Why a Therapist Needs a Theory

I'm concerned. Although some of my early career supervisees graduated from programs that provided a solid theoretical base, that isn't always the case. Some master's programs seem set up to introduce their students to a little bit of this, a little bit of that; a course on child development, a course on pathology, a statistics course, etc. but with no unifying theory. The goal of such programs seems to be to prepare their students to pass a licensing exam, with little thought to the importance of giving them an organizing structure for their thinking.

From my point of view, this situation is a serious problem. I really don't care what theory my supervisees have learned, as long as they learned one. With the exception of treatment for a few diagnoses (e.g. Dialectical Behavior Therapy for Borderline Personality Disorder; Cognitive Behavior Therapy for Anxiety), there is no conclusive evidence of overwhelming superiority of one theory over another.

But without a theory, these new clinicians are relying on their good intentions, a few techniques learned in school and good listening skills to be helpful to people who may be experiencing complicated and painful issues. They don't have the compass and guide for their assessment and treatment that a unifying theory provides.

What is a Theory?

A theory is simply a set of principles that a therapist adopts to explain people's thoughts, feelings and behaviors. Included are ideas about what causes those thoughts, feelings and behaviors and what techniques will help people change them so they can live more productive, satisfied and happy lives. In practice, the theory we adopt helps us assess a patient's

strengths as well as the nature of their distress and informs how we plan our goals and interventions to help the patient heal. Practicing therapists each discovers or develops a theory about the human condition that we feel is both congruent with our own ideals and beliefs and helpful to those in pain.

It's inevitable that a therapist's attachment to any theory will change over time as we become more experienced and more sophisticated in our work. That being said, it's important to settle on the construct from which we work at any given time. Yes, it's possible to become "eclectic" but it's important to be purposeful in our eclecticism. (See related articles.)

If you are a therapist who graduated from a program with a strong integrated theoretical orientation, you can skip the rest of this article. But if your program did not ground you in a particular theory, I suggest you think about the following reasons to devote yourself to in-service education that will give you one.

If you are considering a career in therapy and are researching graduate programs, I urge you to look for one that has a strong, integrated theoretical orientation. Here's why:

Why We Each Need to Settle on a Theory

To ground us: To be constantly questioning the basis of our thinking makes it impossible to come to any conclusion about anyone or anything. Sloppy eclecticism results in sloppy thinking. Deciding on a theory that works for us lets us both assess and treat our clients with clarity and consistency. That alone often provides grounding for the client as well.

To organize our thinking: Patients who enter treatment are overwhelmed by their thoughts and feelings and can easily overwhelm the therapist. A theory provides a structure for sorting and organizing all the information. Whether a therapist adopts the work of the psychodynamic thinkers, the behaviorists, the cognitivists, or the post modern school of family therapy, the theory provides a structure for inquiry and guidance for developing interventions.

To develop a mutually understood language with our clients: Each school of therapy has beliefs and values that are expressed in a unique way. Therapists teach their clients the vocabulary of their theory so they can co-evolve an understanding of what has caused and/or maintained the client's distress and what needs to be done to address it.

To serve as the basis for assessment: Each theory has a different point of view for the *cause* of the problem or for the behavior that supports it. Simply put as examples: Psychoanalysts see pathology as the outcome of unresolved internal (*intra*personal) conflicts. Carl Rogers defined pathology as incongruence between an individual's real self and ideal self. Family Systems therapists look for dysfunctional patterns of relating among family members (*inter*personal conflicts) while narrative family therapists separate individuals from their problem., Behavioral therapies reject a causal point of view and instead focus on carefully defining the present issues. Narrative therapy was created as a non-pathologizing approach but does include guidance for observing a family's struggle with their own story.

To set treatment goals: Assessment always drives treatment. To continue with the above examples: Psychoanalysts focus on resolving those unresolved intrapersonal issues. Rogerians help their patients bring their real and ideal self into alignment so they can work toward self-actualization. Family therapists work on healing family

relationships. Behaviorists identify discrete behaviors that need to change. Narrative therapy aims to transform the effects of the problem.

To determine who should be in the session: Intrapsychic theories confine therapy to the individual so rarely include other people in the treatment. Interpersonal family therapists generally see the family as a whole as well as members of subsystems (parents, siblings, etc.) within the family.

To determine the type of intervention: Theory also determines methods (techniques) a therapist uses. Psychoanalysts work with the client to create "transference" with the therapist (a recreation of a historic relationship) so it can be understood and corrected. Rogerians provide unconditional, positive regard within sessions to re-establish congruence between self and experience. Behaviorists develop interventions that positively or negatively reinforce behaviors. Many family therapists prescribe homework assignments to give the family experience in interacting differently. Narrative family therapists support the family in using their own competencies to create a new story.

To measure progress: Most therapists rely heavily on their own clinical judgment and client self-reports. Psychodynamic therapists assess the client's report of symptom relief. Rogerians look for client progress in becoming a fully functioning person (as defined in Rogerian terms). Behaviorists keep data to determine if change is occurring. Family therapists of all stripes rely on the family's report of change in their dynamics. Narrative therapists observe an increase in the family's use of their own skills to guide them toward a more successful life.

I do think all therapists would benefit from using concrete measures for determining progress although, with the exception of behaviorists, few do. But that's another conversation.

To help when we're "stuck": Therapy rarely proceeds in an orderly way from identification of the problem to resolution. When therapy seems "stuck," when little or no progress is being made, it is often helpful to go back to our theory to review our thinking about our assessment, goals and interventions. Often, thoughtful reconsideration of the case within the construct of our theory provides guidance for getting through the impasse.

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