Schools of Psychotherapy and the Beginnings of a Scientific Approach

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Abstract

The theoretical, clinical, and empirical foundations of psychotherapy come from five primary movements that still exist today, continue to evolve, and remain scientifically productive: psychodynamic, cognitive-behavioral, humanistic, systemic, and integrative. The goal of this chapter is to examine the philosophical, clinical, and scientific underpinnings of each of these major traditions in detail. Experts in these five approaches will describe: (a) the model of psychopathology (especially focusing upon etiological and maintenance factors emphasized in assessment and case formulation); (b) the focus and specific techniques used in treatment planning and implementation; (c) the hypothesized therapeutic mechanisms of change; and (d) the outcome literature/empirical support for each modality. We conclude with a look toward the future of the science of psychotherapy and the scientist-practitioner model of psychotherapy.

Keywords: psychotherapy, psychodynamic therapy, cognitive-behavior therapy, humanistic therapy, systemic therapy, integrative therapy

Schools of Psychotherapy and the Beginnings of a Scientific Approach

If defined as a "talking cure," psychotherapy has a very long history. The moral therapy that Pinel developed in the 18th century included not only the unchaining of patients (as it is often portrayed in undergraduate abnormal psychology textbooks), but also involved establishing safe and comforting relationships at both a personal and institutional level. As part of their therapeutic responsibilities, staff members of the asylums were asked to walk, listen to, and talk with patients with the ultimate goal of helping them find solace from the social afflictions that were believed to be partly responsible for their mental conditions. A similar philosophy toward mental disorders can be traced back to Ancient Greece, where temples were created to help individuals restore a balance of Hippocrates' major bodily humors. In addition to the prescription of rest and music, the restorative treatments might well have involved meaningful (and hopefully soothing) verbal exchanges, if only as a reflection of Hippocrates' belief that an intimate relationship between patient and healer was important to health. Arguably, however, the foundation of modern talking cures resides in Breuer and Freud's (1893) cathartic method, where successful treatment was assumed to require three conditions: (1) the patient remembering the traumatic event at the origin of his/her symptoms; (2) the patient re-experiencing the emotions felt during this traumatic event; and (3) the patient expressing both the event and emotional experiences to the therapist (Nisole, 1977). These three conditions, interestingly, are very consistent with today's leading treatment (exposure therapy) for post-traumatic stress disorder.

Although the cathartic method is no longer used (at least as originally prescribed by Freud and Breuer), it directly led to Freud's development of psychoanalysis proper. Though still practiced today, Freud's classical psychoanalysis did not remain static, but also spurred the development of several other important treatment approaches that are linked by a common goal of uncovering and understanding the (often unconscious) conflicts and early developmental experiences associated with the client's symptoms.

However, as early as the 1920's, opposition to psychoanalytic thinking and methods also served to galvanize the beginning of a second major tradition or school of therapy. Born in laboratories and intimately linked with animal research (e.g., Pavlov's and Seligman's dogs, Watson's rats, Skinner's pigeons, and Wolpe's cats), behavioral and later cognitive-behavioral approaches represented an effort to understand and treat abnormal behavior that was based on the implementation of methods derived from the physical sciences.

With the 1950's came the genesis of another movement often called the "third force" in psychology. It was in large part a reaction to several of the deterministic assumptions shared by psychodynamic and behavioral orientations. Rejecting the notion that human behaviors could be fully understood as the result of past learning or developmental conflicts, scholars and clinicians associated with humanistic/existential/experiential traditions constructed models and therapeutic interventions focused on notions of emotional awareness, the creation of meaning, a person's capacity for choice, and human tendencies toward healthy growth and the actualization of potential.

A fourth movement was born in the late 1960's early 1970's. This group of systemic and family-centered approaches emphasized the many complex and subtle interpersonal processes that shape and control human behaviors at least as much as (if not more than) intrapersonal forces (e.g., intraspsychic conflict, classical and operant conditioning, actualization of potentialities) at the core of the previous three traditions.

As will be shown below, these four movements still exist today, continue to evolve, and remain both theoretically and empirically productive. As it seems clear that many, if not most, of

currently available forms of therapy can be linked in some way to these four traditions, the goal of this chapter is to examine them in detail. Experts in these four approaches will describe: (1) the model of psychopathology (especially focusing upon etiological and maintenance factors emphasized in assessment and case formulation); (2) the focus and specific techniques used in treatment planning and implementation; (3) the hypothesized therapeutic mechanisms of change; and (4) the outcome literature/empirical support for each modality.

Although we believe that each of these major approaches to psychotherapy is here to stay, it is also clear that the majority of practicing psychotherapists (at least in the United States) define themselves as eclectic or integrative (Norcross, 2005). As an attempt to improve psychotherapy based on points of convergences and complementarities between different schools, the integration movement has been described as a Zeitgest (Lecomte, 1987) in the literature. In our effort to provide a complete (as much as possible) picture of the contemporary landscape of psychotherapy, the chapter will offer a brief history of the integration movement, as well as a description of its current trends and empirical contributions.

As a way to further establish the scientific foundation of psychotherapy, the chapter will end with a plea for more research on the process and outcome of current approaches (including the integrative movement), as well as on principles of change that cut across most of them. It will also be argued that the future growth of the scientist-practitioner model underlying modern psychotherapy will likely benefit from research conducted with active collaborations between researchers and clinicians.

Psychodynamic Approach [1]

"Psychodynamic therapy" is a broad term used to encompass the many approaches for fostering understanding and alleviating human suffering that were directly influenced by Sigmund Freud, the intellectual father of psychodynamic therapy. Like all children, Freud's progeny have made choices that, while individual and autonomous, are nonetheless reflective of his influence. Some have decided to adhere closely to Freud's original formulations, others intensively focused upon one or more aspects, and several reacted against core principles while retaining others. This rich heterogeneity eventuated in a multitude of approaches with which therapists can flexibly treat the vicissitudes of human psychopathology, but also had the unintended consequence of making it particularly difficult to summarize across modalities without gross oversimplification or error. While acknowledging this risk, we will attempt to broadly describe the current state of the field. Prior to discussing specific content, it will be helpful to cast this modality in sharper relief by briefly describing what some have termed the psychodynamic "sensibility" (e.g., McWilliams, 2004).

This sensibility has many components. Psychodynamic therapists could be described as operating under a "hermeneutic of suspicion" (Ricoeur, 1970). Specifically, the superficial or manifest contents of speech, actions, and symptoms are often not taken at face value, but are instead openly questioned in the hope of revealing other meanings/values that may have been lost, disavowed, or never fully considered. Such meanings (though somewhat hidden) are nevertheless thought to possess relevance for, and impact on, the patient's present life, level of distress, and understandings of self and other. A corollary of this is a belief in, and overriding respect for, the complexity of human thought, action, emotion, and behavior in all of its many varieties and shades. This can be seen in Wäelder's (1936) concepts of "over-determination" (i.e., the belief that every mental event has many causes) and "multiple function" (i.e., that every action/symptom intended to solve one psychological conflict or problem is simultaneously an attempt to solve other problems). Further, understanding oneself and increasing freedom from

the many determinisms present in life requires a high level of honesty/self exploration (for both patient and therapist). What is *not* said can be as important as what is, and therapists strive to attend to the multiple levels of verbal and non-verbal communication; for, as Freud wrote in 1905, "betrayal oozes out of… every pore." Finally, the dynamic sensibility could also be characterized by a profound recognition of the human psyche's fragility. Namely, no one is immune from falling ill, psychopathology exists on a continuum (and in normal life), and we are all more vulnerable than we think. This can clearly be seen in dynamic therapy's proposed etiologies.

Models of Function and Dysfunction

Although psychodynamic theories of pathology can diverge markedly, they are unanimous in viewing both psychopathology and health in developmental terms. This emphasis on the formative role of early experiences in current functioning is evident in two of the main psychodynamic subtypes. For instance, traditional drive and ego psychologists typically conceptualize patients in terms of psychosexual development and conflict. Early experiences influence and shape characteristic conflicts between sexual and aggressive wishes/impulses, external reality, and internalized societal prohibitions. As a result, certain *compromises* between these conflicts arise, some of which are maladaptive (e.g., depressive symptoms), as a means of attempting to cope with them. In contrast, healthier individuals who have successfully passed developmental challenges or who have undergone psychotherapy presumably possess more effective compromises (i.e., they are regulated by more developmentally-mature defenses such as the sublimation of aggressive urges) that elicit minimal anxiety. Thus, these individuals may be more flexible and better able to satisfy their needs using multiple adaptive behaviors.

Another important school of dynamic thought has been termed the object relational approach. Object relation theorists, influenced by Klein, Winnicott, and Fairbairn, believe that *relationships* (especially early ones) constitute the building blocks of both our character and our adult relational patterns. This shift away from emphasizing the primacy of sexual and aggressive drives and towards relationships (and relatedness itself) represented a significant theoretical modification from both classical psychoanalysis and ego psychology. *Objects* (an unfortunate choice of words meaning "that to which a subject relates" - usually other people) are internalized (i.e., psychically "taken in") over the course of human development. If a person does not have "good enough" caregivers who adequately meet their physical and emotional needs, and therefore do not have opportunities to internalize *adaptive* objects, a future of interpersonal conflicts and an inability to maintain psychic homeostasis is often, but not always, the result (e.g., the borderline conditions). Further, inordinate levels of either dependence or independence in relationships (instead of healthy adult interdependent mutuality and respect) can also be a sequela.

Psychopathology viewed in object relational terms is a necessary adaptation to deficient environmental, innate, and interpersonal conditions. In contrast, the achievement of both a stable identity and object constancy (i.e., the capacity to tolerate loving and hostile feelings for the same person, view people as unique, and not use others instrumentally) is indicative of healthy object relations. The environment, ones biology, and ones parents need not be perfect, of course, but must allow for the healthy development of these more nuanced views of self and other. Further, the work of therapy (and the therapeutic relationship itself) can move individuals towards healthier functioning. In ending this section it is important to note that, in spite of all dynamic theories' emphasis on early development, they all seriously consider genetic and temperamental contributions to the development of psychopathology.

In line with the diversity and complexity of factors involved in dynamic models of health and psychopathology, the assessment process is a multilayered one. Although some therapists decry the use of the predominant nosological systems (i.e., DSM-IV-TR and ICD-10), many find it very important to possess an accurate and complete symptom topography. However, most dynamic therapists do not find these phenomenological descriptions sufficient in isolation, and they are usually supplemented with additional assessments. For instance, therapists try to understand their patient's character structure (i.e., neurotic, borderline, or psychotic), developmental and interpersonal histories, characteristic expressions (and non-expressions) of affect, and coping styles (e.g., defenses).

In addition, dynamic therapists attempt to listen to three complementary levels of discourse/communication. First, they try to be "objective" and realistic observers of their patients and their problems without being clouded by personal reactions, prejudgments, or preferences. Second, dynamic therapists attempt to fully *resonate* with their patients' idiosyncratic experiences. It is held to be of the utmost importance to understand (and subjectively capture) events in the world as they are colored through their patients' eyes. Third, the therapist's own idiosyncratic human reactions to the patient's experiences must be closely attended to. This not only provides crucial information about how others likely react to the patient, but also may serve to circumvent certain interpersonal "pulls" that may be less than therapeutic. The combination of these three different levels of communication (and the corresponding tension between subjective-objective and participant-observer) allows the therapist to triangulate relevant problem areas. Data derived from observations at these three levels also lends focus to the complex process of psychodynamic psychotherapy.

The Process of Therapy

Targets of dynamic psychotherapy. In a quote attributed to Freud (but not found in his corpus) it is stated that the capacity to love and work are indicators of mental health and, therefore, preeminent targets of treatment (Erikson, 1963). These goals possess a commonsense and intuitive appeal, and further seem to converge with the *realistic* worldview of the psychodynamic therapies.

This willingness to realistically interpret oneself and the world without "rose colored" or "dark-colored" glasses pervades several other targets of therapy. For instance, attaining a realistic sense of self and other is a principal focus of many dynamic approaches (e.g., object relational and self psychologies). This necessarily entails a recognition (and possibly acceptance) of traits and qualities that may be unattractive or unflattering, yet nonetheless real. Relatedly, helping to instill a sense of realistic hope for patients is also important, as is an acceptance of the many determinants in life (e.g., including much of what would fall under Heidegger's concept of "thrownness," or the fact that we exist, that we exist in a particular time, that we have particular parents or, put another way, that we were "thrown" into a world not of our choosing). We would argue that the acceptance of that which cannot be changed and an ability to take pride and enjoyment in who and what one is are both strong indicators of psychological health. Further, these factors are also conducive to the attainment of authentic senses of meaning and purpose.

Along with these somewhat more abstract targets, dynamic therapies also share clinical goals with other modalities. Symptom relief is often emphasized, especially in short-term psychodynamic psychotherapies (e.g., Milrod, Busch, Copper, & Shapiro, 1997) where longer-term goals (e.g., significant personality modification) may be inappropriate or unrealistic. Dynamic therapies also assist patients in freeing themselves from repetitive patterns

(interpersonal or otherwise) that inevitably only lead to despair, pain, and thwarted potential. As with behavior therapy, there is a desire to help patients adapt to their particular environmental demands and contingencies. And as is probably universal among the many talk therapies, there is a general belief that flexibility is good, and rigidity is undesirable.

Therapist techniques and the emergent properties in therapy. Most interventions contained in the armamentarium of dynamic therapists (e.g., see Thoma & Kachele, 1994) can be roughly divided into expressive and supportive techniques (Luborsky, 1984); the former focuses on uncovering relevant clinical material as well as increasing self-understanding and self-attunement. Expressive techniques are epitomized by "interpretations" in which observable thoughts, feelings, or behaviors are directly linked to the dynamic content which are assumed to give rise to them. It is important to note that expressive techniques are not merely arid intellectual exercises, but must take place with affective urgency (and relatedness) in order to be effective.

In contrast, supportive techniques are intended to bolster and support adaptive defenses, shore up ego boundaries, make the patient feel more comfortable/more accepting of themselves, and facilitate the development of a positive therapeutic alliance. Some authors also consider interventions to be supportive if they facilitate the therapeutic process itself and enable patients to "open up." However, supportive techniques do not lead to or encourage regression, but instead are typically intended to combat immediate distress and return patients to their level of baseline functioning.

We term the many subtle forms of interaction arising between patient and therapist "emergent properties." This would include constructs such as the therapeutic alliance, transferences, countertransferences, and the "real" relationship. The therapeutic alliance has received much discussion (e.g., Hatcher & Barends, 2006), and will not be described further here. The current status of key dynamic constructs as transference (the attributing of qualities from earlier life relationships/experiences onto the therapist) and countertransference (the therapist's subjective experiences that are triggered by patient material) differ in some significant ways from Freud's original formulations, and definitions remain both in flux and hotly contested. In general, though, whereas transference was once seen as primarily a contributor of grist for the analytic mill, it has been increasingly viewed as important on its own terms due to its many relational implications. Further, countertransference has ceased being viewed as merely a negative indicator of unresolved therapist issues, and is more often seen as an important font of clinical information in its own right. Finally, there is the "real" relationship, which has typically been considered the way patient and therapist relate on their own terms and not as "parent substitute or working partner" (de Jonghe, Rijnierse, & Janssen, 1991, p. 696). It is important to note, however, that these various distinctions between relational constructs may not be as clear cut as they seem, for a therapist's "real" character traits may serve as "hooks" upon which they can more plausibly hang their transference reactions (e.g., an obese therapist may engender particular transferences, Baudry, 1991). Further, all of these may have a direct (e.g., alliance) or indirect (e.g., interpretation of the transference leading to self-understanding) impact on outcome.

Taken together, the application of expressive and supportive techniques in a judicious manner (taking into account the idiosyncratic character, context, and strengths of the patient), when utilized in conjunction with the above-mentioned emergent properties, all join together to set the stage for work towards dynamic targets. However, we have yet to discuss the various therapeutic actions that may mediate dynamic therapy outcome.

Therapeutic actions. Although therapeutic actions have been discussed in the literature, and several edited volumes on the topic exist (e.g., Lifson, 1996), empirical work and evidence have significantly lagged behind theory. We group therapeutic actions into increases in self-understanding (SU) and the attainment of corrective emotional experiences (CEE).

We have found it useful to conceptually subdivide "global" SU into specific subtypes, and we will briefly describe five of them here. First, the exploration of conflicts (both intrapersonal and interpersonal) is considered to be a core focus of dynamic therapy leading to greater self-understanding and positive outcome. Second, a patient's characteristic defense mechanisms or "character armor" (Reich, 1933) are held to be expressions of these very same unconscious conflicts, motivations, and desires. And, consonant with classical psychoanalysis, understanding and changing defenses are primary foci in psychodynamic therapy. Third, the exploration of patient's object relations and capacity for object relatedness is thought to increase self-understanding as well as contribute to therapy outcome. This often takes place in the context of the transference. Fourth, therapists who adopt a more hermeneutic approach to therapy look to narrative change as a means for increasing SU. In this, self/life-narratives are explored (and often co-written) in order to make them more coherent, comprehensible, nuanced, and capable of reflecting and encompassing the many complexities of lived human experience. A greater understanding of self and other is thought to result. Finally, reflective functioning is also related to SU. Reflective functioning, also termed mentalization (Fonagy, 2002), is the capacity to understand the behavior of oneself (and others) in terms of internal mental states (i.e., beliefs, thoughts, and emotions).

CEEs, or "reexperiencing the old, unsettled conflict but with a new ending" (Bridges, 2006, p. 551) may be another important therapeutic action. As one prototypical example of a CEE, a patient becomes angry with the therapist and holds the expectation that the therapist (like others) will respond to anger with rejection and more anger. However, the therapist's different-than-expected responses to anger (e.g., curiosity and empathy) provides the patient with a novel experience holding the potential to modify rigid schemas, foster interpersonal flexibility, and even (if powerful enough) modify psychic structure. Whereas some early theorists toyed with directly influencing the therapeutic environment in order to elicit these experiences (e.g., Alexander & French, 1946), most today would view CEEs more broadly and less manipulatively. CEEs can occur without the therapist necessarily deviating from "normal" dynamic therapy protocol. In this conception of CEEs, the empathic mode of non-judgmental listening, interpersonal reliability, and therapeutic structure can provide patients with reparative experiences. Further, the very act of feeling understood and accepted by another can elicit profound changes, as can the presence of an important individual in one's life who acts in ways (as described above) that do not "fit the pattern" one expects.

Empirical Support

Whereas other schools of therapy (e.g., behavior therapy) developed hand in hand with an empirical and experimental approach, dynamic therapy arose from within a different methodological tradition. Historically, psychodynamic research focused primarily upon the intensive study of individual patients (i.e., the case study) instead of large scale trials. The latter were likely hindered by a popular belief that dynamic therapy could not really be accurately studied because any operationalization of dynamic constructs into therapy manuals (a prerequisite for clinical trials) ineluctably made them enervated and sterile. There was also a widespread belief that existing measures of patient change were inadequate to capture dynamic change. However, several researchers began exploring the efficacy and mechanisms of dynamic

treatments in the 1970s (e.g., Malan, Luborsky, and Strupp, to name a few).

In fact, evidence for the effectiveness of different forms of dynamic therapy exists. In longer dynamic treatments, evidence is consistent with the idea that lengthier and more intensive (e.g., Sandell, Blomberg, & Lazar, 1997) treatments evince better outcomes. With regard to short-term approaches, meta-analyses indicate that dynamic therapy is as effective as cognitive-behavioral therapy in treating Axis-I and personality disorders (Liechsenring & Leibing, 2003; Leichsenring, Rabung, & Leibing, 2004). Although these findings are supportive of the effectiveness of dynamic therapy and the fact that it is at least equivalent to other approaches, additional research is needed, especially using the methodology of randomized clinical trials in order to compare it to well-established therapies for clearly defined disorders.

In addition to outcome literature and research into *general* processes of therapy that may exist *across* modalities (e.g., the therapeutic alliance, a construct also shown to have a causal role in patients' improvement in dynamic therapy [Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000]), several *dynamic-specific* constructs and therapeutic actions have received empirical attention and support, and three will be discussed here. First, dynamic interpretations have been found to be generally beneficial (Orlinsky, Rønnestad, & Willutzki 2004) and, more specifically, accurate/appropriate interpretations are associated with outcome (e.g., Crits-Christoph, Cooper, & Luborsky, 1988). However, this relationship between interpretations and outcome may be moderated by a patient's quality of object relations, although the direction of the relationship is unclear (e.g., Connolly et al., 1999; Hoglend et al. 2006). Second, dynamic therapy has been found to improve adaptive defensive functioning (e.g., Hersoug, Sexton, & Hoglend, 2005), and these changes are also associated with outcome (e.g., Coleman, 2005). Interestingly, one study demonstrated that treatment continued past symptom recovery led to a normalization of defenses (Akkerman, Lewin, & Carr, 1999). Third, Levy et al. (2006) have shown that one year of expressive dynamic therapy (but not supportive dynamic therapy or dialectical behavior therapy) was associated with significant increases in reflective functioning in patients with severe personality disorders). These and other findings are promising, but additional elucidation of dynamic constructs (and their complex relation to outcome) is needed.

In closing, although high quality research into dynamic therapy has begun, many more questions than answers remain, and certain core constructs (e.g., narcissistic vulnerabilities, internalization of the therapist as an object) have yet to be rigorously evaluated. However, it is heartening that many scholars have worked to operationalize their concepts and manualize their therapies (see Table 1 for examples). This makes it possible to both reliably train new psychodynamic therapists and adequately replicate empirical findings.

Cognitive Behavioral Approach [2]

Cognitive-behavioral therapy (CBT) is probably better called cognitive and behavioral therapies, given that there are many treatments and traditions that fall under the rubric of CBT. These therapies emphasize different theories or integrations of theories (e.g., cognitive versus behavioral). Historically, behavior therapy developed out of the learning theory traditions of Pavlov (1927) and Skinner (1953), both of whom considered animal models of learning and their implications for psychopathology. More direct examinations of behavioral principles as applied to clinical theory were first developed by Mowrer (1939), Watson and Rayner (1920), and later by Wolpe (1952) and many others. The integration of notions of cognitive concepts with behavior therapy included work by Beck (1976), Ellis (1962), Goldfried and Davison (1976), and Meichenbaum (1977) in the 60s and 70s.

From its outset, cognitive therapy was built on principles included in behavior therapy (see Beck, 1976), but with a focus on using such principals to facilitate the modification of cognitive distortions which were proposed to be the primary factor involved in the maintenance of depressive and other symptoms. In the last 30 years, there has been significant progress in understanding the cognitive and behavioral maintenance factors related to psychopathology in general (Harvey, Watkins, Mansell, & Shafran, 2004), and specific disorders in particular (e.g., Clark & Wells, 1995; Dalgeish, 2004; Mathews & Mackintosh, 1998; Mogg & Bradley, 1998), though there is still much to understand. In addition to the increased sophistication and empirical study of behavioral and cognitive mechanisms involved in psychopathology, there has been an increasing emphasis on emotion as an important construct within these theories (Barlow, 2002; Power & Dalgleish, 1997; Samoilov & Goldfried, 2000; Teasdale & Barnard, 1993). In line with these and other recent developments, the current status of CBT theories can be viewed as an integrative approach, considering cognitive, behavioral, emotional, and interpersonal factors in treatment, as well as biological issues. The advances in treatments will be described further below.

Models of Function and Dysfunction

The basic tenets of CBT theory of human functioning and mental illness is that psychopathology is comprised maladaptive associations among thoughts, behaviors, and emotions that are maintained by cognitive (attention, interpretation, memory) and behavioral processes (avoidance, reinforcement, etc.). Within CBT theories, there are different emphases on aspects of the characteristics of psychopathology and their maintenance mechanisms (e.g., Beck, 1996; Brewin, 2006; Foa, Huppert, & Cahill, 2006; Mineka & Zinbarg, 2006; Teasdale & Barnard, 1993). In general, CBT theories are stronger in their hypotheses regarding maintenance than etiology, and most interventions are aimed at interrupting or modifying cognitive, behavioral, emotional, and physiological processes and/or altering pathological beliefs, emotions, and behaviors that are involved in maintenance of maladaptive or problematic behaviors.

It is beyond the scope of the current chapter to describe all of the various CBT theories of pathology and treatment in detail (some of these are books in and of themselves; e.g., Barlow, 2002; Power & Dalgleish, 1997). Instead, the common intersections of most of these theories will be described, with some examples from various theories used to illustrate the principles. Early behavioral theories suggested that associations between stimuli (S-S relationships) and between stimuli and responses (S-R relationships) lead to learning maladaptive behaviors which underlie psychopathology (Mowrer, 1939; Watson & Raynor, 1920). Early cognitive theories proposed that idiosyncratic negative cognitive schemas underlay the cognitive, behavioral, and physiological symptoms of depression and other pathology (Beck, 1976). Interventions that targeted both dysfunctional interpretations and predictions as well as underlying beliefs (schemas) would therefore alleviate such pathology. Theories have expanded on the early cognitive and behavioral theories to create idiographic cognitive models for most disorders of psychopathology (Clark, 1986; Clark & Wells, 1995; Ehlers & Clark, 2000; Fairburn, Cooper, & Shafran, 2003; Salkovsksis, 1999; Rapee & Heimberg, 1997, etc.). Each of these models attempt to explain the core symptoms of specific disorders by developing a model of interacting cognitions, behaviors, and physiological responses which are maintained through lower and higher level cognitive processes including attention, interpretation, memory, and appraisal processes.

Cognitive and behavioral theories were not only integrated, but cognitive theories were also developed to explain many behavioral models of psychopathology, including the revised helplessness model of depression (Abramson, Seligman & Teasdale, 1978) and emotional processing theories of anxiety and habituation (Foa & Kozak, 1986). The helplessness model of depression suggested that attribution of negative events to personal, permanent, and pervasive factors maintains depressogenic beliefs and may account for the depressive states caused by inescapable aversive situations, as described in the original behavioral account of learned helplessness (Abramson et al., 1978). Emotional processing theory (Foa & Kozak, 1986) followed Lang (1977) by suggesting that fear structures are propositional networks that contain information about 1) stimuli, 2) verbal, behavioral, and physiological responses, and 3) the meaning of the stimuli and responses. Further, Foa and Kozak (1986) proposed that for modification of a fear structure to occur, there are two necessary components: activation of the fear structure and incorporation of new, disconfirmatory information into the fear structure. Thus, cognitive processes were proposed to account for both within and between session habituation. Similarly, Barlow (1988) integrated cognitive appraisals of control and predictability into Gray's biobehavioral emotion theory account of anxiety to advance theory and treatment. These types of theorizing helped to create a dominance of cognitive theory within CBT, acquiring significant empirical support as well as clinical utility in advancing treatments.

In the last two decades these theories have been expanded upon and refined based on accumulating evidence. Some of these theories have undergone significant revision to accommodate new findings (Abramson, Metalsky, & Alloy, 1989), while others have worked on updating the theories without a complete revision (Barlow, 2002; Beck, 1996; Foa et al., 2006). Many of these updates include the incorporation of recent information regarding the nature of the same processes that were originally discussed such as learning, memory, attention, and extinction, as well as the advancement of newer findings regarding emotion regulation and similar constructs (Gross, 1998). Some newer theories have focused specifically on the accumulation of information on competing information in memory (e.g., Brewin, 2006), while others have attempted to understand psychopathology in terms of multiple levels of information processing that occur in both benign and emotional circumstances (Beevers, 2005; Power & Dalgleish, 1997; Teasdale & Barnard, 1993). One of the earliest multi-level theories was the Interactive Cognitive Subsystems (ICS) of Teasdale and Barnard (1993). ICS proposes that there are multiple codes (various forms of information) which are stored at two levels of meaning: generic and specific. These codes can be converted to one another, but are stored in separate memory systems. Emotion-related schematic models contain features of protypical situations that have elicited the emotion in the past. Generic meanings typically activate such schema and are overgeneralized and maintained in a cognitive loop in most forms of psychopathology. This model has been further expanded by Power and Dalgleish (1997, 2008), incorporating substantial information from emotion theory (attempting to account for most forms of psychopathology via the five basic emotions), and cognitive theory (in a highly-complex model including four levels of representations of information).

The empirical status of CBT theories is strong and developing further. Recent studies have suggested the potential causal role in attentional and interpretive biases in developing anxiety (see Mathews & MacLeod, 2005). Longitudinal studies are demonstrating the importance of specific forms of cognition on the development of psychopathology (Bryant & Guthrie, 2007; Huppert, Foa, McNally, & Cahill, 2008) and, as described below, a number of studies have demonstrated that changes in cognitive and behavioral mechanisms proposed to be

core aspects of CBT theories are related to symptom improvement (Huppert et al., 2008; Ingram, 2007). Overall, current CBT theories of psychopathology have incorporated findings from many areas of experimental psychopathology, basic areas of psychology, and neuroscience, allowing for further development of current notions of psychological processes into our understanding of the nature and treatment of psychopathology.

The Process of Therapy

Prior to discussing the specific CBT focus, techniques, and processes it is important to note that the CBT focus on techniques, while essential, is conducted within the context of a therapeutic relationship. In many forms of CBT, the therapeutic relationship is established during the initial evaluation and sessions. Data suggest that the therapeutic alliance in CBT is quite strong and positive, and that therapists are seen as warm, caring, and authoritative (though not authoritarian) (Keijsers, Schaap, & Hoogduin, 2000), which is indeed the goal. In addition, the therapeutic stance is one of genuineness, transparency (the therapist provides a general framework of what will happen in therapy, and discusses the plan for each session at the beginning of the session), and collaborative empiricism (explicitly working together towards a common goal of understanding the patient's problems by testing out hypotheses generated by the patient and therapist). Socratic questioning is used with the goal of having patients contemplate and process information fully, making them more likely to remember and apply it. Most CBT therapies do not emphasize discussions of the therapeutic relationship as a facilitator of change unless there are reasons to believe that ignoring such issues will interfere with the treatment from the outset (e.g., Linehan, 1993; McCullough, 2003; Young, Klosko, & Weishaar, 2003). In fact, data suggest that the improvements in the therapeutic alliance in CBT may follow cognitive change and symptom reduction rather than preceding them, at least in some forms of CBT (e.g., Tang & DeRubeis, 1999). At the same time, since the beginning of CBT, the context of a positive therapeutic relationship has been emphasized (c.f., Chapter 3 in Beck, Rush, Shaw, & Emory, 1979), and other data suggest that patients' perceptions of therapist empathy predicted changes in outcome while changes in outcome did not predict perceptions of therapist empathy (Burns & Nolen-Hoeksema, 1992). Overall, the role of the therapeutic relationship in CBT is seen as important, but not the essential ingredient (see Castonguay, Constantino, McAleavey, & Goldfried, in press). This is also demonstrated by the efficacy of self-help using CBT for a number of disorders (Newman, Erickson, Przeworski, & Dzus, 2003).

The basic focus in most forms of CBT is on the thoughts, behaviors, physical sensations, and emotions experienced by the patient which are typically related to their presenting complaint or form of psychopathology. The main concept is to understand the context of problematic situations for the patient by examining recent situations in which the individual experienced an extreme or excessive emotional or behavioral response (fear, shame, embarrassment, depression, anger, etc.). The thoughts, appraisals, and beliefs, behavioral responses (typically in order to cope by avoiding, suppressing, distracting, etc.), and physiological responses are examined in a detailed fashion in order to understand the pattern of responses that the patient engages in in response to such situations (i.e., a careful functional analysis).

Most forms of CBT encourage a process of emotional engaging in the memory of the situation (to facilitate "hot cognitions" or "emotional processing") followed by some level distancing. The distancing may be in the form of cognitive challenging (re-evaluating the thoughts that occurred in the situation), or examining the alternative behaviors that could have been engaged in (exposure to feared experiences).

All forms of CBT ultimately are attempting to actively create new learning experiences (modifying associations of meaning within the multiple levels of schemata), though different streams of CBT will emphasize different methods of doing so. More behavioral forms of treatment (such as exposure therapy for anxiety disorders or behavioral activation for depression) will emphasize changes in behavior to facilitate new learning while cognitive approaches will emphasize methods of testing predictions and thoughts via cognitive challenging and behavioral experiments. Ultimately, most schools of CBT incorporate behavioral strategies with cognitive strategies, oftentimes within the same exercise. The therapist's goal is to use the power of the relationship and the power of persuasion to help the patient engage in experiences which challenge their beliefs about themselves, the world, and the future.

There are a number of techniques that are common to most (though not all) forms of CBT. These include psychoeducation, monitoring, cognitive restructuring, in-vivo exposure, imaginal exposure, behavioral activation, and homework assignments. These techniques are tailored to the individual patient to target the core problems that appear to be maintaining pathological emotions, thoughts and behaviors. An individualized case conceptualization is essential, where one takes into consideration both the presenting disorders and the patients' unique contributions to the problems they are experiencing.

Ultimately, the information and techniques utilized in the therapy office are seen as mechanisms to facilitate learning that need to be generalized to real-world situations. Most cognitive, behavioral, emotional patterns of living cannot be changed via treatment occurring one hour a week. At times, this means doing therapy outside of the office (especially with exposures) to facilitate generalization, but it most commonly includes completing homework assignments, one of *the sine qua non* of CBT. Homework's importance has been researched relatively thoroughly and shown to be a significant predictor of outcome in CBT (Kazantzis, Deane, & Ronan, 2000). Conceptually, the use of homework in CBT is similar to that of learning a new language. As such, one needs to immerse oneself in the language if one is to be fluent enough to use it difficult situations. While the therapy sessions may provide the basics of grammar and vocabulary for the language, only using it in every opportunity one can will one truly master it and be able to use it independently even long after treatment. This metaphor is often provided as homework rationale directly to the patient.

Empirical Support

Over the last 30 years, there have been many advances and developments in both behavioral and cognitive aspects of the treatment, including an abundance of treatment outcome studies demonstrating CBT's efficacy for most forms of psychopathology including anxiety disorders, depression, eating disorders, schizophrenia, personality disorders and more (for a review of meta-analyses see Butler, Chapman, Forman, & Beck, 2006). In fact, outcome research on CBT comprises the lionshare of the empirical evidence for the effectiveness of psychotherapy via randomized clinical trials. There has also been substantial progress in demonstrating the durability of CBT over long periods of time from 1 to 10 years for many treatments (Hollon, Stewart, & Strunk, 2006), and that outcomes in practice are similar to those obtained in randomized trials (Stewart & Chambless, 2009). These studies have included careful studies of mechanisms, randomized trials versus medications, placebos, and therapy controls. Results of these trials have had major implications in various healthcare environments throughout the world. First, the majority of treatments considered to be empirically supported are CBT-oriented (c.f., Barlow, 2008; Nathan & Gorman, 2007). Second, healthcare systems (whether it be insurance or governmental) have begun to allocate significant funding to the dissemination of

CBT treatments, with the notion that such dissemination will ease both burden of illness (e.g., unemployment, time off at work, etc.) as well as decrease service utilization (for two examples, see the National Institute for Clinical Excellence in the UK, www.nice.org.uk and the USA Veterans' Affairs Central Office Initiative (http://www.avapl.org/pub/2009%20Conference/Presentations/AVAPL%202009%20-%20Karlin.pdf). Finally, given the results of clinical trials showing the equivalent effectiveness or superiority of CBT over medications for some conditions, psychiatric guidelines are increasingly calling for CBT to be a first-line treatment for many disorders including anxiety disorders, eating disorders, and affective disorders (see http://www.psychiatryonline.com/pracGuide/pracGuidehome.aspx).

In addition to the substantial body of research supporting the efficacy and effectiveness of CBT, research has also supported the importance of many of the main tenets of the theories and use of many of the specific techniques. For example, a number of studies have demonstrated the relationship between cognitive change and symptom change (see Huppert et al., 2008 or Ingram, 2007 for reviews or Tang & DeRubeis, 1999 for a specific example). In addition, numerous studies have shown the relationship between exposure techniques and outcome (see Foa et al., 2006), and between homework and outcome (Kazantzis et al., 2000). More sophisticated data analytic procedures continue to provide specific tests of CBT theories (see Ingram, 2007). While data are overall supportive, results are far from definitive, and more data examining CBT theories is clearly warranted.

CBT is a rich, creative, and effective set of treatments which have been developed over the last 50 plus years. The demand in CBT for assessment, application of idiographically-tailored empirically validated techniques (followed by further assessment) and the desire to help achieve maximal benefit for the therapy is reflected both on the local (case-by-case therapeutic stance) and macro (treatment studies) levels. Thus, there is constant work on evaluating what is working within CBT and how it can be improved.

Humanisitic / Experiential Approach [3]

The most central characteristics of humanistic approaches to psychotherapy are promoting in-therapy *experiencing*, a belief in the uniquely human *capacity for reflective consciousness* plus a *positive view* of human functioning based on the operation of some form of *growth tendency.* Humanistic approaches adopt a consistently *person-centered* view that involves concern and real respect for each person. Major approaches within this orientation, are Person-centered, Gestalt, Psychodrama and Existential. Some more contemporary experiential therapies, such as Emotion-focused (Greenberg, 2002) and Experiential therapy (Gendlin 1996; Mahrer 2005) based on a neo-humanistic reformulation of the above classic humanistic values, have emerged. In these the traditional humanistic assumptions have been expanded to incorporate modern views on emotion, dynamic systems, constructivism, and the importance of a process view of functioning to help clarify the humanistic views of growth and self-determination.

Models of Function and Dysfunction

A general principle that has united all experientially-oriented theorists is that people are wiser than their intellects alone. In an experiencing organism, consciousness is seen as being at the peak of a pyramid of nonconscious organismic functioning. Of central importance is that tacit experiencing is seen as potentially available to awareness, as an important guide to conscious experience, and is fundamentally adaptive. In addition, behavior is seen as the goal-directed

attempt of people to satisfy their perceived needs, to maintain consistency (Rogers, 1951; Perls, Hefferline, & Goodman, 1951) and more recently, to regulate affect (Greenberg, 2008).

Internal tacit experiencing is most readily available to awareness, when the person turns his or her attention internally within the context of a supportive interpersonal relationship. Interpersonal safety and support are thus viewed as key elements in enhancing the amount of attention available for self-awareness and exploration. Experiments in directed awareness, in addition, help focus and concentrate attention on unformed experience and intensifying its vividness. The classical humanistic-experiential theories of functioning posited two main structural constructs, self-concept and organismic experience, as well as one major motivational construct, a growth tendency. An additional important concept was that of an organismic valuing process.

Rogers developed the most systematic self-theory and equated the self with the self concept. For Rogers the self was viewed as an organized *conceptual* system consisting of the individual's perceptions of self, of self in relation, as well as perceived *values* attached to these perceptions. Needs were seen as important determiners of behaviour, but a need was thought to be satisfied only through the selection and use of behaviour that was consistent with the self concept. In contrast to the self concept, Rogers (1959) defined experience as all that is "going on" within the organism that at any moment is potentially available to awareness. Awareness of in-the-moment embodied "goings-on" was thought essential to being able to access the information implicit in organismic intelligence.

Experiential theorists posit a core human tendency towards growth. Rogers defined an actualizing tendency as the "inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism" (Rogers, 1959, p. 196). This view asserted that the person was not solely guided by regulating internal deficiencies, but also was a proactive and self-creative being organized to grow. Neither Rogers nor Perls saw actualization as the unfolding of a genetic blueprint. Rather, they were committed to the concept of an inherent organismic tendency towards increased levels of organization and evolution of ability. Maslow's (1954) concept of hierarchy of needs from survival to being needs was also incorporated into the humanistic understanding of motivation.

Rogers explicitly, and Perls implicitly, also proposed an *organismic valuing* process, believing that experience provided an embodied felt access to this organismic valuing capacity. Organismic valuation is thought to measure how present events are consistent with, respect, and serve important organismic needs. This proposed organismic evaluation does not provide a logical valuation of truth or falseness, but rather a global apprehension of the meaning of events in relation to lived well-being. This valuing process was proposed to be the governor of functioning.

Humanistic theorists see the self as central in explaining human functioning. A central assumption is that to avoid anxiety the person must 'maintain' the experience of consistency between an acceptable self-concept and both organismic experience and behaviour, and that individuals limit awareness of current feelings and needs that may motivate self-inconsistent behaviour. This disowning of feelings and needs is viewed in the long run to lead to maladjustment, and to the thwarting of actualization.

Additional concepts recently introduced by neo-humanistic perspectives are affect regulation as a core motive, emotion schemes as central structures and "voices of self organizations" as aspects of functioning (Greenberg, 2002; Stiles 1999). Behavior is then seen as being motivated by the desire to have the emotions one wants and not have the emotions one

does not want. Emotion schemes are internal organizations of past lived emotional experience that when activated produce current emotional experience. People are seen as multi-vocal with many different interacting self organizations and the interlinked traces of experiences into emotion schemes when activated form a *community of voices* within the person. Un-integrated voices tend to be problems, whereas assimilated voices are resources, available when circumstances call for their unique features and capacities.

Healthy Functioning. All humanistic/experiential theorists view the person as a complex self-organizing system. The greater the awareness of experience of the self, and the field or environment in which the person is operating, the greater the integration of all aspects of experience and the more engagement with the environment. In this view it is the integration in awareness of all facets and levels of experience (Greenberg & Safran, 1986; Mahrer, 2005; Perls, 1969; Resnick, 1995; Rogers, 1961; Schneider & May, 1995; Yalom, 1980) that is seen as important in healthy functioning. When functioning well people can access well-differentiated aspects of self as an immediate felt referent, and use it as an on-line source of information to inform present and subsequent behaviour (Gendlin, 1962; Rogers, 1957, 1959).

The above traditional humanistic assumptions have been expanded by neo-humanistic perspectives to help clarify the humanistic views of growth and self determination (Greenberg, Rice, & Elliott 1993; Greenberg Watson, & Leitaer 1998). Contemporary *emotion theory* (Frijda 1986; Greenberg & Paivio, 1997; Greenberg & Safran, 1986) holds that emotion is biologically adaptive system that provides rapid appraisals of the significance of situations to peoples' well-being and, therefore, guide adaptive action. Emotion thus provides a process by which the growth tendency and the organismic valuing process function (Greenberg, 2002). In this view, emotion helps the organism to process complex situational information rapidly and automatically, in order to produce action appropriate for meeting important organismic needs (e.g., self-protection, support).

In addition, humanistic perspectives on subjectivity and perception have been connected to *constructivist* epistemology and views of functioning. Within this framework, people are seen as dynamic systems in which various elements continuously interact to produce experience and action (Greenberg & Pascual-Leone, 1995, 2001; Greenberg & van Balen, 1998). These multiple interacting self-organizations can be described metaphorically as "voices" or parts of self (Elliott & Greenberg, 1997; Mearns & Thorne, 1988; Stiles, 1999). In this view, the "I" is an agentic self-aspect or self-narrating voice that constructs a coherent story of the self by integrating different aspects of experience in a given situation; however, this voice has no special status as an "executive self."

In a neo-humanistic view, growth is seen as emerging, not only through the self-organization of some type of biological tendency, but also from genuine dialogue with another person. In such an I-Thou dialogue (Buber, 1978), each person is made present to and by the other. In therapy, the therapist both contacts and confirms the client by focusing on particular aspects of the client's experiencing. Contact involves a continual empathic focus by the therapist on the client's subjective experience, confirming the person as an authentic source of experience and strengthening the self. Confirmation validates the other and by focusing on strengths and internal resources promotes growth. It is the therapist's focus on subjective experience and strengths that help facilitate client growth and development.

Dysfunction. In general, experiential approaches viewed pathology as resulting from the inability to integrate certain experiences, into existing self-organization. From the experiential perspective what is unacceptable to the self is dealt with, not by expelling it from consciousness but by failing to own experience as belonging to one's self, i.e., not experiencing it. In addition,

what is disowned is not by definition pathogenic. Therefore, in the experiential perspective because healthy experiences and feelings may be seen as unacceptable by other self organizations, they are as likely to be disowned as are unhealthy feelings or trauma. Experiential theory therefore sees dysfunction as occurring both from the disowning of healthy growth oriented resources and needs, as well as from the avoidance of painful emotions.

In the neo-humanistic process view, it is the inability to integrate aspects of functioning into coherent harmonious internal relations that is viewed as a major source of dysfunction rather than incongruence between self-concept and experience. Thus, different voices in the self representing one's wishes and fears, one's strengths and vulnerabilities, or one's autonomy and dependence may at any moment be in conflict and at any moment in danger of being disowned. Notice that conflict here is between different self organizations, not conscious vs. unconscious, or moral vs. immoral.

The second central source of dysfunction is the *inability to symbolize bodily felt experience* in awareness. Thus, one may not be aware or be able to make sense of the increasing tension in one's body, of the anxiety one feels, or of unexpressed resentment, and this will lead to being out of touch with how one feels and, therefore, disoriented and unable to act most adaptively. A third major source of dysfunction involves the activation of *core maladaptive emotion schemes*, often trauma-based (Greenberg & Paivio, 1997). This leads to painful emotions and emotional memories and to maladaptive emotional experience and expression or the avoidance of these. The operation of this process implies that not all basic internal experience is an adaptive guide, and that in addition to the benefits of becoming aware of basic experience, basic experience itself sometimes requires therapeutic change.

The above three general processes of dysfunction are supplemented by the operation of a large variety of more specific cognitive/affective processing difficulties that help explain different types of dysfunctional experiential states. A variety of particular experiential difficulties have been described by Greenberg, Ford, Alden, & Johnson (1993). Difficulties such as problematic reactions, in which one's view of an experience and one's reaction don't fit; self evaluative splits, in which one part of the self negatively evaluates another; unfinished business, involving unresolved emotional memories; and statements of vulnerability involving a fragile sense of self. All involve different types of underlying emotion schematic processing problems. Each state requires different interventions designed to deal with the specific emotional processing problems. This focus on different problematic in-session states offers a differential view of dysfunction in which current determinants and maintainers of disorders are identified by a form of process diagnosis in which therapists identify markers of in-session opportunities for implementing specific types of interventions and change processes.

The Process of Therapy

In the most general terms, humanistic-experiential therapy is based on two basic principles: first, the importance of the relationship; and, second, the consistent and gentle promotion of the deepening of the client's experience.

The relationship. The relationship is seen as both curative, in and of itself, and as facilitating of the main task of therapy, that is, the deepening of client experiencing. The relationship is built on a genuinely prizing empathic stance and on the therapist guiding clients' experiential processing toward their internal experience. An active collaboration is created between client and therapist, in which neither feels led, or simply followed by the other. Instead, the ideal is an easy sense of co-exploration. Although the relationship is collaborative, when disjunction or disagreement does occur, the therapist defers to the client as the expert on his or

her own experience. Thus, therapist interventions are offered in a non-imposing, tentative manner, as conjectures, perspectives, "experiments," or offers, rather than as expert pronouncements or statements of truth. Interventions are construed as offering tasks on which clients who are active agents can work if they so choose. Maintaining a responsive relational bond always takes precedence over the pursuit of a task. Although the therapist may be an expert on the possible therapeutic steps that might facilitate task resolution, it is made clear that the therapist is a facilitator of client discovery, not a provider of "truth," nor a psycho-educator. Experiential therapy thus recognizes both the power of the understanding relationship and the importance of different in-therapy tasks in promoting different types of therapeutic change.

Strategies and interventions. In experiential therapy deepening experiential processing and subsequent meaning construction is accomplished by (1) creating a safe trusting environment conducive to experiential processing and providing emotion coaching that models approach, valuing, and acceptance of emotion; (2) providing words for understanding and symbolizing peoples unformulated experience to help clients both regulate and express experience; (3) directing clients' attentional resources to the edges of awareness; (4) using empathic exploration and evocation to activate tacit meanings, bring them emotionally alive and explore what is at the periphery of awareness; and finally, (5) using emotion stimulating interventions to activate emotional experience to help clients access and express alternative adaptive emotional resources (Greenberg, 2002).

The purpose of deepening emotional processing in experiential therapy is to activate internal emotional resources in the client, that is, the client's adaptive tendencies and resources towards adaptive growth (Gendlin, 1962; Greenberg 2002; Rogers, 1957). As clients access an experience of their feelings, they will also experience related needs, as well as action tendencies that may actualize the meeting of these needs in the world. While accessing internal emotional resources is thought by some to occur sufficiently in a person-centered relationship, experiential therapists work towards accessing alternate emotional resources of the client in more focused ways by the use of specific techniques. These may include: experiments in attention; focusing; working directly with embodied expression; and by empty-chair and two-chair dialogues (Greenberg et al., 1993; Greenberg & Watson, 2006).

Experiential therapy as process theory. An important distinguishing characteristic of experiential therapy is that it offers a process theory of how to facilitate experiential knowledge, and rather than a content theory of personality or psychopathology, it offers a process theory that specifies both the moment-by-moment steps in the client's process of change and the therapist interventions that will facilitate these steps. The emphasis in each step always is on how to promote the direct sensing of what is concretely felt in the moment to create new meaning and how to promote a next processing step.

The key to experiential therapy is to have clients experience content in a new way, so that this new experience will produce a change in the way they view themselves, others and the world. Experiential therapy thus emphasizes that symbols, schemes, and even behavior must interact with the body-based, experiential, level of existence in order to produce change (Gendlin, 1996). It thus offers a process theory of how body and symbol interact, and a set of methods for promoting this process.

Case formulation in this approach involves an unfolding, co-constructive process of establishing a focus on the key components of the presenting problems (Greenberg & Goldman, 2007). Formulation emphasizes making process diagnoses of current in-session states and exploring these until a clear focus on underlying determinants emerge through the exploratory

process. In developing a case formulation, the therapist focuses first on salient poignant feelings and meanings, follows the client's emotional pain and notices the client's initial manner of cognitive-affective processing and what will be needed to help the client focus internally. Then, working together, client and therapist develop a shared understanding of the underlying emotional determinants of the presenting problem the main therapeutic tasks and, finally, of the client's emerging foci and themes. Formulation this emerges from the dialogue and is a shared construction involving deeper understandings of the problem and goals of treatment. The defining feature of an experiential approach to case formulation and assessment is that it is *process diagnostic and marker focused* (Greenberg et al., 1993) rather than person diagnostic. Diagnostic focus is on in-session problematic processes in which clients are currently be engaged.

Differential process diagnosis involves the therapist attending to a variety of different in-*session markers* of in- the- moment problematic states. Problematic states are then addressed by interventions designed to address the specific difficulty. These processes may include process markers of clients' emotional processing style such as being externally focused or emotionally dysregulated or of particular problem states such as self critical conflict or unresolved bad feelings to a significant other. Attention is paid to *how* clients are presenting their experiences in addition to *what* they are saying. Formulation and intervention are therefore constantly and intimately connected, span the entire course of treatment, and occur constantly at many levels.

Empirical Support

A series of meta-analyses of controlled and uncontrolled studies on the outcome of humanistic-experiential therapies have demonstrated their effectiveness (Greenberg, Elliott & Lietaer 1994). Elliott, Greenberg & Lietaer (2005) presented a meta-analysis of 64 studies of experiential therapies. Eighteen examined Emotion-focused individual therapy (EFT); 10 evaluated EFT for couples; 10 studied Gestalt therapy, 11 investigated encounter/sensitivity groups, and 15 looked at the outcome of various other experiential/humanistic therapies (e.g., focusing-oriented, psychodrama or integrative). The average *pre-post* effect was .99, considered large. Clients maintained or perhaps even increased their post treatment gains over the post therapy period, with largest effects obtained at early follow-up. Control-referenced effect sizes of pre-post differences in the 42 treated groups in which experiential treatments were compared to wait-list or no treatment controls were also considered large.

Results of 74 comparisons between experiential and non-experiential therapies showed no overall difference between experiential and non-experiential treatments. In 60% of the comparisons no significant differences were found. In 18 % of comparisons clients in non-experiential treatments did significantly better; while in 22% of comparisons experientially-treated clients did significantly better. A sub-sample of 46 studies compared effects between experiential and cognitive behavioural therapy (CBT). In general experiential therapies and CBT therapies were shown to be equally effective.

As an example of a humanistic approach that has been empirically studied, Process Experiential Emotion-focused (PE/EFT) therapy, was found to be highly effective in treating depression in three separate trials. In two studies PE/EFT was compared to a purely relational empathic treatment, and one study compared PE/EFT to a cognitive behavioral treatment. All three treatments were found highly effective in reducing depression. PE/EFT was found to be more effective that a pure relational empathic treatment in reducing interpersonal problems, in symptom reduction, and in preventing relapse (Goldman, Greenberg, & Pos, 2005; Greenberg & Watson, 1998). Watson, Gordon, Stermac, Kalogerakos, & Steckley (2003) found no significant

differences in symptom improvement between PE/EFT and CBT for the treatment of major depression. However, clients in PE/EFT therapy reported being significantly more self-assertive and less overly accommodating at the end of treatment than clients in the CBT treatment. In addition, EFT has been shown to be effective intreating chilhodd trauma, abuse and interpersonal injuries (Paivio & Greenberg 1995; Paivio, Hall, Holowaty, Jellis, & Tran, 2001).

The majority of research on experiential psychotherapy has focused on the whether depth of experiencing relates to outcome. Hendriks (2002) has reviewed 91 of these studies. Experiential processing was explored within various treatments (not solely experiential) for varied diagnostic categories, from schizophrenia, to marital discord, to depression. The vast majority of studies found that higher experiencing levels measured related to better psychotherapy outcomes measured by a variety of outcome measures.

Systemic Approach [4]

The essence of the systemic approaches to psychotherapy is their focus on defining and conceptualizing clients' psychological problems contextually. Most often, the context or frame of interest is the couple or the family, but it may also be a broader context, such as an extended family or classroom of students and teacher. While assessment and case conceptualizations are informed by this perspective, in practice, specific interventions are directed not only at the family or couple but may also be directed at an individual. As discussed later, there are numerous approaches to systemic therapy. What specifically, then, defines a systemic approach to therapy, and how do systemic approaches differ from other approaches? To fully answer these questions, we consider both the defining features of systemic therapy models and their evolution as a distinct approach to treatment. This is followed by a detailed description of selected systemic therapy approaches, followed by a summary of outcome and change process research.

Models of Function and Dysfunction

Although systemic therapies can differ from each other substantially in practice, they share certain common philosophical and conceptual features which distinguish them from other therapy approaches. Most importantly, systemic therapies focus not solely on *intrap*ersonal or individual dynamics, rather on the *inter*personal and *inter*actional dynamics that shape and maintain problems in one or more members of the system. A system (e.g., couple, family) is a set of dynamic elements (e.g., people) which mutually act upon, and are acted upon, by the others. For example, in a couple, the emotional or physical avoidance of one partner may "cause" the other to approach the partner, which in turn begets more avoidance behavior by the partner, then more approach behavior by the first person, and so on. Although the partners themselves often punctuate this ongoing sequence in a linear way that blames the other and exonerates themselves ("she started it," I wouldn't bug him if he didn't avoid me"), the systemic therapist takes a "metaperspective," focusing instead on circular causal explanations of the ways in which the couples' joint pattern of interacting sustains their unhappiness.

The same is true in the family context. Systemic therapists assess a child's problem behavior by considering it not in isolation but within the context of the family system. For instance, a child's externalizing behaviors may function to draw a distant parent into more contact with the other parent and the child, or to deflect conflict between the parents onto the child. Each person's behavior is part of a web of elements in which the whole is more than the sum of its parts. Thus explanations of psychopathology in an individual require an expansion of the frame of reference: "If a person exhibiting disturbed behavior (psychopathology) is studied in isolation, then the inquiry must be concerned with the *nature* of the condition and, in a wider sense, with the *nature* of the human mind. If the limits of the inquiry are extended to include the

effect of this behavior on others, their reactions to it, and the context in which all of this takes place, the focus shifts from the artificially isolated monad to the *relationship* between parts of the system. "The observer of human behavior then turns from an inferential study of the mind to the study of the observable manifestations of relationship" (Watzlawick, Beavin & Jackson, 1967, p. 21).

Early theorizing and clinical observation yielded a number of heuristically rich corollaries that provide the underpinnings for systemic models. The first assumption is that communication is the vehicle by which relationships (both healthy and disturbed) are defined and thus much is learned from a study of not just *what* people within a system say to each other, but *how* they say it. Tone of voice, sarcasm, humor, interruptions, kinesics, even silence, communicate information about not only the content of the communication and how to "read" it, but also about the relationship itself. Another assumption is that family and other human systems have a kind of psychological equilibrium which is maintained by positive and negative feedback to the system. Negative feedback is information that signals a deviation from the steady state (homeostasis) and the necessity of some self-regulating adjustments, e.g., when an adolescent's emerging needs for independence feeds conflict and results in shifts in established family patterns of interaction. Positive feedback is information that signals, "we're on course, no change is needed." Since in a family system, the behavior of each person continually provides feedback to the others, the result is a complex and dynamic system in which "concepts of pattern and information" (Watzlawick et al., 1967, p. 32) are the focus of clinical assessment. This stands in contrast to most other psychotherapy approaches in which characteristics of individuals -- intrapsychic drives and conflicts, problematic affective states, or distorted cognitions -- are the focus.

At the time it was developed in the late 1960's, the systemic model was a radical shift from the psychoanalytic, psychodynamic, and humanistic psychotherapy approaches that were dominant; it developed in parallel, however, with the emerging behavioral therapies that were applied to families. Some of these assumptions have subsequently been challenged or refined in newer systemic therapy approaches. However, they served to further define the transformative nature of the systemic approach. Although systemic approaches are now firmly established, they continue to present interesting challenges to traditional assumptions and habits of thinking on questions such as: Who is the client? How should change be measured? How can we classify and assess distressed relationships and family systems? (See Kaslow, 1996; Kaslow & Patterson, 2006, for discussion of relational diagnosis).

Current systemic therapies must be understood within the context of their evolution (see Becvar, 2003, for an excellent summary). From the beginning, systemic therapy has had broad interdisciplinary roots. It was born of the exchange of ideas and in some cases, actual collaborations between those interested in general systems theory in the biological sciences, mathematicians, communications researchers, anthropologists, and psychiatrists (Ruesch & Bateson, 1968; von Bertalanffy, 1950; Watzlawick et al., 1967; Watzlawick, Weakland, & Fisch, 1974; Weiner, 1948). Translation and use of these ideas in clinical settings and early forms of family therapy in the 1960's and 1970's were powerful, generative, and occasionally misguided, as in the case of the double-bind theory of schizophrenia (Bateson, Jackson, Haley & Weakland, 1956). The fact that this *was* a radically different view of psychological problems no doubt accounted for the development, in some of its applications, of a singular, if not zealous, focus on the system to the exclusion of the individual, leading some to question whether the "self" had been lost in the system (Nichols, 1987). As major advances were made in the 1980's and 1990's

in understanding the role of cognition and emotion in psychopathology, the role of attachment in adult relational problems, and the ways in which brain biochemistry both affects and is affected by experience, these developments became incorporated into the newer evolving forms of systemic family and couples therapies. As will become clear shortly, these newer approaches integrate both individual-level and systems-level dynamics in their theories and practice.

The Process of Therapy

Current systemic therapy interventions draw heavily on the foundations established by the "classic" approaches, e.g.., behavioral family therapy (Falloon, 1991; Patterson, 1971), structural family therapy (Colapinto, 1991; Minuchin, 1974), strategic therapy (Haley, 1963, 1973; Madanes, 1981), interactional/MRI approaches (Watzlawick et al., 1974; Segal, 1991). They are, however, more integrative and more cognizant of the ways in which systems outside the nuclear family and the forces of gender, race, culture and socioeconomics interact with the family system. And there are a few models that marry systemic thinking with postmodern philosophy, the "social construction therapies" (Anderson, 2003). Two systemic approaches are described in some detail below. They were chosen from the many current approaches (see Gurman & Jacobson, 2002 and Lebow, 2005) as illustrations of the variety of interventions that characterize systems treatments, and because they each have strong empirical support.

Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT; Santisteban, Szapocznik, Perez-Vidal, Kurtines, Murray, & LaPerriere, 1996); Szapocznik & Kurtines, 1989; Szapocznik, Perez-Vidal, Hervis, Brickman, & Kurtines, 1990) is a set of interventions for families of adolescents with externalizing behavior problems such as conduct disorder and delinquency, as well as substance abuse. BSFT focuses on the dysfunctional family relationship patterns that are associated with these (often, co-occuring) problems. It also targets the school and peer systems. BSFT entails 3 steps, each equally important (Horigian et al., 2005). *Joining* is the first step, and BSFT has pioneered techniques that work for engaging difficult families, including (1) consultation by phone even before therapy starts to get family members to come in, (2) forming an early alliance with each family member to learn what his/her goals are work toward them, (3) successfully joining the family system by working within existing structures at first. The therapist's goal is to become a trusted, temporary leader of the family, one who is seen by each member as both respectful and capable of helping them resolve their problems. The therapy was developed with Hispanic families and is especially attuned to cultural considerations, including respect for the most powerful family members.

In the next step, *diagnostic assessment,* the therapist creates enactments in the sessions that allow him/her to assess the family's typical patterns of interactions by observing them *in vivo* rather than just hearing accounts of them. The BSFT therapist studies their organization (leadership, subsystems, communication), resonance (emotional connections between them), and their developmental stage as a family. He or she also notes which member is the "identified patient" and the family's conflict resolution style. This assessment allows the therapist to develop a formulation of how the family interactions are sustaining the problems behaviors and from that, to launch the third step, *restructuring* their maladaptive styles of interaction to healthier ones. Working with the family conjointly, the BSFT engages the family in active work on the here-and-now process of how they interact with each other during the sessions. BSFT training and the therapy manual (Szapocznik, Hervis & Schwartz, 1993) provide directions for orchestrating change via techniques of reframing, assignments that create shifts in boundaries and alliances, and tasks within the therapy session and (once they have been successfully

completed there) outside of it, e.g., parents talk together the establish a curfew. Treatment typically lasts 12-16 sessions, with booster sessions as needed, and it ends when both family functioning and the adolescent problem behavior are significantly improved. There is also a one person form of BSFT for those families that cannot be engaged as a whole (Szapocznik, Kurtines, Foote, & Perez-Vidal, 1986).

Emotionally Focused Couple Therapy

Emotionally Focused Couple Therapy (EFT; Greenberg & Goldman, 2008; Greenberg & Johnson, 1988; Johnson, 1996; Johnson & Greenberg, 1994; 1985; Johnson et al., 2005) is also a brief, structured treatment that focuses on emotion and relational bonds together in order to decrease couple distress and dissatisfaction. Specifically, EFT interventions are targeted at "identifying the negative cycles of interaction, accessing the emotions that are both a response to and organizers of these cycles, and reprocessing these emotions to create new responses that shape secure bonding events and new cycles of trust and security" (Woolley & Johnson, 2005, p.387). The therapy proceeds through three stages: *desescalation of negative cycles, restructuring interactional positions toward secure connection, and consolidation and integration.* Though these are articulated sequentially, the work proceeds in an iterative fashion and setbacks may require some backtracking, so that in actual practice, the couple and therapist may be working on more than one step at once. *Deescalation* is accomplished by active involvement of the therapist, beginning with building an alliance with each partner individually (there may be long stretches where the therapist is talking with one person empathically while the other just listens) to establish safety and security within the therapeutic relationship. As in BSFT, the therapist then observes the clients' relational behavior to identify the negative interaction cycle; with couples this is often a pattern such as pursue/withdraw, blame/placate, criticize/defend. The therapist then uses gentle but persistent experience-focused questions to access and bring out the previously unacknowledged attachment emotions that underlie the patterned interactions, e.g., feelings of being unworthy, fear of abandonment. The other partner, of course, is a witness to this work but is enjoined from jumping in to defend him/herself, to invalidate the others' emotional experience, etc. This stage culminates in the therapist articulating a construction of the problem in terms of how each partner's underlying emotions and attachment needs are related to their negative and jointly created, interactional cycle. This is done matter-of-factly, avoiding blame and striving to keep each partner feeling understood and supported by the therapist as the second stage is entered.

Here, the work deepens as the therapist focuses in on the disowned emotional needs, and works toward the central change events, "withdrawer reengagement" and "blamer softening." Theoretically, the outcome of this work – thought it may take a while -- is the partners' acceptance of the other's emotional experiences and resulting shifts in interactional positions that allow partners to share their needs and wants directly, and become closer and more emotionally engaged as a couple. This undermines the rigid, conflictual patterns of relating. In the final stage, the work is about consolidating the new ways of relating and integrating them reliably into their life together beyond the therapy sessions.

Empirical Support

There is strong empirical support for the efficacy of couple and family systems therapies as a class of therapy (Pinsof & Wynne, 1995; Sexton, Alexander & Mease, 2004). But because these therapies are myriad and diverse, the better question is, *which* approaches have empirical support? In general, solid empirical support is strongest, but not limited to, those therapies with a strong behavioral or cognitive behavioral focus.

In the couples' therapy domain, behavioral couple therapy (BCT: Jacobson & Margolin, 1979); integrative behavioral couple therapy, which adds an acceptance component to traditional behavioral couple therapy (IBCT: Christensen & Jacobson, 1998; Baucom, Christensen & Yi, 200**5**), insight-oriented marital therapy (IOCT; Snyder, 1999; Synder & Wills, 1989), and emotion-focused couple therapy (EFT) have been demonstrated in clinical trials to be more effective than no treatment and about equally effective as each other (Sexton et al., 2004)**.** However, a robust finding in this literature is that couples' therapy of *any* kind results in significant improvements in relationship satisfaction for under 50% of couples and that even for those couples, gains in relationship satisfaction erode significantly within a year after treatment (Snyder, Catellani & Whisman, 2006).

In the family therapy domain, again, certain approaches have strong empirical support. These include: functional family therapy (FFT; Sexton & Alexander, 2003), multisystemic family therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), multidimensional family therapy (MDFT; Liddle, 1995) and brief strategic/structural family therapy (BSFT; Szapocznick & Kurtines, 1989). Attachment-based family therapy for depressed adolescents (ABFT) has good preliminary empirical support as an effective, distinct model (Diamond, Diamond & Hogue, 2007; Diamond, Siqueland & Diamond, 2003). With the exception of the latter, these all share a focus on families with delinquent or substance abusing adolescents. Other empirically supported family treatments include: parent management training for child conduct disorders (Brestan & Eyberg, 1998), psychoeducational family interventions for schizophrenia (Lam, 1991) and bipolar disorder (Miklowitz, George, Richards, Simoneau & Suddath, 2003; Rea et al., 2003), and systemic treatments for substance abuse problems (O'Farrell, 1993; Stanton & Shadish, 1997) and adults dually diagnosed with substance abusing and Axis I disorders (Moore, 2005).

However, other popular family therapy approaches have simply not yet been adequately tested, and family therapy efficacy research focuses primarily on externalizing disorders of youth. Meanwhile, other approaches such as strategic therapy (Fisch, Weakland & Segal, 1982; Madanes, 1981) solution-focused therapy (de Shazer, 1985; de Shazer, 1991), and postmodern social construction therapies, including narrative therapy (White & Epston, 1990) and collaborative therapy (Anderson & Goolishian, 1988) continue to be practiced and developed. Progress in outcome research continues (Sprenkle, 2002) as do ongoing debates continue about the best ways to assess outcomes and study the process of therapy in a manner compatible with a systemic perspective (Sprenkle, 2002; Sprenkle & Piercy, 2005).

Research on the change process of change is just beginning (Friedlander & Tuason, 2000; Heatherington, Friedlander & Greenberg, 2005) and is greatly needed. Though the treatments reviewed here are diverse, they share common features and (theoretically) some common change mechanisms that are specific to a systemic approach. These mechanisms should include processes between therapist and clients and also *between the clients* within the couple or family, as well as *within* individual members of the system. Articulating these mechanisms or "principles of effective change" (Castonguay & Beutler, 2006) and testing them empirically is the key to the healthy growth and future of systemic therapies. Christensen, Doss and Atkins (2005) provide a good illustration of how to articulate transtheoretical, testable principles of change in the couples therapy domain. An example is an "evocative intervention," that, theoretically, facilitates corrective experiences for the couple. In emotion focused couple therapy and integrative behavioral couple therapy (Cordova, Jacobson, & Christensen, 1998), for example, the therapist elicits emotional, less defensive, more honest and vulnerable reactions in a partner which,

ideally, are processed by the other partner; a "softening" on one person's part feeds "accessibility" on the others' part and as each person experiences a different sense of self, and a different sense of the other, they draw closer. Evidence supports this theorized change process (Bradley & Furrow, 2004; Greenberg et al., 1993). Another transtheoretical process that has received empirical support is transforming or reframing the clients' construction of the presenting problem. This includes the kind of reframing done in BSFT, the transformation of an individual narrative about the problem to an interpersonal, systemic one in constructivist family therapy (Coulehan, Friedlander, & Heatherington, 1998; Sluzki, 1992), and "relational reframing" of an adolescent's depression as a schism or rupture of trust in the adolescent-parent subsystem in ABFT (Diamond et al., 2003). The evocative intervention and the reframing interventions are good examples of the ways in which contemporary systemic approaches explicitly incorporate individual processes (emotion and cognition, respectively) into theory and therapy practice, in tandem with attention to interpersonal processes. They also illustrate the ways in which systemic thinking continues to be cross-disciplinary, and the ways in which many current approaches have built clinically-grounded, testable propositions into the theory itself.

Psychotherapy Integration [5]

Although a substantial number of psychotherapists identify themselves as eclectic or integrative (Norcross & Goldfried, 2005; Orlinsky & Rønnestad, 2005), the acceptance of psychotherapy integration was a process that evolved over several decades. A seed for psychotherapy integration was first planted by Alexander French in his address of the 1932 meeting of the American Psychiatric Association (later published as French, 1933). In this address, French drew parallels between psychoanalysis and Pavlovian conditioning (e.g., the similarities between repression and extinction). Subsequently, the potential for psychotherapy integration received attention from only a handful of authors between 1932 and 1960 (e.g., Dollard & Miller, 1950; Rosenzweig, 1936), and did not emerge as a latent theme until the 1960s and 1970s, beginning with Frank's (1961) *Persuasion and Healing*. This book addressed itself to the commonalities cutting across varying attempts at personal influence and healing in general. Soon after, the important concept of "technical eclecticism" was introduced in 1967 by Lazarus, who argued that clinicians could use techniques from various therapeutic systems without necessarily accepting the theoretical underpinnings associated with these approaches. By this time, many clinicians were arguing that rather than being irreconcilable, techniques from divergent approaches could be viewed as complementary. For example, Wachtel (1975) maintained that many instances of relapse following behavior therapy might possibly be linked to the client's maladaptive patterns that might more readily be identified when reviewed from within a psychodynamic framework.

In 1976, Garfield and Kurtz published findings indicating that approximately 55% of clinical psychologists in the United States considered themselves eclectic. Prochaska (1979), in a textbook describing diverse systems of psychotherapy, concluded with a chapter that made the case for developing a transtheoretical orientation that would encompass what had been found to be effective across different approaches to psychotherapy. With these developments, psychotherapy integration became a bona fide movement in the 1980s. An important contribution was made in a seminal paper by Goldfried (1980), who, noting past attempts to find commonalities across psychotherapies, argued that a fruitful level of abstraction at which such a comparative analysis might take place would be somewhere between the specific techniques and theoretical explanations for their potential effectiveness. Goldfried (1980) maintained that it is at

this intermediate level of abstraction—the level of clinical strategy—that potential points of overlap may exist.

Another significant event in the history of psychotherapy integration was the formation of an international organization devoted specifically to this endeavor. Formed in 1983, the Society for the Exploration of Psychotherapy Integration (SEPI) was established as a way of bringing together the growing number of professionals interested in this area. In the mid to late 1980s, in order to provide forums for these many voices, new journals appeared that directly addressed clinical and research issues pertinent to integration. One journal was the *International Journal of Eclectic Psychotherapy*, later renamed the *Journal of Integrative and Eclectic Psychotherapy* in 1987. The 1990s witnessed a continued growth of writing on psychotherapy integration, as well as a continued trend toward more therapists identifying themselves as eclectic/integrative. In 1991, SEPI began publishing its own journal, *Journal of Psychotherapy Integration.* The first edition of the *Handbook of Psychotherapy Integration* (edited by Norcross and Goldfried) was published in 1992, followed by the *Comprehensive Handbook of Psychotherapy Integration* (Stricker & Gold, 1993). These handbooks, journals, as well as the establishment of SEPI, are clear signs that psychotherapy integration has grown from being an idea (or dream) evoked by a few visionaries (and/or heretics within their own schools of thought) to becoming nothing less than a *leitmotif* in psychotherapy textbooks and training programs. For a more comprehensive review of the history of psychotherapy integration, see Goldfried (2005).

Factors Contributing to Psychotherapy Integration

Although the majority of therapists (at least in the United States) identify themselves as integrative or eclectic (Norcross, 2005), psychotherapy integration has only developed into a defined area of interest in the past twenty years. Of the many factors that have fostered this movement, a number of empirical findings have led numerous scholars and therapists to consider the contributions of a plurality of theoretical orientations in their attempt to both understand and improve psychotherapy (see Castonguay, Reid, Halperin, & Goldfried, 2003).

1. Although psychotherapy works, some clients fail to fully improve, others terminate prematurely, and yet others deteriorate.
2. Although some treatments (e.g., CBT) appear to be more effective than others for particular clinical problems (e.g., obsessive-compulsive disorder), major forms of psychotherapy tend to have equivalent outcomes.
3. Descriptions and observations of psychotherapists (including leading figures such as Freud, Rogers, and Wolpe) suggest that there are differences between their theoretical writings and clinical practice (see Castonguay, 1997; Castonguay et al., in press; Castonguay & Goldfried, 1994).
4. Process research suggests that in their regular clinical practice, therapists of different orientations can show more similarities than differences (e.g., Goldfried, Raue, & Castonguay, 1998).
5. Process research not only demonstrates that factors that are common to different approaches (e.g., the alliance) predict client improvement, but that some variables typically associated with one orientation (e.g., emotional deepening, exploration of attachment to early significant figures) are associated with positive outcome in other orientations (e.g., CBT) (Castonguay et al., 1996; Hayes, Goldfried, & Castonguay, 1996).

In addition to these empirical findings, leaders of major orientations have voiced serious criticisms of their preferred theoretical approaches, while encouraging an open-minded attitude

toward other orientations. Strupp (1976), for instance, denounced the "closed-shop" mentality that prevailed in psychoanalytic milieux and urged his colleagues to consider the contributions of learning theories and research in their conceptualization of therapy. Similarity, Thorensen and Coates (1978) lamented that a complacent orthodoxy was bred within behavioral therapies and that a critical revision of its conceptual rationale (including the consideration of the "purpose of life") was needed.

Furthermore, clinicians of different orientations recognized that their approaches did not provide them with the clinical repertoire sufficient to address the diversity of clients and their presenting problems. For example, Goldfried and Castonguay (1993) argued that CBT has paid limited attention to the therapeutic relationship and emotion. Integrating contributions from psychodynamic, interpersonal, and humanistic approaches, they argued that the examination of the way clients interact during sessions as well as the use of emotional deepening techniques could help CBT therapists to identify and modify core schemas and maladaptive patterns of interpersonal behavior.

Pathways of Psychotherapy Integration

There are a number of routes to psychotherapy integration, and these multiple pathways are understood to fall into one of four categories: technical eclecticism, theoretical integration, common factors, and assimilative integration. Research by Norcross, Karpiak, & Lister (2005) reveals that each of these is embraced by a significant number of self-identified eclectics and integrationists.

Technical eclecticism. The least theoretical of these pathways, technical eclecticism, seeks to select the best intervention for the person and the problem based on the best available data. Thus, the foundation is more empirical than theoretical. Examples of technical eclecticism include Lazarus's (2005) multimodal therapy and Beutler's (Beutler, Consoli, & Lane, 2005) systematic treatment selection and prescriptive psychotherapy (STS). Technical eclectics utilize interventions from different sources without necessarily identifying with the theories that generated them. Unlike theoretical integrationists, there is less interest in the convergence between disparate systems and their connection with specific techniques.

Theoretical integration. The most theoretical of these pathways, theoretical integration seeks to integrate two or more therapies with the intention of developing an overlapping theoretical system that is better than the constituent therapies alone. There is an emphasis on integrating the underlying models, along with their theory specific techniques into an overarching framework. Examples of this approach include Wachtel, Kruk, & McKinney's (2005) effort to integrate psychoanalytic and behavioral theories with his cyclical dynamics, and Ryle's (2005) cognitive-analytic therapy. As noted by Norcross (2005) "the primary distinction between technical eclecticism and theoretical integration is that of empirical pragmatism and theoretical flexibility" (p. 9).

Common factors. Stemming from the work of Frank (1961) and Garfield (1980), a common factors approach seeks to elucidate the core ingredients that different therapies share in common. This method is predicated on accumulating research that commonalities across treatments (e.g., the working alliance) may be at least as important in accounting for psychotherapy outcome than the unique factors that differentiate among them. However, it is widely recognized that the debate between common and unique factors in psychotherapy represents a false dichotomy, and these factors must be integrated to maximize effectiveness.

Assimilative integration. Assimilative integration was defined by Messer (2001) as "the incorporation of attitudes, perspectives, or techniques from an auxiliary therapy into a therapist's

primary, grounding approach" (p. 1). This form of integration calls for a firm grounding in one system of psychotherapy with a willingness to incorporate practices and views from other systems. This entails adherence to a single, coherent theoretical system that assimilates techniques and interventions from multiple systems into this system. Examples of this approach to integration include Castonguay, Newman, Borkovec, Grosse Holtforth, and Maramba's (2005) cognitive-behavioral assimilative integration and Stricker and Gold's (2005) assimilative psychodynamic therapy. It has been argued that assimilative integration does not represent its own integration pathway; rather, it serves as a prime example of how the above approaches are not mutually exclusive, and in clinical work, the distinctions among them are not so apparent (Norcross, 2005). Assimilative integration may be conceptualized as a bridge between technical eclecticism and theoretical integration, and this is often accomplished through the lens of common factors. One specific method for building this bridge is based on a theory of change involving change principles, such as the ones identified by Goldfried (1980) (see Boswell, Nelson, Nordberg, McAleavey, & Castonguay, in press).

Theories of Change

As previously described, a significant source of motivation for integration stems from clinicians' dissatisfaction with single-theory systems that do not fully explain, or cannot be applied to a diverse set of clients and presenting problems. Integration becomes an attempt to grapple with the inherent complexity of psychopathology and its treatment. An integrative theory of change can take many forms. However, two major, complementary systems have been advocated: principles of change, or core clinical strategies that cut across divergent theoretical orientations, and the transtheoretical model.

Change principles. Change principles are general guidelines of intervention that cut across different theoretical orientations. As described by Goldfried (1980), such principles (e.g., facilitation of a corrective experience, expectation that therapy can be helpful, participation in a therapeutic relationship, obtaining a new perspective of self and other, and opportunity for repeated reality testing) are found at a level of abstraction between specific techniques and the theoretical models developed to explain why these techniques work. As argued by Goldfried (1980; Goldfried & Padawer, 1982), given this intermediate level of abstraction, change principles can be used as an implicit guide, or heuristic, for therapists in addressing a diverse number of clients and presenting problems.

It is important to note that these levels (theory, technique, and common change principles) interrelate. One who is technically eclectic cannot disregard theory, just as one who is a theoretical integrationist cannot disregard techniques, and common change principles would not be possible in the absence of both. For Goldfried, techniques are parameters to facilitate change processes. For example, techniques such as interpretation and cognitive restructuring are viewed as particular manipulations of the same general principle of change: providing a new perspective. As argued by Castonguay (2000), however, principles or strategies of change need to be framed within an articulated theory of human functioning and change. Whether it is integrative or closely related to one of the four pathways described in this chapter, this theory is necessary to help clinicians decide when and how to foster a principle of intervention.

A complementary approach to understanding change processes has been the conceptualization of stages of change (see Prochaska & DiClemente, 2005). Individuals are assumed to progress through a series of stages as behavior is modified. These stages in include: pre-contemplation, contemplation, preparation, action, maintenance. Clinical experience and research evidence indicate that change processes (e.g., interventions and their mechanisms) are

differentially effective, depending on the client's stage of change. For example, individuals judged to be in the contemplation stage are thought to benefit from interventions that raise their consciousness around problem behaviors, impacts, etc., and individuals, while individuals judged to be in the action stage are thought to benefit more from interventions that directly address behavioral processes (e.g., counterconditioning and contingency management).

Empirical Support

Despite being the focus of a large theoretical and clinical literature, empirical research on psychotherapy integration has been slow to progress. However, evidence has begun to accumulate in recent years for factors that support and/or contribute to integration and treatments that fall under most of the major categories of psychotherapy integration (see Schottenbauer, Glass, & Arnkoff, 2005 for a comprehensive review).

A number of common factors have also received empirical support (see Weinberger & Rasco, 2007). The therapeutic relationship, for example, has been extensively studied across a number of treatment approaches and specific disorders and has been shown to be a robust and consistent predictor of positive treatment outcome (Castonguay, Constantino, & Grosse Holtforth, 2006; Martin, Garke, & Davis, 2000). Empirical support has also been found for client expectancies of treatment effectiveness (Baskin, Tierney, Minami, & Wampold, 2003; Frank, Nash, Stone, & Imber, 1963; Howard, Kopta, Krause, & Orlinsky, 1986; Kirsch & Henry, 1977). Although the area of focus and the specific techniques used may differ between approaches, exposure is another common therapeutic factor with significant research support (Franklin & Foa, 2002; Heimberg et al., 1990; Roth & Fonagy, 2005).

In terms of eclecticism, the work of Beutler and colleagues has provided useful guidelines for prescribing specific types of interventions for certain types of clients (e.g., clients with high vs. low level of reactance), leading to the development of Systematic Treatment Selection and Prescriptive Psychotherapy. This system has accumulated the greatest empirical support for client-treatment matching (see Beutler et al., 2005 for a review).

Several treatments developed from an assimilative integration approach have garnered empirical support. For example, Greenberg and colleagues developed a process-experiential therapy that has been tested in both individual and couples modalities. This therapy integrates process-directive and experiential interventions for specific client markers within a person-centered framework (Greenberg & Watson, 1998) and has been shown to be effective in the treatment of depression. Also from an assimilative integration perspective, in an effort to increase the effectiveness of a previously supported treatment, Castonguay designed and tested an integrative treatment for depression (ICT; Castonguay et al., 2004), which uses techniques from humanistic and interpersonal therapies to help repair alliance ruptures in traditional cognitive therapy and has been shown to be superior to a waitlist control group in a randomized trial for depression. In a replication trial, Constantino et al. (2008) found that clients in the ICT condition evidenced greater post-treatment improvement than clients who received traditional cognitive therapy, and they also reported higher alliance and therapist empathy ratings across treatment. Other examples of integrative treatments with some empirical support include cognitive-behavioral assimilative therapy for generalized anxiety disorder (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008), and mindfulness-based cognitive therapy for depression (MBCT; Segal, Teasdale, & Williams, 2002).

Examples of theoretically driven integrative treatments with empirical support also exist (e.g., Ryle's [2005] cognitive analytic therapy). Transtheoretical psychotherapy, based on the Transtheoretical Model (TTM; Prochaska & DiClemente, 2005) posits five stages of change

(precontemplative, contemplation, preparation, action, and maintenance), with specific processes of change and related interventions to be used at specific stages. The transtheoretical psychotherapy model has been applied and tested in a variety of problem areas, for both health behaviors and mental disorders, and has been shown to related significantly with changes processes and outcome (Prochaska & DiClemente, 2005; Schottenbauer et al., 2005). Perhaps the most well studied integrative treatment to date is Linehan's dialectic-behavior therapy (DBT) for borderline personality disorder. A number of process findings and efficacy studies have been conducted which lend support to this treatment and it assumptions regarding client change (Linehan, Cochran, & Cochran, 2001).

Conclusion

Psychotherapy is a vibrant domain of theoretical, applied, and empirical knowledge that has benefited over more than a century from contributions of many mental health professions (e.g., psychology, psychiatry, social work). The vitality of this field is reflected by a large variety of psychotherapeutic treatments which, as we suggested in this chapter, can be clustered into four major contemporary orientations (psychodynamic, cognitive-behavioral, humanistic, and systemic) and one movement aimed at fostering different pathways of integration between them.

Each of the four specific systems of therapy is based on a model of human health and maladaptive functioning and each emphasizes a number of interventions and mechanisms of change to foster and explain the process of therapy. Consistent with an argument made almost three decades ago (Goldfried, 1980), not many similarities can found in the conceptual models underlying these four major system. However, also in line with Goldfried's (1980) paper, a number of strategies or principles of interventions appear to cut across most if not all of them, such as the importance of establishing a therapeutic relationship and the facilitation of new and corrective experiences. As we described above, these principles of change, along with other common factors, reflect one of the current pathways of integration.

All of the contemporary approaches to psychotherapy, "pure-form" or integrative, have also generated research. The willingness of psychotherapy scholars to submit their claims of success (and some of their hypotheses regarding the process of change) to empirical investigation has provided the field with some solid scientific foundations. But we would like to argue that we are only witnessing the beginning of psychotherapy as a scientific approach. Consistent with it epistemological bases, and reflecting its predominance in the list of ESTs, CBT has demonstrated a longer and more systematic commitment to empirical scrutiny than other orientations. The lag between clinical (and/or theoretical) contributions and research support seems to be particularly wide within the integration movement (Castonguay et al., 2003). This is most unfortunate, not only be because most of the therapists (at least in North America) currently identity themselves as integrationist, but also, as Goldfried (2009) recently reminded us, SEPI was created to facilitate the integration of different schools of therapy as well as the integration of research and practice.

If attended to carefully, however, the unfortunate level of enthusiasm toward research in psychotherapy integration can actually address what has been viewed by many as the most important problem of the field of contemporary psychotherapy: The shaky state of the scientist-practitioner model upon which it is assumed to rest. As argued elsewhere, clinicians are more likely to pay attention to research findings if they are involved in research (Castonguay in Lampropoulos et al., 2002); and since a large number of clinicians are integrative in their approach, one could expect that their increased engagement in research will lead to more empirical attention given integrative issues. To maximize the probability of this occurring,

however, we would argue that clinicians need to be involved in all aspects of research - its design, implementation, and the dissemination of results (rather than simply being asked to hand out questionnaires or apply a treatment protocol, as is too frequently the case in current research). In other words, for psychotherapy to reach its full potential as a scientific field, we believe that it should cease its almost exclusive reliance on what has been called "empirical imperialism" (Castonguay, in Lampropoulous et al., 2002), where researchers (most of them seeing only a few clients) dictate what to study and how to study it. A full and equal collaboration between researchers and clinicians, as aimed at by recent practice research networks (see Castonguay et al., 2009 a, b), may instead be a more fruitful way to provide the field with clinically relevant and scientifically rigorous research.

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Table 1

Examples of Psychodynamic Treatment Guides/Manuals for Specific Disorders

Source	*Disorder*	*Source*	*Disorder*
Busch et al. (2004)	Depression	Milrod et al. (1997)	Panic Disorder
Luborsky et al. (1995)	Depression	Leichsenring et al. (2007)	Social Phobia
Crits-Christoph et al. (1995)	Generalized Anxiety Disorder	Yeomans et al. (2002)	Borderline Personality Disorder

Footnotes

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