

# **Integrating Feminist Narrative Therapy, Person-Centered Therapy, and Rational Emotive Behavioral Therapy: A Short-Term Case Study**

*Loni Crumb*

## **Abstract:**

There is increased literature in the mental health field regarding the merits of integrating techniques and procedures from multiple therapeutic frameworks to facilitate a positive change process. This article presents an integrative approach using feminist narrative therapy, person-centered therapy, and rational emotive behavior therapy to address behavioral, emotional, and psychological concerns. The author provides an overview of each therapeutic approach followed by a justification of the theoretical and therapeutic viability. A case illustration is provided to demonstrate the integration of the three noted therapeutic approaches. Finally, limitations and implications for practice are discussed.

**Keywords:** Integrative, mental health, feminist narrative therapy, person-centered therapy, rational emotive behavior therapy

-----

## **Introduction**

Mental health professionals must be flexible in their therapeutic approaches and interventions in order to accommodate the extensive psychological, behavioral, social, and emotional concerns of diverse clientele (Erskine, 2015;

Erskine & Trautmann, 1996; Ratts & Greenleaf, 2018). Pairing evidenced-based approaches, such as cognitive-behavioral therapies that consist of collaborative therapeutic alliances and cognitive restructuring with culturally-responsive approaches that support egalitarian relationships and social context exploration, can help mental health professionals address the unique needs of diverse clients and demonstrate measurable treatment outcomes (Crumb & Haskins, 2017; Erskine, 2015). Nevertheless, there is a need for researchers and practitioners to provide illustrations of how to practically integrate established therapeutic approaches. In response to this need, the current article proposes the application of feminist narrative therapy (FNT), person-centered therapy (PCT), and rational emotive behavior therapy (REBT) through an integrative framework that comprises elements from behavioral, humanistic, and postmodern paradigms. The integration of such approaches may help mental health professionals to address a host of personal and sociocultural matters that influence clients' overall personal development and well-being. The following sections provide an overview of the theoretical composition and viability of FNT, PCT, and REBT, and a case illustration demonstrating the use of the integrated approach. Finally, limitations of the approach and implications for practice are provided.

### **Theoretical Composition**

The integrative approach described in the current article was informed by Prochaska's (1995) transtheoretical therapy model which identified a series of stages that people pass through when changing their behavior. The transtheoretical model espouses that no one theory has the "monopoly of truth" (Prochaska, 1995, p. 407). Prochaska postulated that practitioners could systematically integrate insights and techniques from diverse therapies to meet the need of the client. The maximum impact strategy of integration was utilized to promote client growth that would influence change processes across the designated levels of change including symptom/situational, cognitions, and intra/interpersonal conflicts (Prochaska, 1995).

Feminist narrative therapy (FNT) is an evolving approach to narrative therapy (White & Epston, 1990) that incorporates feminist principles. Grounded in a constructionist perspective, FNT posits that individual understandings of reality are socially constructed through stories used to make meanings out of everyday life experiences (Brown, Weber, & Ali, 2008; Lee, 1997). Practitioners of FNT postulate that women's self-narratives are embedded in gendered stereotypes and gendered scripts, influenced by the dominant culture (Banker, 2010; Gremillion, 2004; Lee, 1997). The approach is critical of the power dynamics that devalue

women's voices and therefore intentionally strives to understand a woman's unique narrative, in an effort to avoid universalizing women's experiences in the counseling process (Lee, 1997).

Person-Centered Therapy (PCT) is a model of psychotherapy that shares concepts with humanistic and existential perspectives (Corey, 2016). PCT assumes that clients have an innate ability to change by altering their attitudes toward their problems (Rogers, 1979). Mental health professionals practicing PCT value their client's worldview and position the client as the expert (Bohart, 2012). PCT supports the client's capacity for self-change by creating a growth-promoting climate through the instillation of three core conditions (a) empathy, (b) congruence, and (c) unconditional positive regard (Rogers, 1979).

Rational Emotive Behavioral Therapy (REBT) is a form of psychotherapy oriented around cognitions and behaviors. Mental health professionals practicing REBT attend to clients' thinking, judging, deciding, analyzing, and actions in therapy (Ellis, 1996; Corey, 2016). Clinical problems are largely viewed as the result of irrational beliefs that consist of demands that clients place on themselves, others, and life conditions (Ellis, 1996; Guterman & Rudes, 2005). REBT advances that clients intensify their distress by the way they interpret situations. Mental health professionals who practice REBT utilize various techniques to promote positive change such as challenging absolutist beliefs, behavioral tasks, psychoeducation, and imagery exercises (Ellis, 1996).

### **Theoretical Viability**

Literature has indicated that constructs from FNT, PCT, and REBT can be coherently integrated into the therapeutic process. PCT has been most prominent in demonstrating that the therapeutic relationship is essential to the process of change (Erskine & Trautmann, 1996; Prochaska, 1995). FNT utilizes PCT's three core conditions of empathy, congruence and unconditional positive regard to build an egalitarian therapeutic relationship (Brown & Augusta-Scott, 2007). Both FNT and PCT use the client's frame of reference to promote empowerment and self-directed change (Bohart, 2012; Brown et al., 2008). While sharing similar principles, FNT extends PCT by allowing the mental health professional to be an active facilitator in the therapeutic process (Lee, 1997). Additional researchers and practitioners have supported the active role of the therapist (see Erskine, 2015). A feminist narrative perspective also emphasizes clients' strengths and allows for the integration of additional techniques to raise clients' consciousness of their ability to resolve troublesome issues (Brown et al., 2008).

Key principles from PCT are utilized in REBT as well. Practitioners of REBT advise that helping professionals unconditionally accept their clients, as in PCT and FNT, as a precursor to encouraging clients to unconditionally accept themselves (Ellis, 1996). REBT, however, expands the concept of acceptance by actively-directly teaching clients ways to unconditionally accept themselves, others, and life conditions that they cannot control (Ellis, 1996). All three theories uphold the constructionist belief that there is no absolute way of determining reality (Dryden & David, 2008; Ellis, 1997; Lee, 1997; Rogers, 1979). Similar to FNT, REBT posits that clients should be flexible in their interpretations of ideals based on dominant society and underscore how specific interpretations can lead to self-helping or self-defeating behavior (Brown et al., 2008; Ellis, 1997; Lee, 1997).

### **Case Illustration**

The following clinical case offers an illustration of how the integration of FNT, PCT, and REBT can be facilitated in a short-term therapy framework. The client's identifiable information is modified in accordance with the American Counseling Association's (ACA) ethical standards (ACA, 2014). The case conceptualization and session progression are documented below.

### **The Client**

Anna, a 37-year-old female, received psychotherapeutic counseling services at a private counseling practice. Anna was college-educated and had been gainfully employed for nine years. She was in a two-year romantic relationship with a male partner. She expressed that her co-workers and close friends recommended that she seek counseling, but she avoided following through on referrals for a year, stating she did not "like getting help."

### **The Mental Health Professional**

Anna was assigned to a female mental health practitioner (the primary author, referenced hereby as *counselor*), who was a Licensed Professional Counselor with experience in clinical mental health. The counselor supported egalitarian, strength-based therapies that emphasize clients' inherent strengths and respect clients' self-definitions of reality (Lee, 1997; Ellis, 1997; Moursund & Erskine, 2004; Rogers, 1979). The counselor supported the concept of sharing power with the client and owned the privilege of being trained in multiple therapeutic approaches that can facilitate the change process (Lee, 1997). An

integrative approach that demonstrated flexibility in incorporating insights and techniques from empirically supported theories to meet the client's specific needs was most valued by the counselor. It was the counselor's belief that psychotherapeutic change can be mediated by many methods ranging from self-directed change (White & Epston, 1990), the use of the therapeutic relationship (Erskine, 2015; Rogers, 1979), the use of teaching behavior tasks, or the use of psychoeducational material (Ellis, 1997). Finally, the counselor believed mental distress can originate from various origins such as biological/intrapersonal conditions or sociocultural factors (Ellis, 1997; Erskine, 2015; White & Epston, 1990). Each approach chosen (i.e., FNT, PCT, and REBT) has constructs that are congruent with the counselor's personal and therapeutic philosophy.

### **Initial Clinical Interview**

During the initial clinical interview, the counselor utilized a subjective method of history taking (Carrey, 2007). A subjective approach involves allowing clients to share their personal accounts about experiences they perceive to influence their overall health and wellbeing (Carrey, 2007). The counselor engaged Anna in a collaborative conversation centered on reasons for seeking counseling, personal and family history, and counseling preferences. The counselor paid special attention to the language Anna used while providing her history and noted Anna's strengths and availability of resources (Lambie & Milsom, 2010). The counselor provided a synopsis of the theoretical orientations that guided her practice and asked Anna to complete the Stages of Change Scales (McConaughy, DiClemente, Prochaska, & Velicer, 1989).

### **Primary Presenting Issues**

From information attained through the clinical interview, Anna's primary presenting issues were identified as (a) resistance to seeking help, (b) upholding absolutist beliefs and demandingness of others, and (c) self-depreciation. The counselor speculated Anna was in the precontemplation stage (see Norcross, Krebs, & Prochaska, 2011). The precontemplation stage is a stage in which clients are unaware or underaware of their problems and would reasonably demonstrate resistance or apprehension to supportive services due to having less awareness of problems (Norcross et al., 2011; Prochaska, 1995). Gold (2008) proposed that a client's resistance may reflect a narrative that consists of beliefs about the legitimacy of seeking help or an opposition to problem solving with others. In order to move Anna from the precontemplation stage and get her to commit to therapy,

the counselor anticipated she would need to address Anna's beliefs associated with receiving and giving help (Gold, 2008; Prochaska, 1995).

Secondly, the counselor considered it important to address Anna's problem-saturated story. Anna reported feelings of self-blame, unhappiness, resentment, and embitterment, which may have been resultant of distress due to positioning herself in a gendered prototype. Anna's dominant narrative appeared to be based on absolutist beliefs that stemmed from gendered roles prescribed by the dominant culture.

Finally, the counselor addressed Anna's self-deprecating attitude. Anna stated she had not received the treatment she felt she deserved in most of her relationships. As a result of her dominant narrative, Anna unremittingly helped others and suppressed her own needs. She appeared to exhibit low self-entitlement and the counselor believed she could potentially benefit from recognizing her voice and personal power in an expectation that such awareness would change her pattern of behavior.

### **Linking Presenting Issues to Therapeutic Approaches**

The counselor expected Anna to exhibit resistance in the initial stages of counseling due to her delay in seeking mental health services that may possibly have been related to her under-awareness of her problems. The core conditions of PCT could potentially be helpful to use to establish trust in the counseling relationship (Gold, 2008; Prochaska 1995). Anna reported she had to "grudgingly" care for her younger siblings. Anna also referenced that she acted like "Mother Theresa" in her current relationships. Overall, Anna's personal narrative from past to present revealed that she positioned herself in a nurturing role, given the many examples she provided of supporting her boyfriends, co-workers, and friends. From a feminist narrative perspective, the counselor postulated that Anna's self-concept was interwoven with the stories of others regarding a woman's role in relationships. A feminist narrative approach would help Anna develop an understanding of how dominant discourse may have influenced her problem description and help Anna to reconstruct a more preferred personal narrative (Brown et al., 2008; Lee, 1997).

From a REBT perspective, the counselor proposed that Anna had specific absolutist beliefs reflected in her dominant narrative of feeling obligated to help others. Thus, it could be implied that Anna was exacerbating her distress by upholding the belief that she should and must subjugate her needs and wants to

appease others. REBT was useful to assist Anna in generating more flexible interpretations of the underlying beliefs that guide her actions. REBT also provides techniques that aid counselors in teaching methods to reduce distress and recognize patterns of behavior.

Relatedly, Anna displayed a demandingness that others should live by her standards. For example, Anna stated she had “insisted” that a boyfriend stop using drugs and told a boyfriend what he “should know” about himself. REBT suggests that demanding others must change is a self-defeating pattern of behavior (Ellis, 1994). Through the use of REBT perspectives, the counselor anticipated she could teach Anna the philosophy of Unconditional Other Acceptance (Ellis, 1996) and help Anna accept aspects of others that she cannot change.

### **Primary Clinical Themes**

Two clinical themes framed Anna’s presenting problems: (a) Anna constructed her personal narrative from the position of *received knowing* (see below), thus the development of her own voice and personal value system has been restricted (Belenky, Clinchy, Goldberger, & Tarkle, 1986) and (b) Anna’s moral stage of development reflected an under-awareness of her pattern of behavior which prompted Anna to subjugate her wants to appease others (Gilligan, 1982).

Women’s ways of knowing theory was used to conceptualize how Anna’s knowledge and meaning-making systems were constructed. The theory designates a knowledge perspective termed *received knowing* in which a woman’s knowledge is constructed by identifying with and conforming to social norms, gender roles, and the expectations of others (Belenky et al., 1986). Received knowers model themselves after the sociocultural ideals of what a woman should be as communicated by outside entities, such as religious groups, family members, and other authorities (Belenky et al., 1986). Anna appeared to construct her knowledge and beliefs from a received knowing position as evidenced by her reports of obligations to care for others, having to be a “goody two shoes,” and receiving the message that she would “go to hell” if she demonstrated behavior that did not conform to the social norm for women.

Carol Gilligan’s “ethics of care” theory was used to frame the clinical theme in relation to Anna’s moral and personality development. Ethics of care refers to the perspective that people value relational and context-bound approaches regarding moral development and decision making (Gilligan, 1982). Gilligan

postulated that a woman's development is heavily influenced by the values of her family and friends (Gilligan, 1982). Accordingly, a woman may center her thoughts and actions on the needs and interests of others. Anna's development appeared to align with the stage Gilligan referred to as "overemphasis on others." Gilligan asserted that women in this stage equate goodness with self-sacrifice and often suppress their personal needs. Anna displayed behaviors comparable to this stage, as evidenced by stating that she infrequently received mutual respect and satisfaction in her relationships and sharing how she obligated herself to help others while being reluctant to accept help in return. Gilligan speculated that a woman may exhibit destructive behaviors if her wants are suppressed long-term.

### **Proposed Counseling Goals**

The goals and expectations of therapy were negotiated and co-constructed (Brown et al., 2008) between the client and the counselor. The first counseling goal was to encourage Anna to revise her relationship with her problems and develop a more preferred story. The aim of this goal was to increase Anna's awareness of the misogynous metanarrative that had possibly molded her dominant story (Lee, 1997). The anticipated outcome was that Anna would be able to identify personal values and strengths to re-construct a preferential and empowering personal narrative.

The second goal was to help Anna develop skills (e.g., assertive communication skills) to establish mutually satisfying relationships. The aim of this goal was to increase Anna's ability to identify self-helping and self-defeating behavior patterns (e.g., absolutist thinking, demandingness, self-deprecating attitude) and move toward positive change.

### **Session Progression**

Sessions were scheduled weekly and progressed to bi-weekly as the client moved from the precontemplation stage to becoming more active and committed to therapy (Prochaska, 1995).

**Session 1.** During the first session, the counselor utilized active listening skills, empathic responses, and conveyed unconditional positive regard to create a nurturing environment (Ngazimbi, Lambie, & Shillingford, 2008). The counselor invited Anna to share about herself. Anna disclosed that she was apprehensive to seeking professional services due to stigmas associated with seeking mental

health services. The counselor honored her feelings and helped her to normalize her thoughts regarding seeking professional support (Gold, 2008; Erksine, 2015). The counselor and Anna negotiated how they could integrate Anna's preferred style of being with the counselor's style of helping (Gold, 2008). Anna stated she did not want to feel judged in therapy. The counselor assured Anna that she would value her perspectives. The counselor also shared with Anna the philosophy of the feminist narrative approach which values the subjective experiences of women (Lee, 1997). The counselor did not engage in further questioning during this session to avoid overwhelming Anna as she worked through resistance. The counselor asked Anna to think about areas she wanted to explore in the next session.

*Between session activity:* The counselor wrote and mailed Anna a letter thanking her for attending the session and being willing to share her story. Writing letters personalizes the relationship and reduces professional distance with clients (White & Epston, 1990).

**Sessions 2-3.** The counselor checked-in by asking Anna to share her thoughts from the previous session. The counselor asked Anna if she felt comfortable with the method of questioning because this would be her primary way of understanding Anna's experiences. Anna stated she was open to questioning. The counselor posed circular questions from an exploratory position to demonstrate that she does not imply any privileged access to the truth and genuinely sought to understand Anna's experiences (Erskine & Trautmann, 1996; Monk, 1997). The counselor asked Anna to share more of her story and reflect on identifying her presenting problem. Anna disclosed stories about her childhood, experiences in her workplace, and details about her romantic relationships. The counselor paid close attention to Anna's language and was careful to utilize Anna's language when paraphrasing and providing feedback (Lee, 1997). Anna identified her problem as assuming the *helper's role*, which has impacted nearly all of her relationships. Anna stated that she frequently felt feelings of unhappiness, resentment, embitterment, and dissatisfaction, although at times, she truly enjoyed helping others in need. At the conclusion of the sessions, the counselor asked Anna to reflect on how the problem she identified had influenced her life and document them in a journal.

*Between session activity:* Journaling.

**Sessions 4-5.** Anna progressed to the preparation stage as evidenced by her journaling instances in which she was aware that problems existed and

considered ways to address the issues (Prochaska, 1995). The counselor continued to explore Anna's story and engaged Anna in externalizing conversations to help her separate herself from the problem (Lee, 1997). The counselor explored the meaning that Anna attached to accepting and maintaining her helper's role, in order to gain a greater depth of understanding. As Anna shared her story, she became more aware of how the problem was affecting her life and relationships. The counselor supported Anna in this process by co-identifying areas in Anna's story in which being the helper may have impacted her decision making. Anna realized that she chose to move to a deteriorating home, in a drug-laden neighborhood, so that she could attract people in need, even though with her yearly salary she was able to afford to live in another location. Anna also acknowledged that she sought out her romantic partners in the community where she lived, as this is the reason why she has often attracted partners with substance abuse issues. By session six, Anna's awareness of how the helper's role had affected her life was demonstrated by her ability to provide more details of how she had passed-up opportunities to date men with monogamous intentions who shared similar values and interest as her. The counselor mapped the influence of Anna's problem to support Anna in exploring her dominant story (White & Epston, 1990).

*Between session activity:* Anna wrote about the pros and cons of maintaining the helper's role in her journal. The counselor wrote Anna a letter to support her efforts in deconstructing her story as a means of client-empowerment.

**Sessions 6-7.** Anna demonstrated that she was in the contemplation stage by reporting that she had made a positive change by choosing not to give money to her boyfriend for drugs. Anna stated that she was ready to make more changes in her life because she had gotten in trouble at work. Anna also stated that her boyfriend was dating one of her friends and she was confused as to why she was still interested in seeing him.

The counselor used these sessions to educate Anna on REBT's constructs of absolutist thinking and demandingness and highlighted how these beliefs may have contributed to Anna's discontent in relationships. The counselor reinforced how Anna's prior absolutist beliefs about maintaining the helper's role may have derived from the wider social context and thus inhibited her willingness to prioritize her own needs (Lindsley, 1994). The counselor helped Anna identify instances in which she held absolutist beliefs and demanded others to change. Anna was educated in various ways that the moral and personality development of women was often influenced by societal standards (Brown & Augusta-Scott, 2007; Gilligan, 1982). The counselor assisted Anna in generating more flexible interpretations of

how she could build her self-esteem and self-efficacy and help others without having to suppress her own needs. The counselor modeled assertive communication skills. The counselor engaged Anna in the process of re-telling her story with the inclusion of ways that Anna can value herself in her new story. The counselor encouraged Anna to use her personal experiences and self-ideal as part of re-telling her story to avoid adopting generalizations of womanhood from wider societal contexts.

*Between session activity:* The counselor asked Anna to identify historical unique outcomes (White & Epston, 1990) in order to recall events from her past that contradict how the problem has affected her life and relationships. The counselor asked Anna to document these situations and strategies she used to successfully resolve these situations in her journal. The counselor provided Anna psychoeducational material related to communication skills, building self-esteem, and coping with stress to illustrate how distress influences the body, thoughts, feelings, and behavior (Perlman, 2002; Ussher, Hunter, & Cariss, 2002).

**Sessions 8-9.** Anna was fully engaged in the action stage as evidenced by her ability to begin to re-author her story. Anna used more positive language and asserted her own interpretations. She stated that she used assertive communication skills in a conversation with her romantic partner. She reported that she was able to express to him that she would no longer tolerate him dating her friend and requested that he value her as his girlfriend. Anna displayed the capacity and agency to intervene in her own life and relationship as she reconstructed her story in a more preferred fashion (Brown et al., 2008). Anna continued to identify current unique outcomes. The counselor reinforced Anna's progress by asking her to continue to journal her experiences throughout the re-authoring process. The counselor proposed that together she and Anna could create a self-help book of personal success stories with the journal entries and letters that were written throughout the counseling process. Writing success stories transforms the relationship of the person or problem as well as enables a client to self-reflect should the problem re-emerge (White & Epston, 1990).

*Between session activity:* Anna started to gather content for her self-help book.

**Sessions 10-11.** Anna and the counselor worked on composing her self-help book in session. The self-help book referenced Anna's former problem-saturated story provided contradictions to the dominant plot and documented new interpretations of the problem (White & Epston, 1990). The counselor worked toward identifying an audience to reinforce Anna's progress. Narrative therapy

practitioners believe that new stories take hold when there is an audience to appreciate and support them (White & Epston, 1990). Anna expressed that she had been working with elderly persons in the community. The counselor engaged in planning ways to connect Anna with a network of community leaders who shared the same passion for caring for the elderly. The counselor informed Anna that the group of community leaders had a structured process for raising money for elderly persons by hosting weekly fundraising activities. The counselor considered this group ideal for Anna because she would have a chance to pursue her passion for helping people in a more constructive manner.

*Between session activity:* The counselor linked Anna to the community organization.

**Session 12-13.** Anna expressed how her participation in the community humanitarian group was helpful because she was involved in a worthy cause in which she felt valued by others. Anna stated that she was ready to terminate therapy because she had a better understanding of how she had accepted and maintained the helper's role and how this influenced her wellbeing. Anna stated that she had learned how to value and voice her feelings by setting limits in her relationships. Anna also stated that she did not demand others to live by her standards and recognized that everyone had their own reality. The counselor proposed that a definitional ceremony would provide a framework to facilitate a meaningful closure to the therapeutic relationship (Lenz, Zamarripa, & Fuentes, 2012). A definitional ceremony offers clients the opportunity to tell parts of their stories to a carefully chosen audience - audience members respond to the stories by emphasizing the positive impact of the stories, garnering witnesses to the clients' worth, vitality, and being (Leahy, O'Dwyer, & Ryan 2012; Lenz et al., 2012; White, 1995). Anna stated that she would make arrangements for the ceremony and the counselor agreed to attend.

*Between session activity:* Anna chose to conduct her definitional ceremony during her humanitarian group meeting. During the ceremony, Anna shared about the development of a new narrative toward helping, changes in valuing herself and others, her passions, and readiness to accept new responsibilities (Lenz et al., 2012).

**Termination session and follow-up.** Anna was in the action stage by the time of termination of therapy as evidenced by the reports in her definitional ceremony. Anna verbally reinforced that she felt validated and supported in her relationships. Anna agreed to use the self-help book as a means of reflection to continue

progress once therapy was concluded. Anna stated that she felt more empowered to follow her own destiny and more confident in her decision making. The counselor mailed Anna a certificate of appreciation for completing therapy and welcomed her back if additional work was needed. The follow-up session was conducted two months after termination. Anna stated that she was still involved in the humanitarian group weekly. Anna stated that she was having fewer issues at her job and that her romantic relationship had improved. Anna also stated that she was planning to move to another neighborhood that would be more conducive to her personal development.

### **Assessment of Intervention Effectiveness**

Anna's progress was assessed by her ability to start re-authoring her life story. By session termination, Anna demonstrated the ability to recognize the sources of her problem and used a more empowering narrative. Intervention effectiveness was also evaluated by Anna demonstrating the ability to recognize risky thoughts such as absolutist thinking and demandingness and by her ability to use assertive communication skills to improve her relationships.

The counselor also administered the post session Stages of Change Scales, to measure Anna's progression through the stages of change since beginning therapy (McConaughy et al., 1995). The counselor concluded that Anna had successfully navigated from the precontemplation stage to the action stage based on her pre and post responses on the scale.

### **Limitations**

Literature has shown that each approach used has specific limitations. For example, PCT has been criticized for its non-directedness (Kahn, 1999). FNT's emphasis on subjectivity and relativity has been critiqued by various scholars (Brown & Augusta-Scott, 2007) and REBT has received much criticism for its forceful nature (Guterman & Rudes, 2005). Despite these limitations, all three of the therapies are identified as successful in managing emotional distress in relation to psychological and emotional issues (Banker, 2010; Dryden & David, 2008; Proctor, 2008). Last, it is important to note that the case illustration encompassed a short-term counseling framework spanning 13 weeks and caution should be applied in generalizing the content to shorter or longer counseling processes as the beliefs, attitudes, behaviors, and resources of clients and counselors vary.

### **Implications for Practice and Conclusion**

This article illustrates how mental health professionals can integrate feminist, cognitive-behavioral, and person-centered principles and techniques into the therapeutic process. Using a collaborative counseling relationship grounded in trust, empowerment, and compassion, mental health practitioners can help clients to claim their own voice and individuality and move toward positive change (Crumb & Haskins, 2017; Moursund & Erskine, 2004). However, when using integrative approaches, it is important to consider that clients may not be receptive to the principles espoused in each theory. Mental health professionals should be careful not to pressure clients to adopt their personal values, which may contradict a client's belief values and belief system. Mental health professionals should engage in the process of practitioner reflexivity, in which the professional consciously separates his or her personal views from the clients' worldviews (Lee, 1997). Attending to the client's subjective experiences and establishing transparency throughout the therapeutic process is imperative.

Furthermore, clients and mental health professionals may not have consensus on issues such as (a) relative preferences for stability versus change, (b) investment in the change process, or (c) willingness to consider alternative explanations of the presenting problem (Gold, 2008). These issues can potentially defeat attempts to resolve the client's presenting problem. Therefore, it is essential that mental health professionals remain flexible in their therapeutic approach. In order to enhance a client's receptiveness to therapy, mental health professionals should utilize a variety of methods such as valuing the client's thoughts and feelings, providing insight, providing psychoeducational material, and teaching the client communication and behavioral techniques, all of which are accomplished through therapeutic flexibility and integration (Erskine, 2015; Moursund & Erskine, 2004).

**Author:**

*Dr. Loni Crumb* is an Assistant Professor in the Counselor Education Program in the Department of Interdisciplinary Professions at East Carolina University and a Licensed Professional Counselor. Dr. Crumb received her Ph.D. in Counseling and Student Personnel Services from the University of Georgia, M.A. in Education and Community Counseling from Clark Atlanta University, and B.A. in Psychology from North Carolina State University. Her research interests include counseling in rural areas, promoting retention and persistence of underserved students in higher education, college student mental health, and social justice and multicultural training.

## References

- American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.
- Banker, J. R. (2010). Dating is hard work: A narrative approach to understanding sexual and romantic relationships in young adulthood. *Contemporary Family Therapy: An International Journal*, 32(2), 173-191.
- Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarkle, J. M. (1986). *Women's ways of knowing*. New York, NY: Basic.
- Bohart, A. C. (2012). Can you be integrative and a person-centered therapist at the same time? *Person-Centered & Experiential Psychotherapies*, 11(1), 1-13. doi:10.1080/14779757.2011.639461
- Brown, C., & Augusta-Scott, T. (2007). *Narrative therapy: making meaning, making lives*. Thousand Oaks, CA: Sage Publications.
- Brown, C. G., Weber, S., & Ali, S. (2008). Women's body talk: A feminist narrative. *Journal of Systemic Therapies*, 27(2), 92-104.
- Carrey, N. (2007). Practicing psychiatry through a narrative lens: Working with children, youth, and families. In C. Brown, T. Augusta-Scott (Eds.), *Narrative therapy: Making meaning, making lives* (pp. 77-101). Thousand Oaks, CA: Sage Publications.
- Corey, G. (2016). *Theory and practice of counseling and psychotherapy* (10<sup>th</sup> ed.). Belmont, CA: Cengage Learning.
- Crumb, L., & Haskins, N. (2017). An integrative approach: Relational cultural theory and cognitive behavior therapy in college counseling. *Journal of College Counseling*, 20(3), 263-277. doi:10.1002/jocc.12074
- Dryden, W., & David, D. (2008). Rational emotive behavior therapy: Current status. *Journal of Cognitive Psychotherapy*, 22(3), 195-209. doi:10.1891/0889-8391.22.3.195
- Ellis, A. (1994). Post-traumatic stress disorder (PTSD): A rational emotive behavioral theory. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, 12(1), 3-25. doi:10.1007/BF02354487
- Ellis, A. (1996). A social constructionist position for mental health counseling: A reply to Jeffrey T. Guterman. *Journal of Mental Health Counseling*, 18(1), 16-29.
- Ellis, A. (1997). Postmodern ethics for active-directive counseling and psychotherapy. *Journal of Mental Health Counseling*, 19(3), 211-226.
- Erskine, R. G. (2015). *Relational patterns, therapeutic presence. Concepts and practice of Integrative Psychotherapy*. London, UK: Karnac Books.
- International Journal of Integrative Psychotherapy, Vol. 9, 2018*

- Erskine, R. G., & Trautmann, R. L. (1996). Methods of an Integrative Psychotherapy. *Transactional Analysis Journal*, 26(4), 316-328. doi:10.1177/036215379602600410
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Gold, J. M. (2008). Rethinking client resistance: A narrative approach to integrating resistance into the relationship-building stage of counseling. *Journal of Humanistic Counseling, Education & Development*, 47(1), 56-70.
- Gremillion, H. (2004). Unpacking essentialisms in therapy: Lessons for feminist approaches from narrative work. *Journal of Constructivist Psychology*, 17(3), 173-200.
- Guterman, J. T., & Rudes, J. (2005). A narrative approach to strategic eclecticism. *Journal of Mental Health Counseling*, 27(1), 1-12.
- Kahn, E. (1999). A critique of nondirectivity in the person-centered approach. *Journal of Humanistic Psychology*, 39(4), 94-111.
- Lambie, G. W., & Milsom, A. (2010). A narrative approach to supporting students diagnosed with learning disabilities. *Journal of Counseling & Development*, 88(2), 196-203.
- Leahy, M. M., O'Dwyer, M., & Ryan, F. (2012). Witnessing stories: Definitional ceremonies in narrative therapy with adults who stutter. *Journal of Fluency Disorders*, 37(4), 234-241. doi:10.1016/j.jfludis.2012.03.001
- Lee, J. (1997). Women re-authoring their lives through feminist narrative therapy. *Women & Therapy*, 20(3), 1-22. doi:10.1300/J015v20n03\_01
- Lenz, A., Zamarripa, M., & Fuentes, S. (2012). A narrative approach to terminating therapy. *Journal of Professional Counseling: Practice, Theory & Research*, 39(2), 2-13.
- Lindsley, J. R. (1994). Rationalist therapy in a constructivist frame. *Behaviour Therapist*, 17(7), 160-162.
- McConaughy, E. A., DiClemente, C. C., Prochaska, J. O., & Velicer, W. F. (1989). Stages of change in psychotherapy: A follow-up report. *Psychotherapy: Theory, Research, Practice, Training*, 26(4), 494-503. doi:10.1037/h0085468
- Monk, G. (1997). How narrative therapy works. In G. Monk, J. Winslade, K. Crocket, D. Epston (Eds.), *Narrative therapy in practice: The archaeology of hope* (pp. 3-31). San Francisco, CA: Jossey-Bass.
- Moursund, J., & Erskine, R. G. (2004). *Integrative psychotherapy: The art and science of relationship*. Pacific Grove, CA: Brooks/Cole.
- Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of change. *Journal of Clinical Psychology*, 67(2), 143-154. doi:10.1002/jclp.20758

- Ngazimbi, E. E., Lambie, G. W., & Shillingford, M. (2008). The use of narrative therapy with clients diagnosed with bipolar disorder. *Journal of Creativity in Mental Health, 3*(2), 157-174. doi:10.1080/15401380802226661
- Perlman, A. (2002). *REBT Self Esteem Workbook*. Center City, MN: Hazelden Publishing.
- Prochaska, J. O. (1995). An eclectic and integrative approach: Transtheoretical therapy. In A. S. Gurman, S. B. Messer (Eds.), *Essential psychotherapies: Theory and practice* (pp. 403-440). New York, NY: Guilford Press.
- Proctor, G. (2008). Gender dynamics in person-centered therapy: Does gender matter? *Person-Centered & Experiential Psychotherapies, 7*(2), 82-94.
- Ratts, M. J., & Greenleaf, A. T. (2018). Counselor–Advocate–Scholar model: Changing the dominant discourse in counseling. *Journal of Multicultural Counseling and Development, 46*(2), 78-96. doi:10.1002/jmcd.12094
- Rogers, C. R. (1979). The foundations of the person-centered approach. *Education, 100*(2), 98-107.
- Ussher, J. M., Hunter, M., & Cariss, M. (2002). A woman-centered psychological intervention for premenstrual symptoms, drawing on cognitive-behavioural and narrative therapy. *Clinical Psychology & Psychotherapy, 9*(5), 319-331. doi:10.1002/cpp.340
- White, M. (1995). *Re-authoring lives: Interviews & essays*. Adelaide, AU: Dulwich Centre Publications.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.