Chapter 1
Theory in Practice

Michelle R. Evans and Rhonda Peterson Dealey

The Essence of Theory for Clinical Practice

"I just don't understand why we are spending so much time studying theory," remarked the clinical graduate student frankly. "Who cares what a bunch of dead white guys think! I just want to know how to do therapy the right way." Her remarks likely express the thoughts of many other students who have felt exasperated by Freud's adherence to the psychosexual stages or by the dense yet ambiguous writings of object relations theorists. Why can't students just learn the "skills" of effective therapy without exploration of theoretical history and metacognitive exercises into the why's and how's of therapeutic efficacy and effectiveness? Is theory really that important? This chapter explores the notion of theory and its importance for clinical practice, provides a brief overview of the evolution of clinical theory, and describes a framework for how theory directly informs day-to-day clinical practice.

Practitioners of any scientific discipline are fundamentally theoretical problem-solvers (Kuhn, 2012). Theory allows for explanation of what is observed in one's world, in essence a "symbolic model" (Ford & Urban, 1998, p. 6) of one's experience and environment. It provides a structure or systemization of ideas and thoughts to answer important questions about what has been observed and what remains supposition. It allows for possibility and hypothesis testing, for analysis and deduction. Theory supplies explanation and meaning and affords the theorist with a mechanism for identification and for prediction. Applied theory attempts to "describe aspects of the natural world that can be applied to create a benefit or reduce a cost" (Heesacker & Lichtenberg, 2012. p. 72). In clinical practice, theory helps explain

M. R. Evans (✉)
School of Social Work, Aurora University, Aurora, IL, USA
e-mail: mevans@aurora.edu

R. P. Dealey
Social Work, Washburn University, Topeka, KS, USA
e-mail: Rhonda.PetersonDealey@washburn.edu

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what is seen and heard, ascribes meaning to client experiences, behaviors and problems, and suggests methodology and mechanisms for intervention. Clinical practice theory answers the questions: *What is the problem and how did it arise? What needs to happen now in order for change to occur?* and *What constitutes meaningful change?*

So how does theory inform clinical practice? Theory serves a multitude of functions for the clinician, four of which are offered here as contribution to the argument that being theoretically informed is corequisite with ethical and competent practice: *(1) theoretical adherence lays a foundation for professional skill development; (2) theoretical knowledge establishes the context for theoretical relationship and interaction; (3) study of theory provokes practitioners to gain a deeper understanding of themselves,* and *(4) theory serves to define and connect evidence-informed practice and practice-informed evidence.* Specific instances of where theory informs the day-to-day practice of the clinician and client will be examined later in this chapter.

Theoretical adherence lays a foundation for professional skill development. The student asks why one cannot simply be trained in the necessary skills to provide therapeutic intervention without having to study and think about the philosophical and esoteric concepts of clinical theory. The answer is that it is theory itself that suggests what skills are needed. Clinical theory informs the understanding of pathology and wellness, how problems evolve and change occurs. A theoretical framework which purports insight as the key mechanism of change will demand a different set of skills than a framework which suggests that behavior is altered through environmental reinforcement and aversion avoidance. A theoretical paradigm which asserts that problems develop as a result of intrapsychic forces and internal conflicts will likely require different forms of intervention than a theoretical paradigm which maintains that problems develop as a consequence of external injustices and disparities. Assessment of childhood experiences and early familial relationships is highly valued by adherents of Adler's Individual Psychology (Adler, 1969). Assessment for proponents of solution-focused brief therapy, on the other hand, looks very different, and rarely encompasses details from the distant past (De Shazer, 1985). Honing the skills of one's craft, then, is largely dependent upon the understanding of what one's craft is and does. Theory helps the practitioner know what to look for and what steps to take when intervening.

Theoretical knowledge establishes the context for theoretical relationship and interaction. Nearly all contemporary approaches to clinical psychotherapeutic processes acknowledge that a working alliance is a critical component to effective intervention. Quantitative research and meta-analysis (Wampold, 2001, 2010) suggest that contextual factors such as therapeutic relationship and alliance, and the personal and interpersonal skills of the therapist are primary determinants of therapeutic outcome, and that technique has significantly less effect. Even so, theory informs the understanding of relationship within the therapeutic context. Is therapeutic relationship necessary and sufficient for change (Rogers, 1961, 1967) or is it a necessary collaborative effort, but a non-causal factor in client change (Dattilio & Hanna, 2012)? What considerations are given to power structures in the therapeutic environment (Brown, 2010)? Is the therapeutic relationship a focus of communication

in the therapy setting or an irrelevant topic that distracts from the function of therapy? Theory seeks to answer such questions and aids the clinician in developing a therapeutic context conducive to client success.

Study of theory provokes practitioners to gain a deeper understanding of themselves. Who the therapist is and how that enters the therapeutic context is key to ethical practice and positive client outcomes (Baldwin, 2013.) Attention to one's own inner woundedness allows a therapist to embrace one's own vulnerability and prepare for boundary-appropriate joining with clients (Miller & Baldwin Jr, 2013; Piercy & Bao, 2013). Such inward reflection may even reduce a practitioner's risk of burnout (Miller & Baldwin Jr, 2013). Inner self-exploration can be sparked through a variety of means: the clinician's own experience in therapy and/or supervision; spontaneous awareness of countertransference triggered in provision of services; or an intentional effort to practice reflectively and reflexively. The theoretical understanding a clinician has of clients is essentially the same understanding the clinician has of oneself (Stedmon & Dallos, 2009). The study of theory in practice affords the practitioner an avenue for searching one's own values, beliefs, experiences, and worldview, to challenge uncovered bias and prejudice, and to consider new ways of understanding oneself and others. Theory can even inform one's approach to studying theory and practicing reflection.

Theory serves to define and connect evidence-informed practice and practice-informed evidence. Theory informs the work of both scientific researchers and practitioners of clinical psychotherapy and may, in fact, function as a bridge between the two (Heesacker & Lichtenberg, 2012). Researchers and practitioners are interested in causal effects and correlations which give insight into client experiences and outcomes. Both scientists and clinicians are interested in the operationalization of concepts of theory into observable processes, that is, the transformation of thought constructs into actionable interventions and/or tools of outcome evaluation. In the era of managed care and quality outcomes reimbursement models, practitioners and payor sources are forced to consider the effectiveness of treatment modalities. A case could be made that the experience of each client system is in essence a research venture. A hypothesis is formulated and tested, conclusions are drawn, and future implications are noted. These pseudo-experiments in aggregate serve as the building blocks of clinical wisdom for practitioners and are the practice-informed evidence which guides future work with new client systems. Such practice-informed evidence, grounded in theory, should be the guiding force for scientific inquiry. Without the guidance of practice-based inquiry, scientific-based inquiry risks privileging theoretical influence in ways that may be detrimental to understanding what is best practice and most helpful to clients. Some theories by nature are easier to operationalize and therefore study. Popularity of a modality and/or connectedness of a theoretical proponent to sources of power and resource, e.g., research funding, may privilege what research is done and for whom. It is via a pathway of theoretical dialogue that practice and research can come together to inform the evolution of theory and treatment.

The Evolution of Clinical Theory

Sigmund Freud (1989) is often credited as being the first to theorize that mental illness could be understood and treated using talk therapy. Freud proposed a model of personality structure, pathology development, and methodology for treatment based on the premise that neuroses exist as a result of internal drive and conflicts. Freud's structure of the clinical hour in which exchange of language between a paying client and a trained therapist still informs clinical work to this day. While Freud's ideas became widely accepted worldwide and dominated approaches to mental illness treatment for decades, even in his own time Freud was not without critics. Contemporaries of Freud who challenged his ideas and hypothesized differently the determinants of mental illness and the motivations of human beings are often referred to as Neo-Freudians. Carl Jung (1961), once a valued colleague of Freud's, challenged his friend's psychosexual theories and ventured off to theorize a spiritual approach which emphasized a quest for meaning as a motivating force. Jung suggested that not only is a person's past determinant of the present state, but so, too, is the future aspiration. Jung's contributions, including the collective unconscious, dream functions, and the notion of individuation as integration of conscious and unconscious material, are still helpful to clinical therapists today (Harris, 1996). Alfred Adler (1969), also once an esteemed colleague of Freud's, theorized concepts such as the inferiority complex and importance of birth order which inform clinical practice and the common vernacular yet today.

Next-generation clinicians, often referred to as the Ego Psychologists, were less concerned about the drives and more concerned about the development of the ego. Anna Freud's (1936) ego defense mechanisms are an important part of clinical education and have made their way into everyday language. Hartmann's (1939) hypothesis that aspects of ego development occur outside of conflict was an important evolution of understanding human experience. Erikson's (1950) optimistic framework of crisis and mastery of stages across the entire lifespan continues to inform understanding of human development.

Psychoanalytic theory continued to evolve during the 1940s and 1950s when several American and British practitioners diverged from Freud's theory that human motivation is driven by satisfaction of sexual and aggressive needs and suggested that human relationship is central to formation of the psyche and motivates human behavior. Their theories are categorized as object relations theories and focus on the internalized images of self in relation to significant others, referred to as objects, namely the mother. While they all focused on how early relationships create mental representations of self and others which inform relationships in later life, the ideas of individual object relations theorists varied widely. Melanie Klein, who is often credited with founding the object relations approach to psychoanalysis, developed her ideas from her work with infants and young children and suggested that experiences in the first months of life were critical. Ronald Fairbairn's conceptualization of a splitting defense to create good objects and bad objects continues to inform psychoanalytic understanding and practice. D. W. Winnicott, a British pediatrician

who trained in psychoanalysis, conceptualized a child's developing capacity to separate me and not-me and the symbolic use of an object, which led to an understanding of the significance of transitional objects in self-soothing. These and other object relations theorists contributed much more which continues to inform clinical practice. The evolution of psychoanalytic understanding diverged further into an understanding of the concept of self, including such matters as self-esteem, self-regulation, and self-cohesion (Goldstein, 2001).

While much of clinical theory evolved as a progression from early psychoanalytic thoughts, a great deal of clinical theory developed as a rejection of psychoanalytic understanding and particularly the deterministic understanding of human experience. Existential and humanistic approaches to clinical work beginning in the 1940s and 1950s provided a new philosophy related to human suffering and human potential. Existential therapy, based on a way of thinking rather than a subscribed modality of treatment, arose following the devastation of World Wars I and II and emphasized the difficult issues of suffering, anxiety, isolation, and tragedy. Existential thinkers suggest that individuals are free to choose their actions and reactions to circumstances. Finding meaning and accepting responsibility and power for change are key tasks in an existential approach (Frankl, 1963; Yalom, 2003). Humanistic theorist, Abraham Maslow (1943), argued that people are basically good and are capable of growth and healing, and that the function of therapy is to help clients remove the obstacles that interfere with their self-actualizing tendencies. Carl Rogers' (1961) non-directive approach, which placed the client as expert of their own experience, was a radical departure from psychoanalytic models. The non-judgmental stance of the therapist, the focus on the here-and-now, and the emphasis on empathic understanding of Rogers' person-centered approach garnered a very different therapy experience for client and practitioner.

Different yet, behavioral approaches to therapy applied principles of classical and operant conditioning to the treatment of psychological problems and behavioral functioning. By the 1970s behavioral models, such as Bandura's (1977) theory of social modeling, significantly impacted psychotherapy as well as education and other forms of social work practice. Behavioral approaches quickly broadened to encompass cognition as the site of distress and the locus for change. Rational emotive behavior therapy (Ellis, 1997) suggested that people's beliefs about events and circumstances contribute to their emotional distress and symptoms. Beck's (1963, 1976) early depression research suggested that clients' cognitive distortions resulted in negative biases for how they interpreted life events. According to cognitive behavioral theorists, automatic and maladaptive thoughts and feelings impact individuals more than actual events, and psychoeducational approaches to behavioral change can be used to change maladaptive thinking (Beck & Haigh, 2014). A "third wave" of cognitive behavioral approaches has changed the landscape of therapy by valuing holism and health and emphasizing context, acceptance, relationships, and goals. Mindfulness-based therapies, dialectical behavioral therapy, and acceptance and commitment therapy are examples of this third wave of behavioral theory (Hayes & Hofmann, 2017).

Feminist theories inform much of contemporary psychotherapy. Growing out of the women's movement of the 1960s and 1970s, feminist theorists sought to move away from the perspective of internalized psychopathology and toward a focus on understanding the impact of social, political, and cultural factors which marginalize and constrain women. Clinicians began to integrate feminist ideologies and values with existing therapeutic modalities, challenging the patriarchal systems which previously defined the therapy experience. The feminist perspective continued to evolve, challenging not only gender roles and stereotypes, but calling out other forms of oppression, analyzing power structures in society and within the therapeutic relationship, and utilizing a sociocultural perspective to understand and address client problems (Enns, 2004).

Postmodernist perspectives have influenced clinical theory and practice dramatically in recent decades. Suggesting that truth is subjective and contextual, postmodern theorists privilege language systems as the basis of construction of meaning. Social constructionists suggest that knowledge of reality is constructed and influenced by the historical social context and dominant language. Practitioners who subscribe to a postmodern, social constructionist viewpoint disavow the idea of therapist as expert and elect a more collaborative interaction with clients (De Shazer & Berg, 1988). Solution-focused brief therapy and narrative therapy are two popular forms of clinical therapy which are informed by postmodern perspectives.

Theoretical evolution and paradigmatic shifts occur as a result of a changed worldview (Kuhn, 2012). Clinical theory in the past 100 years has changed markedly as the world in which it exists has changed markedly. It is difficult to know exactly how many forms of clinical therapy are actually being utilized currently. The Psychology Today website, which is designed to assist individuals in finding a local therapist who would be a good match, describes 66 different common types of therapy. Herink (1980) identified more than 200 forms of therapy. And certainly, anyone form of therapy is practiced somewhat uniquely by individual adherents.

Theoretical approaches are based on underlying philosophical assumptions about human nature, mental health, and pathology which inform methods and processes in clinical practice. Since the days of Freud and Jung, arguments of theoretical superiority have existed. All forms of therapy have been scientifically shown to be effective, and some research suggests that the level of allegiance of the clinician to the treatment model, that is, the belief that their theoretical approach is superior to other approaches, accounted for any variance between outcomes in differing approaches (Wampold, 2001, 2010). Debates have arisen as to the value of theoretical singularity versus theoretical plurality and integration. A newer orientation toward process-based therapy over traditional methods-based approaches may emerge as the next standard of evaluation (Hayes & Hofmann, 2017). Regardless, the overall interpretation of the body of research suggests that therapy, executed with fidelity and competence, is beneficial to patients (Lambert, 2013).

Creating a Clinical Framework Using Theory

Theory provides us with the basis to understand the complex lives of our clients in an orderly way. Concepts about the person, human behavior in the environment, and the person's resiliency, among other topics, must be fully considered in order to be able to understand what interventions might be useful to help the client achieve their goal. Theories provide the clinician with a foundational base to understand why problems occur for humans and what needs to change to help the person enhance their wellbeing. In the best interventions, theory, research, and practice are combined in a meaningful way that allows the clinician to understand the interpersonal and environmental factors that are impacting the client. The experience that the clinician gains while in practice and the knowledge from research and training provide the clinician with a base to continue to develop knowledge on an ongoing basis that benefits the field of practice.

It is important to understand the difference between a theory and a therapy. Clinical theory incorporates the held beliefs that explain some aspects of human phenomenon, pathology, and cure. A clinical therapy is a more specific treatment modality that provides an explanation of specific interventions that should be used to correct a specific impairment. Therapies are created from theory. These terms are often used interchangeably but there is a difference between the two. A therapy has specific interventions and protocols that are recommended and which may provide the clinician with guidance for activities, interventions, and clinician behaviors, while a theory may encompass a larger scope and may be less prescriptive.

Many clinicians use evidence-based practices (EBP) which are therapies that have gone through peer-reviewed research to prove their efficacy with specific populations. Using a proven EBP is considered best practice; however, there is still research lacking for many populations and therapies. As more research is completed, additional EBPs will be identified. Clinicians often work with individuals from populations that are under-researched. Therefore, the clinician must use the best available knowledge and experience to make appropriate treatment decisions for that individual's needs. Beginning clinicians should seek supervision when choosing a theory or therapy for a client that may be under-researched for that population.

Using theory to understand how to help clients has many advantages. It gives the clinician an opportunity to organize principles to assess the client accurately. It minimizes the bias of the clinician's experience as it provides a framework that the clinician can focus on, instead of focusing only on their own experiences. The theory can also provide a basis for rationale for making clinical decisions. Evidence-based practices, especially, provide clear researched evidence for why a specific intervention is chosen to help a client.

A clinical framework is a structural plan or basis for action based on clinical theory or therapy. This framework is based upon the theory or therapy that the clinician is using to understand the client. To build this clinical framework, the clinician must first choose a theory or therapy that is aligned with the client's reason for seeking treatment. For instance, cognitive behavioral therapy (CBT) is an evidence-

based practice to treat substance use disorders. If a clinician is seeing a client with a substance use disorder, they may consider using this therapy as a basis for their clinical framework. Once the clinician decides on the therapy that they will use in their work, they will develop a hypothesis of the presenting problem based on the therapy. The term hypothesis is being used here as a tentative assumption or working idea as to what may be causing the client's presenting problem. Using the example of the clinician that has chosen to use CBT to work with their client, they would examine the client's thinking patterns during the initial assessment to identify problematic thought patterns and core beliefs, for instance. This theory-based assessment would allow the clinician to identify what thoughts or behaviors are most problematic for the client. Once these thoughts and behaviors are identified, the clinician will create a hypothesis of what thoughts and behaviors will need to change to help the client. This hypothesis would be supported by the evidence of the client's thoughts, behaviors, internal and external experiences reported during the assessment process. The hypothesis will be instrumental in helping the clinician set and evaluate goals and interventions for the client during the treatment process.

Developing Client Goals Using Theory

Once the clinician has identified the hypothesis that will be guiding their work, they will use this information to set client goals. Many of the theories encourage the clinician to work with the client to set goals collaboratively. These goals are guided by the theory's explanation of the problem and how people change. For instance, using the example above, a clinician using CBT would collaboratively set goals with the client that are related to addressing cognitive distortions or maladaptive behaviors as CBT promotes client psychoeducation and collaboration as an intervention. Other theories might not value the collaboration or psychoeducation as highly and thus a different approach might be taken.

The clinician may create goals that are specific or more general depending on the nature of the services that are being provided and the theory in use. If a goal is too vague or does not align with the theory, the clinician and client may find themselves unclear as to the therapeutic work that needs to be accomplished. If the clinician and client find that they are not moving forward, the clinician should review the hypothesis and realign the goals with the original understanding of the reason for requesting services to help the client achieve a good outcome from treatment.

Planning and Implementing Change Strategies

Once the clinician has identified theory-based goals that will help the client, they will design interventions that are supported by the theory. For instance, if the clinician has been using CBT to create their clinical framework, the interventions should

directly address the goals created within this framework. A client with the goal of reducing cognitive distortions might initially participate in the intervention of receiving psychoeducation to help them identify cognitive distortions.

Interventions are chosen based on the client's readiness to engage in change and their willingness to participate. Clients that are hesitant about change may benefit from the use of change strategy models such as the stages of change or motivational interviewing. These two models can provide clinicians with tools to help a client move forward in their commitment for change and can often be used in conjunction with many theories and therapies to help the client move toward their goals.

In addition to using change models, clinicians can integrate other theories or therapies to better meet client needs. When doing this, the clinician needs to ensure that the interventions align with the goals and current needs of a client. This can be very helpful for both the clinician and client, especially when working with clients from under-researched populations. A clinician may choose to use a few techniques from the alternate therapy to meet the needs of the client, or they may choose to use another theory altogether when working with one specific problem that the client has. For instance, if the client with a substance use disorder also has unresolved grief from a childhood incident that has been impacting their mental health, the clinician may use a narrative model to help the client process and "re-author" this incident (White, 2007). The clinician and client may return to using CBT regarding the current use of substances, but they may find that a different approach is more helpful for this particular issue that the client is facing. However, integrating other therapies should be done with caution to avoid losing focus on the goals of the clients.

Using the Clinical Framework to Develop a Plan for Termination

A clinician begins to plan for termination during the initial assessment. As the clinician assesses the individual, they must develop an idea of what the client will need to achieve to allow them to feel that they have resolved the presenting problem. From that picture of what the client should have achieved at termination, the clinician is able to consider the client's need for change from where they are at initial intake to termination within the framework of the theory. For instance, using the client described above, the picture that the clinician using CBT might develop is a client that is able to avoid cognitive distortions and utilize coping skills consistently to manage urges and thoughts to use substances. If the clinician develops a solid hypothesis, the goals and interventions that are based on the hypothesis will lead the client to that picture of success at termination.

The evaluation for termination is ongoing as the client participates in ongoing goal evaluations. When the client has achieved all goals and there are not any additional goals that the client wishes to address, termination can be considered. This is typically done collaboratively.

Summary

Theory is the foundation of all clinical work. It provides an understanding for why clients develop problems and how change can happen. Four arguments were presented regarding the contribution of theory to ethical and competent practice: *(1) theoretical adherence lays a foundation for professional skill development; (2) theoretical knowledge establishes the context for theoretical relationship and interaction; (3) study of theory provokes practitioners to gain a deeper understanding of themselves, and (4) theory serves to define and connect evidence-informed practice and practice-informed evidence.* In this chapter, the history of the development of clinical practice theory was discussed. The use of clinical theory with clients was reviewed with a discussion of how theory guides clinical interventions to help clients meet their goals. In each of the following chapters, a specific clinical practice theory will be reviewed with an application to a case. The reader is encouraged to peruse the chapters in whatever sequence seems most relevant and interesting.

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