terms are presented throughout this text in boldface with bold definitions. Boldfaced terms are also noted in bold in the index.

individual (e.g., the self) that is the focus of study and target of intervention. Other theories hold that relationships (healthy and unhealthy) are crucial to understanding behavior and should be viewed as treatable. Some clinicians hold that mental problems are housed in language, and treatment should act as a re-narration of a person's life. There is one common thread in all psychotherapy—the counselor is a change agent.

PARADIGMS OF COUNSELING AND PSYCHOTHERAPY

This textbook recognizes real differences across theories of counseling being applied in the practice of mental health treatment. In 1992, Cottone proposed that counseling theories and psychotherapies could be classified across what he defined as ***counseling paradigms***. In an update of his ideas, Cottone (2012) defined counseling paradigms as follows:

> The word *paradigm,* although viewed as trendy by many and viewed as confusing by others, is simply a way of saying "a large, theory-encompassing model." The word *paradigm* is borrowed from Kuhn's (1970) classic work describing scientific paradigms, *The Structure of Scientific Revolutions,* and it is modified in this text to apply to mental health services. . . . Paradigms of counseling and psychotherapy (also called "counseling paradigms") are models that, to a large degree, are mutually exclusive and *based on different professional, political, and philosophical positions* related to the nature of the psychotherapeutic enterprise. Because paradigms in the mental health services account for professional and political issues, as well as practical-theoretical issues, the discussion of theories according to paradigm-relevant issues makes this text unique. Paradigms are larger than theories in counseling and psychotherapy. (Chapter 1, paragraph 1)

Cottone identified four counseling paradigms:

> Four paradigms will be presented in this text, and each paradigm has several theories under its wing. The four paradigms are: (a) the organic-medical paradigm; (b) the psychological paradigm; (c) the systemic-relational paradigm; and (d) the social constructivism paradigm (Chapter 1, paragraph 2)

Paradigms, in other words, provide a big picture—an encompassing organizational framework for understanding the work of counselors and psychotherapists. For example, counselors working in a hospital's psychiatric ward work with psychiatrists and other medical doctors, and they are likely to be involved in medically oriented interventions as well as medically informed psychotherapy. On the other hand, a counselor working at a college counseling center is likely to be working with clients addressing adjustment problems or problems defined in the context of the student's college work; in this case, the likely interventions are more focused on individual psychological adjustment and decision making of the college student. As another example, consider counselors working in a marriage or family counseling center; such counseling typically focuses on the problems in the relationships of clients, like marital problems or family problems. The counselor in a family service agency is usually trained in and applies relationship interventions. Therefore, paradigms provide the overview—they give counselors and psychotherapists information about the focus of treatment, and they recognize the context of mental health treatment.

This text is organized according to the paradigm framework. Part II of the text addresses approaches from both the organic–medical and psychological paradigms. Part III addresses systemic–relational approaches and Part IV reviews approaches aligning with social constructivism philosophy. Theories were carefully chosen in each part to represent the collective philosophy of the paradigm, but they also show ***within-paradigm theoretical variations***, meaning that even within paradigms, each theory provides a unique approach to treatment that varies from other approaches within the paradigm. For example, within the psychological paradigm, Freudian psychoanalysis is unique and quite different from the behavioral approaches addressed in the same part of the book. Also, some psychological theories focus more on feelings of clients, whereas others focus more on thoughts of clients. Therefore, ***within-paradigm variations*** **are simply therapies that accept similar overall paradigm premises, but they also are different and unique in providing specialized ways to do therapy within the paradigm framework**. Part V addresses ***cross-paradigm approaches*****—therapies designed by proponents that purposefully draw tenets, propositions, or techniques from at least two of the identified four paradigms**. Therefore, overall, counseling paradigms provide an organization framework for counseling theories used by mental health professionals.

HOW DOES PSYCHOTHERAPY WORK?

In *Words Were Originally Magic*, Steve de Shazer (1994), one of the founders of Solution-Focused Brief Therapy, explored the idea that psychotherapy is mysterious or even magical. He quickly challenged the idea that magic is involved. His book's title is actually a phrase of Freud's, who argued that words are a means of human influence. People are influenced all the time by messages around them. There is no magic to it—it is the way people affect each other in everyday interpersonal interchange. Short of physical intervention (e.g., torture, infliction of pain, physical reward), the main method of affecting others is communication with them. Humans are social, and they are proficient with language as their primary social vehicle. So it is no mystery that people can be influenced by communication, and therefore, their behaviors, thoughts, feelings, and relationships are modifiable through language intervention. Where people have problems, language is a means of problem solving.

Sometimes a person's problems are easily addressed through education and logical guidance. Some clients learn easily through a guiding and ethical interaction with someone who cares. Counselors in this regard are teachers—teaching one-on-one. They use logic to explain a situation and to teach the client a new way of thinking, feeling, acting, or interacting, and the client, ideally, learns and responds. The counselor's theory guides the therapy. The theory is the counselor's educational road map, so-to-speak. It provides a framework of understanding and intervention. This is counseling at its best, and at its easiest.

Sometimes the problems of clients are complicated. They have multiple layers of difficulty, and client histories can be described as atrocious. They may have been emotionally, physically, or sexually abused. They may have been harmed either physically or emotionally by nature or by other people. They may suffer serious illness, debilitating disability, or incurable disease. They may be genetically predisposed to act, feel, or think in ways that prevent good social fit in the culture within which they find themselves. These people are in need of attention. They are in need of an educated, guiding hand

that can lead them to a better place. Counselors are highly educated professionals who are directed by ethical codes to help people in need. Psychotherapists, no matter what their professional affiliations, are bound by the ethical principles of ***beneficence*** **(doing good)** and ***non-maleficence*** **(avoiding harm**; Cottone & Tarvydas, 2016). Counselors are paid to produce results. It is their ethical obligation to do their best to help clients solve problems, no matter how complicated or challenging the problems may be. In this sense, counselors and psychotherapists are social agents. They are given license (literally) to provide treatment to those who need it to better their lives, and to help them find comfort in a community that embraces and supports them. Counselors are treatment professionals with the charge of alleviating the symptoms, pain, and mental disorders of clients. Counselors play the role of social advocates, as counseling is a profession that aspires to embody social responsibility.

The counselor–client relationship cannot be ignored. In fact, the way the magic of psychotherapy happens is the result of the **caring, ethical, guiding, and collaborative relationship** that is established by clients and counselors. Research shows that this relationship can be called the ***therapeutic alliance***, and it has been statistically shown to be powerful at producing healthy outcomes in treatment. The concept of therapeutic alliance has its roots in the work of Bordin (1979), who defined the therapeutic "working alliance" as involving interaction between the counselor and the client on goals, tasks, and bond (the interpersonal connection of the client and the counselor). Working alliance was proposed to cross all mental health treatment approaches and was not specific to one type of psychotherapy. The therapeutic alliance (a more contemporary but related concept) may be the most significant factor in producing outcomes in psychotherapy (see Beutler, 2000). Aside from specific treatment approaches, it is one **common factor (a factor that is present in counseling no matter what theory is applied, which also is associated with successful outcomes)** that is influential in human clinical interactions. Common factors are addressed again in the last chapter of this book, Chapter 17.

IS COUNSELING MANIPULATION?

The best counselors may be those who are master manipulators. How can a therapist always care about clients? Aren't there clients whom counselors do not like? How do therapists always show empathy and regard for clients when some clients' behaviors may be abhorrent to the professionals? Is it not dishonest to act like one cares when one does not really care? Counselors are ethically obligated to serve their clients whether they like them or not. In this sense, psychotherapy can be viewed as a professional strategy—tactics to produce change in clients whether they are motivated or unmotivated to change. In a way, counseling can be thought of as **deviance control**. The counselor can be viewed as a warrior, and the war is against maladaptive behavior, disturbing behavior, harmful relationships, and destructive social systems. The idea that psychotherapy is strategic is an idea that may have some credibility, but it certainly has negative overtones. In general, the concept of manipulation has a negative connotation. It challenges the therapist who is guided by the ethical principles of **veracity (being truthful)** and client **loyalty (being faithful)** (Cottone & Tarvydas, 2016). Yet, it cannot be denied that counselors are expected to get results, and to some degree there must be forethought, planning, and engineering to establish the optimal conditions for changing the clients. Counseling should not be *manipulation* in the negative sense; **it should be a professionally designed activity with the intent of facilitating healthy and functional client outcomes**. This is

true whether the client shares values with the counselor, is not likable, or has done something that the counselor finds discomforting. The primary responsibility of counselors is to their clients (Cottone & Tarvydas, 2016). Counselors must enter into relationships with clients with the intent of "doing good" for them, just as lawyers sometimes must serve clients with whom they have serious moral or value differences. Counselors can always rely on technical clinical factors when faced with a situation of moral or value conflict—they can focus on the application of theory to design and to implement methods that can produce changes for the benefit of the client and society in general. Technique, therefore, may be a fall back when counselors are confronted by challenging value or moral conflicts with clients, because some clients act in ways that are disturbing.

HOW IS MENTAL HEALTH DEFINED?

Mental health is not just the absence of mental disorder. The American Psychiatric Association in 2013 published its widely used *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (***DSM-5***), which provides a listing of mental disorders and the criteria used to diagnose them. It is a typology of mental disorders—mental illnesses viewed as within the person. Counselors and psychotherapists are paid to remedy conditions listed in the *DSM-5*, and medical insurance companies are required (in most cases) to pay for medical psychotherapy services for their enrollees so long as the services are provided by a mental health professional licensed to treat such disorders. Any number of counseling theories that apply to treatment of individuals can be used to treat *DSM-5* disorders, and such treatment is likely to be reimbursed by the medical insurance company. A good number of the theories described in this text serve as medical psychotherapies. Insurance companies might refuse to pay for those approaches that are relationship focused (marital or couple therapies) or family relationship focused. Even some relationship focused therapies are being reimbursed by some insurance carriers or ***third-party payers* (organizations that pay for a client's treatment)**. Generally, then, psychotherapy is designed to lessen, cure, or reduce the symptoms of mental disorders. It is designed to help clients function better. Its goal is to help clients face their challenges with support and comfort. Just as physicians serve patients with physical disorders, psychotherapists serve clients with mental disorders.

Counseling and psychotherapy are not just about treating *DSM-5* disorders. The absence of mental disorder does not necessarily constitute mental health. In fact, many of the therapies presented in this text are undergirded by theories of personality. For example, Freud's (1909/undated, 1940/1949; 1917/1966) psychoanalysis subscribes to a conflict model of personality, meaning that the personality is in an internal conflict (the id vs. the superego) that needs to be resolved. Rogers's (1951) Client-Centered Therapy (now known as Person-Centered Therapy) purports that healthy personalities have self-concepts that are internally *congruent* and capable of *full functioning* psychologically. Perls's Gestalt Therapy holds that the personality should be holistic in its functioning, embracing thoughts, feelings, and behaviors synergistically (see Perls, Hefferline, & Goodman, 1951). Therefore, many of the theories themselves present a framework of mental health, and they are designed to facilitate movement from problematic functioning to healthy functioning.

Some counseling theories have no foundational theory of personality. Rather, they describe some basic propositions about how people operate, and then the therapy derives from the basic propositions. For example, Ellis's (1962) Rational-Emotive

Therapy (now known as Rational Emotive Behavior Therapy [REBT]) assumes that people have a propensity to think irrationally, and rational thinking is preferable and healthier. REBT's basic proposition does not constitute a theory of personality, but it does act as a foundational tenet that guides REBT practice.

As the reader progresses through any study of theories of counseling and psychotherapy, he or she is encouraged to analyze theories on the grounds of his or her internal consistency, theoretical and paradigm alignment, ease of application, context for optimal application, and underlying assumptions about the human condition. This text is designed to facilitate that journey so that readers have a good understanding of the theory itself and have a basic grounding in techniques and applications of the theory in practice.

IS COUNSELING DEVIANCE CONTROL?

In 1974, Thomas Szasz, a psychiatrist (Figure 1.1), wrote a book entitled *The Myth of Mental Illness*. In that book, he argued that mental illness is a myth. He argued that psychiatry has medicalized problems. He argued that the purview of most social and personal treatment by psychiatrists was that of social and personal problems—problems in living. He stated:

> It is customary to define psychiatry as a medical specialty concerned with the study, diagnosis, and treatment of mental illnesses. This is a worthless and misleading definition. Mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice, they deal with personal, social, and ethical problems in living. (p. 262)

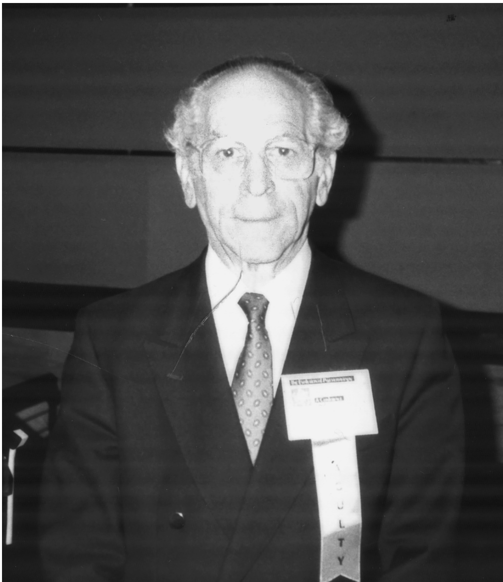

FIGURE 1.1 Thomas Szasz argued that mental illness is a myth.
Source: Photo by R. Rocco Cottone.

Szasz's attack on his own profession was highly credible. He made an articulate and compelling case against the treatment of deviant behavior with medical methods. He argued against the use of the *medical* metaphor when addressing human problem behaviors. His arguments apply not only to psychiatry, but to any mental health professional working with clients exhibiting abnormal behavior.

Consider school counseling. Often school counselors are consulted on a case when a child is manifesting a behavior that is disruptive in some way to the educational process. A child may be overactive in the classroom, sleeping through lectures, or disturbing other students in the class. The child may be insubordinate, threatening, or even aggressive in the school setting. He or she may have a school or test phobia. In such cases, it is the school counselor's

role to assess and to intervene to produce some change in the situation. The counselor might act as a therapist, addressing behaviors with the intent of stopping, lessening, or preventing specific problematic behaviors or interactions. In this way the counselor is acting as a means of behavior change to better help the child fit within the educational context. Any problem (deviant) behavior must be brought under control. On the other hand, if the school counselor cannot intervene therapeutically with the student, then there are two choices: (a) encourage the child and parents to seek treatment outside the school from a health professional (e.g., a psychiatrist or pediatrician who might prescribe medication to control the child's behavior); or (b) act to make a case against the child remaining in the regular educational setting, thereby screening the child from the standard classroom. Regardless, the counselor's role in such cases is the control of behavior outside the norm of acceptable regular classroom demeanor. This is certainly a constricted view of the school counselor's role, as some would argue that the school counselor's role is much broader and may involve educational, preventative, and **strength-focused (focusing on success**) activities. Sometimes the disciplinary role in the school gets blurred with the counselor role, and certainly, in some cases, counselors may be primarily a means of deviance identification and control.

The disease model of mental disorder and its treatment in the form of psychotherapy may have done the field of counseling an injustice from the very beginning. Szasz followed up his book on the myth of mental illness with a book entitled *The Myth of Psychotherapy* (Szasz, 1978). In that book, he argued against viewing psychotherapy as a medical intervention. He stated: "The promiscuous use of the term *psychotherapy* is an important sign of the debauchment of the language of healing in the service of dehumanizing and controlling persons by technicizing and therapeutizing personal relations" (p. 215). He argued for a new terminology to replace the concept of *psychotherapy* based in logic and rhetoric. He believed that psychiatrists (and now all mental health professionals) should act less like physicians and should recognize their role in social and moral action (Szasz, 1974). Counseling and psychotherapy, in other words, cannot be isolated from the social, political, and moral context within which they exist. In fact, the term *counseling* may better represent the de-medicalized version of traditional *psychotherapy*.

In this text, theories listed under the systemic–relational and social constructivism paradigms appear better positioned to acknowledge and to address fully the social context of treatment, whereas organic-medical and purely psychological approaches appear less sensitive to the social nature of problem formation and solutions, consistent with Szasz's critique of psychotherapy.

CONCLUSION

This chapter serves as an introduction to theories of counseling and psychotherapy. It addresses some issues about the therapeutic enterprise, and it asks some questions that should whet the appetite of the reader. Paradigms of counseling and psychotherapy were defined and constitute the organizational framework of this book. Questions were raised about the nature of psychotherapy, how it works, whether it is simply a conversation or something like interpersonal manipulation, and whether its purpose is to treat mental disorders. Some of the answers to these questions are embedded in the chapters that follow. Also, following the challenge of Szasz (1974, 1978), the social nature of human discomfort and psychotherapy must be recognized and addressed by both philosophy and method. The next chapter begins by presenting the most medical of

the psychotherapies, Psychiatric Case Management, which is then followed by Freud's Psychoanalysis—the first psychological psychotherapy.

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