Development and Importance of Theoretical Orientation in Psychotherapy

Literature Review and Experiential Project

Presented to

The Faculty of Adler Graduate School

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In Partial Fulfillment of the Requirements for the

Degree of Masters of Arts in

Adlerian Counseling and Psychotherapy

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January 2014

Abstract

In the field of psychotherapy, there remains an information gap around the development and importance of theoretical orientation that spans from the general public to healthcare professionals to mental health professionals themselves. With better understanding of theoretical orientation, patients are better able to be proactive in their care and seek out the best suited psychotherapist not only for their presenting concern, but for their personal temperament. Being rooted in a personal theoretical orientation that aligns with personal values, experiences, beliefs and education also benefits the psychotherapist in numerous ways, including providing a professional framework for intentional counseling. When a patient is aligned with an appropriate therapist, their treatment outcomes are greatly increased. In an effort to bridge this information gap, a presentation was given to a team of healthcare professionals at a large healthcare management company. This paper reviews the background of the information gap problem, history and development of theoretical orientation, the presentation itself and future implications for the role theoretical orientation may play in years to come.

Development and Importance of Theoretical Orientation in Psychotherapy

Information Gap

General Public

"The more than 400 theoretical orientations that have now been developed vary widely in focus and scope," (Corsini & Wedding, 2008). While many in the field of mental health understand this statement to be true, most in the general public do not. When an individual is referred to a professional, or of his/her own volition, decides to seek out support through psychotherapy, he/she commonly will take the referral, without question, given them by his/her doctor or friend that has suggested a certain clinician.

There remains a large gap in knowledge, for the general public, regarding how mental health professionals may vary in their practice, specifically in their personal theoretical orientation. The purpose of my presentation and this paper is to acknowledge the gap and to attempt to address the problem through education surrounding the development and importance of the theoretical orientation of psychotherapists.

The hope is that this information may promote awareness concerning the variance in theoretical orientation and increase outcomes for future clients seeking support through their personal advocacy of selecting a therapist that is the best fit for their individual concerns as well as their personalities.

Healthcare Professionals

Everyday healthcare professionals make referrals to individuals to seek out psychotherapy. Unfortunately, too many healthcare professionals have not been provided the proper education needed to give guidance to their patients in selecting the most appropriate psychotherapist for them, as individuals. In the minds of many healthcare professionals, all

psychotherapists are one and the same. In reality, there are numerous differences in how some psychotherapists work with their clients as compared with the practices of other clinicians, based upon their background, education, and overall theoretical orientation.

There are therapies that are empirically proven through evidence-based studies to be better for certain conditions than other therapies (Craighead, Miklowitz & Craighead, 2008). For example, "DBT is considered an evidence-based and empirically supported treatment for BPD and suicidal and self-injurious behaviors," (American Psychiatric Association, 2006). The referral a patient receives from his/her general practitioner on receiving DBT for their suicidal daughter, may not be coming from a physician who understands current best practice of mental health treatment. Instead the referral may be to a therapist the physician knows to have had success with other unrelated disorders, or to a clinician they know because they are housed in the same building. The physician may assume that all therapists would be highly skilled in the requested therapy, and with that misunderstanding, he/she is unable to coach the family on how to ask appropriate questions to advocate for themselves upon meeting the therapist.

This particular therapist to whom the physician makes his referrals, may only be loosely familiar with the most appropriate therapy that the parents are seeking. We can hope the therapist would acknowledge his lack of familiarity to the family and refer them to someone new, but this does not always happen. Inadequate referrals based on misunderstandings may delay therapy, which in turn may be fatal. Unfortunately, many healthcare professionals and most of the general public are not aware of the right questions to ask to advocate for the best possible care for their mental health needs.

Mental Health Professionals

Unfortunately**,** not only is there an information gap with the general public and healthcare professionals, but within the mental health community as well. Many newly licensed therapists are beginning their practice, unclear about their own theoretical orientation. It should be noted that the development of theoretical orientation, to be covered later in the paper, is a process, and not every student will graduate with a confidence in their own orientation. Developing a theoretical orientation requires experience and contemplation. Some therapists have no intention of deciding upon their theoretical orientation, rather idealize becoming an eclectic therapist. In a study by Garfield and Kurtz (1976), we see that as early as the 1970's, 55% of respondents considered themselves to be eclectic. While not always the case, "portraying oneself as eclectic is an 'easy out' when one is asked about personal theory. We have heard several students say that, while interviewing for clinical positions, they present themselves as eclectic in an attempt to avoid presenting a theory not endorsed by the interviewer," (Halbur, 2011, p.44).

There should be a distinction made here that eclectic, by definition of utilizing multiple techniques from theories that align well with your home base, is very different than being eclectic in the sense that you are unwilling, or unable, to confidently and perhaps even courageously, share with your colleagues and clients where your practice is rooted.

<p align="center">**Theoretical Orientation Presentation**</p>

In an effort to address the identified information gap, a presentation was given to a team of Healthcare Professionals working at Cigna Behavioral Healthcare in Eden Prairie, Minnesota on Wednesday, December 18, 2013. The presentation was given by this author, a graduate student in psychotherapy, using information compiled through schooling and research on original

and current literature on the development, importance and use of theoretical orientation in the practice of psychotherapy.

The presentation was made to Cigna employees working together on an Integrated Personal Health Team (IPHT), which provides personalized coaching services to the customers of Cigna Healthcare. Integrated Personal Health Teams are comprised of registered nurses, health educators, exercise physiologists, registered dietitians, pharmacists, medical doctors and licensed mental health clinicians. In attendance at the Cigna presentation were approximately twenty team members representing varying backgrounds.

Theoretical Orientation Overview

The presentation opened with a conversation about varying definitions of theoretical orientation. Though there was a psychiatrist and numerous licensed mental health clinicians in attendance, the majority of the attendees were not as familiar with the concept of theoretical orientation. Definitions of, "a stage to translate theory into practice- a tool belt," and "one's understanding of how a person's problems have developed and how they can be solved," were offered as quality examples of working definitions of theoretical orientation for the presentation. The central objectives, listed below, were also covered in the presentation opening.

-Gain a better understanding of theoretical orientation

-Why theoretical orientation is important for both the client and the therapist

-How to educate your clients on finding a good fit for them personally

-Development of personal theoretical orientation as a clinician

-How different clinicians with varying orientations might approach the same case

During this opening time, an overview of what the presentation was not was also covered. Explanation was given that the presentation was not meant to be an in depth overview of the

various schools of psychology and the theories housed within them; but rather to highlight that there are different schools of thought and that the importance of understanding this concept both as a potential client themselves and as a health care professional is critical in the successful connection of a client to an appropriate therapist.

Importance for the Clinician

There are numerous benefits in the determination of personal theoretical orientation, for the clinician, including the avoidance of the delusion that he/she are capable of being all things to all people and the critical importance of having a home base to return to that provides grounding during therapy sessions (Halbur, 2011).

The concept of intentional counseling was discussed, and how this can best be facilitated for the clinician when he/she is working from a professional framework that is provided by a solid understanding of his/her personal theoretical orientation. While people truly are multi-dimensional, and theory is not 'one size fits all', a clinician's theoretical orientation can provide consistency; ways to listen and organization of information within the therapy sessions that keep both the clinician and the client on track (Halbur, 2011).

Therapy can be messy and it can get complicated and jumbled. The professional framework that theoretical orientation can provide allows clinicians to keep a steady direction as they pull from their bag of appropriate tools.

Importance for the Client

Understanding your therapist's theoretical orientation can increase the odds of a good client/clinician fit. Theoretical orientation can speak to one's personal philosophy, beliefs and communication style. A client picking the first therapist in the phonebook that has a theoretical orientation that is very opposed to the client's core beliefs is not likely to result in a successful

match. After an unsuccessful pairing, the client will be increasingly less likely to seek out help in the future.

Development of Theoretical Orientation

Finding oneself, seeking personal therapy, understanding one's personality, finding inspiration, reviewing one's counseling skills on videotape and supervision are all suggested methods of exploring a theoretical orientation that is right for the clinician (Halbur, 2011).

A logical place to start with this process is examination of where you naturally are, right in this moment. The "day in the life" exercise directs an individual do a 24 hour recall of the various situations they may have encountered throughout the previous day (Halbur, 2011). For example, this might include getting your nails done by an unwed young mother of three in a struggling relationship, interacting with a handicapped waiter while at lunch and your cousin phoning and sharing about her new interracial relationship with a man she met overseas.

Noting your reaction and your internal dialogue to various situations can be a valuable exercise in examining your personal philosophy and tolerance. Did the reactions you had with others throughout the day resonate with your chosen theoretical orientation? (Halbur, 2011). For example, with a chosen Humanistic-based theoretical orientation you would want to observe an ability to be genuine and an exhibition of unconditional positive regard. Note what was natural for you, despite how you may have wanted to react.

The development of personal theoretical orientation is a culmination of a clinician's life experience. This includes not only his or her personal beliefs, values and philosophy on life, but his/her education and influential personal and professional experiences. As therapists mature in their practice, it is not uncommon for them to branch out from an original declared orientation. Many therapists report that through experience they discover limitations to their original

preferred orientations, and that "their theoretical framework could not always adequately address what they were seeing in the consulting room," (Boswell, 2009, p.294). This experience can lead clinicians and researchers to explore other frameworks. "Consistent with the evidence that supports the incorporation of techniques and practices from differing orientations (see Schottenbauer, Glass & Arnkoff, 2005), these clinicians found that their patients benefited," (Boswell, 2009, p.294)

Considerations in Selecting a Therapist

When working with clients, health care professionals will find that, there are frequent opportunities which may arise to make referrals to see mental health professionals. Therapists will generally be open about their backgrounds, theoretical orientation and specialties in their advertising and websites. It is always a good decision to seek out therapists that have a specialty in the area pertinent to a client, in that they tend to be more educated in the specific areas of distress, to be most up to date on the latest research on best practices, and most importantly, likely to have a passion for the work in that area.

Health care professionals can assist patients in finding the most appropriate therapist through filtering for specialties as you make a referral and by encouraging clients to research therapists they are interested in seeing and to ask questions on their first visit, such as: "Can you tell me about your theoretical orientation?" "What types of techniques or exercises can I expect in our sessions together?" "What is your experience in working with my particular concern?" "How long would you expect our therapy to last?"

Some types of therapies may require looking back into your past or drawing upon your spiritual side. Others are more solution-focused in the here and now, and depending upon your personal philosophy, beliefs, and even temperament and openness, you are likely better suited for

some therapies more than others. It is always appropriate to have a discussion with the therapist within the first couple sessions about not only their background and beliefs about therapy but about the client's own to determine if it is a good pairing or if they could provide the client with some referrals that might be a better fit.

Schools of Thought

As previously mentioned, the aim of the presentation was not to provide an in-depth overview of psychological theories, but to illustrate that different psychological theories exist . The main schools of thought and the umbrellas that they provide to house various theories were illustrated. For example, Adlerian, also known as Individual Psychology, is from the early Psychodynamic school of thought (Halbur, 2011), but its main principles are carried over into numerous later developing theories such as CBT and even more modern day Narrative Therapy. There is just as much overlap as there is variance among most of the present day theories.

Case Study

To illustrate the way therapists with varying theoretical orientations might approach the same case, a case study was given in the presentation, followed by four examples of approaches that might be used by therapists grounded in four common theories today.

Case Study: *"Ann", 22 year old, single female*

Currently living with her mother and brother (age 20)

One older sister, in medical school, she lives in the shadow of (age 25)

Concerns- Depression, indecision about dropping out of college, poor self-image, lack of support, isolation, experimenting with cutting, poor relationship with Mother and Sister, avoidance of romantic relationships

The four home-based theories were selected with the audience in mind. Adlerian, CBT, Family and DBT are all theories that the IPHT reported having frequently heard clients discuss in their interactions; either as something of interest to the clients or a method in which they were participating, though, the healthcare professionals in the audience themselves may not have been particularly familiar with the therapy itself.

The format used in the presentation was to provide the following information for each of the theories: pioneers, school of thought origination, key concepts, time frame for therapy and the forms of distress for which the therapy is commonly used. For the purposes of this paper, those details will not be discussed here.

Individual psychology. An in depth interview about the client's life, including but not limited to birth order, early recollections, private logic and values is typically conducted within the first several sessions with an Adlerian-grounded theoretically oriented therapist (Carlson, Watts & Maniacci, 2008). The Lifestyle, being central to the Adlerian therapeutic process, enables the clinician to provide the client with intervention and insight into their struggles (Shulman & Mosak, 1988).

Since Adlerians believe the bulk of the client's personality was established in their earliest years of life, it makes sense that taking an in depth look back at this time is an important part of therapy (Adler,1930). The focus aimed at how the client viewed their developmental years. What mistaken beliefs were developed? How did their earliest memories shape the way they now see the world? How are they fulfilling their life tasks? What is their typology? (Watts & Carlson, 1999).

Case study example. Through Ann's lifestyle analysis they discover that she developed a distrust of men at a young age. In looking at her family constellation, parental influence and

family values she is able to see how her father's departure from the family for a career overseas left her feeling incredibly unimportant and that success, as a family value, was very education/career focused in her family of origin and has affected her feelings of self-worth today.

Ann shares an early recollection (ER) with her therapist of being at a park at approximately the age of 4 with her parents and siblings. Her younger brother just an infant and her older sister approximately age 7. Her sister was throwing a fit wanting to go home to watch a show. Ann was having a good time swinging and wanted to stay at the park. She remembers having to get off the swing and go home because her sister wanted to. The standout memory being her parents telling her to get off the swing. The feeling: I am not important.

She is able to take her insights from this and other ER's to understand a mistaken belief of: "I am insignificant. The world is not fair. Therefore, I might as well not try." Through understanding the source of these deep feelings and tying them to her present day feelings of insignificance she is able to see how those feelings are based on faulty logic and she is able to begin the process of replacing these mistaken beliefs that have held her back for so many years.

Cognitive behavioral therapy. CBT-based therapists work from the framework that the client is responsible for making the needed changes and has contributed to their own psychological problems by the way they interpret events and situations. It is the client's own thoughts that have led to their behavior (Beck, 1995; Ellis, 2004).

The CBT therapist focuses on challenging a client's patterns and beliefs and replacing their errors in thinking by focusing primarily on the presenting problem in the here and now (Burns, 1999; Ellis, 1988).

There is a large element of psycho-education that may go on during CBT sessions. There is comfort in knowing that you're not alone and that others have found helpful strategies to

overcome their struggles. A CBT therapist commonly educates clients on their specific problem, such as panic attacks, depression, cutting or phobia (Beck, 1976).

Case study example. In speaking with Ann, the therapist does some psycho-education around depression, self-harm, and the negative feedback loop that has been keeping her stuck in such low regard of herself.

Together they are able to identify some of the symptoms she is having, such as social withdrawal, passivity and a sense of worthlessness, and trace them back to some possible distortions in her thoughts, such as "people won't like me," "everything is too hard," and "I'm a loser."

She is then asked to keep a daily journal of these thoughts, putting them in two columns, as they arise throughout the day. The first column is automatic thoughts and the second is rational responses. Through review in follow up sessions she is beginning to grasp how her thinking plays a significant role in how she is feeling and to make better choices, feeling more empowered, moving forward.

Structural family systems. Structural family therapists do not see families as having a sick or dysfunctional individual, but a sick or psychosomatic family. Though there will typically be an "identified patient" that initiates the family coming to therapy, such as the alcoholic father or anorexic daughter, the family, as a whole, is seen by the therapist. "Focusing exclusively on individual patients and their problems often obscures the influence of family interactions in perpetuating such problems- and their underutilized potential for helping to resolve them," (Nichols & Tafuri, 2013, p.208).

There is psycho-education around appropriate communication that is typically done in early sessions. Techniques such as reframing, which attempts to redefine family behaviors to

keep the family united as a functioning unit, can help family members to gain insight into one another and foster a change in patterns through giving behavior new meaning (Raymond, Friedlander, Heatherington, Ellis & Sargent, 1993).

Family systems are commonly much more complicated than they may first appear. The skilled family therapist uses a joining technique to better observe and listen to each member and create a relationship of being almost an extended member of the family (Minuchin, Nichols & Lee, 2007). The therapist pays close attention to both unspoken and spoken family rules and boundaries and looks for areas of unbalance and begins tightening or loosening these boundaries and hierarchies, as appropriate.

Case study example. Ann's mother and siblings, being concerned about her dropping out of school and the cuts on her arm, agree to attend family therapy with her. While Ann may be viewed by the family as the identified patient, the therapist views the family as having dysfunction, as a whole.

The therapist notes that Ann and her brother Bill always sit together and are clear allies within the family. Mother and sister Abby sit together across the room from the two and seem to glance at them with a disapproving coolness. The therapist begins to physically break up these alliances by changing up their seat positioning at the top of sessions.

Listening techniques including restatement of content, reflection of feelings, taking turns expressing feelings and non-judgmental brainstorming are some of the methods utilized in communication skill building. Through voicing her own feelings and getting appropriate feedback Ann learns that her sister Abby values her greatly and has always been very proud and envious of her artistic ability and connection to nature. Her mother is able to apologize for her perceived lack of warmth and invite Ann to be open with her on how she can begin to build their

connection again. These are communications that likely would have gone unspoken if not for the unique environment family therapy provides.

Each member of Ann's family is requested to bring in a family photo from the past. Through discussion of photos and notation of both verbal and non-verbal responses to the photos, the therapist more clearly sees the family relationships, rituals, structure, roles and communication patterns. Ann's mother chooses to bring in a very early family photo from a time when the family, including Father, was intact and the children were very young. Ann's mother shares about this picture being the last time she saw her entire family together and happy. The pain in her voice sheds new insight to Ann on the depth of sorrow her mother went through as their family separated years ago and helps her to understand her mother's demeanor and detachment; as if to not make up for it, but to soften it for her and allow her to embrace an acceptance that facilitates her to move to a new place of compassionate understanding and readiness for growth as she becomes ready to let go of so much resentment that has kept her feeling stuck in her perceived inadequacy.

Dialectical behavior therapy. DBT, being a derivative of classic cognitive behavioral therapy, uses a combination of standard CBT techniques for reality-testing and emotion regulation with concepts of acceptance, distress tolerance and mindful awareness taken from Buddhist meditative practices (Dimeff & Linehan, 2001).

Validation is a key principle in DBT therapy. For some populations and disorders, the process of CBT and the 'push for change' can feel invalidating of their emotional distress. Through 'making sense' of the person's behaviors within the context of their experience, even without necessarily agreeing with their actions, the therapist assists the client in feeling validated. Dialectics refers to this balancing of acceptance of the person exactly as s/he is in this

moment *with* intense efforts to change the person's life to increase adaptive functioning and decrease maladaptive behavior (Linehan, 1993).

DBT is a skill-based form of therapy used in both individual and group settings. There are four modules that are covered, each having numerous skills and exercises embedded within. The four modules are: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness (Rizvi, Steffel & Carson-Wong, 2012).

Case study example. Through use of diary cards, Ann's DBT therapist encourages her to share about significant trends she noticed in the week leading up to their current session. The diary card facilitates the conversation about how feelings of cutting herself were more frequent and she is having trouble not ruminating on the shame she felt in being put on academic probation last quarter resulting in the desire to drop out of school. They are able to discuss how her thinking has affected her behavior and brainstorm together how she might better work through these feelings if they return.

Through use of validation, the therapist works through some of Ann's feelings about not measuring up to her sister that led to her recent poor choices. This process allows Ann to 'make sense' of, but not condone, her choices, when in understanding of how her choices were rooted in her emotions.

A skill called 'ACCEPTS' is used to deal with distress tolerance, which can be useful when Ann begins to sink into depressive thoughts about her life circumstances and to isolate herself from others. The skill encourages her to get outdoors, to connect with nature and to contribute to the well-being of others, among other things.

Personal Declaration of Theoretical Orientation

My personal declaration of theoretical orientation is that of being Adlerian. Adler's holistic focus, ideas on movement, mistaken beliefs, encouragement and social interest (Mosak & Maniacci, 1999), are very compatible with my personal philosophy on life. While I consider Individual Psychology to be my home base, as a licensed mental health clinician I plan to draw upon other theories and techniques that align well with my home base to put in my tool box, as is appropriate for the client.

My background in coaching has given me a great number of tools which I find useful within motivational interviewing, Rogerian and CBT, such as psycho-education, eliciting change talk and decisional balance techniques (Miller & Rollnick, 2013). I particularly appreciate the person-centered approach, commonly used in coaching, of building a relationship on trust and belief in the individual's actualizing tendency towards realization of their own potential (Rogers, 1951).

My holistic and spiritual nature draws me towards the Existential Humanistic work of Viktor Frankl, who was a psychiatrist and survivor of the Auschwitz concentration camp (Boeree, 2006). From his experience he wrote on self-actualization, acceptance and finding meaning in one's life (Schulenberg, Hutzell, Nassif & Rogina, 2008; Frankl, 2006). The theory that arose from his work is called Logotherapy, which has been referred to as the third Viennese School of Psychotherapy; the first school being Adler's doctrine of the will to power, and the second, Freud's will to pleasure and Frankl's the will to meaning (Allport, 2006).

I appreciate the work of Martin Seligman, who seeks to "find and nurture genius and talent" and "to make normal life more fulfilling," (Seligman, 2011, p.33) rather than merely treating mental illness. I'm drawn towards building upon a client's strengths and striving to flourish, not just to return to baseline (Seligman, 2000; Seligman 2011). My personal values and

philosophies align well with positive psychology and I see myself drawing from the positive psychology toolbox in my future work with clients

Presentation Outcome and Future Implications

The presentation was received very well by the audience and achieved its objective of educating the health care professional audience about the development and importance of understanding theoretical orientation in psychotherapy. There were numerous questions following the presentation that shed further light not only to the other audience members, but to the presenter, regarding how very large this information gap was and the benefits of sharing this knowledge.

Through taking questions during and after the presentation, it was clear that very little was known, even to this highly educated health care professional audience, on the extent of the existence of theoretical orientations among therapists. "I had no idea that therapists could vary so much! I can see now the importance of knowing your own and your therapist's beliefs and how that has potential to affect treatment outcomes," shared one RN (registered nurse).

Other audience members shared about how they commonly follow up with customers to whom they have given a therapist referral, only to be told that after a few sessions they decided therapy wasn't for them; wasn't what they expected at all or didn't find it to be a positive experience. "There are people I've referred that had poor experiences, and after this presentation, I now feel were likely just not a good match with their therapist. These are people that may never be open to subjecting themselves to therapy again, thinking it's all the same. I wish I'd known more about this back then so I could encourage them to continue to seek support," shared a dietitian from the IPHT.

Numerous audience members shared personal experiences in making referrals to a therapist, through our EAP (employee assistance program), only to bypass the filter for specialty and give the customer the first several names listed near their home zip code. There was a request for me to put together a 'cheat sheet' of questions we could suggest to members to consider for themselves and to bring to an initial appointment, when seeking a therapist.

I was able to find an excellent piece of writing on psychotherapy that addresses the importance of theoretical orientation, from the APA (American Psychological Association, 2013) and to add a handful of suggested questions to the document. I presented this document to our chief Medical Director, a psychiatrist, for review. He promptly responded that he felt the document was quality and I had permission to distribute to all coaches on IPHT and that if this information is not available in our current depression and anxiety workbooks, it should be considered for inclusion during the next revision, at a corporate level. Furthermore, I have been asked to deliver the presentation to the quarterly RN meeting in Eden Prairie in the Spring of 2014. This is a meeting of nearly one hundred nurses, including teleconferencing nurses across the country, who meet to discuss current topics, changes and challenges in healthcare that allows them to best do their job as nurse case managers for the company.

Future of Theoretical Orientation

There is speculation that moving to a more consistent theoretical orientation for all therapists would be beneficial (e.g., Anchin, 2008, Magnavita, 2006; Sternberg, 2005). While I understand the proposed benefits of consistency among therapists, I have to disagree that the benefits would outweigh the costs. It is said that there is too many faults in each of the individual theories to be reliable as a whole (Melchert, 2013). "Despite its remarkable growth and many achievements, the field has also found it challenging to develop consensus explanations of

personality, psychopathology, and behavior change that provide a solid scientific foundation for the clinical practice of psychology," (Melchert, 2013, p.1) My argument would be that the benefits of providing a professional and philosophical framework, paired with the ability to combine a home base with pieces from other theories, make up for this and give merit to maintaining individual therapist theoretical orientation. Despite structured education, it would be difficult, and not beneficial to attempt to fully take away the individuality that theoretical orientation gives to clinicians.

Steering future therapists into a 'one size fits all' accepted orientation would rob the clinician of connecting to their work at a personal level that they believe in. In my opinion this would sterilize and affect the quality of the services provided. Let us not forget that therapy is a unique science, a unique piece of the medical puzzle, in that the relationship and connection of the therapist and client play a central role in the therapies efficacy.

There is, in fact, no one hundred percent unified theories among any of the sciences, including physics, biology and chemistry, yet they are regarded as scientifically sound (Melchert, 2013). Still, there is much to be learned from them and much learning to do. Why should the field of psychology and the important facet of theoretical orientation be any different?

My proposal would be a blending of the respect of the current theoretical orientations model while weaving in some of the benefits of a new unified model, such as the emphasis on current best practice prevailing, holistic perspective on behavioral health care and less competition between theories (Melchert, 2013). I believe this is possible to do while still honoring the benefits of traditional theoretical orientations, but moving to view them as re-conceptualized therapies, that therapists can continue to identify with as a home base in their practice.

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