Whether you are currently in or preparing to enter the mental health profession, you are most likely aware that an important evolution is taking place in the field, significantly changing the practice of counseling and psychotherapy. When we first began to provide mental health services, there were few limitations on practice, such as the number of sessions allowed or the type of therapy provided. Within the last 10 years, enormous changes have occurred in the field. The impetus for change comes primarily from three forces:

1. Managed care, which demands accountability and efficiency in the provision of mental health services.
2. Research and evidence-based practice guidelines, which are becoming the touchstone of psychotherapy.
3. Culture-sensitive or diversity-sensitive therapies, which are promoted to address the needs of ethnic minorities and other diverse populations.

All of these factors have been highly influential in defining appropriate treatment and services for clients. In a survey of 62 psychotherapy experts regarding the future direction of the mental health field (Norcross, Hedges, & Prochaska, 2002), there was a strong belief that almost all systems of psychotherapy will develop short-term therapies to conform with managed-care systems and that efficient therapies will grow in importance. The expert psychotherapists predicted that of the different theoretical orientations, the eclectic and the cognitive-behavioral will assume greater importance because they are amenable to the development of concrete goals and brief treatment strategies. A survey conducted to determine the theoretical orientation of a group of psychologists revealed the following percentages: eclectic (35 percent), psychodynamic (21 percent), cognitive-behavioral (16 percent), Rogerian/Humanistic/Gestalt/Existential (6 percent), Systems/Family Systems (3 percent), and Interpersonal (3 percent) (Norcross, Hedges,
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& Castle, 2002). Allegiance to these orientations may change dramatically in future years depending upon the ability of each theoretical framework to meet changing demands in the mental health field.

Psychotherapies are evolving and beginning to meet demands for accountability by using efficient, research-supported treatment and accommodating diversity issues. For example, from psychoanalysis came the object relations and the self-perspective theories that led to short-term psychoanalytic approaches such as the core conflictual relationship theme method (CCRT) and interpersonal therapy (IPT), an empirically supported approach for depression. Additionally, some psychoanalysts are emphasizing the need to examine the cultural values of both the therapist and the client in the therapeutic relationship (Bucci, 2002) and increase the role of research in psychoanalysis (Schachter, 2005). Similarly, person-centered approaches have given rise to motivational interviewing, a concrete and goal-oriented therapeutic approach. In addition, some practitioners are calling for humanistic therapies to incorporate aspects of empirically supported treatments and to use quantitative documentation to evaluate treatment outcome (Joiner, Sheldon, Williams, & Pettit, 2003). Both psychodynamic and humanistic approaches are including more action-oriented techniques into their therapies. In contrast, cognitive-behavioral therapies have always stressed the importance of research and technical skills, while placing less emphasis on the quality of the therapeutic relationship in treatment outcome. However, there has been a recent shift within the cognitive-behavioral school of thought and there is now an effort to explore and incorporate relationship variables between the therapist and client in a systematic manner (Lecompte & Lecompte, 2002). These changes, which are occurring across different theoretical orientations, are important not only because they benefit the consumer, but also because they offer therapists more flexibility in the provision of services.

Evidence-based guidelines have been developed for many mental disorders and are now considered the standard of practice from which to determine the appropriateness of a selected treatment. These treatment recommendations are based on outcome research and clinical expertise and are advocated by the American Psychiatric Association, National Association of Social Workers, American Psychological Association, and the American Counseling Association. These guidelines, combined with the identification of research-based relationship variables and therapeutic techniques, will have a great impact regarding the provision of mental health services and the curricula of mental health training programs. Newcomers to the field and experienced practitioners alike will be expected to be familiar with new treatment guidelines.

Although culture-sensitive therapies do not fit under the efficiency or effectiveness models, they are expected to increase in importance as more attention is paid to the needs of our increasingly diverse society. Practitioners
face several areas of controversy when dealing with diversity issues in psychotherapy. First, when considering diversity, should the major emphasis be on ethnic groups or do we need to consider additional areas of diversity (gender, age, sexual orientation, disability, religion, social class, etc.)? Second, should we modify existing psychotherapies to incorporate diversity issues, or develop specific therapies for each group? How therapy should be modified to deal with diverse populations is still a matter of debate. The culture-sensitive movement, however, has been instrumental in changing the view that mental health difficulties reside solely within an individual to include consideration of a person-environment interaction. In other words, social context is increasingly recognized as vitally important in the assessment and treatment of psychopathology.

All of these changes are both challenging and exciting. They allow therapists an opportunity to be creative and in the forefront of meeting the new demands of the field. Additional skills needed in the mental health profession are also addressed in this text. In Chapter 16, we cover best practices and specific techniques for dealing with crises confronted by many clinicians, including situations where there is a concern about suicide or violence toward others. There has been increased attention on behavioral medicine and psychopharmacology in the mental health field. Many mental health professions now require courses on and knowledge of psychotropic medications. This has become more important as medical professionals increasingly collaborate with mental health professionals and the integration of services (both mental and physical) becomes an accepted model of treatment. Medication is a topic we cover in depth in Chapters 17 and 18. For the remainder of this chapter, we will focus in greater detail on the changes occurring in the mental health field.

**Impact of Managed Care**

An observation made by Cohen (2003) regarding social work applies equally to other mental health training programs: “traditional curricula are no longer adequate to prepare students for practice in the era of managed-care. Managed-care’s emphasis on the provision of mental health services at contained costs requires specialized practice skills, particularly rapid assessment, brief treatment, and the ability to document treatment outcomes” (Cohen, 2003, p. 41). What are the skills needed to meet the demands of a managed-care environment? In most training programs, a primary focus involves helping students develop interviewing and interactional skills. Bradley and Fiorini (1999) found that, in a survey of mental health programs, the most frequently addressed practicum competencies involved the microskills (listening, reflection of feelings, empathy, and genuineness) emphasized by Rogerian theory.
Less than one third rated “readiness for employment as an entry level counselor” as an expected competency. As Bradley and Fiorini concluded, “...this heavy focus on basic listening skills may need to be questioned in light of the increasingly complex clients who are being seen by practicum students. Competence in basic attending skills may no longer be sufficient for success in practicum or internship courses” (p. 117). This observation is especially true both in terms of the more severe and chronic populations faced by mental health professionals and in meeting the requirements of insurance companies and managed-care systems.

Unfortunately, most psychotherapy textbooks and mental health training programs do not address the need for new skills in a comprehensive manner. This leaves trainees without adequate background preparation. Textbooks have been deficient in providing a bridge between the theories and the current work requirements of mental health professionals. Most texts present the theories of counseling and psychotherapy without much guidance regarding how they can be adapted to meet the challenges posed by managed-care requirements or in work with diverse populations. During internships, especially in managed-care settings, the theories of therapy learned by students are of little help in meeting assessment, therapy, and outcome requirements. Brief models and techniques that have evolved from these theories are not presented, nor is there much focus on the applicability of theory to practice. This leads to a disconnect between what students learn from texts and the skills they are expected to apply under managed care and accountability guidelines. Also, students receive little guidance in working with diverse populations.

In addition to interviewing techniques, what skills are necessary for practitioners working in a managed-care environment? According to a managed-care representative, the following are expected (Anderson, 2000):

1. Diagnosis. The ability to diagnose using DSM-IV-TR and to describe symptoms used to justify the diagnosis is essential; the diagnosis often determines whether the treatment is covered for insurance reimbursement.

2. Treatment plan. An individualized treatment plan must be developed for each client that includes goals, objectives, and interventions for treatment. The plan should include: (1) a clear statement of the client’s problems, (2) specific and concrete goals, and (3) measurable criteria to evaluate goal attainment.

An example incorporating these features for a client suffering from depression might include:

*The client currently exhibits flat affect, depressed mood and reports disturbed sleep (no more than 4 hours a night for the past month) and decreased appetite*
(has been eating one meal a day for the past 2 weeks), and has not engaged in pleasurable activities for 3 weeks. The goals are (1) to make a list of three pleasurable activities from which client will choose one to perform 3 days out of the week, (2) to eat two well balanced meals a day for one week, and (3) to identify triggers to depression by writing in a journal three times a week. I plan to see the client in weekly individual sessions. I will be using cognitive-behavioral techniques to help identify triggers to depression as well as client-centered therapy to enhance the therapeutic relationship . . . I am requesting 12 sessions. At the end of these sessions, client progress will be reevaluated. (Anderson, 2000, p. 347)

This degree of specificity is not only important for meeting managed-care requirements, but also helps both the client and therapist understand the goals for treatment and planned interventions. Although the above example involves the cognitive-behavioral perspective, other therapeutic approaches can be utilized as long as goals and treatment strategies are clearly specified. In the case of psychodynamic approaches, techniques must be adapted for managed-care. Since there is little time allowed for traditional transference analysis (client reactions to the therapist because of childhood conflicts), psychoanalytically oriented therapists may focus on transferences that exist within the client’s current relationships. Instead of analyzing transference reactions to the therapist, insight techniques are employed to help the client understand core conflictual themes from childhood that are responsible for the relationship difficulties. The insight is then explained in behavioral and affective changes as indicated in the follow case:

A retired woman came into therapy complaining of sleeping difficulties, discomfort even at home, and dissatisfaction with her relationship with friends and family. The interpersonal pattern itself was life-long and had roots in her childhood as a result of a dominant and aggressive father and an attentive but passive mother. (Sperling & Sack, 2002)

The woman could have received traditional psychoanalysis with years of weekly or even more frequent sessions. However, because of managed-care constraints, therapy focused on the analysis and interpretation of interactional patterns with two of her closest friends. By understanding current relationship problems as the result of past childhood difficulties, the client was able to “chip away at the repression of negative feeling” (p. 367) and improve her interpersonal relationships. To meet managed-care requirements, psychodynamic therapists can use alternative language to describe their therapy. Instead of referring to positive transference, the process can be described as modeling. Instead of interpretation, terms such as reattribution or reframing are used to describe the process in which the therapist works to relabel the client’s perceptions so that problematic situations or behaviors
are interpreted in a more positive light. Not all psychoanalytically oriented therapists, or those of other theoretical orientations, agree to these changes. However, therapists of all orientations need to be willing to make modifications in their therapy if they are to participate in current health care plans. We can no longer use global statements such as “develop insight into patterns of behavior” or “help the client improve self-esteem” in our work with clients. We will be expected to describe precisely how the client will be different in terms of behaviors and life choices once the therapeutic goals have been attained.

Some mental health professionals believe that the need for specificity in treatment detracts from the human aspect of psychotherapy. As one client-centered therapist lamented, “Humanistic therapy looked like what graduate students imagined therapy should be: a sensitive, understanding, caring, supportive, and authentic person engaged in a personal encounter with the client in a manner that facilitated personal discovery and learning. Yet, many of these graduate students would eventually embrace cognitive or cognitive-behavioral or some of the ‘brief’ or ‘strategic’ approaches emphasizing therapist technique and wizardry” (Cain & Seeman, 2002). The reason for this change is due to the current “therapeutic zeitgeist” of managed-care with its emphasis on diagnosis, treatment planning, and rapid remediation of clients’ symptoms. Although many therapists see managed-care as an unwelcome impediment, the positive side is that theories are continuing to evolve and incorporate these requirements. Additionally, as we will illustrate later, the need for rapid assessment and treatment does not preclude the use of empathy and other interpersonal skills when working with clients. It is essential that, as mental health professionals, we develop the ability to perform assessment, define goals, provide brief interventions, and evaluate client progress and outcome within the context of a positive therapeutic relationship.

Evidence-Based Practice and Empirically Supported Therapies

On a videotape, a 10-year-old girl, Candace, was seen begging for her life. She was wrapped tightly in a blanket and pressed upon with pillows by four adults. The girl was undergoing “rebirthing therapy” to treat a purported diagnosis of reactive attachment disorder, a condition thought to prevent the girl from forming loving relationships. The therapy was to enable Candace to be “reborn” and thus, able to bond with her adoptive mother. The session was supposed to be a simulation of birth with the womb represented by the blanket and pillows. Candace underwent this process for 70 minutes and complained about not being able to breathe. After being unwrapped, Candace was no longer breathing. According to the coroner, the cause of death was suffocation. The state of Colorado has since enacted a law specifically outlawing rebirthing therapy. (Kohler, 2001)
As a therapist, how do you decide what form of therapy to apply with specific mental health problems? Should therapists be allowed to choose whatever therapy they believe will be effective? Should therapies be subject to evaluation? If so, what kind of process would this involve? Currently, there are hundreds of different forms of psychotherapy and few restrictions on what can be practiced. Within the court system, the Frye standard (Frye v. United States, 1923) is often utilized to determine whether a particular treatment, such as “rebirthing therapy,” is effective or appropriate (Beutler, 2000a). It depends upon the principle of general acceptance by the appropriate scientific community. Under this principle, therapies frequently practiced by therapists are deemed to be valid and “true” regardless of their effectiveness or potential for harm. In some cases, consideration is given to the principle of the respectable minority, in which treatments cannot be considered for malpractice if they are based on a theory and supported by a “respectable minority” of therapists. Again, whether the therapy is effective or responsible for harm to a client is not taken into account. In 1993, the Supreme Court set the Daubert Standard (Daubert v. Merrel Dow Pharmaceuticals) regarding the admissibility of expert witness testimony in federal courts. This was done to eliminate “junk science” from the courtroom. Under this standard, theories or techniques must be falsifiable through empirical testing, subjected to peer review and publication, and generally accepted by the appropriate scientific community. This is a welcome move, although judges will now have to serve as gatekeepers and deal with controversial issues such as repressed memory and syndromes such as sex abuse accommodation and parental alienation. Unfortunately, many judges do not have the scientific background to understand aspects of the Daubert decision such as falsifiability and still rely on the Frye standard (Dahir et al., 2005).

Evidence-Based Practice

Currently, all mental health professions (psychiatry, social work, clinical psychology, or counseling) are espousing the view that treatments should have a research base. Evidence-based interventions are being increasingly promoted in social work (Bledsoe et al., 2007; Gibbs & Gambrill, 2002), school psychology (Kratochwill, 2002), clinical psychology (Degear & Lawson, 2003), counseling psychology (Chwalisz, 2003), and psychiatry (Eisendrath et al., 2003). However, research and clinical practice often travel separate paths, with little connection between the two. This is surprising since mental health programs often require a number of courses dealing with scientific methodology. With the advent of managed-care and the need for accountability in health care, the demand for evidence-based practice has increased. This emphasis is reflected in the President’s New Freedom Commission on Mental Health (2003), which calls for disseminating research findings on treatment
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to both service providers and the public. The commission argued for more effective means of identifying, disseminating, and utilizing evidence-based practices in providing mental health care.

Similarly, the American Psychological Association has promoted empirically supported treatments (ESTs) that have been evaluated using specific research criteria. Based on the type and quality of research evidence, certain treatments have been designated as being either “well-established” or “probably efficacious.” Empirically supported treatments are available for a number of disorders involving anxiety and stress, depression, chemical abuse and dependence, childhood problems, and marital discord (Chambless & Ollendick, 2001; Woody & Sanderson, 1998). There is an increased expectation for mental health professionals in all disciplines to be aware of current research on effective treatments. Research has also been directed toward discovering empirically supported therapy relationship variables (ESRs) that are related to treatment outcome. In outcome research, therapist variables have demonstrated consistent and robust effects (Norcross, 2000). The conclusion of the Division 29 Psychotherapy Task Force of the American Psychological Association (Ackerman et al, 2001) was that the following therapist qualities were “demonstrably effective”: (1) therapeutic alliance, (2) empathy, and (3) goal consensus and collaboration. The “promising and probably effective” variables included: (1) positive regard, (2) congruence/genuineness, (3) feedback, (4) repair of alliance ruptures, (5) self-disclosure, (6) management of countertransference, and (7) quality of relational interpretations. These qualities are discussed in detail in Chapter 3.

Training programs are beginning to incorporate techniques that have received empirical support. Eisendrath et al. (2003) described a research-based treatment program for depression. Before this program was instituted, psychiatric residents treated patients suffering from major depression using long-term psychotherapy, even though there was no strong evidence for the effectiveness of this approach with this disorder. After reviewing the research literature on interventions and medications for depression, Eisendrath and his colleagues identified components recommended for successful treatment and developed a comprehensive, empirically based therapy package that included:

2. Patient education information available in written form and on a website.
3. 12 week cognitive group therapy (CBT) model based on the manual by Munoz et al. (1995).
4. 16 week interpersonal psychotherapy (IPT) involving individual treatment as described by Klerman, Weissman, Rounsaville, and Chevron (1984).
5. Booster sessions of CBT or IPT for relapse prevention.
6. Medication management based on guidelines from a review of the literature.
7. Initial and regular follow-up using the Beck Depression Inventory to monitor clinical symptoms, course, and to inform treatment decisions.

Since the program was developed, psychiatric residents are now formally trained in both CBT and IPT, both of which are empirically supported treatments, and in the use of medication guidelines for specific disorders. The residents also learn to analyze objective outcome information to supplement their clinical assessments. Due to the scientific foundations of their training model, Eisendrath and his colleagues believe that they have established an evidence-based ethic among the residents.

Need for a Scientific Framework in Clinical Practice

In a survey of 860 therapists, 51 percent endorsed the belief that memories of actual events as far back as birth can be retrieved through hypnosis (Yapko, 1994).

Bennett Braun, a prominent pioneer in the field of dissociative disorders, and a former president and co-founder of the International Society for the Study of Dissociation, lost several lawsuits filed by former clients who claimed he inappropriately used hypnosis and drugs to convince them that they had hundreds of personalities, and in one case, had a client believe that she was a high priestess in a satanic cult, had sexually abused her own children, and had eaten meatloaf made of human flesh (Associated Press, 1998).

The above examples indicate that, as mental health professionals, we need to develop critical or scientific thinking regarding psychotherapeutic practice. For many mental health programs, the evidence-based approach represents a paradigm shift from training models based primarily on a specific theoretical model or the clinical experience of the practitioner (Belar, 2003). Both are subject to bias. For example, one’s theoretical orientation can influence diagnosis even when using objective measures. Although the commonly used DSM-IV diagnostic system is thought to be theory-free, many clinicians using this system rely on their own theoretical orientation in deciding if a client belongs in a specific diagnostic category, giving greater weight to symptoms that fit their theoretical model (Kim & Ahn, 2002). Wholesale acceptance of a particular theory is not a part of the scientific method. It prevents the consideration of data that do not fit the theory. For example, social workers in one study showed a clear preference for a
confirmatory strategy; that is, they only sought information that supported their hypothesis and disregarded information that was inconsistent with their view (Osmo & Rosen, 2002). Confirmatory strategies are not consistent with a scientific model in which hypotheses are tested and alternative hypotheses are developed and evaluated. Instead of relying only on theory, professionals and trainees need to use a scientific or evidence-based methodology in formulating a diagnosis, providing appropriate treatment strategies, and in evaluating their performance with clients. To do this, therapists must learn the skills to evaluate research findings associated with the various constructs and techniques of each of the psychotherapeutic theories. In clinical work with clients, we need to treat our clinical intuitions as hypotheses to be tested and be willing to formulate alternate hypotheses, if needed. Treatment selection should be based on research findings, and interventions strategies should be continually evaluated for effectiveness as treatment proceeds.

**Practice Guidelines**

Practice guidelines have been developed for a variety of disorders. These guidelines, together with those developed in the future, are becoming “the standard for care” by which the appropriateness of a selected treatment is evaluated and are based on comprehensive reviews of research and clinical data. For example, guidelines developed by the American Psychiatric Association describe the clinical features that may influence the treatment plan and suggest the use of specific forms of psychotherapy and medication that have been found to be effective for different mental disorders. As might be expected, the guidelines of the American Psychiatric Association tend to emphasize the importance of medications over psychotherapeutic orientations. However, the clinical recommendations are quite useful because they identify possible co-occurring problems and suggest therapeutic strategies for dealing with the specific disorders. For example, the treatment suggestions for clients with borderline personality disorder include the following (American Psychiatric Association, 2001):

1. A safety evaluation should be performed because suicidal ideation and attempts are common.
2. Plans should be developed for responding to crises and monitoring the client’s safety.
3. Psychoeducation about the disorder should be provided to the client, particularly with respect to symptoms such as emotional reactivity.
4. Special issues associated with this disorder that one should prepare for include (1) dichotomous (black or white/good or bad) thinking on the
part of the client and (2) boundaries issues (e.g., client may attempt to initiate contact outside of sessions).

5. Direct discussion is best with clients who violate boundaries. For example, the therapist might say, “You recall we agreed that if you feel suicidal, then you will go to an emergency room. If you cannot do this, then your treatment may need to be changed” (p. 9).

6. Goals for treatment and strategies should be developed collaboratively with the client and a clear and explicit plan should be agreed upon.

7. Regardless of type of psychotherapy, features found to be important in treatment are a strong *therapeutic alliance*, validating the client’s suffering, encouraging clients to take responsibility for their actions, having them learn to manage their feelings, promoting reflective rather than impulsive action, and setting limits on self-destructive behaviors.

8. Families and significant others of the client can benefit from psychoeducation about the disorder, its course, and treatment.

9. Psychopharmacology can be used to treat symptoms associated with the disorder such as depression and anger. SSRIs are the recommended treatment, with low dose neuroleptics added for those with poor behavioral control.

Practice guidelines are based on the research and clinical data that are currently available. If significant new information is obtained, the guidelines are updated. Standards of care have also been developed for specific populations by other organizations and include: gender identity disorder (Levine et al., 1998), older adults (American Psychological Association, 2003c), gay and lesbian clients (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force, 2000), and other special populations (Sue & Sue, 2008). These guidelines are useful since they alert the clinician to possible problems associated with certain disorders and offer treatment recommendations. Practice guidelines and research-based treatments will gradually become the standard of practice for mental health professionals in the treatment of specific disorders and with specific populations. They can be very helpful since mental health professionals are expected to have research support for their clinical decisions.

**Cultural and Diversity Issues**

Another major emphasis in the mental health field is acknowledging the influence of cultural and diversity factors on mental health, psychopathology, and therapy. In psychotherapy, culture-sensitive or multicultural therapy is expected to become more important as our society becomes increasingly di-
verse (Norcross, Hedges, & Prochaska, 2002). Culture-sensitive therapy involves the modification of psychotherapy to take into account cultural values and societal context. However, at this point it is not clear, from an evidence-based perspective, whether culturally-sensitive therapy (CST) is more effective with ethnic minority clients than traditional forms of psychotherapy (Hall, 2001). There is some evidence, however, that the ethnic identity of a client can influence the rated credibility of therapies such as cognitive therapy and time-limited dynamic psychotherapy (Wong, Kim, Zane, Kim, & Huang, 2003).

The emphasis on social and cultural factors is gaining importance as the United States becomes increasingly diverse. When the population reaches an estimated 383 million in the year 2050, people of color will constitute the majority group (U.S. Census Bureau, 2000). Other aspects of our society are also undergoing change. We are an aging population. By the year 2030, those 65 and older will constitute 20 percent of the population. Diversity in the structure and definition of family has also increased. There has been a large increase in married women who are employed, single parent households, blended families, adoptive families, and mixed ethnic families. By the year 2010, married couples will no longer constitute the majority of households (Robinson & Howard-Hamilton, 2000). Can the theories of counseling and psychotherapy developed many decades ago deal with the changing characteristics of our population? Are mental health professionals equipped to meet the complex characteristics of clients that include variations in race, ability, gender, economic status, health status, sexual orientation, and religious beliefs, to name a few?

Population-Specific Approaches

Attempts to develop population-specific approaches for ethnic groups has often led to fragmentation, confusion, and controversy in the field of counseling and psychotherapy. Diversity training has been accused of professionally sanctioned stereotyping in which cultural attributes are given primary consideration, rather than understanding the uniqueness and life circumstances of the individual client (Freitag, Ottens, & Gross, 1999; Sue & Sue, 2003). In our attempt to acknowledge group-specific differences, we are in danger of developing a cookbook approach, in which the characteristics of groups are memorized and suggested counseling techniques are applied (Speight, Myers, Cox, & Highlen, 1991). Weinrach and Thomas (1998) believe that there is no need for diversity sensitive therapy since “widespread assimilation may reduce the urgency for radical modification of existing counseling theories” (p. 117). Should we maintain our traditional training model or do we need an alternative approach to conceptualizing and meeting the diverse needs of our clients?
These conflicting viewpoints on diversity sensitive therapy can be confusing for mental health professionals and students alike. Our current model of multicultural training generally leads one to believe that there are two types of psychotherapy, “regular therapy,” which is taught in traditional counseling and psychotherapy courses, and “multicultural therapy,” which is often a separate course. In training for regular therapy, trainees spend countless hours practicing microskills (interviewing and communication skills) and other therapy techniques (Ivey, Ivey, & Simek-Morgan, 1993). Students and practitioners are warned, however, that these skills may not be appropriate for individuals from different cultural backgrounds. This admonition results in confusion and feelings of inadequacy in mental health students and professionals when exposed to clients of a different ethnic background. Textbooks on counseling and psychotherapy have attempted to acknowledge diversity issues by devoting small sections of chapters to the discussion of ethnic and cultural influences. Such an approach once again promotes the view that there are two types of counseling and does not address the changing nature of the population and the increasing probability that we will be seeing large numbers of culturally diverse clients. We believe that the diversity considerations should be a standard part of assessment, diagnosis, and treatment. In later chapters, we will illustrate how this can be accomplished, but we will first discuss how the mental health professions are attempting to acknowledge cultural and societal issues.

Current Diversity Guidelines

Recently, specific guidelines have been published by mental health organizations to address sociocultural factors when providing psychotherapy. The DSM-IV-TR (American Psychiatric Association, 2000) has taken a step in this direction with Axis IV of the multiaxial assessment. This axis focuses on “psychosocial and environmental problems” as they play “a role in the initiation or exacerbation of a mental disorder” (p. 29). Examples given of such problems are acculturation conflicts, discrimination, and housing and economic difficulties. Also, in Appendix I of the DSM-IV-TR, clinicians are asked to be aware of the possible impact of cultural factors on assessment, diagnosis, treatment, and the therapeutic relationship. However, there is little guidance in terms of what to do if cultural factors are judged to be important. Similarly, in the “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations” (American Psychologist, 1993), psychological service providers are asked to consider the impact of issues such as political, social, and economic factors on the sociopsychological development of different populations. If they are found to play a significant role, the psychologist is to: “help clients to understand/maintain/resolve their own sociocultural identification” and to “help a client determine whether a ‘problem’
stems from racism or bias in others so that the client does not inappropriately personalize problems” (p. 46). Again, there is no guidance on how sociocultural factors are to be assessed. Although the guidelines from the American Psychological Association are somewhat more specific than those in DSM-IV-TR, problems remain. With the exception of the fields of social work and multicultural therapy, mental health theories and therapies have focused primarily on the individual, with little attention to socioenvironmental factors.

Contextual Framework

There has been a call for a “reconstruction” of our mental health training in shifting from the “sole location of client issues in the individual to the recognition of the contexts in which all human behavior is embedded” (McAuliffe & Erickson, 1999, p. 269). To accomplish this, changes have to be made in the process of assessment and therapy so that therapeutic approaches and techniques are not imposed on the client, but are modified and evaluated in terms of the degree of fit with the client’s perspective. We believe that to work successfully with clients, it is necessary to understand how each client experiences the world and that therapy is most successful when adapted to the client’s worldview. The recognition of contextual issues necessitates an acknowledgment of potential etiological influences on problems from individual, family, cultural, and situational contexts. It allows societal issues involving gender, disability, aging, and other forms of discrimination to be addressed.

Impact of Worldview and Values on the Therapist

Therapists need to acknowledge and recognize their own set of attitudes, values, and expectations when providing services to diverse populations. For example, several mental health organizations have established the following guidelines:

*Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief religion, and mental or physical disability.* (National Association of Social Workers, 1999, p. 6)

*Counselors will actively attempt to understand the diverse cultural backgrounds of the clients with whom they work. This includes, but is not limited to, learning how the counselor’s own cultural/ethnic/racial identity impacts her/his values and beliefs about the counseling process.* (American Counseling Association, 2005, p. 11)
Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves. (American Psychological Association, 2003b, p. 17)

Dealing with diversity issues in therapy involves consideration of issues from multiple perspectives. First, diversity issues need to be considered for all clients. Second, as therapists, we must identify how our beliefs, experiences, attitudes, and values influence the way we provide therapy to each client we work with.

Evidence-Based Practice and Diversity Issues in Therapy

Evidence-based practice is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273)

The central theme of this book is the need to prepare students and practitioners for the evolving standards in the mental health profession. In doing so, we are in accord with the definition of evidence-based practice set forth by the APA Presidential Task Force, which considers the importance of research, therapist skills, client characteristics, and cultural factors in the provision of psychotherapy. We believe it is essential to consider each of these areas in assessment, case formulation, intervention, and evaluation of outcome.

The book is organized in the following manner: The current chapter, Chapter 1 (Science and Diversity in Psychotherapy: Important Perspectives), addressed the need for scientific and diversity training in psychotherapy to meet the demands for accountability and effectiveness in treatment. Chapter 2 (Evidence-Based Practice in Psychotherapy: Techniques and Relationships) prepares the reader to use scientific and critical thinking skills in clinical practice. Chapter 3 (Therapist-Client Relationship Skills) presents research-supported therapy skills, and strategies for establishing joint goals and interventions strategies. Chapter 4 (Contextual and Collaborative Assessment) incorporates diversity issues in traditional clinical assessments such as the intake interview and the Mental Status Exam. Chapter 5 (Diagnosis and Conceptualization) covers differential diagnosis, the use of DSM-IV-TR, and case conceptualization with an emphasis on diversity considerations. Chapters 6 through 15 cover the major theories that form the foundation of counseling and psychotherapy (Psychodynamic, Humanistic, Cognitive-Behavioral, Multicultural) as well specific techniques and manualized treatment approaches connected to the theories (Interpersonal Therapy, Core Conflictual Relationship Theme Therapy, Motivation Enhancement Therapy, Cognitive-
Behavioral Therapy, Dialectic Behavior Therapy, and multicultural practice guidelines and strategies). Chapter 16 (Assessment and Interventions in Emergency Situations) reviews current research and best practices when dealing with psychological crises, including threats to self or others. Chapter 17 (Understanding Psychopharmacology) and Chapter 18 (Medications Used with Psychological Disorders) cover most common types of medications used in mental health settings, research involving their effectiveness, and the need to consider cultural beliefs regarding medication.

The different theories of counseling and psychotherapy are presented in the following manner:

- An overview of the theory
- Psychotherapy techniques derived from the theory
- Modifications to incorporate diversity issues
- Research findings
- Manualized treatments developed from psychoanalytic, humanistic, and cognitive behavioral theories

We have included examples of manualized therapies so that readers can have a clear understanding of how specific theories are used in practice, and have included the reference for the original sources at the end of each therapy chapter. Books on counseling and psychotherapy rarely show how therapy is conducted from the initial session to termination. For each therapy, we will demonstrate how the therapeutic relationship is established, the types of assessment employed, and treatment strategies. Exposure to the actual process involved in different evidence-based therapies is vital to the education and training of practitioners. We believe this textbook will prepare students and current mental health practitioners to work in the changing field of mental health and to develop the necessary skills to practice in a managed-care environment with increasingly diverse clients.