SECOND EDITION

Comprehensive Textbook of PSYCHOTHERAPY

Theory and Practice

Edited by
ANDRÉS J. CONSOLI
LARRY E. BEUTLER
BRUCE BONGAR

OXFORD

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To my parents, Lidia y Nicolás; my children, Julián y Benjamín; and my partner, Melissa—AC

To Jamie, Jana, Kelly, Gail, and Ian, who are always my heroes, and, of course to Lady, Jojo, and Chase, who gave me their all—LEB

To my son, Brandon Fortune Bongar; my wife, Karen J. Friday, MD; and Donna, Gordon, Jamie, Jeff, Larry, Monica, Peter, and Ms. Robyn—Dum Vivimos, Vivamos!—BB

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Preface to the First Edition

Over 100 years have passed since Freud's talking cure dramatically changed the shape of our world. The past century has witnessed the development of numerous modifications of Freud's psychoanalysis, along with hundreds of new theories and clinical models—and at least as many books that describe these theories and models. These diversities have often been profound and have produced a field that is filled with vitality as well as controversy. Unfortunately, it has become the bane of psychotherapy that the richness of theoretical diversity has never been matched at the level of practice. Although theoretical constructs are varied and elaborate, leading one to believe that the adoption of a particular theoretical framework will lead to a discriminating method of practice, the usual observation has been that therapists from different schools do similar things with similar results.

At present, the variability of our clinical practice appears to be more dependent on each therapist's level of experience and on the setting in which the interventions are applied than on any particular theoretical model that is presumably guiding the process. In a time of consumer advocate groups, managed health care, and the specter of national health care, this has led to a popular assumption that psychotherapy is psychotherapy is psychotherapy—that theoretical models, practitioners, and the population on which each model is applied are all interchangeable.

As if to perpetuate such a belief, textbooks on psychotherapeutic theories have traditionally devoted only small sections of each chapter to reviewing research findings and practical applications. Thus, practical guidelines are neither easily nor directly derived from theoretical treatises. If the richness of theoretical developments is to have an impact on the lives of our patients and to advance the mission of health care, these matters must be translatable to practical applications that are distinctive and focused. The value of training practitioners in various theories must be proven by evidence of distinctive levels of benefit or differential outcomes when applied to different populations and problems. This fact has been recognized in the recent development of manuals or guidebooks, developments that have arisen directly from the evolution of psychotherapy research.

Furthermore, when compared to psychotherapy practice, psychotherapy research is a relatively recent derivation. Applications of scientific methods to validating the efficacy and to understanding the processes of psychotherapy are now in only their fifth decade. For most of this time, this research has had the important but relatively unstimulating task of testing the belief that psychotherapy is an effective way to alter emotional distress and disorders. However, in the past two decades increasing research attention has been paid to translating theoretical differences into distinctive psychotherapy practices. The result has been the development of psychotherapy manuals, along with measures by which to assess a given therapist's compliance and skill in applying a chosen theory. These manuals provide guidelines for practice and direct the therapist in the selection of theory-consistent procedures that are designed to effect improvement in the patient's life. Although the stated goals of these

manuals are to facilitate research that tests the relative efficacy of different theories and extends our knowledge of which patients can be most effectively treated by each model, manuals also have revitalized psychotherapy training. These manuals have accomplished this task by providing clear goals, methods of application, and standards by which one can determine and compare therapists' levels of proficiency and skill. With the pending development of national health care and the challenges posed by consumer advocate groups, there has never been a greater necessity of integrating the theory, practice, and science of psychotherapy than there is at present.

This book is not just a book of theories. It is a book of theories and psychotherapy manuals. It is designed to serve the needs of a broad audience—from undergraduate students who are taking their first course in psychotherapy to graduate students and practitioners who are trying to apply these principles in practice. The first chapter by Orlinsky and Howard sets the stage for the scope of chapters presented by placing psychotherapy, psychotherapy research, and psychotherapy practice within a historical context. The chapters in Part I represent major theoretical approaches in which standard manuals have either been developed or are in the process of development. Psychodynamic psychotherapy, behavior therapy, experiential and existential therapies, cognitive therapy, group therapy, systems therapy, and integrative-eclectic therapy were chosen to represent the major themes and models in the field. Each of these theoretical approaches is represented in this book by two chapters. The first chapter on each theory presents the historical developments, variations of the model, and major theoretical concepts of the theory. This historical chapter also provides an overview and selective review of the research that is available on the efficacy of the therapeutic model. These historical and theoretical chapters will be of greatest interest to beginning students or practitioners who wish to refresh their memory about an alternative viewpoint to their own.

The second chapter on each theory serves as a mini-manual for applying one of the general theoretical models to practice. This latter chapter defines the assumptions that are extracted from the broad theoretical framework and outlines distinguishing characteristics of the format, length, and therapeutic procedures utilized. This chapter also defines for whom the approach is considered to be most usefully applied, the limitations of the approach, and requirements of the model for training and research. This set of chapters will be of most interest to graduate students and practitioners who are seeking to apply theories, learn new skills, and achieve advanced proficiency.

The authors of the chapters in Part I are distinguished contributors to theory and research, and each was selected because of his or her contributions to knowledge in a specific theoretical area or therapeutic philosophy.

Part II of this book is comprised of a series of chapters on psychotherapeutic applications to special populations and circumstances. We have included chapters on the treatment of women, members of ethnic and minority groups, children and adolescents, older adults, and people who are in crises. These approaches are not accompanied by separate treatment manuals because of the broad focus of the topics. The concepts presented are designed to cut across theoretical approaches. The authors of these chapters were selected because of their breadth of experience and knowledge, and because each has made significant contributions to research and practice within the area of their presentation.

Part III is designed to provide an extension and integration of the material presented in the earlier chapters. The authors who contributed to this part were selected because of the breadth of their perspectives and their wisdom in the broad domain of science and practice. Although research implications, training methods and considerations, and professional issues are addressed in each part as applied to each specific theory or topic, the contributions in this section focus on cross-theoretical issues. In this spirit, the final chapter provides an overview of the field with a view toward the future. This chapter aptly caps the presentation and brings the historical reviews and the contemporary practices into focus.

We wish to thank the authors of the chapters in this volume. We have enjoyed working with them and appreciate their willingness to comply with deadlines, tolerate our pressure, and let us critique their ideas. They were congenial, forgiving, and prompt, making our jobs much easier than expected and by far easier than has been our experience with any other edited volume. We also thank Ms. Lynn Peterson, Drs. Ray William London and Julia Shiang, Captain Robert Bigler, and Ms. Peggy Goodale for their persistence, assistance, and support. Most of all, we have enjoyed coming to know one another through this process. We enjoyed ourselves.

August 1994

B. B.
Marina Del Rey, California

L. E. B.
Santa Barbara, California

Acknowledgments

We deeply thank each and every member of the sizable, international community of authors who contributed to and ultimately made this textbook possible. Their dedication to the task, their adherence to the outline provided, and their openness to editorial feedback are all most appreciated and have strengthened the overall value of the textbook. We would like to express our appreciation to Sarah Harrington and Andrea Zekus from Oxford University Press for their indefatigable support and assistance. Andrés would like to thank his partner and colleague Melissa, his sons Julián and Benjamín, his parents Nicolás and Lidia, for their companionship, support, and inspiration, Joshua Sheltzer and Ana Romero Morales for their editorial assistance, and Larry Beutler for his precious mentorship that has been ongoing since 1991. Larry would like to thank his wife, Jamie, for her enduring support and his children for modeling the creativity and wisdom that have served him as a psychotherapist. Bruce would like to thank his wife, Karen, and their son, Brandon, for their steadfast love and support. Bruce would also like to add his personal thanks to Sarah Harrington and Andrea Zekus of Oxford University Press for their amazing support and patience for this complex project; and also to acknowledge the vision and unflagging support of our colleague, Joan Bossert of Oxford University Press, for not only this book but for the creation of the Oxford clinical psychology series. Finally, Bruce would like to acknowledge the brilliance, dedication, and commitment of Andrés Consoli to this work and to Larry Beutler, his role model as the quintessential scientist-practitioner clinical psychologist.

About the Editors

Andrés J. Consoli, PhD, has been a faculty member in the Department of Counseling, Clinical, and School Psychology at the University of California, Santa Barbara since 2013. Dr. Consoli was born and raised in Buenos Aires, Argentina, where he received a *licenciatura* degree in clinical psychology at the Universidad de Belgrano (1985). He earned a master's (1991) and doctorate in counseling psychology at UCSB (1994), and he received postdoctoral training in behavioral medicine in the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine (1994–1996). Prior to joining UCSB, Dr. Consoli was professor and associate chair of the Department of Counseling, College of Health and Social Sciences, at San Francisco State University (1996–2013). He is a visiting professor at the Universidad del Valle in Guatemala (2004–present) in their master's and doctoral programs and a licensed psychologist in California. Dr. Consoli has served as president of the National Latina/o Psychological Association (2014), as member-at-large of APA's Division 52: International Psychology (2011–2013), as president of the Interamerican Society of Psychology (2007–2009), and as president of the Western Association of Counselor Education and Supervision (2001). He has served in the Council of National Psychology Associations for the Advancement of Ethnic Minority Interests (CNPAAEMI) (2014–2016), chairing it in 2016. In 2015, Dr. Consoli received the Interamerican Psychologist Award for distinguished contributions to the advancement of psychology in the Americas, an award granted by the Interamerican Society of Psychology every two years to only two psychologists. Dr. Consoli's professional and research interests involve transnational collaborations, program evaluation and community-based participatory action research, multicultural supervision, psychotherapy integration and training, systematic treatment selection, ethics and values in psychotherapy, access and utilization of mental health services within a social justice framework, and the development of a bilingual (English/Spanish) academic and mental health workforce.

Larry E. Beutler, PhD, is William McInnes Distinguished Professor Emeritus of Clinical Psychology, Palo Alto University, and Professor Emeritus, University of California, Santa Barbara. Dr. Beutler received his PhD from the University of Nebraska and subsequently served on the faculties of Duke University Medical Center, Stephen F. Austin State University, Baylor College of Medicine, the University of Arizona Health Sciences Center, and the University of California at Santa Barbara. He is the past director of the National Center for the Psychology of Terrorism and the continuing director of the Institute for the Study of Equine Assisted Change at Palo Alto University (PAU).

Bruce Bongar, PhD, ABPP, FAPM, CPsychol, is Calvin Distinguished Professor of Psychology at

Palo Alto University and visiting professor of psychiatry and behavioral sciences at Stanford University. Dr. Bongar received his PhD from the University of Southern California and served his internship in clinical community psychology with the Los Angeles County Department of Mental Health. For over 30 years, Dr. Bongar maintained a small practice specializing in psychotherapy, consultation, and supervision in working with the difficult and life-threatening patient. Past clinical appointments include service as a senior clinical psychologist with the Division of Psychiatry, Children's Hospital of Los Angeles, and work as a clinical/community mental health psychologist on the psychiatric emergency team of the Los Angeles County Department of Mental Health. Dr. Bongar is past president of the Section on Clinical Crises and Emergencies of the Division of Clinical Psychology of the American Psychological Association, a diplomate of the American Board of Professional Psychology, a fellow of the Divisions of Clinical Psychology (Div. 12), Psychology and the Law (Div. 41), and Psychotherapy (Div. 29) of the American Psychological Association, a fellow of the American Psychological Society and of the Academy of Psychosomatic Medicine, and a chartered psychologist of the British Psychological Society. His research and published work reflects his long-standing interest in the wide-ranging complexities of therapeutic interventions with difficult patients in general, and in suicide and life-threatening behaviors in particular.

Contributors

Héctor Fernández Álvarez, PhD, Aiglé Foundation, Buenos Aires, Argentina

Harlene Anderson, PhD, Houston Galveston Institute and The Taos Institute

Kimberly Balsam, PhD, Center for LGBTQ Evidence-Based Research (CLEAR), Palo Alto University

Morgan Banks, PhD, United States Army

Alinne Z. Barrera, PhD, Department of Clinical Psychology, Palo Alto University

Guillermo Bernal, PhD, Institute for Psychological Research, University of Puerto Rico, Rio Piedras Campus (UPR-RP), San Juan, Puerto Rico

Ephi J. Betan, PhD, Clinical Psychology Program, Georgia School of Professional Psychology, Argosy University/Atlanta

Larry E. Beutler, PhD, ABPP, Department of Clinical Psychology, Palo Alto University

Jeffrey L. Binder, PhD, ABPP, Center for Time-Limited Dynamic Psychotherapy, Nashville, Tennessee

Benjamin Bizar-Stanton, JD, Department of Clinical Psychology, Palo Alto University

Bruce Bongar, PhD, ABPP, FAPM, Department of Clinical Psychology, Palo Alto University *and* Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine

Lisa M. Brown, PhD, ABPP, Trauma Program, Department of Clinical Psychology, Palo Alto University

Joyce Chu, PhD, Diversity and Community Mental Health, Palo Alto University

Andrés J. Consoli, PhD, Department of Counseling, Clinical, and School Psychology, Gevirtz Graduate School of Education, University of California, Santa Barbara

Sergi Corbella, PhD, Facultat de Psicologia, Ciències de l'Educació i de l'Esport Blanquerna, Universitat Ramon Llull, Barcelona, Spain

Erika A. Crawford, MA, Department of Psychology, Temple University

Kevin Delucio, MA, Department of Counseling, Clinical, and School Psychology, Gevirtz Graduate

School of Education, University of California, Santa Barbara

Jeremy Doughan, PsyD, Department of Psychiatry, University of California, San Francisco and San Francisco VA Medical Center

Robert Elliott, PhD, School of Psychological Sciences and Health, University of Strathclyde Glasgow, Scotland, United Kingdom

R. Wyatt Evans, MS, Center for LGBTQ Evidence-Based Research (CLEAR), Palo Alto University

David Giannini, MA, Department of Clinical Psychology, Palo Alto University

Jerry Gold, PhD, The Derner Institute, Adelphi University, Garden City, New York

Peter Goldblum, PhD, Center for LGBTQ Evidence-Based Research (CLEAR), Department of Clinical Psychology, Palo Alto University

Marvin R. Goldfried, PhD, Clinical Psychology, Stony Brook University

Keishalee Gómez-Arroyo, PhD candidate, Department of Psychiatry, University of Puerto Rico Medical School

Leslie S. Greenberg, PhD, Department of Psychology, York University, North York, Toronto, Canada

Alexandra L. Hoff, MA, Department of Psychology, Temple University

Lori Holleran, MS, Department of Clinical Psychology, Palo Alto University

Kasie L. Hummel, MA, MS, Department of Clinical Psychology, Palo Alto University

Adriana Hyams, MA, PhD candidate, Department of Psychology, University of Alabama

Larry James, PhD, United States Army

Elana R. Kagan, MA, Department of Psychology, Temple University

Alex R. Kelman, MS, Department of Psychology, Palo Alto University

Philip C. Kendall, PhD, Department of Psychology, Temple University

Victoria Kendrick, MA, Department of Clinical Psychology, Palo Alto University

Gerald P. Koocher, PhD, ABPP, College of Science and Health, DePaul University

Orah T. Krug, PhD, Existential-Humanistic Institute San Francisco, California *and* Department of Psychology, Saybrook University, San Francisco, California

Uri Kugel, PhD, Department of Clinical Psychology, Palo Alto University

Lucas S. LaFreniere, BA, Department of Psychology, Pennsylvania State University

Amy Leino, PhD, Department of Clinical Psychology, Palo Alto University

Samarea Lenore, MS, Department of Clinical Psychology, Palo Alto University

Christopher T. H. Liang, PhD, Department of Education and Human Services, College of Education Lehigh University

Paulo P. P. Machado, PhD, Psychotherapy and Psychopathology Research Unit, CIPsi, School of Psychology, University of Minho, Portugal

Rogelio J. Mercado, MA, Department of Psychology, Temple University

Carin Molenaar, MEd, PhD candidate, Department of Education and Human Services, College of Education Lehigh University

Melissa L. Morgan Consoli, PhD, Department of Counseling, Clinical, and School Psychology, Gevirtz Graduate School of Education, University of California, Santa Barbara

Michelle G. Newman, PhD, Department of Psychology, Pennsylvania State University

John C. Norcross, PhD, ABPP, Department of Psychology, University of Scranton

David E. Orlinsky, PhD, Department of Comparative Human Development, University of Chicago

Wendy Packman, JD, PhD, Joint JD-PhD Program in Psychology and Law, Palo Alto University

Jennifer H. Patterson, PhD, Veterans Health Administration

Samantha Pflum, MS, Center for LGBTQ Evidence-Based Research (CLEAR), Palo Alto University

Michael J. Rohrbaugh, PhD, School of Medicine and Health Sciences, George Washington University, Washington, DC *and* Department of Psychology, University of Arizona

Robert L. Russell, PhD, Child and Family Emphasis, Department of Clinical Psychology, Palo Alto University

J. Scott Rutan, PhD, Boston Institute for Psychotherapy

Forrest Scogin, PhD, Department of Psychology, University of Alabama

Joseph J. Shay, PhD, Private practice, Cambridge, Massachusetts

Joshua M. Sheltzer, BA, Department of Counseling, Clinical, and School Psychology, Gevirtz Graduate School of Education, University of California, Santa Barbara

Ki Eun Shin, BA, Department of Psychology, Pennsylvania State University

Varda Shoham,[†] **PhD,** Division of Adult Translational Research and Treatment Development, National Institute of Mental Health, Bethesda, MD *and* Department of Psychology, University of Arizona

Matthew Skinta, PhD, Center for LGBTQ Evidence-Based Research (CLEAR), Palo Alto University

Danielle Spangler, MA, Department of Clinical Psychology, Palo Alto University

Will D. Spaulding, PhD, Department of Psychology, University of Nebraska—Lincoln

Meagan L. Stanley, MS, Department of Clinical Psychology, Palo Alto University

George Stricker, PhD, ABPP, American School of Professional Psychology at Argosy University, Washington, DC

Scott Stuart, MD, Department of Psychiatry, University of Iowa

Stanley Sue, PhD, Department of Clinical Psychology, Palo Alto University

Mary E. Sullivan, MSW, Department of Psychology, University of Nebraska—Lincoln

Anna J. Swan, MA, Department of Psychology, Temple University

Rainey Temkin, MS, Department of Clinical Psychology, Palo Alto University

Hui Qi Tong, PhD, Department of Psychiatry, University of California, San Francisco *and* San Francisco VA Medical Center

Elisa Vasquez, MA, PhD candidate, Department of Counseling, Clinical, and School Psychology, Gevirtz Graduate School of Education, University of California, Santa Barbara

[†] Varda Shoham unfortunately passed away in 2014, before this book went to press.

Melba J. T. Vasquez, PhD, Private practice, Austin, Texas

Sherry C. Wang, PhD, Department of Counseling Psychology, Santa Clara University

Amy Wenzel, PhD, ABPP, Department of Psychiatry, University of Pennsylvania School of Medicine, *and* Wenzel Consulting, LLC

Oksana Yakushko, PhD, Clinical Psychology Program, Pacifica Graduate University

Barrett E. Zimmerman, BA, Department of Psychology, University of Scranton

Leila Zwelling, LSW, Department of Psychiatry, University of California, San Francisco *and* San Francisco VA Medical Center

COMPREHENSIVE TEXTBOOK OF PSYCHOTHERAPY

1

Introduction: History, Theory, Research, Practice, and Diversity in Psychotherapy

Andrés J. Consoli
Larry E. Beutler
Bruce Bongar

Abstract
We discuss the contemporary landscape of psychotherapy, starting by honoring some of the complexities surrounding its definition and identifying some of the current trends in psychotherapy. We detail the structure of this textbook and provide specifics concerning the format that the authors were asked to follow in developing their contributions. We address instructors and underscore the strengths of the text, including its focus on history, theory, research, practice, and diversity. We also address our readers, psychotherapists-in-training, practitioners, and supervisors alike, offering our thoughts on how to make best use of this textbook. We conclude by sharing our personal acknowledgments.

Keywords: psychotherapy definition, psychotherapy models, psychotherapy approaches, psychotherapy applications, psychotherapy modalities

Human healing practices have ancient roots (Frank, 1961; Orlinsky, Chapter 2, this volume). Contemporary psychotherapy is in the leading edge of that lineage. A well-established definition of psychotherapy describes it as "the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable" (Norcross, 1990, p. 218). A more contemporary definition of psychotherapy describes it as "the therapeutic management, control, and adaptation of patient factors, therapist factors, relationship factors, and technique factors that are associated with benefit and helpful change" (Beutler, 2009, p. 311). This definition emphasizes the active integration of patient, therapist, relationship, and intervention components for the express purpose of singling out the specific principles of effective therapy. Furthermore, the resolution on the *Recognition of Psychotherapy Effectiveness* adopted as policy by the American Psychological Association's Council of Representatives states that "psychotherapy (individual, group, and couple/family) is a practice designed varyingly to provide symptom relief and personality change, reduce future symptomatic episodes, enhance quality of life, promote adaptive functioning in work/school and relationships, increase the likelihood of making healthy life choices, and offer other benefits established by the collaboration between client/patient and psychologist" (American Psychological Association [APA], 2013, p. 102).

We would like to expand these three definitions by emphasizing not only psychotherapy's concern with human suffering and shortcomings but also

with human strengths and competencies. Practicing psychotherapists readily acknowledge that clients overcome their difficulties and get better over time through the harnessing of their strengths and competencies while expanding their repertoire of thoughts, feelings, and actions. Moreover, as practiced today, psychotherapy addresses disease and disorders as well as health and well-being, and therefore it occupies a central place among the health service professions. Interestingly, it has been demonstrated that "the results of psychotherapy tend to last longer and be less likely to require additional treatment courses than psychopharmacological treatments," that "many people prefer psychotherapy to pharmacological treatments because of medication side effects," and that "psychotherapy reduces overall medical utilization and expense" (APA, 2013, pp. 102 and 103). Furthermore, contemporary psychotherapy involves, at times, client-centered advocacy (CCA) from a social justice perspective (i.e., the righting of a wrong). In California, as an example, CCA is defined as "researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and supports for clients or groups of clients receiving psychotherapy" (California Business and Professions Code, Section 4980.34(h)).

Psychotherapy has been shown to be highly effective. It has an average effect size of about .80, which is considered a large effect size in the behavioral sciences, while "the average client receiving psychotherapy is better off than 79% of untreated clients" (Campbell, Norcross, Vasquez, & Kaslow, 2013, p. 98). The evolution of psychotherapy practice and research underscores the importance of other factors beyond diagnoses in explaining outcome and designing treatment. Specifically, dimensions such as clients' general severity, chronicity, and complexity of their problems; clients' strengths such as resilience and resources; psychotherapists' factors; and relational and contextual factors must be intentionally considered to facilitate better outcomes (Beutler, 2009; Wampold & Imel, 2015). Moreover, the intersectionality of psychotherapists' factors and clients' dimensions such as racial/ethnic minority status is becoming an important focus of contemporary research (Hayes, Owen, & Bieschke, 2015).

Psychotherapy practice and research have demonstrated the crucial role of the therapeutic alliance in the acquisition of treatment gains and ends. In fact, the vicissitudes of the working alliance, such as its development, strains, ruptures, and repairs, may constitute the focus of treatment. Moreover, successful psychotherapy is anchored on a mutually construed agreement on the goals and tasks of the treatment. For such mutuality to be materialized in the psychotherapy relationship, the cultural competence and humility of the psychotherapist are of utmost importance (APA, 2003).

Though contemporary psychotherapists are trained in one of the many models of professional identity including, but not limited to, *scientist-practitioner*, *practitioner-scientist*, *practitioner-scholar*, *professional-scholar*, or *practitioner as a local scientist* (Consoli, Fernández-Álvarez, & Corbella, Chapter 29, this volume), all of these models share a commitment to evidence-based practice and practice-based evidence. And today, models must also grapple with community-defined evidence (Martinez, Callejas, & Hernandez, 2010). Psychotherapists within APA are urged to integrate "the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Task Force on Evidence Based Practice, 2006, p. 273). Crosscutting matters also shared by all training models emphasize the importance of cultural competence on the part of psychotherapists and the need to adapt treatments to make them culturally relevant (APA, 2003; Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009).

While these evidence-based practice and practice-based evidence components are fundamental to the core of psychotherapy, it is often unclear how empirical research and such indefinite factors as "clinical expertise" and preferences can either be measured or balanced to produce an optimal mix. It is also important to consider the theories that inform the research and practices discussed in this textbook. Before learning about specific theories, it is useful to first ask what a theory is. The APA *Dictionary of Psychology* defines *theory* as "a principle or body of interrelated principles that purports to explain or predict a number of interrelated phenomena." In his book about theory and practice, Wampold (2012) contextualizes this definition by offering this description: "In psychotherapy, a theory is a set of principles used to explain human thought and behavior, including what causes people to change. In practice, a theory creates the goals of therapy and specifies how to pursue them" (p. x). Ultimately, theory attempts to guide the clinician and client toward solutions to a problem by illuminating the causes and functions

behind the issue at hand. Without any theoretical conceptualization, the structure and rationale of psychotherapy may be lost. As Wampold (2012) also explained, "Without a guiding theory, we might treat the symptom without understanding the role of the individual" (p. ix). Whether a researcher is designing a new study or a clinician is seeing a new client, theory is the backbone of understanding humans and their behavior, and it is integral to the ideas presented in this textbook. We hope that this discussion about theory will help the reader absorb the chapters of this textbook with a better understanding of the structure behind the different models, practices, and research presented in each section.

PSYCHOTHERAPY TWO DECADES LATER

While this second edition of the *Comprehensive Textbook of Psychotherapy* preserves the overall structure of the first edition by addressing the fundamentals of psychotherapy, almost all the chapters are unique and expressly written for this new edition. Moreover, the chapters' contents capture important changes in the field in the last 20 years since the first edition was published (Bongar & Beutler, 1995).

What are the contemporary trends in psychotherapy? Gelso (2011), who from 2004 through 2010 was the editor of *Psychotherapy*, the flagship journal of APA's Division 29: Society for the Advancement of Psychotherapy, identified six main trends in the field from the vantage point of his editorship and according to the manuscripts submitted to the journal. In all, the trends, as Gelso sees them, are (1) the increasing integration of techniques and the therapeutic relationship that transcends the historical dichotomy between these two perspectives in psychotherapy while acknowledging their unique contributions; (2) the increasing focus on the integration of theoretical orientations to the point where integrative has become the more common theoretical orientation among psychotherapists; (3) the increasing efforts at research-practice integration through research-practice networks, which are overcoming the historical animosities between practitioners and researchers by emphasizing evaluation, accountability, and clinical relevance; (4) the increases in integrative, quantitative reviews that cover ever more specific a topic within psychotherapy (e.g., the different, specific ingredients in psychotherapy relationships; see Norcross, 2011); (5) the integration of biological, neuroscience understandings of psychotherapy and its healing qualities in a manner that overcomes the traditional dichotomy between nature and nurture and embraces their mutuality; and (6) the integration of diversity and cultural considerations into psychotherapy in an effort to determine how cultural factors such as race and ethnicity operate within psychotherapy. These trends have influenced significantly the second edition of this textbook and the content articulated by the authors within.

The overall structure of this textbook includes three parts. Part I focuses on *Models of Psychotherapy*, Part II addresses *Psychotherapy by Modalities and Populations*, and Part III covers *Research Methods and Randomized Clinical Trials*, *Professional Issues, and New Directions in Psychotherapy*. Specifically, Part I begins with an exposition of the basic structural features shared by modern psychotherapies beyond common factors theory and is followed by chapters arranged in pairs, each one honoring the theory and practice subtitle of this textbook. The first chapter of each pair addresses the historical and theoretical perspective of one of the six main clusters of psychotherapy models (i.e., psychodynamic, cognitive-behavioral, existential-humanistic-experiential, interpersonal, systemic, and integrative therapies), and it is followed by a second chapter that elaborates on the specific application of the model (i.e., time-limited dynamic psychotherapy, Beckian cognitive-behavioral therapy, emotion-focused therapy, interpersonal psychotherapy with depressed adults, family consultation, and systematic treatment selection), anchored by a comprehensive vignette. This second chapter, in each case, is designed to serve as a brief introduction to a specific, extant, manual-based therapy.

Part II addresses *Psychotherapy by Modalities and Populations*, and each chapter within Part II articulates theoretical, scientific, and practical aspects of a given modality in psychotherapy (i.e., group therapy, family therapy, electronic based therapy) or when working with a specific population (i.e., psychotherapy with children and adolescents; women; men; lesbian, gay, and bisexual clients; racial/ethnic minority groups; immigrants and refugees; clients in the schizophrenia spectrum; military personnel and veterans; people exposed to mass casualty events; and clients in clinical emergencies). As in Part I, each chapter's content in Part II is illustrated by an extensive vignette that poignantly underscores the

matters discussed by the authors of each chapter. Part III covers a range of issues and concerns that are of relevance to psychotherapy, extending from scientific issues such as research methods and the methods of randomized clinical trials, to training matters such as the professional development of psychotherapists over the course of their lifespan, to practice itself such as legal and ethical issues; it concludes with a chapter on the current status and future of psychotherapy.

Congruent with the format of the first edition of this textbook, we invited many of the most established scientist practitioners in the field, based on their expertise in a given area, to be part of the project. The resounding affirmative response resulted in over 75 authors from several continents. We sought to foster the true spirit of a textbook, that is, a volume where experts guide aspiring professionals in their efforts to become knowledgeable about theory, research, and practice, by inviting the authors to write directly to the potential readers. To maximize the reader's and the instructor's experiences throughout the 32 chapters that constitute this tome, we asked every one of our contributors to adhere strictly to an outline we provided to all of them. Specifically, we asked authors to share briefly the historical background of the model, approach, or modality they are experts on; to address its major theoretical developments and variations; to articulate how human change processes are conceptualized and facilitated by their model, approach, or modality; and to specify the research on efficacy and effectiveness supporting the model, approach, or modality. Moreover, we asked authors to discuss how their model, approach, or modality addresses the issue and role of diversity pertaining to clients/patients' age, gender, gender identity, sexual orientation, race, ethnicity, culture, national origin, religion, (dis)ability, and socioeconomic status. We would like to underscore that to maximize the pedagogical value of the final product, we required authors to start their chapter with an abstract and keywords, and to end it with a short list of conclusions and key points. Similarly, we asked authors to provide a set of five review questions concerning salient content addressed in their chapters, and a list of resources, including readings beyond those in the references, as well as websites, and/or audiovisual materials they would recommend to the readers interested in deepening their understanding of the content addressed in the chapters.

FOR INSTRUCTORS

Of particular interest to us as coeditors of this textbook is to offer instructors a way to transcend the "proprietary and trademarked" approaches of psychotherapy by focusing on the principles of human change and stability processes that are endorsed, and ultimately utilized, in psychotherapy practice (Daya, 2001; Rosen & Davison, 2003). To achieve this, we invited David Orlinsky (Chapter 2, this volume), of world renown for his generic model of psychotherapy, to launch Part I: *Models of Psychotherapy*. Moreover, we structured the rest of the section along the six main clusters of psychotherapy "models," specifically psychodynamic, cognitive-behavioral, existential-humanistic-experiential, interpersonal, systemic, and integrative therapies, and in that order to reflect, in part, the historical and dialectical evolution of the field but also to organize the models around anchoring theoretical constructs characterizing their main thrust and contribution. These anchoring theoretical constructs, some of which have been framed as "forces" in the psychotherapy literature, include, but are not limited to, motivation (psychodynamic or first force), learning (cognitive-behavioral or second force), meaning-making (existential-humanistic-experiential or third force), relational (interpersonal), context (systemic, inclusive of culture and referred to as the fourth force), and plurality (integrative, inclusive of gender) (Consoli & Jester, 2005; Fernández-Álvarez, 2001). It is important to underscore the interplay that has taken place among the main clusters of psychotherapy models over time. For example, as the psychodynamic perspective evolved, its own understanding of human motivation also evolved, expanding beyond its intrapsychic early formulations and becoming more interpersonal and ultimately relational. Meanwhile, as the cognitive-behavioral perspective has evolved, it has become more intrapsychic and introspective, needing to resort to concepts such as schema, tacit knowledge, and stream of consciousness in order to better articulate the hidden processes within learning. Furthermore, it is important to us to offer instructors a textbook that embraces the complexity of psychotherapy's contribution to redress human suffering and affirm human strengths: None of the six constructs alone can harness the power of psychotherapy, and psychotherapists ought not to force

clients to fit into the procrustean bed made of one such construct known well by a given therapist. It is incumbent upon us all to become imbued in all six of the constructs advanced by the psychotherapy models. Needless to say, it is equally important to recognize that these constructs are a major part of each psychotherapy model yet not their entire contribution.

We sought to distinguish a theoretical model from the "application" of a model, the latter being the specific, concrete use of a model. An application typically is not a rendering of a "new theory," but the translation into practice of one already in existence. This distinction is reflected in Part I by a leading chapter that addresses the history and main thrust of a given model (e.g., psychodynamic, Gold & Stricker, Chapter 3, this volume), which is then followed by a specific application of that model, that is, an approach (e.g., time-limited dynamic psychotherapy, Betan & Binder, Chapter 4, this volume). All chapters describing an application are properly illustrated by an extensive vignette.

By structuring Part I in the way that we have, we wanted to overcome the pull to count approaches that has characterized the presentation of psychotherapy theories in many texts, reaching three dozens in 1959 (Harper, 1959), slightly over a hundred in the 1970s (Parloff, 1976), to several hundreds in the 1980s (Karasu, 1986), and into the thousands in the new millennium (Lebow, 2012, citing Garfield, 2006). The counting of approaches is not only misleading, it misses the zeitgeist of contemporary psychotherapy with its emphasis on principles of human change and the stability processes that are harnessed to redress human suffering and affirm human strengths in an integrative manner. Equally misleading, if not outright dangerous, is the encouragement of the development of a theory by each psychotherapist-in-training. While such assignment in a theory course can be facilitative to the process of appreciating one's own level of development as it pertains to acquiring theoretical knowledge, it can also subtly communicate the notion that every personal theory is equally valid and useful. We encourage instructors to consider inviting their psychotherapists-in-training to reflect on their own process of synthesizing their existing knowledge based on the organizing principles we have detailed herein. In other words, and for example: What is my current understanding of constructs such as motivation and learning and how they interact to shape human experience? How am I using them to conceptualize clients' strengths and difficulties? How are such principles honored and reflected in my strategies, interventions, and techniques? Finally, what are the strengths and areas for growth of my current and ongoing synthesis?

As detailed earlier, Part I is followed by Part II, where *Psychotherapy by Modalities and Populations* is highlighted, detailing theoretical, scientific, and practice aspects of each. Specifically, group therapy, family therapy, and electronic-based therapy are the three modalities addressed in Part II, while psychotherapy with children and adolescents; women; men; lesbian, gay, and bisexual clients; racial/ethnic minority groups; immigrants and refugees; clients in the schizophrenic spectrum; military personnel and veterans; people exposed to mass casualty events; and clients in clinical emergencies are the populations discussed in Part II. Each chapter is properly anchored by an extensive case illustration. To facilitate the teaching and learning processes as well as to allow comparisons across chapters, we required the authors to adhere to an outline (available from the first coeditor). Finally, Part III addresses scientific, training, legal, and ethical matters in psychotherapy and closes the book with a chapter on psychotherapy's future.

Throughout this textbook and congruent with contemporary psychotherapy, we have emphasized research and diversity. We requested that authors discuss the research on efficacy and effectiveness supporting the model, approach, or modality they represent. Similarly, we asked authors to discuss how their model, approach, or modality addresses diversity matters pertaining to age, gender, gender identity, sexual orientation, race, ethnicity, culture, national origin, religion, (dis)ability, and socioeconomic status. As coeditors, we were struck with how facile it was for some authors to write about such matters while others seemed to have sizable difficulties articulating how their approaches dealt with such topics.

As instructors ourselves, we believe other instructors will appreciate the pedagogical value of starting every chapter with a summary and keywords, of including resources in each chapter above and beyond those in the reference list itself, and of ending every single chapter with detailed conclusions and key points as well as review questions. We are eager to receive your feedback on this textbook, and we would

be most appreciative if you were to take the time to send it to us (CTP2ndEd@gmail.com).

FOR OUR READERS

Coming to know and appreciate the material in an entire comprehensive textbook of psychotherapy can seem like an arduous task; however, it is important to remember that each of the theories and approaches discussed in this book is intended to provide insight to a way of understanding the complex nature of psychotherapy. It is not uncommon for students and practitioners alike to question their understanding of the human condition, the best way to help someone, or the development of mental health problems. Because of these expected doubts, uncertainties, and confusion, we offer a few suggestions and helpful components that we hope will aid readers along the way through their journey of understanding and discovery.

First, after completing a chapter, it may help to reflect (i.e., introspect) on how the ideas might be applicable in your personal life as well as in the areas of research and practice. Then, you may find it helpful to discuss these ideas with peers (i.e., "interspect;" Consoli, 2015). Furthermore, if you have the opportunity and, with proper supervision, apply some of the theories and approaches discussed in this textbook with clients of your own, and see how they work for you and for your clients. Many of the theories may seem to contradict each other; however, to the degree that current research has compared approaches head to head, none of the predominant methods have been found consistently to be superior to any of the others, except in very specific, narrow circumstances. A summary of these circumstances and their exceptions is contained in each of the chapters on specific approaches under the heading of "Research on Efficacy and Effectiveness." It may serve the reader best to take in the material, keep an open mind, apply newly learned theories and techniques to real-life situations, and then decide how the ideas in these chapters can be best utilized and understood.

This textbook attempts to assist you in your journey of becoming a practitioner, researcher, or supervisor by using a clear, parallel structure that is easy to follow. Additionally, there are case studies that illustrate each theory as it is actively applied that will help you understand how the various theories are used in practice and which appear to fit the real-life demands with which you are most familiar. We hope that these components will enrich the reader's experience and lead to a better understanding of psychotherapy.

Remember the popular saying: "The mind is like a parachute, it only works when open." We invite you to cultivate your openness to a range of ideas because we believe that flexibility and a broad latitude of acceptance are important qualities in a psychotherapist, together with courage and persistence. Psychotherapy training and the journey of becoming a psychotherapist are life-transforming phenomena. As recommended by Kottler (2004), keep your significant others informed about your journey and process, share it with them to minimize the chances of misunderstanding as encountered by the liberated prisoner in Plato's allegory of the cave. Again, seek your significant others' take on the matters you are studying, and most important, grow your social support network to help you not only survive this "impossible profession" (Malcom, 1981) but also to achieve mastery and actually thrive in it.

REVIEW QUESTIONS

1. What is your current understanding of how psychotherapy works?
2. What do you find exciting about being a psychotherapist, and what do you find most challenging?
3. In seeing yourself as a cultural being, what values, beliefs, and attitudes are most likely to influence your work as a psychotherapist?
4. Who are the clients with whom you are most effective, and who are the clients you find most challenging?
5. How do you think your current knowledge and beliefs about psychotherapy are going to interact with new knowledge gained from reading this textbook?

RESOURCES

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American Psychological Association video series. *Introduction to psychotherapy*. Available from http:// www.apa.org/pubs/databases/streaming-video/intro-to-psychotherapy-systems.aspx?tab=1.

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Society for the Exploration of Psychotherapy Integration (SEPI): http://www.sepiweb.org

Society for Psychotherapy Research (SPR): http://www.psychotherapyresearch.org

World Council of Psychotherapy: http://www.world-psyche.org

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PART I

Models of Psychotherapy

2

Unity and Diversity Among Psychotherapies

David E. Orlinsky

Abstract

This chapter aims to show the basic structural features shared by the wide variety of modern scientific psychotherapies such as those described by other authors of this book in their respective chapters. The approach to these shared structural features was inspired by, but goes well beyond, the "common factors" tradition, which had its origin in the writings of Saul Rosenzweig (1936) and Jerome Frank (1961). Unlike those precedents, the approach taken in this chapter was grounded in extensive reviews of empirical research on the processes and outcomes of psychotherapy. In terms familiar in biological classification (Linnaeus), the shared structural features of different modern therapies represent a taxonomic *genus* of which the various therapies are distinct *species*—which is the reason this conceptual analysis is called "the generic model of psychotherapy." Six generic aspects of therapeutic process that are found in all therapies are described, as are their functional interrelations, highlighting the generic potentials that are realized in different ways by the specific forms of psychotherapy.

Keywords: psychotherapy integration, psychotherapeutic process, systematic comparison of psychotherapies

Psychotherapeutic activities or their equivalents have been carried on since time immemorial. Examples of this are plentiful. In preliterate tribal societies, shamans journeyed into the spirit world in order to combat the supernatural beings that were believed to have possessed suffering fellow tribesmen. The Bible tells how the melancholic fits of King Saul were assuaged by the music played for him on the lyre. In later times, Biblical scribes in Judea advised troubled congregants on how to conduct their lives in accordance with God's Law. In classical Athens, Sophist philosophers engaged their rhetorical skills, for a fee, presenting rational arguments to persuade depressed citizens out of melancholy moods. Throughout the ancient Mediterranean world, mystagogues led devotees through esoteric rituals designed to loosen their souls from astrological bondage to the fate-determining stars. During the Middle Ages, priestly confessors heard sinners' admissions of their transgressions and prescribed penances to cleanse their souls. Individual mystics everywhere have engaged in ascetic practices to achieve release from the desires and suffering evoked by the material world, and the communal symbolism of Greek tragic drama or Catholic sacred mass or Evangelical revivalist prayer meetings has provided emotional catharsis through the ages for their participants by purging them of anxiety and guilt.

Every culture has devised activities of some sort to provide guidance, relief, or consolation to vulnerable individuals in ordinary times, and to ordinary individuals in times of extraordinary stress. The examples cited earlier can be seen as true antecedents and functional equivalents of modern psychotherapy. Alternatively, and more precisely, the modern scientific psychotherapies can be seen as modes of traditional healing that have been "reinvented" to suit the secular, rational, technological culture that

predominates among the broad middle and elite strata of urban industrial societies.

Magical, religious, or secular practices that have a psychotherapeutic function can be found in every culture. The reason for this is that every culture posits an ideal type of personality, or a set of related ideal types, which Rieff (1968) referred to as its "character ideal." Every culture also posits an ideal lifecycle, or a set of related life cycle patterns, often differentiated according to gender, social class, or caste (e.g., Kakar, 1981).

Individuals are valued and, perhaps more important for their mental health, experience themselves as leading lives worthy of acceptance and self-esteem, to the extent that they embody appropriate character ideals. By the same token, insofar as they deviate from dominant character and lifecycle ideals of their culture, individuals are likely to reject themselves and to be rejected by others. Yet there are individual differences among people in every culture, based on variability in their biological inheritance and constitution, differential socialization experiences, occupation of diverse roles in the adult division of labor, and (always and everywhere) the random play of accident or fortune. These differences mean that most individuals will deviate to a slight or moderate extent from the cultural ideals for character and life cycle development (whatever those may be), while a few individuals may deviate to a disturbing degree from those ideals.

Minor deviations from cultural ideals are so common that they are taken for granted as "approximately normal" or reflections of "individuality," are attributed to "idiosyncrasy" or "eccentricity" if moderate, and are viewed as "abnormality" only if extreme. Major deviations are rare by definition, but they may constitute socially problematic forms of deviance that require the elaboration of specialized cultural procedures.

The sociologist Talcott Parsons (1964) described the conditions under which societies interpret behavioral deviance as reflecting "illness" to be treated, rather than as "crime" deserving to be punished, "disloyalty" meriting banishment, or "sin" justifying moral condemnation. Parsons noted that "the primary criteria for mental illness must be defined with reference to the social role-performance of the individual"—and that "it is as an *incapacity* to meet the expectations of social roles that mental illness becomes a problem in social relationships . . . for both the sick person and others with whom he (*sic*) associates" (p. 258, emphasis added).

This criterion has a double aspect, since an individual's capacity for social participation involves age-appropriate or "mature" *self-management skills* as well as situationally appropriate *interpersonal skills*. Self-understanding, self-affirmation, and self-control are just as essential for social participation as are social capacities for attachment, assertiveness, and the ability to "take turns" or compromise. However, whether the *incapacity* is primarily a lack of interpersonal or of self-management skills, it has to be viewed by all concerned as essentially *involuntary* to qualify as "illness." As Parsons observed:

> One of the principal criteria of illness [is] that the sick person "couldn't help it." Even though he (sic) may have become ill or disabled through some sort of carelessness or negligence, he cannot legitimately be expected to get well simply by deciding to be well, or by "pulling himself together." Some kind of underlying reorganizing process has to take place, biological or "mental," which can be guided or controlled in various ways, but [the incapacity] cannot simply be eliminated by an "act of will." On the other hand, both obedience to norms and fulfillment of obligations . . . are ordinarily treated as involving "voluntary" decisions; the normal individual can legitimately be "held responsible." (1964, p. 271)

Following Parsons, we can define *psychotherapeutic* activities, no matter what their form, as efforts to guide and control the "underlying reorganizing process" (i.e., executive functions or ego functions) that are needed to restore and upgrade the individual's *capacity* for participation in "normal" social relationships. Since that capacity has both *intra*personal and *inter*personal aspects, therapeutic measures might be focused primarily on problems that are viewed as occurring either "within" the person or "between" persons, or in both areas concurrently.

It is, of course, essential to note that what is regarded as "normal" depends in part on the *expectations* that individuals have for their participation in significant relationships, and that in turn depends in part on the *expectations* that others have of them. What seems like a tolerable level of deviance (i.e., as merely idiosyncratic or eccentric) in some social settings and for some people may be experienced in

other settings or in other persons as sufficiently distressing to require "therapeutic" intervention. In fact, individuals who do not appear at all "abnormal" may seek psychotherapy if they are often involved in situations demanding a high level of self-discipline (e.g., putting the needs of others before their own, being morally nonjudgmental in responding to others) or a high level of interpersonal skill (e.g., listening empathically, expressing themselves tactfully yet persuasively). This is often the case for persons who work in the "helping professions" (e.g., as teachers, ministers, counselors, or psychotherapists) but can apply as well to ordinary people like individuals during stressful life transitions, couples needing to improve their communications, and parents coping with children going through "a difficult phase."

Needless to say, if "psychotherapies" (in some form or shape) exist in every culture, there must also be individuals in every culture who act as "psychotherapists." These persons may be defined, in the sociological terms used earlier, as persons who become *expert* at facilitating and guiding the "underlying reorganizing process" within and between individuals, and who practice their *expertise* as a *vocation*. They may be shamans, healers, priests, doctors, or counselors—depending on the cultural pattern that predominates in their society. Typically, they belong to an occupational community (e.g., a clan of healers, a church, or a professional society) that trains them, certifies their competence, regulates their activities, and provides a healing ideology to explain and justify their practices.

The idea that "psychotherapies" and "psychotherapists" exist in every culture must be very strongly qualified by the phrase *in some form or shape*, because in each society these culturally universal features have to be given specific form and shape inspired by and adapted to the prevailing social conditions and dominant cultural beliefs. Otherwise they could not serve as convincing methods for restoring the psychologically distressed or disabled individuals living in those societies to "normality" and a sense of well-being. The forms of "psychotherapies" found in tribal and traditional societies include magical and religious practices given credibility by the authoritative sources of belief recognized in each society. They differ greatly from practices that would be recognized in developed societies as psychotherapies (e.g., like those highlighted in this book) and would be viewed as "functional equivalents" of modern psychotherapy mainly by anthropologists (e.g., Kakar, 1982) and historians of religion (e.g., Holifield, 1983), rather than by contemporary "mental health" professionals (for important exceptions, see Frank & Frank, 1991; Gielen, Fish, & Draguns, 2004; Kleinman, 1991).

A classic formulation of different kinds of cultural authority operating in the context of politics and religion was developed by the great sociologist Max Weber (1922/1947). These sources of authority are *tradition*, *charisma*, and *rationality*. Authority that is culturally sanctioned by *tradition* and socially institutionalized in *custom* is based on the belief that social practices have "always been done this way" since the time of revered ancestors, with a moral imperative that time-honored custom should be followed in the present as it was in the past. Kings, priests, and venerable elders rely on the authority of tradition. Societies ruled by tradition generally have institutionalized religious or "priestly" forms of therapy for *ministering* to the "spiritual" and emotional needs of individuals in their care.

By contrast, authority that is culturally sanctioned by *charisma* is based on a belief that certain individuals are divinely inspired or possess superhuman "heroic" qualities. Prophets, revolutionary leaders, and "magnetic" personalities rely on the authority of charisma. Societies in which charismatic individuals are viewed as the highest source of authority generally have healing cults in which suffering adherents are "magically" transformed by healers and healing rituals (e.g., a "laying on of hands") that can arouse positive states of "possession" by powerful "benign spirits" or can exorcise the evil influence of "baleful spirits."

Finally, authority that is sanctioned by *rationality* is based on appeals to reason and empirical evidence, which together define the "realities" to be dealt with and the most effective ways for doing so. Rational authority is epitomized in the concept of science, and the findings of scientific research ("evidence" or "facts") are relied on to explain and justify the methods of practitioners in the varied fields that claim a scientific basis (e.g., engineering, medicine, and "modern" psychotherapy). These modern societies regard science as authoritative, define the emotional problems and behavioral abnormalities of persons as disturbances of "mental health," and only endorse psychotherapies with "naturalistic" approaches to their explanation and treatment.

Although tradition, charisma, and rationality are not mutually exclusive, one or another of them tends to be the ruling or hegemonic principle in particular societies; and while Weber's analysis focused on the realms of politics and religion, they also apply to the realm of "psychotherapies," with consequences for the cultural forms of therapy they support.

MODERN PSYCHOTHERAPIES

In developed or "modern" societies, all psychotherapeutic systems derive their legitimacy from the cultural authority accorded to science. Each system represents itself as having a scientific basis, either in a "new" science it claims to have discovered (e.g., psychoanalysis as a science of the unconscious mind) or via novel applications of established science (e.g., techniques of cognitive-behavioral therapy based on cognitive and behavioral psychology). Accordingly, the practitioners of "modern" psychotherapies are typically scientifically trained individuals with advanced educational degrees, such as doctors of psychological or medical science, or university-trained counselors and social workers with degrees in the social sciences.

Modern psychotherapies can be viewed as "scientific" in two different senses. First, the theories they propound about causes of psychological illnesses and appropriate therapeutic interventions are strictly *naturalistic* and do not invoke divinities, spirits, or other supernatural agencies. Descriptions and explanations of mental, emotional, and behavioral phenomena depend exclusively on conditions, forces, or agents that are observable in nature or society. Of course, there are still disagreements as to whether psychological problems are due mainly to genetic flaws, traumatic experiences, conflicts of biological drives with ego defenses, faulty cognitive habits, inadequate interpersonal skills, existential dilemmas, or various combinations of these factors, which is one reason why there are so many different approaches among the modern psychotherapies.

The second sense in which the modern psychotherapies claim to be scientific is their reliance on *systematic empirical research* to demonstrate their clinical effectiveness and provide an understanding of the therapeutic process. Treatment approaches that offer a convincing claim to be scientific (in this sense) are currently called "evidence-based" treatments, and the more "scientific" their claims appear to be, the better their reputation. This aspect of authorization in the eyes of our scientific culture has come to be felt by some practitioners only relatively recently, and even so is not felt by all to the same degree. Nor is there yet agreement, even among researchers, as to what kinds of evidence and which sciences (cognitive, behavioral, biological, social, linguistic, etc.) provide the most relevant bases for therapeutic practice. Controversy also exists with respect to optimal and appropriate methods for obtaining evidence. Some hold adamantly that randomized clinical trials (RCTs), modeled on psychopharmacological studies, provide a "gold standard" for psychotherapy studies and disdain the accumulated evidence of naturalistic and quasi-experimental studies, while others argue persuasively for the necessity of multiple research designs to inform clinical practice (e.g., Beutler & Forrester, 2014). This is another reason why there are different approaches among the modern psychotherapies (see Part I of this volume).

Contemporary therapies have also become differentiated in terms of their formats and the populations they serve (see Part II of this volume). In terms of format, there are "individual" therapies (one client with one therapist), couple therapies (two married or cohabiting clients with one therapist), family therapies (typically parents and children as clients with one therapist), group therapies (typically six to eight or more unacquainted persons as clients with one or more therapist), and milieu therapies (e.g., patients in a hospital ward with ward staff as therapists).

Different forms of therapy also developed to deal with diverse client populations. Classical psychoanalysis originally evolved as a treatment model for hysterias and obsessive-compulsive neuroses. Interpersonal psychoanalysis, as developed by Sullivan, Fromm-Reichmann, and Searles, evolved initially as a treatment model for schizophrenias. Cognitive therapy evolved as a treatment model for depression, as did interpersonal psychotherapy. Behavior therapy evolved initially as a treatment for phobias. Family therapy developed as a method for resolving intrafamilial and intergenerational conflicts. Other forms adapted to specific types of clients include child psychotherapy (e.g., play therapy), geriatric therapy (e.g., life reminiscence), feminist therapy (conscious-raising), and support groups for alcohol- and drug-dependent patients and their relatives.

Differences among those who practice psychotherapy add still more variation. The curious fact remains that *although there are many professional psychotherapists, there is no single profession of psychotherapy as such* (e.g., Henry, Sims, & Spray, 1971). Members of various professions effectively claim the right to practice psychotherapy, typically as subspecialties within their professional fields. In the contemporary United States one finds psychotherapy offered by *some* clinical and counseling psychologists, *some* clinical social workers, *some* psychiatrists, and *some* psychiatric nurses, both within institutions and in private practice. School psychologists and social workers provide therapeutic counseling in educational settings; one finds some trained professional marital counselors connected to the courts of law and far too few psychologists and psychiatrists working in prisons where many inmates have serious "mental health" problems. Finally, and even less visible to secular observers, an important pastoral care system exists that is sponsored by religious denominations, in which ministers and ordained pastoral therapists provide personal therapy and spiritual guidance.

The fact that there are so many and such diverse forms of psychotherapy in modern societies can be explained sociologically by the fact that urban technological societies are highly differentiated social and cultural systems. Within this social context, efforts to restrict an understanding of "psychotherapy" as a set of technical interventions applied by clinicians, while ignoring participant and contextual factors, clearly seem ill advised. A complex division of labor in economic affairs results in a great degree of occupational specialization. Large populations in urban areas are typically ethnically diverse and culturally pluralistic, with consequent diversification of beliefs and values. In personal life, the pattern of marriage and parenthood in nuclear families formed by individual choice (based on attraction and love), in contrast to arranged marriage and multigenerational extended families, ensures a thorough mixing of parental backgrounds and cultural models, as does the ubiquitous presence of mass communications and social media. These factors foster a broad range of inherited temperaments, favor wide differences in childhood socialization, and emphasize individual development in styles of adult identity.

Given the remarkable social and cultural pressures for extensive differentiation in urban-technological societies, it is not surprising to find them fostering a similar degree of differentiation among the modern psychotherapies (many of them given richly detailed descriptions in the chapters that follow). It is, of course, possible to study these therapeutic systems one by one, learning something of value from each. However, if the reader steps back to view the field of psychotherapy as a whole, several questions naturally arise.

First, what do these varied psychotherapeutic approaches have in *common*? What basic features link them together and make it sensible to discuss them in a single volume? Second, are the *differences* among these approaches any more fundamental than found among different brands of competing goods and services in the market? If so, what are the key differences among the psychotherapies? Third, how can the psychotherapies be systematically *compared*? Is there a conceptual framework capable of demonstrating their basic similarities while also doing justice to their specific differences?

A useful answer to these questions may be found by applying a type of conceptual analysis that has been long familiar in the biological sciences: the taxonomic scheme for classifying forms of life established in the 18th century by the Swedish botanist and zoologist Carl Linnaeus (1735). This taxonomic scheme is organized hierarchically in a nested set of conceptual levels. The highest and most inclusive level is that of *domain*, within which further levels are distinguished with successively greater specificity as *kingdom*, *phylum*, *class*, *order*, *family*, *genus*, and *species*. The last four of these conceptual levels—order, family, genus, and species—can be aptly applied to clarify the unity *and* diversity of modern psychotherapeutic systems (as shown in Table 2.1).

In this context, the profusion of particular psychotherapies typical of developed societies can be viewed as distinct *species* of the *genus* "modern" (i.e., science-authorized) psychotherapy. In turn, the *genus* "modern psychotherapy" belongs to the more inclusive *family* of "helping relationships," which also includes other *genera* of "helping relationships" such as medicine, ministry, education, and parenting. As a distinctive *generic* form, "modern psychotherapy" gradually differentiated during the 20th century, first from the field of ministry (Abbott, 1988) and then later (and partially) from the field of medicine (Cautin, 2011; DeLeon, Kenkel, Garcia-Shelton, & VandenBos, 2011). The family of "helping

TABLE 2.1 Psychotherapy as a "Helping Relationship:" Generic and Specific Levels of Analysis

Order	Person-to-person social relationships in developed societies				
Family	**"Helping relationships"** (i.e., care-providing relationships)				Nonhelping relationships (e.g., competition, domination)
Genus	**Modern psychotherapy**			*Examples of other modern "helping relationships":* medicine, ministry, teaching, parenting, etc.	
Species examples	*Behavioral*: conditioning therapies	*Cognitive*: attitude-focused therapies	*Experiential*: affect-focused therapies	*Dynamic*: motivation-focused therapies	*Family/Group*: relationship-focused therapies

relationships" is included, in its turn, within the wider *order* of person-to-person relationships, which also contains *families* of nonhelping person-to-person relationships such as competition and domination. However, the basic unity of different *species* of psychotherapies becomes apparent at the level of *genus*. At the level of *genus* rather than *species*, it has been possible to construct a scientifically research-based Generic Model of Psychotherapy.

FINDING UNITY IN DIVERSITY: THE GENERIC MODEL OF PSYCHOTHERAPY

To grasp the significance and value of this conceptual model, it is essential to distinguish between a unifying *genus*-level "research theory" and differential *species*-level "clinical theories" of therapy. The Generic Model (Orlinsky, 2010; Orlinsky & Howard, 1987) evolved as a conceptual synthesis of more than 2,300 empirical findings reported in hundreds of research studies that related varied aspects of psychotherapeutic process to clinical outcomes (Orlinsky & Howard, 1986); it has continued to integrate new research findings as they emerged (Orlinsky, Grawe, & Parks, 1994; Orlinsky, Rønnestad, & Willutzki, 2004); and it has been extended conceptually as researchers explored new aspects of therapeutic process.

It is important to understand that the Generic Model of Psychotherapy is a *genus*-level *research theory*, whose primary function is to guide researchers in conducting studies of psychotherapy: (1) by defining the realm of relevant research variables and rules for their observation; (2) by suggesting interesting research questions and hypotheses about relations among variables to dictate the design of a study; and (3) by helping to interpret the study's results and their relation to the results of previous research studies. This is in contrast to the many *species*-level *clinical theories* of psychotherapy, whose main function is to guide therapists about how best to conduct treatment cases. To do this, each clinical theory (1) provides a *diagnostic* scheme enabling therapists to attribute the observed problems, complaints, and symptomatic behaviors of patients to some "underlying" cause; (2) presents a repertory of treatment interventions or *techniques*, and guidelines for their use, to help therapists respond beneficially to patients' situations; and (3) proposes an optimal manner in which therapists should relate to clients. Differences among specific clinical theories prompt to therapists to construe clients' problems as due to different causes, to propose different techniques as interventions, and to suggest different manners of relating to clients (as will be discussed later in this chapter). However, from the perspective of a generic research theory, all of those specific clinical theories are viewed as process "variables" to be studied and compared.

The Generic Model of Psychotherapy currently distinguishes six facets of therapeutic process (shown in Table 2.2). Each facet includes a range of research variables, but all facets operate concurrently and jointly define the particular features of modern psychotherapeutic systems—just as the different facets of a diamond together define the diamond as an observable object. The complexity of the Generic Model is intentional, reflecting an effort to view psychotherapy as involving domains of interacting factors, while avoiding a mistaken tendency to view it only or primarily as a set of technical interventions. This endeavor to understand psychotherapy in a broad context is paralleled by others' efforts to identify principles of change that integrate different treatment settings, a wide range of interventions, important relationship qualities, and participant characteristics, as

essential elements of effective practice (e.g., Beutler, 2009; Goldfried, 1980).

First, the *organizational* process facet is generally called the ***therapeutic contract***. This defines the respective *goals* and *roles* of patient and therapist, and specifies structural aspects of treatment such as the setting, frequency, and duration of sessions, the intended length of treatment, whether it will be conducted as individual or group therapy, and so forth. The therapist's treatment model is based on the clinical theory of therapy that the therapist espouses, which sets the rules or norms for actions that are *required*, *allowed*, and *prohibited* for those taking the roles of therapist and client. Therapists' *treatment models* basically consist of a more or less explicit concept of human nature (basic personality), optimal functioning (character ideal), and human fulfillment (life status or developmental ideal); a schema of types of psychological disorders to enable expert evaluation of the information and problems presented by clients; a repertory of techniques or intervention methods to ameliorate or resolve the client's problem; and a recommended professional manner to guide formation of a safe and helpful involvement with patients.

Second, the *technical* or instrumental facet of process consists of ***therapeutic operations*** that are performed by the patient and therapist, respectively. This involves the *client's presentation* of relevant information to the therapist, and the therapist's *expert evaluation* of that information in terms of the diagnostic and explanatory constructs provided by the therapist's treatment model. Based on this assessment of the client's "underlying" problem, the therapist's treatment model indicates which *technical interventions* should by most helpful. Finally, to be successfully carried out, therapeutic interventions typically require the active engagement or *cooperation* of the client.

Third, the *interpersonal* facet of process is usually called the ***therapeutic bond***, which is the "personal" relationship or synergy between the individuals taking part in therapy, as distinct from the "technical" activities reflecting their goals and roles as patient and therapist. The therapeutic bond is reflected partly in the quality of their *emotional rapport*: (a) whether they communicate empathically "on the same wavelength" or "just don't get each other," and (b) how they feel toward one another (caring, warmth, and trust vs. indifference, fear, or mistrust). The bond is also reflected in the quality of their teamwork or *task involvement*: (a) how invested they are in the therapeutic work ("really into it" vs. "just going through the motions") and (b) how well they are able to follow each other's cues and coordinate their interactions ("dance well together" vs. "get in each other's way"). The therapeutic bond represents one aspect of the "alliance" concept advanced by Bordin (1979).

The fourth facet of therapeutic process is ***self-relatedness***, a reflexive or *intrapersonal* aspect that is manifested in how the persons each also *respond to themselves* as they take part in therapy. This reflexivity reflects the immanent inner state of each participant's personality: (a) their respective levels of *self-activation* (e.g., drowsy vs. alert, calm vs. tense); (b) the dominant "ego state" or personality aspect defining each participant's *self-experience* (e.g., a situationally and age-appropriate aspect of personality vs. an immature or situationally inappropriate "transferential" aspect of personality); (c) the *self-control* maintained by each participant (e.g., flexible and adaptive vs. constricted and inhibited vs. impulsive and irruptive); and (d) each participant's current level of *self-esteem* (positive vs. negative, nuanced vs. general). In therapy, these reflexive or self-responding qualities contribute to each participant's relative "presence" and "openness to learning" vs. "defensiveness." Individuals in a present and open state of mind can absorb what is offered or available in their surroundings; those in a closed, "defensive" state of mind screen and limit their responses in order to maintain their self-control, self-esteem, or inner sense of safety, and can only avail themselves of whatever matches the limits they impose on themselves.

In-session impacts constitute a fifth process facet that concerns the immediate *clinical* effects of therapeutic interaction. For clients, positive impacts may include new *insight* into their experience and relationships, emotional *relief* from anxiety or distress, and a restoration of *morale* (e.g., cheerfulness, hope for the future, renewed motivation to confront and resolve problems). Positive in-session impacts or "therapeutic realizations" accumulate and, when applied by clients to their problematic life situations outside of therapy, result in favorable treatment outcomes. But in-session impacts can also be negative if patients feel threatened, confused, or overwhelmed by what they experience during sessions. Consistent negative experiences like these can result in a client's deterioration, and they should lead to discontinuing treatment or transfer to another type of therapy or

therapist. While most research has focused on the quality of in-session impacts on clients, studies of therapists' experiences also show the major role of in-session impacts on therapists' performance and professional development (e.g., Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2013).

Finally, a sixth process facet differs from the others in that it is *temporal* or longitudinal rather than cross-sectional, focusing on ***event sequences*** that occur as the other facets unfold and interweave over time. Event sequences may be studied *within* therapy sessions and *across* therapy sessions as session experiences accumulate into treatment *phases* (e.g., an alliance-building phase, working phase, and termination phase) and entire *courses* of treatment. There is a dramatic structure to psychotherapy that unfolds over time, in which successive sessions can be likened to the "scenes" and consecutive *phases* resemble "acts" in a drama that move toward a climax and resolution of the "plot" (a plot that deemed "comic" if with a happy ending, "tragic" if with a woeful ending).

In addition to describing the varied facets of therapeutic process, the Generic Model of Psychotherapy provides a genus-level perspective on how the facets operate, interact, and influence each other. This is represented as a flow chart in Figure 2.1, which shows three layers (*input* at the top, *process* in the middle, and *output* at the bottom), and arrows indicating potential lines of influence.

Input

The *input* level at the top includes the essential conditions that are required for therapy to occur and that exert an influence on the therapeutic process. These are as follows: (1) persons who will occupy and enact the reciprocal roles of client and therapist in therapy vis-à-vis each other (at least one as client and one as therapist); (2) a specific setting where their therapy sessions will take place (e.g., a private office, a university counseling center, an outpatient clinic); and (3) their community's mental health services delivery system, which typically includes a range of settings, types of therapy, and institutional contexts (e.g., medical, educational, correctional, or congregational).

The arrows at this *input* level indicate (1) that the community's mental health services system has a selective influence on the "professional" characteristics of psychotherapists (e.g., their fields of training and relative availability), the "professional" characteristics of people who become patients (e.g., types of problems for which therapy is deemed relevant), and the types of treatment setting where therapy can be found. Other arrows indicate (2) that the treatment setting and professional characteristics of therapists (e.g., clinical theory espoused) and clients (e.g., severity of disturbance) influence the nature of the *therapeutic contract* that is made. Finally, arrows indicate (3) that the "personal" characteristics of therapists and clients (e.g., their respective ages, genders, and interpersonal styles) influence the strength and quality of the *therapeutic bond* they form, as well as their individual *self-relatedness* (reflecting their ongoing, moment-by-moment personality functioning).

Process

The Generic Model *process* facets and the interrelations among them are pictured in the middle layer of Figure 2.1. Formally speaking, the therapeutic process is set in motion through agreement to a ***therapeutic contract***, in which a person who takes the patient role (or someone acting on their behalf) engages with a person taking the therapist role to work together toward mutually approved treatment goals by reciprocally accepted methods. Negotiation of the contract includes explicit agreement on practical matters such as where, when, and how often therapy sessions will take place; who will take part in those sessions; what the sessions will cost; and who will pay for them. The goals and methods of treatment, as well as how long the treatment will last, may or may not be discussed explicitly at first (depending on the sophistication of the patient and the treatment model and customary practice of the therapist). Once the patient freely enters into the contract, an important part of the therapist's job is to protect the contract's continued integrity, so that treatment can be brought to a successful conclusion or at any rate terminated for legitimate reasons. For this to succeed, any "alliance ruptures" that threaten to improperly subvert or abort the contract need to be effectively repaired (e.g., Safran, Muran, & Eubanks-Carter, 2011).

Two other aspects of therapeutic process are initiated as direct consequences of the *therapeutic contract*. First, ***therapeutic operations*** are begun as dictated by the therapist's treatment model. Patients are encouraged to present relevant information about

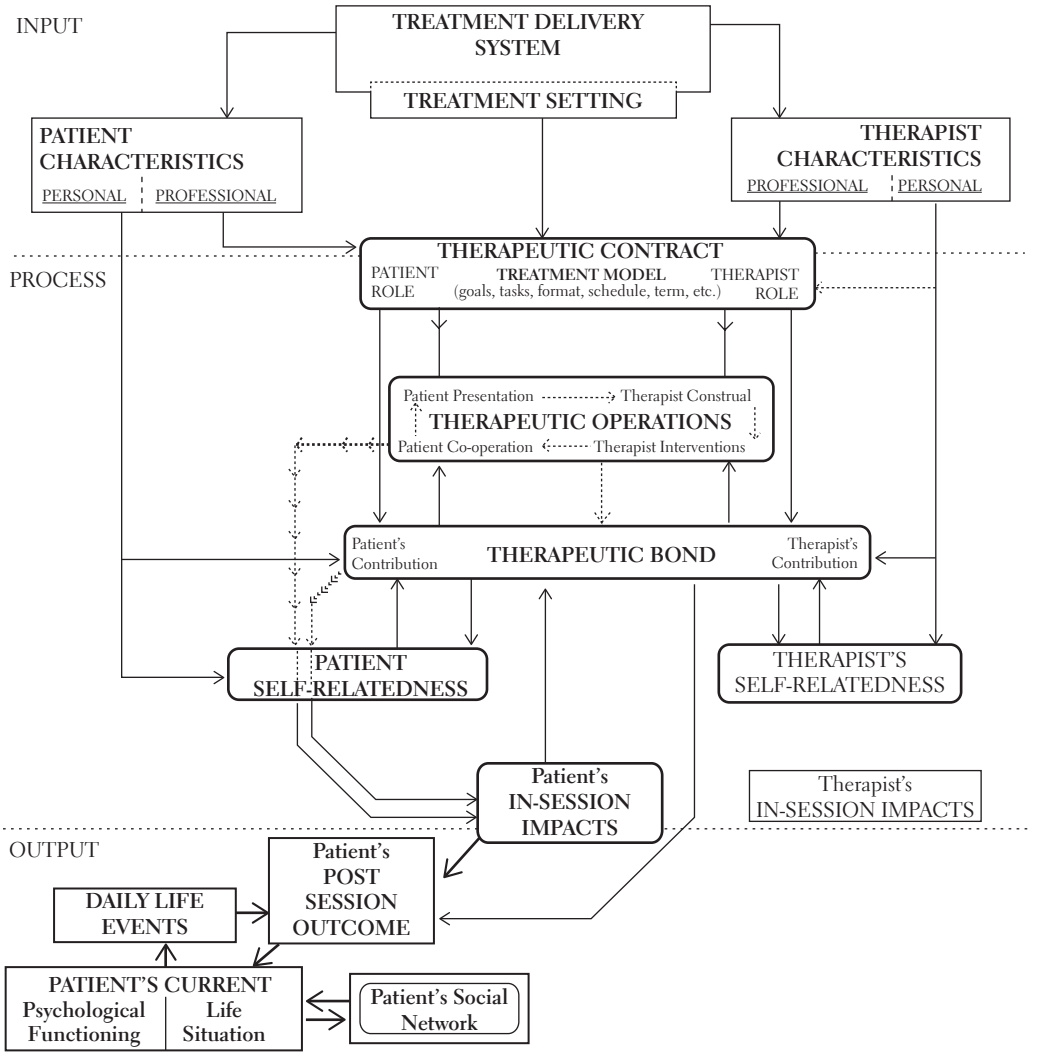

FIGURE 2.1 The generic model of psychotherapy.

their condition and circumstances for the therapist's expert evaluation, on the basis of which the therapist responds with some type of treatment intervention. The patient's cooperative participation (or lack of it) elicits further information for the therapist to evaluate. Generally, the "technical" work of treatment follows this cyclical pattern, and it may also activate further process aspects (e.g., *in-session impacts*, if the patient's state of *self-relatedness* is open and absorbing).

Second, initiation of the *therapeutic contract* also initiates a person-to-person relationship or ***therapeutic bond*** between client and therapist. This may become a focus of treatment or be viewed only as a background factor, according to the therapist's treatment model; but whether overtly emphasized or not, abundant research has shown that the quality of the therapeutic bond is centrally related to therapeutic outcome (e.g., Horvath & Symonds, 1991; Orlinsky et al., 2004). Good outcomes occur most often when the *therapeutic bond* is characterized by mutual affirmation, empathy, and personal investment; poor outcomes occur when mistrust, misunderstanding, and superficial engagement prevail. The human qualities of the bond are determined largely through the interaction of the patient's and therapist's personal

characteristics and interpersonal behaviors, although what the patient and therapist consider "proper" behavior (e.g., how "friendly" to be) in their roles with one another also influences the way that the bond develops.

The process facet of ***self-relatedness*** reflects the client's and therapist's current internal states (openness vs. defensiveness) as those become activated during therapy sessions, but at the same time they are also influenced by what they experience as happening during sessions. A safe, positive, stimulating *therapeutic bond* helps to lower the participants' defensiveness and support their openness; by contrast, a bond that evokes anxiety or boredom is apt to result in a constricted or distracted state of self-relatedness.

The quality of *self-relatedness* is particularly important in relation to ***in-session impact***. Figure 2.1 shows this with a dotted line to represent the client's *self-relatedness* as a gate or filter through for absorbing the effects of the *therapeutic bond* and *therapeutic operations*. Given the same therapist technique and level of empathy, defensive clients are less likely to experience positive *in-session impacts* than those who are open to their feelings and able to reflect upon and gain insight from them. The latter are better able to understand and utilize the therapist's interventions and the supportive atmosphere of the therapeutic bond. At the same time, a therapist whose internal state supports "openness" will be better able to "tune in" to the client's concerns and feelings, and better able to respond empathically.

Output

The bottom or *output* level in Figure 2.1 shows how *in-session impacts* during therapy sessions are retained after the session ends as short-term ***postsession outcomes***. They may last from a few fleeting moments to hours or days, depending on the satisfactions, distractions and challenges presented by *daily life events*. Additionally, having experienced a good *therapeutic bond* during a session can itself promote *postsession outcomes* by enhancing the client's morale.

Positive *postsession outcomes*, in turn, can be reinforced through support from the client's social network (family, friends, colleagues) or overshadowed by ongoing or intensifying stress. Similarly, negative *postsession outcomes* (e.g., feeling worse or more upset after a session) can be diminished by support from the client's social network, or (in the worst case) it can be worsened by ongoing conflicts in the social network and cause deterioration in the client's condition.

Short-term *postsession outcomes* can have cumulative, long-term impacts on the patient's life situation and psychological functioning, and eventually influence the client's life and personality more broadly. To accomplish that, clients need to apply what they have learned in therapy about themselves and others to the problematic relationships and distressing events in their life situations. This can happen gradually and almost imperceptibly, or as a sudden epiphany. It can happen spontaneously and as the result of many small changes, or it can be encouraged through guided practice and "homework" assigned in therapy and carried out by the client. However it comes about, the ultimate result of change is a long-term clinical outcome that is observable at the end of treatment and at follow-up times several months and years after therapy ends.

ACCOUNTING FOR DIVERSITY: SPECIFIC THERAPIES AS VIEWED BY THE GENERIC MODEL

Having shown the shared characteristics and unity of "modern psychotherapy" at the *genus* level, it is equally important to show how the shared characteristics become differentiated into a diversity of specific psychotherapies at the *species* level. Otherwise, readers who fail to see the difference in taxonomic levels might misconstrue the Generic Model as an "integrative" *clinical theory* rather than as a *research theory* of therapy, and incorrectly assume that it focuses solely on what have been called "common factors" while overlooking the specific "change mechanisms" associated with particular therapeutic approaches. An example of this sort of misunderstanding occurred in a recent review of process-outcome research where the authors (Crits-Christoph, Connolly Gibbons, & Mukerjee), describing their own goals, state:

> much of the psychotherapy literature has been reviewed previously (e.g., Orlinsky et al., 2004) . . . [but] we conduct the current review differently in two major ways from previous reviews. First, rather than reviewing the large number of studies of generic, unspecified psychotherapy, we focus our review primarily on studies of the process . . . of specific models

of psychotherapy. (2013, pp. 298–299)To preclude future misconceptions, and to facilitate comprehension of diverse specific forms of psychotherapy, one must show how distinctive features of those specific approaches can be differentiated in terms of the Generic Model's basic concepts. To this end, attention may be drawn to three process facets that show significant variations in different "brands" of therapy.

Therapeutic Contract

Differentiation among specific psychotherapies is obvious with respect to the *therapeutic contract* in terms of the social formats in which treatments are conducted. The most common format for specific therapies is called "individual" therapy, although it actually involves a two-person group (or dyad) consisting of one client and one therapist. Other formats include "group" therapies, in which a small group of unrelated and unacquainted persons jointly are the clients and are treated by one or sometimes two therapists. In this format, there are client-to-client "operational" role (co-clients) and personal "bond" relations (e.g., support vs. rivalry), in addition to the typical client–therapist relationship; and, if there is more than one therapist, there is a co-therapist relationship, too.

By contrast, "family" therapies involve one or two therapists and small groups of related family members—parents and children, siblings, sometimes grandparents or other relatives—who are involved as clients both individually and as a family unit. A common variant on this format is "couple" therapy (e.g., marital counseling), typically a three-person group (triad) in which two romantic partners are co-clients working with one therapist, seeking to get help with their relationship problems.

Other variations in the *therapeutic contract* specify the location, duration, frequency, and number of therapy sessions. Most individual and couple therapy contracts involve weekly sessions lasting 45 to 50 minutes (therapy "hours"), whereas group or family therapy sessions typically are longer (e.g., 80 or 90 minutes) so that there is more time for each of the clients. Contractual variations may include twice-weekly sessions if clients need more frequent contact, or sessions every other week if clients need less contact or circumstances make it hard to schedule more. Sessions in "classical" psychoanalysis and its variants are typically scheduled four or five times per week. With respect to treatment duration, *therapeutic contracts* may be "time limited" with the number of sessions specified in advance (e.g., 12 or 16), but duration is understood implicitly as keyed to agreement by the client and therapist that the goals of treatment have been adequately achieved.

Treatment goals are in fact the core feature of *therapeutic contracts*, since therapy is always an intentional, expert "helping relationship" that is undertaken for a particular purpose. Therapy does not "just happen" coincidentally, as "helping" sometimes does by being connected to friends, family, coworkers, or neighbors. Individuals take on the role of therapy "client"—by choice or under external pressure—to achieve a goal that usually involves one or more of the following: (1) relief from symptoms and emotional distress, (2) problem solving and improved satisfaction in personal relationships, and (3) a search for greater self-understanding, purpose, and meaning in life.

Therapists need to identify and help clients prioritize their goals as part of negotiating the *therapeutic contract* in the first phase of treatment. How therapists approach this task depends largely on the clinical theories or "treatment models" that guide their practice.

Table 2.2 illustrates variations in *therapeutic contracts* based on the nature of client treatment goals and the focus of clinical attention recommended by the therapist's clinical theory or treatment model. Some treatment models focus directly on problem solving and symptom reduction, which are well suited to clients who are deeply distressed or have potentially dangerous symptoms, or who need to improve their self-management and social skills to enhance performance and satisfaction in core personal roles. *Therapeutic contracts* to seek relief from specifically identified symptoms or resolution of circumscribed problem often are framed as short-term treatments and may be undertaken as time-limited contracts, sometimes with an option for additional sessions if the immediate goals are not adequately achieved in the agreed-upon time. They may also include intermittent follow-up "booster" sessions to help clients deal more effectively with stressful events and prevent a "relapse" or recurrence of the client's problems.

Other treatment models focus more on what are conceived as the "underlying causes" of clients'

TABLE 2.2 Therapeutic Contract: Types Based on Client Goals and Therapist Treatment Focus

	Therapist's Clinical Focus	
Client's Treatment Goal	*"Manifest" Symptoms and Problems of Client*	*"Underlying Sources" of Client Problems*
(1) ***Relief***: reduction of emotional distress and noxious symptoms	***Short-term "crisis" or symptom-focused therapy*** (may involve concurrent pharmacological treatment)	—
(2) ***Problem-solving***: improved performance and satisfaction in personal relationships	***Medium-term supportive-exploratory*** therapy (e.g., psychodynamic, cognitive, cognitive-behavioral, experiential, or systemic)	***Medium-term exploratory-supportive therapy*** (e.g., psychodynamic, cognitive, cognitive-behavioral, experiential, or systemic)
(3) ***Enlightenment***: pursuit of self-understanding, sense of purpose, and meaning in life	—	***Long-term exploratory psychotherapy*** (e.g., psychoanalytic or existential-humanistic)

problems. How those "underlying causes" are conceptualized varies according to the theories of human nature (personality), human vulnerability (psychopathology), and human potential (character ideals) that inform the treatment model. Treatment models themselves may be grouped in clusters of conceptually related clinical theories that vary in key ideas and terminology. For example, *psychodynamic* treatment models view personality primarily in terms of motivations and development, variously conceived in different psychodynamic approaches (e.g., those of Freud, Jung, Adler, Klein, or Sullivan), and they view psychopathology as due to motivational conflicts rooted in formative childhood experience that limit or disrupt mature functioning. *Behavioral* treatment models view personality in terms of learned adaptation to life situations, with problems arising from maladaptive learning or inappropriate transfer of training from prior to later situations. *Cognitive* treatment models view normal personality functioning as based on realistic assimilation and rational accommodation to circumstances, and psychopathology as due to illogical, unrealistic, or irrational ideation. *Humanistic* treatment models view personality in terms of potential for growth and self-realization, and psychopathology as grounded in socially or self-imposed limitations on personal fulfillment. *Existential* treatment models view personality and psychopathology in terms of self-consciousness and finitude (awareness of death), rooted in the human condition itself. *Systemic* treatment models view personality in terms of the individual's position within intimate family networks, and psychopathology as due to failures in the family's communications and boundary management that distress one or more family members by distorting family structures and functions (e.g., requiring a child to "parent" an immature or unstable parent).

Whether and how deeply these varied clinical theories truly contradict or are actually compatible with each other is an interesting issue to consider, but one that would require a separate inquiry (e.g., Fancher, 1995). The essential point here is that *professional* psychotherapists necessarily are trained and certified to operate competently within one or another (or several) of these treatment models. Which treatment model or combination of models that therapists follow is clearly a main source of differentiation among therapies at the *species* level of diversity.

Therapeutic Operations

The *therapeutic operations* or technical interventions performed by therapists and clients are the methods designated in the therapist's treatment model to attain the therapeutic goals. Two general sorts of therapist interventions can be distinguished, based on whether their intent is mainly diagnostic or curative. "Diagnostic" interventions aim to facilitate the client's expression of information relevant to the

therapist's treatment model (e.g., spontaneous "free" associations in classical versions of psychoanalysis, or genograms in certain family therapies). "Curative" interventions aim to improve the client's current state and beneficially influence the factors causing the client's problems, as those are understood by the therapist.

Specific psychotherapies differ from one another in their trademark "curative" interventions much as they do in their varied conceptions of personality, personal problems, and what it takes to solve them. For example, a hallmark intervention of psychoanalysis and its psychodynamic variants is "interpretation" of the themes expressed recurrently in the client's "free" associations and recurrent relationship patterns with the aim of helping clients gain insight into their unconscious motivations and resolve their conflicts. By comparison, a hallmark intervention of client-centered and person-centered therapies, among other "humanistic" approaches influenced by Carl Rogers, is "reflection of feelings," in which therapists rephrase for their clients what they perceive as the "felt meaning" conveyed by the client's words and expressions, with the dual aim of testing the empathic accuracy of their perceptions and fostering and deepening the client's self-exploration.

Viewing the whole range of specific therapies reveals a wide and impressive array of interventions, and it would easily be possible to expand the number of examples. Gestalt therapy made famous use of an empty chair and clients' imagination to invent and guide dialogues to help clients integrate conflicting aspects of their experience. Cognitive therapies typically challenge a client's beliefs, expectations, and "automatic" (i.e., implicit) reasoning when they seem ill founded, irrational, or unrealistic, and are likely causing excessive and apparently unjustified emotional reactions (depression, anxiety, paranoia), or serving to constrain or inhibit effective social behavior. Behavioral therapies may rely on relaxation training (e.g., through breathing exercises) coupled with imagined or actual engagement with progressively more distressing stimuli (e.g., "fear hierarchies") in order to reduce painful and disruptive symptoms, and they may also use role-playing to provide clients a way to learn and practice effective social skills. Yet, for our present purposes, what is needed is not a lengthy list of interventions, but a conception or schema that can offer a comprehensive overview of therapist interventions—one that can diminish their identification with specific therapeutic ideologies and make them available to pragmatic therapists interested in finding ways to help clients whose range of individual differences may not match the hypothetical "ideal client" of any one brand of therapy.

A suitable scheme for this purpose is illustrated in Figure 2.2, which shows six observable interlinked aspects of experience that therapists can target as potential paths of influence on clients. The schema is based on two commonsense premises: *first*, that human experience is a complex, multifaceted phenomenon which can be viewed from different sides, like the facets of a gem or crystal; and *second*, that the aspects of experience are interdependent and influence each other, so that change induced in one of the aspects also changes the balance among them and induces further changes among other aspects until a new and relatively stable balance is achieved. Figure 2.2 represents a living system in which change occurs continually, so it is important to visualize the "crystal" as moving or vibrating rather than static, although generally returning to an equilibrium or "adaptation level."

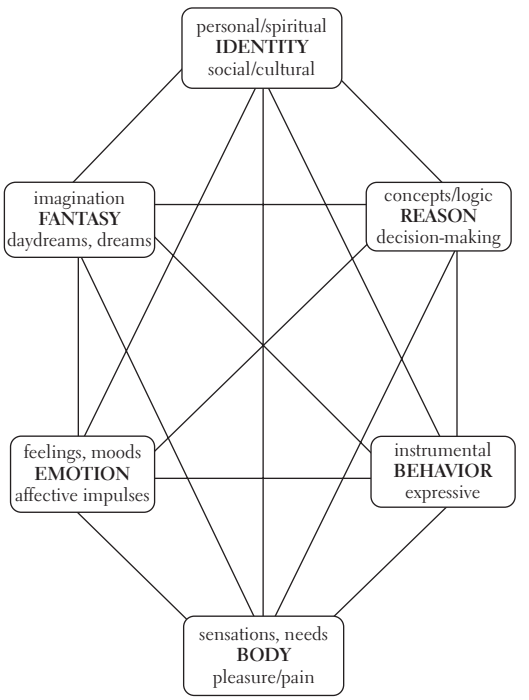

FIGURE 2.2 Therapeutic interventions: areas of potential focus.

Reason, *emotion*, *imagination*, and *action* are terms familiar from an older psychology of "mental faculties," which, even if no longer accepted in academic circles, still persist as commonly understood domains of mental life. "Think about it." "Control your emotions." "Use your imagination." "Express it in action." Statements like these are readily intelligible to almost everyone. It is generally understood that *reason* may govern *emotion* but also that *imagination* can deceive *reason*, and strong *emotion* can overthrow *reason*. Emotions motivate actions, and actions implement plans that reason makes, but engaging in action can also lead to changing how one thinks about something, and how one feels. Moreover, actions that are effective generate a sense of satisfaction, and actions that are thwarted induce frustration. Flawed assumptions and illogical thinking often result in confused or mistaken action. Emotions prompt flights of fantasy and may derail trains of thought. Conflicting emotions may inhibit or lead to inconsistencies in action. The foregoing aspects of experience are arrayed around, connected with, and reciprocally influenced by the main vertical axis of self-experience shown in Figure 2.2: the sensed ground of being a physical *body*, and the overarching, integrative, self-reflective construct of *personal identity* (I, myself).

Body (the subjectively felt body, *not* the biochemical organism of medicine and physiology, though certainly related to it) is the existential ground in which all other aspects of experience are rooted. It is the seat of emotions ("heart") and the instrument of action ("sinew"). The body's needs (hunger, thirst, libido) prompt and direct action toward specific forms of satisfaction. The body's senses of pleasure and pain arouse emotion and reinforce tendencies to act toward or away from (or against) stimuli that set them off. The body's distal senses (sight, hearing, and smell) convey information to the mind and provide raw materials for the imagination. The body's proximal senses (e.g., touch, temperature, weight, balance, pulse, and pressure) are integral to one's sense of orientation and reality. The body's visible, palpable substance extends into the world of physical objects and social others as an agent that attracts or repels, imposes or yields.

Personal identity is the reflective, executive, and supervisory aspect of experience, based on the self-image and self-concept developed in one's "formative" relationships. It mediates the reflexive process creating momentary, situational states of individual *self-relatedness* through which we become self-aware, self-defining, self-controlling, and self-valuing; and it is the developmentally, socially, and narratively organized product of self-in-relation-to-others (role identities). It is the structure of past personal learning that contextualizes particular experiences socially (with a sense community), culturally (with values and ideals), and spiritually (with challenging questions about our origin, destiny, and place in the cosmos).

The fact that these varied aspects of experience influence one another has been selectively utilized by different clinical treatment models. Cognitive therapies challenge the assumptions and reasoning of clients to counteract unfounded or irrational beliefs that lead to emotional symptoms (depression, anxiety, etc.). Behavioral therapies use both imagination (fantasized fear stimuli) and action (live contact with fear stimuli) together with relaxation training to "reciprocally inhibit" anxiety reactions. Psychoanalytic therapies interpret the dreams, fantasies, and spontaneous ideation ("free associations") of clients, as well as recurrent "core-conflictual" relationships in the client's past and present, to enhance clients' self-understanding and better integrate self-identity. Client-centered and related humanistic and "experiential" therapies focus on clients' feelings in order to clarify and strengthen the sense of self-identity and self-assurance. Gestalt as well as emotion-focused therapies concentrates on clients' imagination and expressive behavior to explore clients' covert fantasies, bring closure to emotional "unfinished business," and better integrate the client's personal identity. Bioenergetic and other body-focused therapies employ physical exercises and pressure on areas of muscular rigidity to release inhibited emotions and facilitate their expression and integration.

There is no need to multiply these examples to show that the scheme in Figure 2.2 is comprehensive in its ability to describe and compare the "curative" interventions espoused by different therapy brands, and it is able to delineate those *species*-level interventions in a generic or brand-neutral language. Numerous possibilities for defining interventions exist (6 factorial!), some of which have already been devised, leaving others still to be developed by creative practitioners.

Yet this account emphasizes only part of the variations observed in specific treatment models with respect to *therapeutic operations*. The other part inheres in the different ways that therapists seek to induce

constructive change in focusing on different aspects of client experience. Extensive observation of videos of therapists' techniques suggests that therapists' interventions offer either *challenge* or *support*, and at varying levels of intensity or forcefulness. *Challenge* can be relatively mild and exploratory (e.g., questioning an apparent gap or inconsistency in a patient's account), moderate (e.g., suggesting a possible alternative explanation of an event), or direct and confrontational (e.g., reinterpreting a patient's response to the therapist as a "transference" of emotion from an early formative relationship). Likewise, *support* can be relatively mild and subtle (e.g., an "mmhm" to encourage a patient to continue), moderate and direct (e.g., reassuring patients about something that worries them), or intense and personal (e.g., promising to stand by and care for a patient in the face of imminent troubles).

As individuals, clients vary in their relative openness and susceptibility to interventions focused on different aspects of their experience, and therapists vary in their aptitude for and comfort in focusing on different aspects of client experience. Given the broad range of variation in personality, some clients will be more approachable through one or another aspect of experience. Clients who are highly "intellectual" and used to "playing with" ideas may be easily able to counteract or neutralize a therapist's interpretations, but they may be less well "defended" with respect to emotions, fantasy, or bodily experience, and so more open to interventions that focus on those aspects. By the same token, clients who are highly athletic and physically disciplined are quite likely to "take in stride" interventions drawn from the body-focused therapies, but be less well "defended" by interpretive or imagery-based interventions.

Therapists, as individuals, also differ in how comfortably and competently they are able to offer different levels of *support* and *challenge*, or focus on different aspects of client experience. For example, by virtue of having chosen to practice a "helping profession," therapists may be more comfortable and competent offering a full range of supportive interventions but less comfortable about directly challenging their clients when it would be therapeutically useful to do so. If so, they may have to overcome personal inhibitions of their own in order to strongly challenge clients. Natural variations in clients' and therapists' personalities (which are not routinely recognized in theory but are usually considered in making treatment referrals) lead to recognizing that differences between treatment models are also linked to the *therapeutic bond* as a clinically important process facet.

Therapeutic Bond

A wide range of specific possibilities exists regarding the patterns of interpersonal relatedness that develop as the persons involved in therapy enact their respective roles as clients and therapists. The fit of each individual's personal style or manner with that of the other one jointly influences the *therapeutic bond*, and shape the character and quality of their "personal rapport" and "task involvement."

Theory and research on interpersonal manner has a long history (Benjamin, 1976; Kiesler, 1983; Leary, 1957) that can be used to differentiate specific types of *therapeutic bond*. These theories typically project a circular diagram based on intersecting, independent axes representing dimensions of *affiliation* toward the other (affirming vs. rejecting) and *coordination* with the other (directive vs. receptive). This compass-like "circumplex" diagram can be meaningfully divided into eight equal octants (shown in Fig. 2.3).

Figure 2.3 shows potentially viable styles or manners of therapist behavior, although the four octants on the "east" or right-hand side of the circumplex (friendly/affirming) are probably the most common and personally comfortable for therapists. To make the octants feel more familiar, they can each be given a name associated with a therapist whose therapeutic style is well known either by reputation or through widely observed recordings. Referring to the widely viewed "Gloria" sessions in which one client was interviewed in succession by three well-known therapists (Shostrom, 1966), the north-by-northwest "challenging/confronting" octant might be labeled "Fritz" (for Fritz Perls), the "guiding/teaching" north-by-northeast octant could be labeled "Albert" (for Albert Ellis), and the "caring/supporting" east-by-southeast octant might be named "Carl" (for Carl Rogers). A more recent but also widely known therapist's name ("Les") (for Leslie Greenberg) could be used to label the "engaging/encouraging" east-by-northeast octant, and the two lower octants—"following/learning" at south-by-southeast and "reserved/analytical" at south-by-southwest—could be labeled

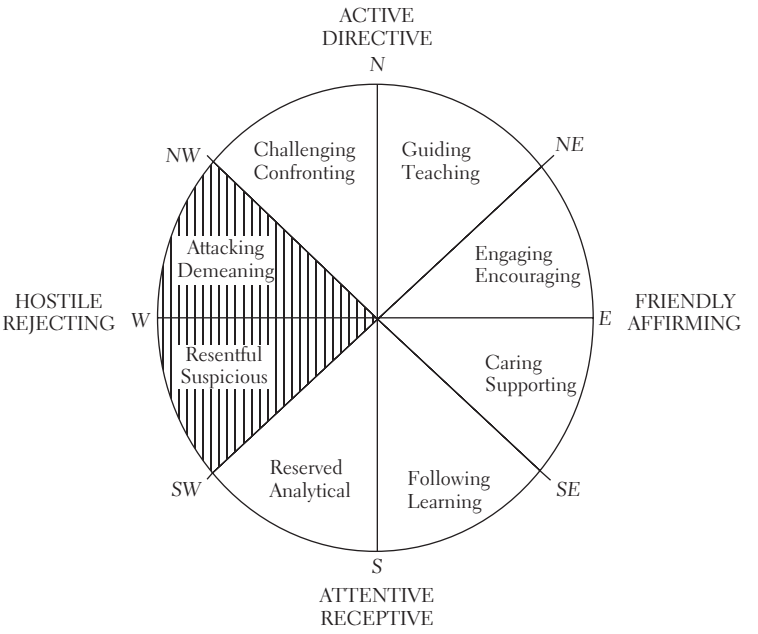

FIGURE 2.3 Therapeutic bond: types of therapist relationship style or "manner" with clients.

"Sigmund 1" (Freud in "detective" mode) and "Sigmund 2" (Freud combating client "resistances").

The two shaded octants are clearly destructive or antitherapeutic, and they could be named respectively for the insulting persona adopted by the comedian Don Rickles ("attacking/demeaning" at west-by-northwest) and the tragic personality of the American president who kept a secret "enemies list," Richard Nixon ("resentful/suspicious" at west-by-southwest). Therapists acting persistently in either of these latter modes would surely produce negative client outcomes.

Figure 2.3 may also be used with octant adjectives that would be more likely to reflect the variety of interpersonal manners that *clients* might display in therapy. The persons who would be easiest for most therapists to work with are "good clients" in the east-by-northeast octant whose manner is "collaborative/engaged" and those in the east-by-southeast octant whose manner is "trusting/confident." On the other hand, the clients who are likely to be problematic for most therapists are those whose interpersonal manner is characteristically in one of the hostile/rejecting octants: those who are "withholding/resistant" at south-by-southwest, "fearful/avoidant" at west-by-southwest, "demanding/critical" at north-by-northwest, and "angry/attacking" at west-by-northwest.

Therapeutic bond is determined by the fit between the interpersonal manners of a client and therapist: a fit that might be one of mutual affirmation and collaboration, one of personal friction, or one of outright conflict. In the 1960s, the psychologist Robert Carson (1969) demonstrated how this would work. Using the same circumplex axes shown in Figure 2.3, Carson noted that, for the *affiliation* dimension, a state of equilibrium exists between similar poles. In other words, a "friendly/affirming" manner in one person elicits and reinforces a "friendly/affirming" manner in the other, while a "hostile/rejecting" manner in one elicits and reinforces a "hostile/rejecting" manner in the other—unless one of them is able to "turn the other cheek," causing A disequilibrium that exerts pressure to change in the direction of a new equilibrium. For example, a therapist's maintaining a "friendly/affirming" manner in the face of a patient's "hostile/rejecting" manner may itself induce change if it is stronger and more persistent.

By contrast, in the *coordination* dimension, equilibrium exists between opposite poles. An "active/controlling" manner elicits and reinforces a

"passive/reactive" manner, whereas a strongly held "passive/reactive" manner tends to push the other toward being "active/controlling." On this axis, equilibrium exists when the participants' manners are complementary (one leading and the other following), and disequilibrium exists when similar manners of relating encounter one another: Two "active/controlling" persons will engage in an overt power struggle until one or the other gives in and shifts toward a "passive/reactive" manner. Likewise, two "passive/reactive" persons engage in a covert (passive aggressive) power struggle that will persist until one or the other is forced to assume an "active/controlling" manner. Here, too, whichever one is more insistent and tenacious tends to induce change in the other, although extreme and persistent disequilibrium in both dimensions can eventually result in terminating the relationship.

Given their commitment to a "helping profession," most therapists are probably strongly inclined to being "engaging/encouraging" and "caring/supporting" which is likely to foster "trusting/confident" and "collaborating/engaged" behavior in clients. These reciprocal behaviors typically generate what would be considered an optimal *therapeutic bond*. Another positive form of *therapeutic bond* is reflected in a therapist manner that is receptive ("following/learning") matched with client behavior that is active and self-directed ("initiating/exploring"). An ideal therapeutic bond may be conceived as one in which client and therapist both come to feel caring toward one another and are able to alternate constructively between taking the initiative and following each other's lead. The importance and beneficial effects of such a strong therapeutic bond have been clearly traced theoretically by Wampold and Budge (2012).

However, the problems for which clients come to therapy often are manifested in interpersonal behavior that is either actively or passively hostile and rejecting—"demanding/critical," "angry/attacking," "fearful/avoidant," or "withholding/resistant"—and these are dissonant with the personal manner preferred by most therapists, with the consequence that disequilibrium is frequently generated in the therapeutic bond. It is easy to maintain a warm affirmative attitude toward a client who responds in kind, but a great deal harder to "turn the other cheek" and remain steadfastly affirming toward a client who recurrently criticizes and attacks. Confronted with such behavior, therapists must reach deep into themselves and their capacity as caring individuals in order to find something to like or respect in the client—as they mostly do (Orlinsky & Rønnestad, 2005). The ability to do this, based on the therapist's personal development (Nissen-Lie & Orlinsky, 2014), may be one defining feature of therapeutic talent.

CONCLUSIONS/KEY POINTS

- Psychotherapy can be viewed as the modern version of a universal social function of societies that aims to reduce degrees of emotional distress and psychological or behavioral deviance in individuals who are considered "abnormal" in a community.
- Modern psychotherapies, broadly defined, represent a type of professional "helping relationship" dealing typically with the problems and vicissitudes of personal experience and relationships in private life.
- The multiple approaches represented in the variety of modern psychotherapies can be understood taxonomically as analogous to biological species belonging to a single genus, all of which share certain basic features.
- Based on the range of variables that have been measured by researchers, the Generic Model of Psychotherapy proposed six facets of therapeutic process that are shared features in all species of modern therapy: (a) a *therapeutic contract* that organizes procedures by defining the goals, methods, and norms for patient and therapist roles; (b) a set of *therapeutic operations* that includes both diagnostic and curative techniques based on the therapist's clinical practice theory; (c) a person-to-person *therapeutic bond*, reflecting their teamwork and emotional rapport, that emerges as the participants work together in their respective roles as patient and therapist; (d) the participants' states of *inner self-relatedness* during therapeutic interactions, reflecting varying levels of self-awareness, self-control, self-esteem, and self-protectiveness; (e) a progression of *in-session impacts* (e.g., insight, relief, or reassurance) that become a positive influence on patients' lives outside of therapy; (f) a series of *sequential events*, within sessions and across the phases of treatment.

- The Generic Model delineates the reciprocal influences among the six process facets and the paths of change reflecting the systemic character of the therapeutic process.
- Observable and meaningful variations in the *therapeutic contract*, *therapeutic operations*, and *therapeutic bond* are used to show how varied forms of psychotherapies arise at the species level within modern scientific psychotherapy at the *genus* level of analysis.
- The Generic Model of Psychotherapy offers a comprehensive guide for psychotherapy researchers and a flexible framework for students and practitioners interested in comparing and understanding the unity and diversity of modern psychotherapies.

REVIEW QUESTIONS

With the Generic Model as a comparative framework, students and practitioners of the modern psychotherapies can raise a number of basic questions about each of the specific clinical approaches and about the empirical research that is relevant to each. The following are examples of some of these questions:

1. How does each approach formulate its *therapeutic contract*? What is its basic clinical theory or treatment model (philosophical anthropology, psychodiagnostic scheme, repertory of intervention methods or techniques, recommended style of relating to clients)? How explicitly does it deal with issues of the therapeutic contract during therapy sessions? What special measures (if any) does it take to protect the psychological and ethical integrity of the contract? How frequently are sessions scheduled? Is the duration of treatment open-ended or specified in advance?
2. How are actual *therapeutic operations* initiated and carried on? What type of information from clients is viewed as relevant to treatment, and how are clients helped to provide that information? How do therapists formulate and utilize their expert evaluations of what clients tell and show to them through their expressive behaviors and interpersonal manner? Are these expert evaluations communicated to the client or just used as the basis for making interventions? Does the therapist formulate an explicit treatment plan or intervention strategy? Is there a typical sequence of interventions? To what extent, and in what terms, are treatment processes explained to clients? What steps (if any) are taken to promote the client's cooperative participation?
3. How much explicit recognition is given to the *therapeutic bond*? Are any specific methods used to enhance the nature and quality of the bond? How do therapists typically use their interpersonal manner during sessions to influence clients and facilitate progress in therapy? How flexible or restricted are therapists in their manner of relating to clients?
4. How much emphasis does each therapeutic approach place on the client's *self-relatedness* (e.g., "defenses")? Are there ways in which optimal self-relatedness is facilitated for therapists? Are specific methods used to foster openness or counter defensiveness in clients?
5. What types of positive *in-session impact* does each approach seek to achieve for patients? What negative in-session impacts does it recognize (if any)? To what are these attributed? How are they dealt with? What methods are used (if any) to help patients maintain positive in-session impacts after they leave the therapy session?
6. How are *sequential events* in therapy organized in each approach? Is there a typical sequence of events within sessions (e.g., starting with formulating an agenda for the session)? What phases of therapy are recognized? How is the termination phase of treatment managed?
7. Finally, how does each approach *configure* the various aspects of therapeutic process? What is the relative emphasis given to each aspect? How are they organized to achieve optimum effectiveness (e.g., Castonguay & Beutler, 2006) with respect to the goals that are sought?

Answering questions like these about each of the specific therapeutic approaches that are presented in the following chapters should help students gain a deeper understanding of the unity and diversity of the modern psychotherapies.

AUTHOR NOTE

This chapter was coauthored by David Orlinsky and Kenneth Howard in the first edition of B. Bongar and L. E. Beutler's *Comprehensive Textbook of Psychotherapy: Theory, Research, and Practice* (Oxford University Press, 1995), and in this edition it is dedicated with love to the memory of Kenneth Howard. Additional portions of it are adapted with permission from Orlinsky (2014).

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3

Psychodynamic Therapies in Historical Perspective

Jerry Gold
George Stricker

Abstract
In this chapter we trace the historical development of psychoanalysis and psychodynamic therapies from their Victorian origins as a limited treatment for hysteria to their modern, broader forms. We review the evolution of the theory of change as it developed from an exclusive emphasis on insight to an inclusion of the role of corrective experiences, and we cover the modifications in the general theory that have emerged over the previous century. We also consider the degree to which this approach has been evaluated empirically and how issues of diversity have been addressed historically within the approach.

Keywords: psychodynamic, psychoanalysis, insight, transference, interpretation

Psychoanalysis is the founding parent of almost all contemporary systems of psychotherapy. All approaches either developed out of psychoanalysis or in opposition to it (think of behavior therapy). What began during the Victorian era in Vienna grew into the system of psychotherapy that for most of the 20th century was the dominant one in the Western world. Today, despite rumors of its demise, psychoanalysis and its descendants, the various forms of contemporary psychodynamic psychotherapies, remain active parts of the psychotherapeutic mix. In this chapter, we will use the terms *psychoanalysis* and *psychodynamic psychotherapy* as loose synonyms. The latter refers to the somewhat less intense and/or shorter versions of the former. Both are based on identical theoretical foundations of change processes and technique.

Psychoanalysis originated at a time when the medical and scientific world was just beginning to understand the workings of the body and the brain. The neuron had just been isolated and observed for the first time, germ theory had taken hold in the area of infectious diseases, and psychology had moved from a subdiscipline of philosophy to its own status as an empirical science. Rationalism was the dominant outlook among the educated populace, encouraging the perspective that all phenomena in the natural and human worlds eventually could be understood through science. The idea that much of what we experience and see was moved and shaped by forces and materials of which we were unaware was crucial in physics, with its study of the atom; biology, in its investigation of cells, viruses, and germs; and physics, with its emphasis on forces and vectors. It was in this intellectual world that psychoanalysis took hold.

This was also a world in which middle-class life was dominated by repression and hypocrisy. Prostitution, child abuse, and venereal diseases were widespread, and yet sexuality was a forbidden topic to the point, for example, that a street in London had its name changed from Petticoat Lane because the idea of an undergarment was deemed to be too stimulating for mention in polite company. Women and children were disempowered and disenfranchised by

their legal position as chattel of husbands and fathers. These tensions, which made themselves known at the level of everyday individual experience, also served as fertilizer for the growth and flowering of psychoanalysis.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS

Hypnosis, "Chimney Sweeping," and Free Association: Classical Freudian Psychoanalysis

Psychoanalysis originated accidentally from unexpected behavior on the part of a patient known to us as Anna O., who was being treated for hysteria by a Viennese physician, Joseph Breuer (1842–1925), during the last years of the 19th century (Breuer & Freud, 1895). The condition known then as hysteria was diagnosed when the patient presented with disturbances in bodily function that did not result from identifiable medical problems. These included such symptoms as blindness, paralyses, headaches, and other symptoms. Today we would include such problems in the categories of somatoform and dissociative disorder.

Breuer and his younger colleague, Sigmund Freud (1856–1939), had been treating patients with hysteria by hypnotizing them and then suggesting that their symptoms would improve once patients had emerged from the hypnotic state. Anna O.'s treatment had begun this way, but it had taken a novel course. While hypnotized, Anna O. began to speak freely about memories, experiences, and events in life, which gradually wove back to the onset of her symptoms. As her treatment continued and her "chimney sweeping" (her term for her recollections) continued, Breuer (and Freud) deduced that her symptoms derived from painful emotional experiences that she could not recall outside of the hypnotic state and therefore seemed to be kept separate from her conscious mind. As Anna's hypnotically supported talking went on, she often seemed to connect and express the emotions of which she had been unaware previously and to then experience some relief from her hysterical symptoms.

Breuer abandoned the hypnotic treatment of hysteria when Anna O. began to express her love for him and even manifested a false pregnancy that she attributed to Breuer's attention. However, Freud was not intimidated by these events, and his study of this case, and of other cases of hysteria, led to his first theory of psychodynamics and eventually to clinical psychoanalysis. Freud concluded that hysteria was caused by emotions that the person deemed to be unacceptable because they caused guilt, shame, or embarrassment, and were therefore deliberately but unknowingly repressed or excluded from consciousness. These repressed or "strangulated" affects did not rest easy in the patient's mind. They seemed to cause psychological tension or anxiety, and sometimes they came dangerously close to emerging in the patient's awareness. Freud hypothesized that the physical symptoms of hysteria represented a psychological compromise between the patient's need to reduce this tension while maintaining repression of the emotions and memories of the events that caused them. He understood, therefore, that symptoms had symbolic meanings: They expressed the repressed emotions in a nonverbal manner while keeping the meaning hidden from the patient. Freud also concluded that insight, or the conscious recovery of the traumatic events, and abreaction, the conscious expression of the repressed emotions, were the necessary curative factors in the treatment of hysteria. To accomplish these therapeutic goals, Freud initially conducted treatment as had Breuer and Anna: He hypnotized his patients and instructed them to verbally trace their symptoms back to their temporal origins, hoping in this way to reach those repressed memories of the central etiological events. Freud soon abandoned the use of hypnosis, as he found that its effects were short lived and that many patients could not be hypnotized. Replacing hypnosis for an interim period was what has come to be known as the "pressure technique": Freud would have patients recline on a couch while placing his hands firmly on their forehead and exhorting them to remember the events that led up to the emergence of their symptoms. Needless to say, this technique was disturbing to many who consulted Freud, and it was abandoned relatively soon. What replaced it were a set of activities on the parts of patient and clinician that came to define psychoanalytic therapy, and which remain central parts of it even today (Freud, 1905).

Patients were encouraged to "free associate" or to report freely and uncritically on their ongoing

thinking, imagery, emotions, sensations, and memories, holding back nothing due to shame, guilt, or embarrassment. Freud likened this process to the way travelers on a train might describe the landscape outside of their windows, without omitting or privileging any particular details due to personal preferences or dislikes. In turn, the clinician would listen without focusing on any particular issues or events, or with what Freud described as "evenly hovering attention." Freud thought that this interaction would create a situation in which the patients' lack of cognitive deliberation and direction, in the presence of an accepting and nonjudgmental physician, would allow repression to be relaxed and warded-off memories and affects to be recovered and expressed. If, as was often the case, the patient was unable to fully attain insight and to experience the relief of a reaction, then the clinician could assist by interpreting the unconscious meaning of the patient's association. Interpretation of this type was made possible by listening as described earlier; that is, with evenly hovering attention. Freed of preconceptions or cognitive intention, this form of listening allowed the listener to hear the latent communication contained in the patient's associations and to offer this insight in the form of an explanation of the unconscious processes that were operating as the patient spoke.

Freud found that patients continued to avoid or to repress full awareness of unconscious material during the process of free association. This defensive or repressive process came to be known as resistance, and its analysis became increasingly important during subsequent periods of the development of psychodynamic psychotherapy.

Central to the process of change and cure was the unraveling of the "transference neurosis" through interpretation of, and insight into, its manifestation and meaning. Freud discovered that, as psychoanalytic therapy proceeded, patients would focus or transfer most of their repressed unconscious wishes on the analyst, hence his description of transference. As the therapeutic interaction was transformed by patients' internal conflicts and fears, patients and their therapist were offered the unique opportunity to study and to understand this revived and recreated core of patients' early psychological life. Insight on the part of patients into these issues was thought to allow them to let go of the wishes (to decathect, in Freudian terms) and therefore to move forward developmentally to a more mature and adult interaction with the world.

Freud rarely wrote about the process of psychotherapy and did not offer any changes to these clinical methods once they were established. What did change during the course of his long career was his understanding of the psychological issues that caused abnormal behavior, and thus had to be addressed in treatment. These changes in theory did not change the method of psychotherapy or the central idea that insight into one's unconscious motives, fears, and conflicts was essential for improvement. The changes in theory did, however, lead to significant change in the view of which psychological issues were central to the patient's problems and therefore to the process of psychotherapy.

During the earliest phases of his thinking, Freud believed that any memory or experience could and would be repressed if it led to high levels of guilt, shame, or anxiety. After he abandoned hypnosis as a therapeutic technique, he revised his theory to one that historically has been named the "seduction theory." This referred to the idea that repression and symptoms resulted from memories of childhood sexual abuse. Abashed by the idea that so many patients could have suffered this type of victimization, and perhaps also by issues he discovered in his own self-analysis, Freud abandoned this theory by the time of his publication of *The Interpretation of Dreams* in 1900. He replaced this theory with the one that became standard in Freudian psychoanalytic thinking and practice for most of its history: that being the idea that neurosis was caused by childhood wishes of a sexual and aggressive nature that led to the famous (or infamous) Oedipus complex. This, in the psychoanalytic view, was the central complex around which all subsequent psychological development and psychopathology were built. The Oedipus complex is a period in the child's early life during which his or her infantile sexual and aggressive wishes toward both parents become so intense and frightening that all are repressed, allowing the child to move into a safer and calmer phase that is known as the Latency stage. However, due to any number of factors that remained unclear to Freud and his followers, these issues could arise during adult life. Symptoms arose as the unconscious psychological response necessary to keep the earlier repressions in place, and thus to avoid the guilt, shame, and fear that would be felt if these wishes were to become conscious. As the patient became aware of these wishes and conflicts through treatment, he or she became able to admit

to them and to let them go, resulting in lessened need for repression and for the symptoms that eventuated from that repression.

Ego Psychology and the Analysis of Character: "Where Id Was, Shall Ego Be"

In two late works published in the 1920s, Freud (1923, 1926) offered a major revision of psychoanalytic personality theory and of psychopathology that was to have a profound and lasting effect on psychoanalytic treatment. We refer here to the monographs *The Ego and the Id* (Freud, 1923) and *Inhibitions, Symptoms, and Anxiety* (Freud, 1926). In the former work Freud introduces his now familiar tripartite structural theory of the mind: the id, ego, and superego. In the latter volume he put forward his final theory of anxiety and of its role in the formation of psychological symptoms.

The introduction of the structural theory expanded the perspective from which the analyst could listen to the patient's associations, and for the first time it allowed the analyst to explore the patient's relationships with the real world as well as with unconscious motivation and conflict. Freud's introduction of the superego, which is composed of one's conscience and of one's aspirations, conscious and unconscious, opened psychoanalysis to consider how these moral and ethical issues contributed to the patient's difficulties and symptoms. Freud's revised theory of anxiety completely turned around the psychoanalytic understanding of its role in symptom formation and its use in psychotherapy. Neurotic anxiety was now understood to be the source of unconscious efforts at repression and defense, rather than the result of these processes. Anxiety resulted from and was a signal of conflicts between the hypothesized structures of the mind (id and ego, or id and superego) and was the trigger for the many defense mechanisms at the disposal of the ego.

Clinical psychoanalysis was then transformed from a therapy focused on making the patient aware of unconscious wishes and fantasies to one in which the goal was a much more complete and complex understanding of the patient's entire personality, including the ways he or she responded to anxiety by defending against the unconscious material that caused that anxiety. The analysis of defense mechanisms, issues of morality that lead to guilt (in Freud's terms, "moral anxiety"), and patients' self-perceived failures to be the person they wished to be all became crucial parts of the psychoanalytic process. In particular, the analysis of resistance and of transference were expanded significantly, as the aspects of these phenomena that originated in the ego or the superego were now included. This meant that patient and analyst continued to explore the wishful, desire-based aspects of these two clinical phenomena, but now added much more intensive and extensive consideration of the anxieties, defenses, ethical concerns, and adaptive capacities that were expressed in resistance and transference as well. As the ego psychological approach was incorporated into psychoanalytic technique and method, a subtle but important reduction in its emphasis on insight as a direct and central change factor emerged. Most analysts (perhaps with the exception of the British object relations school, which will be discussed in the next section) realized that interpretation of unconscious wishes and fantasies did not lead to change if the anxieties and defenses caused by those desires were not addressed first. As a result, analysis and interpretation of resistance, anxiety, and defense became as or more important than analysis of wish or drive, and this ego-oriented work was considered to be the necessary predecessor to exploration of unconscious motivation.

This reorientation of psychoanalytic technique was encouraged particularly by the work of several authors whose seminal contributions remain foundational readings for most psychoanalysts even today. These authors were responding to the theoretical expansions that we have discussed but also to a growing realization within the psychoanalytic community that the success of psychoanalytic therapy up to that point was much more limited than had been hoped for and expected. Certain leaders offered new hope: Perhaps the new focus on anxiety, adaptation, and resistance might lead to improvement in treatment.

The first of these contributions was Anna Freud's (1895–1982), *The Ego and the Mechanisms of Defense* (A. Freud, 1936), which appeared in print in German in 1926. In this volume the author offered the first comprehensive list of defense mechanisms, providing psychoanalysts with a clear, usable guide to recognizing the subtle and sophisticated ways in which patients avoided awareness of their unconscious wishes, conflicts, anxiety, and guilt. As a clinical guide to the newly expanded and much more complicated process of psychotherapy, it was indispensible.

The second text that was responsible for promoting these developments was Wilhelm Reich's (1897–1957) work, *Character Analysis* (1933/45), in which, for the first time, the attention of the psychoanalytic world was turned to the clinical impact of the more permanent aspects of personality, namely unconscious character traits. Reich had observed repeatedly that certain unconscious attitudes on the part of the patient, such as passivity, haughtiness, or contempt, when directed regularly at the analyst and at the work of psychoanalysis, prevented the patient from making use of interpretation and insight. It was as if, he stated, patients were sneering at their analyst, or refusing to take psychological action on the analyst's insights.

Reich pointed out that these character traits seemed to derive from defense mechanisms, yet they no longer were used simply when anxiety was present but had become permanent, if unwitting, parts of the patient's personality. He argued emphatically that such character defenses became impenetrable resistances during treatment and had to be confronted by the analyst before any other work could be accomplished. These ideas and technical prescriptions opened the door to the regular inclusion of character analysis within psychoanalytic treatment and to the understanding that the analyst's observations of the subtleties of the patient's manner of relating and participating were crucial sources of data. Without directly explicating these ideas, Reich's concerns with these issues of character led the way toward an expanded view of what factors were curative in psychoanalytic therapy.

By the 1930s, ego psychology established itself as the dominant psychoanalytic approach, a position it held until the 1970s. But, as we will see, other variants of psychoanalysis were developing alongside it during this period, and they too were to have lasting impact.

British Object Relations Approaches

Competitor to the hegemony of ego psychology were the approaches developed by such figures as Melanie Klein (1882–1960), W. R. D. Fairbairn (1889–1964), and D. W. Winnicott (1896–1971). These British psychoanalysts located the origins of psychopathology in the internal relationships that are established during infancy and childhood, and that unconsciously dominate and distort the adult patients' view of their interpersonal interactions. These "internal objects" usually are harsh, rejecting, demanding, or intruding, and their unconscious influences cause the person much unnecessary fear, anger, and distress when they color and shape his or her conscious interpersonal perceptions.

Klein, Fairbairn, and Winnicott differed in their opinions about the origins of these early representations of others and in their clinical approaches to these phenomena. Klein (1932) believed that infants are possessed of an extraordinarily well-developed phantasy life, in which they see themselves at the center of an aggressive, destructive world, and in which their mother can be engulfing, violent, or in turn damaged or destroyed by the child's hunger, envy, and hatred. These phantasies give rise to extreme anxiety, guilt, and rage, and to complicated defensive mechanisms through which the child attempts to save or heal himself or herself and the mother from the impact of these urges. In later life, to the degree that these phantasies are active for an adult, they will influence her or his perception of ongoing relationships, causing excessive levels of anxiety and defensiveness.

Kleinian analysts gave little weight to real experience as an influence on psychological development or on psychopathology. Their version of psychotherapy was devoted exclusively to the exploration and interpretation of these early object relations phantasies, especially as they were unconsciously manifested in the transference relationship with the analyst. They assumed that, as patients gained insight into these early unconscious representations of others, they would be able to jettison them and to live in a more mature and conscious manner.

Fairbairn and Winnicott also based their theories and methods upon understanding and utilizing childhood images of the self in relation to others. However, they differed significantly from Klein by asserting that these unconscious internal object relationships were derived from, and were reflections of, real childhood experiences. Both found that a healthy personality derived from secure and satisfying experiences with parents, and that such failures of parenting as excessive criticism, rejection, or intrusiveness caused weaknesses in the developing self of the child, and left their marks as internal images of others as unavailable or hurtful. Fairbairn's version of psychotherapy was very similar to traditional psychoanalysis, as he thought that insight into these issues, usually obtained through interpretation,

would lead to mature revision of patients' view of themselves and of others. Winnicott offered a radical revision of psychodynamic technique. He saw the therapeutic relationship as a space in which the patient could regress to infancy or childhood, and thus experience a kind of reparenting. Through this, psychological healing could take place, which would then result in a strengthened self and more benign and mature images of other people. In his view, insight, while important, took a secondary position.

Interpersonal Psychoanalysis: Incorporating the Family, Society, and Culture

"Interpersonal psychoanalysis" is a term coined by psychoanalyst Clara Thompson (1893–1958) (1950) to describe the collective efforts of Harry Stack Sullivan (1892–1949), Karen Horney (1885–1952), and Erich Fromm (1900–1980) and their students and colleagues. These psychoanalytic innovators, whose activities stretched from the 1920s through the 1970s, developed extensions and revisions of psychoanalytic theory and technique that emphasized the role of real experiences and interpersonal interaction in the causation of psychopathology and, therefore, in the treatment of psychological distress and illness.

Although it is unlikely that any of the founders of this branch of psychoanalysis were aware of the work of Fairbairn or Winnicott, or vice versa, from an historical perspective we can accurately point out the similarity and overlap between the findings among these British object relations theorists and their American interpersonal counterparts. Both groups placed early relationships between mother and child at the center of psychological development and, in the clinical setting, emphasized the exploration and understanding of the ongoing effects of those experiences. Another important theorist whose work is related to both of these schools is John Bowlby (1907–1990), the originator of attachment theory and its associated version of psychoanalytic therapy. Bowlby also placed greatest emphasis on the child's early interpersonal experiences as the source of later psychopathology. He suggested that the child encoded developmental trauma as "internal working models" that colored, shaped, and distorted adult perceptions of intimate relationships.

There were certain important differences between these psychoanalytic approaches. Some of the differences between the two schools were linguistic. The British writers saw themselves as working within the tradition of European psychoanalysis and, while introducing many new concepts, wrote using the accepted psychoanalytic vocabulary of the day. The interpersonalists perceived themselves to be outside the tradition of the Freudian world (Fromm, for example, identified himself as a member of the "loyal opposition to Freud") and wrote using novel concepts and terminology. Other critical differences existed in the psychotherapeutic methods that were endorsed by the two schools. As described earlier, Fairbairn worked in a very traditional psychoanalytic way, emphasizing interpretation of unconscious processes and analyzing the transference neurosis, which was assumed to be organized around the central concepts and issues with which the patient was unconsciously preoccupied. In contrast, interpersonal psychoanalysis emphasized the immediate ongoing clinical interaction as a central source of data and as the vehicle for psychological change. Sullivan described the role of the therapist as a "participant-observer": one who attempts to understand the patient's psychology while at the same time understanding that the therapist inevitably has an impact, for better or worse, on the patient. The therapist could be drawn into unwittingly replicating the kind of experience that contributed to the patient's problems, therefore reinforcing them, or he or she could interact in new and positive ways that could lead to new interpersonal perceptions and to change. We can see here that this group saw the potential for change in both insight and understanding, and in the corrective emotional experience that will be described later.

Sullivan, Horney, and Fromm understood anxiety and interpersonal insecurity to be the central dynamic factors in mental illness, and they emphasized anxiety's social nature and roots: It is other people, they claimed, who are responsible for our well- or ill-being, rather than our drives, wishes, or fantasies. If young children are exposed to excessive levels of hostility, rejection, criticism, neglect, or emotional coldness, they will grow up with what Horney described as "basic anxiety" and will see most new interpersonal relationships as potential dangers and sources of the same damage and injury. As a result, as an adult, the person avoids or compromises relationships where intimacy might be possible and, in Sullivan's terms, sacrifices those satisfactions that can accrue from close personal relations in favor of distance and

security. However, there is a price to be paid for these choices, as one's need for adult satisfactions does not disappear and may result in the familiar forms and symptoms of psychopathology.

The founders of interpersonal psychoanalysis did not produce a unified method of psychotherapy, and one does not exist today. Horney, Fromm, and Sullivan all were clinical innovators and mavericks who were impatient with the status quo and who were eager to improvise and experiment with new techniques and interventions that might improve the effectiveness of psychoanalytic psychotherapy. However, it is important, and it is possible, to identify commonalties in their approaches that made an historical impact and that are influential today.

As might be assumed from theories that emphasize social anxiety, these thinkers concurred in the belief that the therapy relationship must be one in which the patient experienced safety and freedom from anxiety. This required an acute sensitivity on the therapists' part, coupled with their understanding of the way they might cause the patient anxiety by behaving in a manner that could be seen as similar to a figure from the patient's past. Unlike the Freudian or British object relations approaches, in this therapeutic approach, analysis of the transference was not seen as sufficient. Therapists had to demonstrate to the patient that they were different from the patient's significant others. As Sullivan pointed out, the patient's experience of that difference, rather than understanding of it, was crucial in allowing the patient to let go of his or her fearful perceptions of other people and to replace them with more secure and optimistic ideas and images.

The security of the therapeutic relationship also was necessary to allow the therapist to gradually but honestly confront the patient with the latter's security operations and destructive character traits. These are methods of avoiding anxiety and of obtaining satisfactions that substituted for healthy intimacy and authentic self-expression. An example of the former might be becoming angry and aggressive when feeling insecure, while an example of the latter is an enduring sense of self-importance that is exaggerated and not based on real achievements or abilities. These problematic behaviors were understood to have been ways of coping with anxiety that worked for patients as they grew up, but that have destructive impact on their present life. Interpretation and understanding of these issues was not considered to be sufficient to change them. Instead, within the context of security established between patient and therapist, they had to be noted, examined, and their impact had to be experienced by the patient in order for him or her to consider giving them up.

Interpersonal psychoanalysis has remained a robust and active segment of the psychoanalytic world, though since the deaths of its founders there has not emerged a single unifying version of its theory or method. Sullivan, Fromm, and Horney all were concerned with the ways families and societies stifle individual growth and development by communicating insecurity and disapproval, and an ongoing concern with these issues, and with clinical methods for correcting and alleviating them, are typical of contemporary interpersonal psychoanalysis. Many scholars and clinicians have made important contributions in this area. Among the more current and influential are such writers as Wolstein, Levenson, Bromberg, and Stern, all of whom have advanced our awareness of the sources of personal suffering and of the ways in which an analyst can actively and effectively participate in the therapeutic process to alleviate that suffering.

Self Psychology: Solving the Riddle of Narcissism

Self psychology was largely the creation of one psychoanalyst, Heinz Kohut (1913–1981), though his contributions in this area eventually brought to him and to his theory a large number of gifted collaborators and followers. Although Kohut originally described self psychology as an outgrowth and extension of Freudian ego psychology, it became apparent to the psychoanalytic world, and to him, that this approach was a radical departure from its predecessors.

Self psychology is, in fact, radically different in theory and in psychotherapeutic methods from any extant version of psychoanalysis past or present. If it resembles any other school of thought in the community of psychotherapy, it might be person-centered psychotherapy (Carl Rogers), a comparison that has been made, usually critically, by many in the traditional psychoanalytic fold.

Kohut's approach grew out of his interest in treating narcissistic disorders, or disorders of the self. By the 1970s when this approach was introduced, these disorders had become increasingly prominent in the practices of psychoanalysts and psychotherapists,

with most clinicians finding little success in treating them. Many therapists found themselves in agreement with Freud (1914), who, in his seminal paper, *On Narcissism*, concluded that patients with this disorder could not be treated because their preoccupation with themselves, and lack of attachment to others, prevented them from attaching to the psychoanalyst in a meaningful and clinically useful way. In Freud's view, narcissistic pathology prevented the development of the necessary transference neurosis.

The history of self psychology includes a paper by Kohut that is of equal significance to its development as was *On Narcissism* to classical psychoanalysis. This paper was *The Two Analyses of Mr. Z*, a case study in which Kohut (1979) described his two successive treatments of the same patient, first done according to the tenets of Freudian ego psychology, and the second following the emerging concepts and methods of what was to become self psychology. In this second analysis, Kohut discovered that narcissistic patients did, in fact, develop transferences to the analyst, but not of the type known conventionally. Instead, he described "self-object" transferences that were typical of the narcissistic patient. "Self-object" refers to a relationship in which Person A (a baby or patient) requires Person B (a mother or psychoanalyst) to provide a psychological function for Person A because Person A cannot provide that function for himself or herself. In this paper, and in his later writings, Kohut described three such self-object experiences that he concluded were crucial in the development of a healthy self, and that were the basis of the psychoanalytic treatment of narcissistic pathology. These were the mirroring self-object function, the idealizing self-object function, and the twinning, or alter-ego self-object function.

Mirroring refers to the empathically based reflection of the baby's experiences and vitality by a mother or father who is willing and able to suspend her or his individuality to provide this function. Idealizing is defined as being seen as a glorified, perfected version of oneself, in order that the child can identify with the strengths and values of that self-object. The twinning or alter-ego self object is experienced by a child when he or she perceives a peer as identical, allowing for consolidation of identity. Healthy and consistent self-object experiences during infancy and childhood led to the development of a coherent, vital, goal-directed self and a confident sense of identity.

Kohut posited that failures in early self-object experiences were the direct cause of narcissistic deficits in later life, and crucially, that these early failures or deficits had to be repaired and remedied in the psychoanalytic relationship. He suggested that narcissistic patients bring to their treatment their unconscious needs for mirroring, idealization, or twinship, and that the analyst can, through consistent provision of those self-object functions, create a healing situation in which the patient's self can become whole, thus resolving his or her narcissistic pathology.

Kohut also stressed the fact that failures of self-object functioning on the part of the analyst could be made use of in critically positive ways during treatment. He found that the analyst's willingness to acknowledge his or her failures of empathy, or failures in satisfying the patient's needs to be mirrored, to idealize, or to twin, could repair significantly these breaches and lead to strengthening of the patient's self through a process that he labeled "transmuting internalization."

As might be gathered from this discussion, self psychologists seem to put much more emphasis on what happens in psychoanalysis than what is discussed. This suggests strongly that this group relies much more heavily on the corrective experience provided by psychoanalytic therapy, and less so on the traditional change process of insight.

Relational Psychoanalysis

A final theoretical development that brings us well into the modern era of psychodynamic psychotherapy is relational psychoanalysis. This is an integrative model that at its core is concerned with exploring, understanding, and changing the patient's problematic patterns of perceiving and participating in intimate relationships. Largely a product of the work of Stephen Mitchell (1946–2000), Jay Greenberg, and their colleagues, the theory is an attempt to synthesize concepts and methods from all of the theories that we have described earlier. These writers hoped to develop a comprehensive and inclusive psychodynamic theory of relationships and, out of this, to broaden and deepen the effectiveness of psychodynamic therapy. They suggested that such a comprehensive theory would allow therapists to tailor their

approach to the unique needs of each patient and to avail themselves of all of the change factors that had been described by these earlier theorists. The relational model assumes that all psychoanalytic theories are plausible and have potential to explain an individual's psychological development, but that each theory is only applicable to certain persons, and not to all. Therefore, it is the relational therapist's job to figure out which psychoanalytic perspective might be most helpful for each patient, or which combination of theories is most suitable, and to use that particular model to guide the therapy.

THEORY OF CHANGE

As psychoanalysis and psychodynamic psychotherapy have evolved, so too have the theories of change that inform clinical work within these frameworks, expanding from a relatively limited view of the potential change processes to a more varied and extensive list. The earliest versions of these therapies depended exclusively on the processes of abreaction and catharsis, with abreaction referring to the conscious experience and release of previously repressed emotions, wishes, and memories, and catharsis referring to the psychological relief and reduction in tension and conflict that was produced by abreaction. When the earliest versions of traditional psychoanalytic technique emerged and were standardized in the first decade of the 20th century, it became clear to Freud and his colleagues that abreaction and catharsis were themselves by-products of another crucial, if not the central change process, that of insight. Insight in psychoanalysis refers to the enhanced and deepened understanding of one's unconscious conflicts, defenses, and wishes; the increased awareness of these processes; and of expanded access to, and experience of, the emotional consequences of these factors. As described earlier, insight usually follows an interpretation that is offered by the analyst, though the spontaneous achievement of insight by the patient as he or she associates is not uncommon in psychoanalytic therapy.

As psychoanalytic theory developed through the 1920s, 1930s, and 1940s, so did its clinical theory of change. The advances of the structural theory of id, ego, and superego allowed analysts to consider additional sources of change beyond insight. Strachey (1934) suggested that modification of the superego, through ongoing contact with the analyst, was as or more important than achieving insight. He reported that many psychological symptoms were caused by excessive unconscious guilt that resulted from an overly strict and punitive conscience and/or by the patient's unwitting attempts to live up to unrealistic and unachievable personal standards. Strachey concluded that the benign, accepting presence of the analyst allowed the patient to tone down his or her cruelly childish, moralistic, ethical demands and to replace them with more mature and realistic internal guidelines, thus lessening his or her guilt, shame, and anxiety that were the end products of natural and harmless wishes and memories.

A related argument for the interactional basis of change in psychodynamic psychotherapy was introduced specifically and controversially by Franz Alexander and Thomas French (1946) in their book, *Psychoanalytic Therapy*. These authors argued that while insight into unconscious processes sometimes did lead to change, this causal relationship was not as frequent or as powerful as assumed. In fact, they argued further that often change led to insight, reporting that patients frequently attained new understanding of themselves and greater awareness of their psychodynamics after something unexpected and powerfully emotional occurred in a therapy session. Their explanation of these events was as follows. If patients' unconscious, transference-based expectations of the analyst were disconfirmed by the analyst's actual behavior, then patients could experience themselves differently, take new action, and only then might attain insight into the anxieties and defenses that had been operating.

Alexander and French dubbed these interactions the "corrective emotional experience" and elaborated a variety of ways that the analyst, taking into account the patient's history and potential conflicts and transferences, could plan to include these experiences in the therapy. While such contrived interactions did not become a generally accepted part of psychoanalytic treatment, the idea that new interactions, inside and outside of therapy, were as or more important than insight did take hold, both within ego psychology and in other schools.

Another important modification of the psychoanalytic theory of change resulted from the work of certain analysts who found that many forms of psychopathology were the result of developmentally based deficits in personality structure, rather

than of intrapsychic conflict. Of this group, the ideas of Winnicott and Kohut are most prominent. These writers pointed out that many patients came to treatment suffering from a lack of vitality and of psychological completion, rather than from neurotic symptoms. This group of patients was much more vulnerable to the everyday stresses and strains of life and, in particular, demonstrated little ability to soothe themselves or to regulate their emotional reactions when even mildly hurt or angered. Winnicott, Kohut, and their followers concluded that these problems were the results of early psychological injury, and that the treatment for them required actual repair through the therapeutic interaction, rather than expanded access to unconscious material. This repair was accomplished by providing patients with those developmental experiences of which they had been deprived, in the hope that their psychological development would then progress, and that the significant intrapsychic deficits would be filled in or compensated for in adaptive ways. We have described earlier the ways in which Kohut and the self psychologists did so. Winnicott and those he influenced argued that a process of "holding," in which the analytic environment became a type of psychological cocoon, was the critical factor in achieving healthy change.

This emphasis on new experience in the therapeutic interaction and, additionally, in the patient's life outside of therapy as central change variables also was present in the interpersonal and relational psychoanalytic perspectives described earlier and in the version of psychodynamic psychotherapy that emerged from Bowlby's work on attachment theory. Implicit in interpersonal models, and entirely explicit in Bowlby's description of psychotherapy, is the idea that the therapeutic relationship becomes a safe haven to return to when the outside world becomes threatening and difficult, and a "secure base" from which to explore that world. The reliable presence of the therapist, to whom patients may become safely and comfortably attached, becomes a kernel of new interpersonal prototypes, allowing patients to examine and perhaps revise the anxiety-generating images of others that resulted from childhood experiences in their family. In these therapies we can observe the necessity for insight, on the one hand, and corrective experiences, on the other, and the way in which each promotes the other. New experiences allow the patient to understand his or her past and its effect on the present, and understanding of the present guides both parties in the therapeutic relationship toward those experiences, in and out of therapy, that will promote growth.

More contemporary versions of interpersonal psychoanalysis and relational psychoanalysis (Mitchell, 1988) have focused on one aspect of the therapeutic relationship as a crucial change factor, that being the identification of and undoing of unconscious interpersonal enactments. An enactment is understood to be an unconsciously motivated repetition of a past or ongoing pattern of relating to others within the therapeutic situation, with the therapist actively but unknowingly participating in this repetition. For example, a patient whose depression was caused in part by excessive criticism on the part of a parent may behave in ways that elicit impatience or criticism by the therapist. Enactments that are undetected and unresolved probably are the source of many therapeutic stalemates and failures (Gold & Stricker, 2011), but if identified and correctly responded to, they can lead both to insight and enhanced self-awareness, to new interpersonal skills, and to corrective experiences in and out of therapy. This is accomplished when the therapist recognizes that an enactment has occurred and initiates the exploration of that pattern of relating, including behaving in a way different than the old pattern would yield.

Implicit in these views of change are other change factors that are well known to psychotherapists outside of the psychodynamic world. The first of these is the change factor of exposure. As patients face the internal processes that give rise to their conflicts, they are unwittingly but powerfully engaging in a process of desensitization, as repeated exposure to these issues allows extinction of the emotional consequences to occur. The second implicit change factor has been mentioned briefly but should be emphasized here, and that is the opportunity to observe and to practice new skills. A great deal of modeling and observational learning take place in psychodynamic therapy, and the patient has the opportunity to internalize and to try out new ways of thinking, feeling, and acting within a safe and accepting relationship. Finally, the well-known relationship factors of prizing, warmth, and unconditional positive regard, as described first by Rogers (1957), are operating as well, though for a long time in the history of this approach they were unacknowledged. By the 1970s psychodynamic authors had begun to integrate these concepts into their work, and they

are commonplace and uncontroversial in current psychodynamic thinking.

RESEARCH ON THE EFFICACY AND EFFECTIVENESS OF PSYCHODYNAMIC PSYCHOTHERAPY

The efficacy and effectiveness of psychodynamic psychotherapy have only recently been investigated to any significant and useful extent. Freud himself discouraged empirical investigations of the clinical impact of psychoanalysis, suggesting that each case was unique and that scientific investigations of the treatment would miss or obscure the individual effects on each patient's functioning. For most of its history, psychodynamic psychotherapy has been a long-term approach that has been conducted in the offices of private practitioners, meaning that most of the necessities of good research (control groups, random assignment of cases, unbiased researchers, sufficient numbers of therapists and patients) were difficult, if not impossible to obtain.

In a review of the research on the outcome of psychodynamic therapy that covers the time period up to the mid-1970s, Fisher and Greenberg (1977) found 10 studies that attempted to evaluate the effectiveness of this approach. Six of these studies were small-scale and naturalistic reports, wherein one therapist reviewed his or her cases and attempted to ascertain what rate of improvement had occurred. In these studies, psychoanalysis or psychodynamic psychotherapy was compared to no treatment at all. Not surprisingly, the treatments were found to lead to more improvement than did the absence of any intervention.

Fisher and Greenberg's review identified four large-scale studies that had evaluated the effectiveness of long-term psychodynamic therapy. Of these, the Menninger Foundation Psychotherapy Research Project is the most well known and well documented (Kernberg, 1972). This project followed 42 patients to the completion of their treatment. Twenty-two of the patients were in psychoanalysis, and 20 were in psychodynamic psychotherapy. The investigators found equivalent improvement rates of about 60% in each group.

The results of this study are consistent with the three other such large-scale projects, conducted at the Columbia Psychoanalytic Center, the New York Psychoanalytic Institute, and the Boston Psychoanalytic Institute, each of which demonstrated that psychoanalysis and intensive psychodynamic psychotherapy are effective more than 60% of the time (Bachrach, Galatzer-Levy, Skolnikoff, & Waltzer, 1991). However, all of these studies have been repeatedly criticized for multiple errors in their research design, statistical analyses, and interpretation.

In a more recent review of the literature, Wolitzky (2003) reported that only in the 1990s had this situation changed for the better, mentioning that approximately 80 new outcome studies had been reported, though again most were naturalistic in nature, lacking control groups and randomized assignment of patients. Wolitzky (2003) saw the findings of these studies as "promising," based on his observation that most of these studies yielded positive results for the effectiveness of psychoanalytically based therapies.

In the decade or so since Wolitzky was writing, the number of empirically sound studies of psychodynamic therapy has increased significantly. In a widely cited and influential paper, Shedler (2010) found six meta-analyses of the effectiveness of psychodynamic therapy that had been published in the first decade of this century. Four of these were based on studies of the effectiveness of short-term psychodynamic therapy (fewer than 50 sessions, or less than 1 year in duration) and two were meta-analyses of long-term treatment. All six of these studies concluded that psychodynamic therapies lead to significant clinical improvement that is at least equivalent to cognitive-behavioral and other approaches, with substantial effect sizes. Support for the efficacy and effectiveness of these approaches has continued to accrue since the publication of this article, but these findings will be reviewed in the next chapter (Betan & Binder, Chapter 4, this volume).

Recent studies of the efficacy of psychodynamic psychotherapy with a variety of populations have yielded encouraging positive results. We will mention briefly a few outstanding examples of this work. Milrod and colleagues (Milrod et al., 2007) conducted a randomized clinical trial of short-term psychodynamic psychotherapy for panic disorder, comparing it with standard behavior therapy. They found much greater improvement in the group that received the psychodynamic therapy. Bateman and Fonagy (2009) demonstrated that psychoanalytically oriented psychotherapy was superior to clinical management in a 19-month

treatment of borderline personality disorder. Driessen and colleagues (Driessen et al., 2007, 2013) compared psychodynamic treatment and cognitive-behavioral therapy in the treatment of major depression, and found equivalent remission rates for both types of psychotherapy. Leichsenring and colleagues (Leichsenring et al., 2014) reported on the long-term outcome of cognitive-behavioral therapy and psychodynamic therapy for social anxiety disorder in a sample of over 400 patients. Patients were assessed 6, 12, and 24 months after treatment was completed. The authors found equal effects for both approaches, with favorable treatment effects of approximately 70%.

ISSUES OF DIVERSITY

Psychodynamic approaches historically have done a poor job of addressing issues such as patient's age, racial background, gender identity, sexual orientation, national origin, and other important social and cultural issues. This is due to several factors. Psychoanalytic theory is structured around the principle of psychic determinism: the idea that all significant behavioral issues are reflective of, and are caused by, intrapsychic factors. Additionally, the theory has had a biological emphasis as well, stemming from Freud's training and experience as a neurologist, and from the medical backgrounds of many of the practitioners of psychoanalysis for most of its history. Additionally, psychodynamic thinking emerged during an historical phase of ethnocentrism and within a strictly middle-class and upper-middle-class context, and psychoanalysis was perceived by its founders as a treatment for this segment of society. A few members of the psychoanalytic community attempted to introduce anthropological and sociological perspectives that would complement the biological/medical approach, but these contributions were ignored by the majority of psychodynamic theorists.

Psychodynamic therapy originally was seen as a treatment for adults. However, by the 1920s, innovators such as Melanie Klein and Anna Freud had expanded its range to include children and adolescents. These therapists recognized that the technique of free association was not appropriate in working with children, and substituted free play in therapy sessions, assuming that this behavior would allow the child's unconscious issues to be demonstrated and thus subject to interpretation.

Psychoanalysts paid little attention to issues of race, national origin, or socioeconomic status during most of the history of the discipline, other than to use these variables as criteria for excluding patients from treatment because of the negative effects of these factors on the patient's "ego strength" and ability to handle the stress of intensive psychotherapy. Certainly, mainstream psychodynamic thinking did not take these issues into account as important factors in patients' psychological development or as contributors to their psychopathology. The individual meaning and impact of one's race, economic situation, gender, or place of origin were, if addressed at all, seen as reflective of deeper unconscious concerns, and therefore of little importance on their own.

Similarly, little attention was paid to cultural or environmental factors in understanding gender identity or sexual orientation. These issues were construed as expressions of universal and unvarying biological trends, or as expressions of developmental arrests, regression, and neurotic conflict. As a result, psychoanalysis tragically contributed to, and often worsened, the suffering of female patients and of gay and lesbian patients, whose discomfort with traditional gender roles or whose sexual orientation was diagnosed as abnormal and as symptoms of underlying intrapsychic disturbances. Women who were saddened, anxious, or angry about their limited choices found little support in most psychodynamic therapies, and instead were told that they were repressing their unresolved Oedipal conflicts. The same-sex preferences of gay and lesbian patients were interpreted as symptoms to be eliminated through treatment, leaving most of these patients feeling ashamed and guilty about their "failures" as patients, and of their "immature" and inappropriate desires. These perspectives dominated psychoanalytic thinking through the 1970s (Socarides, 1978).

There are some important exceptions to these traditional, limited views. Analysts such as Helene Deutsch and Karen Horney offered alternative, culturally based views of the development of gender identity and of women's psychological development. Their theories took into account the effects of the social restrictions with which women were faced upon their unconscious conflicts and anxieties. This foundational work was expanded in the 1960s and 1970s by female analysts such as Juliet Mitchell and Jean Baker Miller, whose thinking and clinical models were influenced by the newly emerging

feminist movement. Their work placed female psychology largely within a cultural context and addressed the ways in which women (and men) are socialized into gender-specific roles that, in turn, give rise to particular unconscious issues and to anxieties, conflicts, and symptoms.

The interpersonal group of psychoanalysts, headed by Horney, Sullivan, and Fromm, were specifically interested in the effects of culture, society, economics, and politics on psychological health and development. For example, early in his career Sullivan traveled to the American South to study the effects of racism and poverty on the psychology of Black children. Fromm began his career by integrating his training in Freudian psychoanalysis with his academic background in sociology and Marxist political thought, and produced a number of brilliant studies of the impact of nationalism, economics, and social structure and social conditions on unconscious mental life and psychopathology, including such diverse societies as Nazi Germany, mid-century America, and rural Mexico.

Horney also was one of the few psychoanalysts to recognize that the anxiety and poor self-esteem experienced by her gay and lesbian patients were a reflection and an internalization of the prejudice and hostility directed at those persons by an unaccepting society, rather than a sign of the inherent abnormality of their sexual orientation. Related contributions to a more culturally sensitive psychodynamic perspective came from such writers as John Dollard (1937) and Frantz Fanon (1952), who studied the effects of race, class, and prejudice on the psychodynamic of American Blacks and on natives of Algeria. Dollard's work was exclusively observational, but Fanon was a practicing psychoanalyst who used his theories to guide psychodynamic psychotherapy in a more culturally and racially sensitive way. However, outside of these contributions, psychodynamic psychotherapy has been sadly silent about these issues until the most recent two decades of its history.

CONCLUSIONS/KEY POINTS

- Psychoanalysis originated as a treatment for hysteria and developed into a broader approach to psychopathology and psychotherapy.
- There exist a number of variants of psychodynamic psychotherapy, but all share an emphasis on the role of early development in the etiology of psychopathology and a focus on unconscious processes.
- The theory of change in psychoanalysis and psychodynamic psychotherapy evolved from an exclusive focus on insight to include an understanding of the importance of new experience and learning in producing change.
- Although current attempts to empirically validate the efficacy and effectiveness of this model are promising, the history of psychoanalysis and psychodynamic psychotherapy is lacking in this area.
- Until recently, psychodynamic psychotherapy did not incorporate a sufficient understanding of diversity and of individual differences.

REVIEW QUESTIONS

1. Describe the differences between the "seduction theory" of psychopathology and Freud's later view of psychopathology.
2. How did ego psychology modify the traditional psychoanalytic approach?
3. Describe the evolution of the theory of change in this model.
4. Describe the central differences between the Freudian approach and the object relations and interpersonal approaches.
5. Describe the strengths and limitations of this model as applied historically to issues of diversity.

RESOURCES

We recommend the following as valuable materials for the reader who wishes to explore these topics in more depth.

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Mitchell, S., & Black, M. (1995). *Freud and beyond*. New York, NY: Basic Books.

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Websites

International Psychoanalytic Association: http:// www.ipa.org.uk

Division of Psychoanalysis (39), American Psychological Association: http://www.apadivisions.org/division-39

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4

Psychodynamic Therapies in Practice: Time-Limited Dynamic Psychotherapy

Ephi J. Betan
Jeffrey L. Binder

Abstract
Time-limited dynamic psychotherapy (TLDP) is a time-sensitive approach that is conceptually rooted in contemporary psychodynamic and relational theories and draws from interpersonal and cognitive techniques (Binder & Betan, 2012). Taking a predominantly relational focus, TLDP emphasizes how dysfunctional schemas and corresponding maladaptive interpersonal patterns contribute to and perpetuate disruptions in one's sense of self, psychological functioning, and quality of life. Accordingly, the TLDP therapist pays particular attention to recurrent themes and patterns in interpersonal experiences, while seeking to identify a patient's potentially maladaptive ways of construing and reacting in relationships. Through a process of inquiry and dialogue, the therapist and patient collaborate in constructing a meaningful narrative of the patient's predominant interpersonal concerns and ways of relating. This narrative provides a framework for both understanding the patient's psychological difficulties and identifying possibilities for change.

Keywords: psychodynamic psychotherapy, time-limited, cyclical maladaptive pattern, inquiry, dialogue

Time-limited dynamic psychotherapy (TLDP) evolved from a theoretically integrative approach that drew from object relations, interpersonal, systems, and cognitive theories and therapies (Strupp & Binder, 1984). Emerging from Strupp's pioneering psychotherapy research at Vanderbilt University, Strupp and Binder developed TLDP as a time-sensitive, psychodynamic therapy that emphasized a transference-focused technical strategy. By "time-sensitive," we mean that whether or not a specific duration or number of sessions is set for the treatment, the therapist engages in certain actions and maintains a certain set of assumptions: (1) The therapist formulates an explanatory hypothesis about the patient's presenting problems in terms of a circumscribed or "focal" interpersonal issue, which may have a long history dating back to early parent–child relationships. Specific therapeutic goals are derived from this circumscribed case formulation. (2) The therapist attempts to help the patient to achieve some therapeutic benefit in each session by staying consistently engaged and active in focusing on the focal interpersonal issue. (3) The therapist makes no assumptions about how long it will take to achieve the established therapeutic goals. (4) The therapist makes no assumptions about the extent of personal change that the patient can achieve in a given amount of time.

Strupp and Binder were strongly influenced by Gill's (1982) work on here-and-now transference, as well as Sullivan's (1953) interpersonal psychoanalysis. At the time, TLDP was one of the first brief

psychodynamic therapy approaches to use object relations and interpersonal theories as a framework for identifying a core focus for intervention. Previously, the early pioneers of brief dynamic therapy—notably Malan (1976), Sifneos (1972), and Davanloo (1978)—focused on identifying and interpreting core unconscious conflicts, which they conceptualized in the classical Freudian language of impulse and defense. They adapted the classic psychoanalytic technical strategy of linking transference enactments of a "core conflict" to early childhood experiences. In contrast, Strupp and Binder shifted the focus away from transference/parent-linking interpretations to understanding the patient's immediate interpersonal assumptions and expectations in the therapeutic relationship.

According to Strupp and Binder, psychological difficulties emerge as a result of an individual's tendency to unconsciously recapitulate maladaptive interpersonal patterns with others. Introducing the concept of "cyclical maladaptive pattern" (CMP), Strupp and Binder provided a framework for articulating an interpersonal pattern of expecting, unwittingly evoking, and then reacting to negative responses from others. Primarily focused on the therapeutic relationship, they articulated how the patient's interactions with the therapist express a fundamental interpersonal schema that unconsciously influences how the patient organizes and interprets experiences. As such, the patient unconsciously casts the therapist in the role of a significant other and perceives the therapist according to the patient's expectations. In TLDP, the treatment goals included gaining insight into the patient's maladaptive interpersonal patterns and providing a corrective interpersonal experience whereby therapists attempt to minimize the extent to which they respond in a manner that corresponds with a patient's negative expectations. In doing so, early TLDP made direct use of the therapeutic relationship to effect changes in patients' fundamentally maladaptive interpersonal patterns. Strupp and Binder's conception of the corrective interpersonal experience reflected their view that countertransference was inextricably intertwined with transference. Unlike the first generation of brief dynamic therapists, Strupp and Binder asserted that countertransference was an inevitable consequence of emotionally connecting with the patient, and identifying its influence could aid in therapeutic work.

Following Strupp and Binder's inaugural work on TLDP, Levenson (1995) summarized their approach and provided didactic guidance for its application and practice. She elaborated their focus on the patient–therapist relationship with even greater attention to the therapist's countertransference in understanding the patient's maladaptive interpersonal pattern. In doing so, Levenson stated that the most effective method for the therapist to track transference-countertransference vicissitudes is for the therapist to maintain consistent attunement to her personal reactions to what is transpiring in the patient–therapist relationship.

Whereas Levenson stayed close to TLDP's focus on transference-countertransference dynamics, Binder (2004) moved away from the strong emphasis on exploring the transference relationship. Instead, Binder focused more on how to actively discuss and effect change in a patient's current relationships. Based on contemporary empirical investigations of transference (Høglend et al., 2006), Binder proposed that work in the transference may be more salient with those patients who have significant difficulties getting along with others, marked by prominent mistrust and expectations of malevolence. With patients who have a poorer quality of relatedness, the therapist must focus more on the therapeutic interactions in order to foster a positive working alliance. This was the type of patient that TLDP was originally designed to treat. In contrast, those patients with relatively benign, although problematic, interpersonal experiences are more likely to have a basic sense of trust with the therapist. Consequently, the therapist and patient can collaborate more readily in examining the patient's most immediate concerns and interpersonal relationships.

Two further developments of the TLDP model have been recently introduced. Levenson (2010) has incorporated emotion-focused and experiential interventions into TLDP. In her experiential approach to TLDP, Levenson maintains the focus on the therapist–patient interactions and prioritizes attunement to a patient's moment-to-moment shifts in emotional experience.

Meanwhile, we (Binder & Betan, 2012) have focused on developing a narrative strategy for identifying a patient's *personal storyline*, the core of which is a maladaptive interpersonal pattern. We have continued to emphasize how those salient concerns that bring a patient to treatment manifest in repetitive

patterns of construing and reacting to the world. We have advanced an approach that seeks to construct an individualized, experience-near narrative of a patient's core assumptions about relationships and the consequently maladaptive ways of interacting. We also have articulated a process of therapeutic inquiry and dialogue to systematically examine patients' interpersonal narratives and increase patients' insight into how they may unwittingly perpetuate their psychological and relational difficulties by repeating maladaptive interpersonal patterns. From our perspective, the primary therapeutic goal involves helping patients break these maladaptive patterns of relating by noticing, understanding, and finding alternatives to how they make sense of and respond to their experiences.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION

Principles of Change

The fundamental goal of TLDP is to change ingrained patterns of interpersonal functioning in order to expand a patient's possibilities for more positive ways of relating to others and for expressing oneself. Key principles of change in TLDP involve (a) facilitating a patient's *insight* into repetitive, maladaptive relational patterns by encouraging a dialogue regarding emotionally salient concerns, (b) enhancing *reflective functioning*, (c) providing a *corrective interpersonal experience*, and (d) encouraging *practice* of alternative ways of perceiving and/or reacting to interpersonal experiences.

Insight

Insight involves helping patients become more aware of how, and why, they may unwittingly constrict possibilities for positive interactions by routinely reacting to new interpersonal situations as though these new relationships are inevitably bound to be the same as earlier painful relationships. As will be elaborated later (see "Treatment" section), insight is facilitated through a process of what we have termed *inquiry* and *dialogue*, involving cognitive and emotional exploration of how patients interact interpersonally and the consequences of their characteristic ways of interacting.

To effect change, our conversations with patients must touch on their most emotionally salient and pressing concerns. Such emotional resonance, where we reach deeply held and deeply felt beliefs, lends meaning to intellectual understanding, allowing shifts in self-regard and enduring modes of relating. In highlighting empathic understanding and resonance, we do not, however, necessarily prioritize emotional processing above cognitive work as the primary mode of intervention. There are key junctures in a therapy session where we determine which to pursue first: a more cognitive understanding of a patient's experiences or facilitating emotional expression. With either intervention, to have an impact, a therapist must be working with emotionally salient issues that resonate empathically with a patient's core suffering. Empathy is often misunderstood as focusing on what a person is feeling. Rather, empathy involves the capacity to put words to another person's experiences and ways of seeing and being in the world, words a patient may not yet have. Empathy depends on the therapist's capacity to step back, reflect on, and give meaning to another person's most salient experiences. These experiences are deeply felt, cognitive realities. We believe a patient's emotions need to be mobilized within the context of growing awareness of relational conflicts that result in maladaptive interpersonal patterns. To promote insight, any truly effective intervention addresses both thoughts and emotions in order to deepen a patient's understanding of core difficulties and promote change in one's sense of self and interpersonal functioning.

Reflective Functioning

Fonagy and colleagues have described *reflective functioning* as the capacity to recognize and make sense of mental states, in oneself and in others, in order to develop realistic appraisals of thoughts, feelings, desires, intentions, and motivations (Bouchard et al., 2008). Reflective functioning involves the ability to predict and explain behavior (social causality) and contributes to coherent and integrated mental representations of self and others (Fonagy & Target, 1996). Those with high capacities for reflective functioning are able to make inferences about one's own and others' behavior in terms of intentional and multidimensional thoughts, feelings, and motivations. The development of reflective functioning is dependent

on generally positive interpersonal and emotional experiences with significant caregivers in infancy and early life (Fonagy & Target, 1996).

Increasing the capacity for reflective functioning is a companion to increasing insight in TLDP. Increasing insight helps the patient recognize a repetitive, maladaptive interpersonal pattern. Fostering reflective functioning guides the patient in stepping back and thinking about what is occurring in an interaction. An individual's maladaptive interpersonal pattern is perpetuated, in part, by repeatedly interpreting others' behaviors and intentions in the same negative way—without considering that the other person may have other intentions and feelings. The focus on reflective functioning encourages patients to recognize their own and the other individual's state of mind in complex, multidimensional ways. In the case illustration that follows, the patient is locked into angrily experiencing her mother as critical and intrusive. When emotionally stirred, she displays some difficulty seeing that her mother may have intentions other than making her feel bad about herself. As her capacity for reflective functioning increases, she may come to recognize her mother's concern for her well-being and appreciate that she, herself, has conflicting feelings and thoughts about her mother (and others). Increasing her capacity to reflect on her own and others' internal states ultimately can help her short-circuit her reflexive negativity in order to develop new ways of experiencing and relating to others.

Corrective Interpersonal Experience

TLDP offers the potential for a *corrective interpersonal experience*, for it relies on establishing a healthy, productive therapeutic relationship and addressing concerns as they emerge. TLDP provides a safe arena for the patient to confront fearful expectations of others and create a different result with the therapist and others. It is vital that this therapeutic exploration occur in the context of a positive therapeutic relationship. The presence of an optimal therapeutic alliance is a basic change principle across psychotherapy approaches, and it is certainly highly influential in TLDP. In TLDP, the therapist facilitates the therapeutic alliance by displaying a keen and genuine interest in what the patient perceives in relationships. Doing so conveys empathy and also creates the potential for a different, more positive interpersonal experience with the therapist.

The potential for a corrective interpersonal experience also rests in the therapist's empathic understanding of the patient's mistrust of or disappointment in others, including the therapist. Working through periods of disagreement or discontent with the therapist not only preserves the therapeutic alliance (Safran, Muran, & Eubanks-Carter, 2011) but also provides the often new experience that a relationship can survive when the roots of disconnection are addressed. This work falls under the realm of transference/countertransference and becomes necessary to varying degrees depending on the patient's level of functioning. TLDP encourages attention to the here and now of the therapeutic relationship if salient interpersonal concerns emerge. Sustaining a positive relationship with the therapist, after working through discord, is a new interpersonal experience that can deepen a meaningful therapeutic dialogue and open up possibilities for change in the patient's ways of relating to self and others.

Practice

Change in patients' ways of relating comes with increasing self-reflection and insight into how they make sense of their interpersonal experiences, as well as experience with alternative ways of perceiving others and relating. For insight to contribute to change, however, it must be instantiated through substituting new ways of relating for old maladaptive interpersonal patterns. In TLDP, *practice* is a key strategy for transforming insight into productive action. Practice emerges naturally during the process of TLDP. For example, once a patient's maladaptive interpersonal pattern has been identified, the therapist encourages practice in helping the patient consider the possibility of doing something different. We encourage patients to catch themselves enacting the maladaptive pattern of relating and to short-circuit its completion. The more a patient can practice being aware of what is happening in relationships, the more likely a patient can eventually behave differently.

Once a maladaptive pattern of relating has been short circuited, discussing ways the patient might respond to or handle a situation differently provides, in and of itself, practice at managing interpersonal situations more effectively. Furthermore, it involves

cognitive rehearsal, which, through repetition, helps the patient develop more effective interpersonal skills. A therapist may employ specific directives as well, such as homework assignments. These techniques are typically associated with cognitive-behavioral therapy, but in TLDP they are implemented more informally. Homework may be intended to directly address particular behaviors that perpetuate the maladaptive interpersonal pattern and, consequently, the patient's emotional distress. For example, with a generally shy, socially withdrawn patient who is terribly lonely as a result, a therapist may, at some point, request that the patient approach others during the week as homework. In this case, the patient's social withdrawal (perhaps to avoid expectations of rejection) keeps others at a distance and feeds loneliness and a sense of unworthiness, because the patient constricts possibilities for any alternative. Targeting behavior change with such homework is one form of practice that could emerge from growing insight into how patients stand in their own way. For more interpersonally or emotionally vulnerable patients, however, such direct behavior change is best used once the therapeutic alliance is well established.

Case Conceptualization

In TLDP, the therapist conceptualizes an individual's difficulties in terms of a cyclical maladaptive pattern (CMP). The CMP provides a framework for constructing coherent narratives of patients' enduring, repetitive patterns of relating that perpetuate their difficulties in life (Binder, 2004; Binder & Betan, 2012; Levenson, 2010; Strupp & Binder, 1984). CMPs are essentially stories about what repeatedly happens in patients' relationships that leaves them feeling distressed and/or symptomatic. TLDP case conceptualization captures a patient's core interpersonal dynamic using the patient's own words and the therapist's empathic constructions to give meaning to the patient's current struggles.

TLDP begins with a basic assumption that early, subjectively perceived relational experiences are internalized as schemas that continually affect the way one interprets and behaves in interpersonal interactions. When early experiences with significant caregivers are mostly painful and disruptive, individuals can become overly concerned with protecting themselves and preserving their attachments. As a consequence, they may unconsciously stifle their interpersonal and self-development in an effort to thwart a caregiver's negative reaction. Although potentially adaptive in childhood, when carried into adulthood, these efforts to avoid anticipated pain in relationships become maladaptive and self-sabotaging.

The goal of case conceptualization in TLDP is first to identify the negative interpersonal schemas that influence one's way of engaging in relationships. Second, using the CMP structure, the therapist articulates how one's defensive efforts to avoid anticipated negative responses from others paradoxically evokes reactions that confirm negative expectations. The reactions of others may, then, further reinforce the patient's negative schema. This recurrent maladaptive interpersonal pattern becomes a vicious cycle.

To create a CMP case conceptualization, the first step involves identifying a primary interpersonal theme by listening for the wishes, needs, and expectations that recur in the patient's descriptions of relationships. Common interpersonal themes include, for example, seeking nurturance or autonomy and self-definition, feeling unappreciated, rejection or abandonment, seeking love and acceptance, or vengeful anger. Finding a primary interpersonal theme helps the therapist identify the patient's core assumptions about relationships that are elaborated in terms of the CMP.

The elements of the CMP include the following:

1. *Needs and desires in relationships (Acts of Self):* This component captures a patient's particular needs and desires in relationships that impact one's sense of self and well-being. Wanting to be loved and nurtured, recognized, and appreciated are at the core of being human. In a maladaptive interpersonal narrative, an individual experiences these needs and desires as thwarted in some way. This sets up one's negative expectations of others and one's efforts to protect against distressing interpersonal and/or emotional experiences.
2. *Expectations of Others:* Early experiences with caregivers give rise to expectations that strongly impact what one perceives and experiences in interpersonal interactions. As a result, an individual may come to expect similar reactions in all interpersonal interactions and relationships—regardless of how others respond in actuality. When interpersonal

schemas become narrow or rigid in this way, it sets the stage for maladaptive modes of relating to others.

3. *Acts of Self-Protection:* Expecting negative reactions from others, one may behave in a way intended to avoid anticipated hurtful behavior of others and/or negative emotional states. These efforts at self-protection can negatively impact the interpersonal interaction because the individual's behavior is apt to better suit the negative expectation rather than the actual interaction. Furthermore, one's self-protective behaviors are often contradictory to one's wishes and needs in relationships. For example, some patients may long to be accepted and liked, but feel unworthy and expect rejection from others. Consequently, these patients may be haughty and act as though they do not need anyone in order to avoid the pain associated with yearning for others' acceptance. As a result, such patients are more likely to experience the anticipated rejection as others withdraw in the face of patients' contemptuous behavior.
4. *Experience of others' responses (Acts of Others):* This refers to others' actual responses, but with a focus on how others' behavior is perceived idiosyncratically by the patient. When a patient misperceives the responses and intentions of others, this reflects the distorting influence of the patient's predominant interpersonal expectations. Yet the patient's perceptions of others' reactions may, in fact, not be distorted. Others may be reacting in ways that are complementary to the patient's mode of relating. At the heart of gaining insight into the patient's cyclical maladaptive pattern, it is imperative to understand that others may actually respond or are perceived as responding in exactly the way the patient expects—as a result of the patient's pattern of interpersonal behavior.
5. *Negative consequences for self-regard and self-treatment (Acts of Self toward the Self):* Negative interpersonal experiences generally lead a person to experience emotional pain and self-sabotaging beliefs that perpetuate one's maladaptive relational patterns by reinforcing a person's negative expectation of how others will respond. Furthermore, attacks on one's own sense of self-worth generally trigger one's keen awareness of interpersonal needs and wishes, leading back to the first component of needs and desires in relationships. Finally, a basic principle of interpersonal theory, repeatedly confirmed in clinical work, is that people tend to treat themselves as they perceived significant others treating them.

RESEARCH ON EFFICACY AND EFFECTIVENESS OF TIME-LIMITED DYNAMIC PSYCHOTHERAPY

This section discusses briefly the research on efficacy and effectiveness on the primary strategies in TLDP. First, at a general level, the basic strategy of fostering insight and self-understanding has a solid empirical base (Connolly Gibbons, Crits-Christoph, Barber, & Schamberger, 2007; Connolly Gibbons et al., 2009). The necessity for a strong, positive therapeutic alliance has overwhelming empirical support (Norcross & Wampold, 2011). Systematic qualitative studies of client-reported experiences (Castonguay & Hill, 2012; Friedlander et al., 2012) are beginning to point to the importance of a corrective interpersonal/emotional experience for a positive outcome.

Several studies indicate that the specific psychodynamic-interpersonal techniques associated with TLDP improve a therapeutic alliance, foster patient engagement, and contribute to positive outcomes. Empirical support exists for the effectiveness of exploring maladaptive interpersonal patterns (Owen & Hilsenroth, 2011; Owen, Quirk, & Hilsenroth, 2012), increasing self-awareness and insight (Connolly Gibbons et al., 2009; Connolly Gibbons et al., 2012; Kallestad et al., 2010), and fostering emotional awareness and expression (Diener, Hilsenroth, & Weinberger, 2007). Furthermore, evidence from studies of integrative treatments support TLDP's emphasis on promoting therapeutic dialogue that touches on emotionally salient concerns at both affective and cognitive levels (DeFife, Hilsenroth, & Gold, 2008). Promoting insight when the patient is emotionally engaged also has solid empirical support (Diener et al., 2007; Goldman, Greenberg, & Angus, 2006).

With regard to specific models of brief dynamic psychotherapy, TLDP has been found to be effective in reducing distress and impairment in interpersonal

functioning, and improving social role satisfaction, among HIV-seropositive men who have sex with men (Pobuda, Crothers, Goldblum, Dilley, & Koopman, 2008). In addition, a number of approaches to brief psychodynamic therapy that share TLDP's emphasis on exploring repetitive interpersonal patterns have received empirical support, including Luborsky's supportive-expressive therapy (Diener & Pierson, 2013; Vinnars, Thormählen, Gallop, Norén, & Barber, 2009), Davanloo's short-term dynamic psychotherapy (Abbass, Joffres, & Ogrodniczuk, 2008), and brief relational therapy (Muran et al., 2009).

ASSESSMENT AND SELECTION OF PATIENTS

TLDP is suitable for a broad range of clients who have psychological difficulties that can be understood in an interpersonal context. The approach was developed with particular interest in working more effectively with patients who have difficulty forming a positive therapeutic alliance. Because TLDP is integrative and individually tailored, the TLDP therapist may use whatever strategies are useful in addressing a patient's particular difficulties.

Patients are selected for TLDP based on several selection criteria. Patients who are open to seeing their struggles in interpersonal terms are apt to benefit from the relational focus of TLDP. Patients may not necessarily understand the nature of their interpersonal difficulties at the outset of therapy, but they must be willing to consider how their relationships may play a role in their symptoms and suffering. In addition, patients need to be open to exploring their experiences of relationships, internal thoughts, and emotional reactions. Finally, although a patient's capacity for a positive alliance may be initially thwarted by maladaptive modes of relating, TLDP patients must have the potential to ultimately develop a collaborative relationship with the therapist.

These selection criteria—seeing their troubles in an interpersonal context, willingness to explore emotions and internal experiences, and potential for collaborative work—increase the likelihood that TLDP will be beneficial. That said, however, given the interpersonal focus of TLDP, the approach is geared toward addressing fundamental difficulties in creating mutual, trusting, and effective relationships. For patients who have especially severe personality problems, establishing an effective working relationship may in fact be the goal of a time-limited therapy, creating the opportunity to build on this foundation in more extended treatment.

TREATMENT

Our approach to TLDP emphasizes therapeutic *inquiry* and *dialogue* as key treatment strategies. As we have noted, the overarching priority in TLDP is the intention to foster a meaningful therapeutic interchange that opens up possibilities for change in the patient's ways of relating to self and others. At the heart of this approach is a collaborative exploration of how the salient concerns that brought a patient to treatment manifest throughout life in repetitive patterns of construing and reacting to the world.

TLDP begins with a systematic process of *therapeutic inquiry*. Inquiry focuses on constructing a coherent narrative that captures the patient's most influential desires, expectations, and reactions in primary relationships. Once patient and therapist have collaboratively constructed this interpersonal narrative, they work to deconstruct it in order to create sufficient psychological freedom for the patient to begin constructing new, healthier narratives about self and others. This occurs in *dialogue*, a collaborative discussion geared toward identifying, examining, questioning, and challenging the rigid assumptions and reactions that interfere with living a satisfying, fulfilling, and productive life. Inquiry and dialogue are intertwined as therapeutic processes and interventions, but the emphasis shifts depending on the immediate therapeutic objective.

Inquiry

Inquiry involves seeking information and getting to know the patient. The main goal is to understand the origins and nature of the patient's recurrent interpersonal patterns and to identify a focused, interpersonal theme. Inquiry involves getting rich, evocative details about a patient's experiences and her subjective ways of making sense of these experiences to truly understand a patient's distress. The therapist encourages the patient to elaborate on the specifics of interpersonal encounters, including the context, tone, emotions, content, and outcome, as well as the patient's

subsequent feelings and conclusions. Focused questions and reflections are key therapeutic strategies for obtaining such specific, concrete examples of interpersonal encounters.

We think of inquiry as "stepping into" a patient's world. We must understand a patient before we can help change enduring ways of relating to self and others. Getting enough detail allows the therapist to enter into the patient's relational world and thereby empathically connect with the patient's subjective experiences. It involves being curious, listening closely, and suspending judgment. In addition, the therapist's inquiry invites the patient to become more self-aware and curious about what happens in relationships. The patient has an opportunity for self-discovery with the "support of the benevolent but tough-minded curiosity of the therapist" (Schafer, 1992, p. 300). Furthermore, in the process of eliciting details, we are also encouraging patients to tell a coherent, meaningful narrative of relational experiences. This, in itself, is therapeutic as it fosters coherence and continuity in how one processes and recalls events.

During inquiry, the therapist listens to patients talk about their lives and searches for interpersonal themes. Regardless of how patients initially describe their difficulties, the therapist tries to couch those difficulties in interpersonal terms or within an interpersonal context. This sets the foundation for developing a narrative that captures the patient's core pain in relationships, assumptions about self and others, and typical ways of interacting that perpetuate the patient's difficulties in life. Identifying a recurrent pattern of maladaptive interpersonal relating is the basis of the case conceptualization (CMP) and therapeutic dialogue that are at the heart of TLDP.

Dialogue

In inquiry, we "step into" a patient's narrative to see the world through the patient's eyes. In fostering a dialogue, we "step out" of the patient's story to comment on what the patient has been telling us and to call attention to the inevitable narrative irregularities that we noticed. In effect, dialogue involves reflecting on and (re)formulating the patient's narrative by engaging the patient in a reflective discussion about what has been recounted. It is a process of collaboratively describing, deconstructing, and retelling the patient's interpersonal and self narratives.

Dialogue intends to foster growing awareness that can lead to changes in the patient's sense of self and typical ways of relating. As such, dialogue focuses on (1) increasing patients' awareness of how they routinely react to new interpersonal situations as though they are the same as earlier painful relationships; (2) facilitating patients' insight into how they unwittingly recapitulate negative experiences by evoking reactions from other people that confirm patients' most distressing beliefs and assumptions; and (3) helping patients extricate from this maladaptive pattern of relating by finding alternatives for making sense of their experiences.

A patient's maladaptive pattern of interpersonal relating is maintained by unquestioned assumptions and beliefs that are associated with painful emotions and distressing experiences. In the therapeutic *dialogue*, therapist and patient systematically deconstruct the narrative of the patient's maladaptive interpersonal pattern. Together, in the spirit of curiosity and discovery, the therapist helps the patient question unquestioned assumptions. The therapist might highlight inconsistencies, contradictions, gaps, and ambiguities in the patient's expectations and interpretations. The therapist might offer an alternative interpretation of an interpersonal experience and invite the patient to consider its implications. The therapist might ask "what if," encouraging the patient to walk through a scenario, changing the plot or trying on a new role. In these ways, dialogue provides an opportunity to disrupt chronic patterns of dysfunctional thinking and corresponding maladaptive modes of relating and to create space for new meanings and possibilities.

DIVERSITY

As an individually tailored approach to creating a relational narrative, a range of diversity variables can be woven into the CMP to account for social, familial, and cultural roots of the patient's difficulties. TLDP encourages therapists to develop an understanding of psychological struggles within the patient's life context, including such culture and diversity factors. In particular, the TLDP therapist is encouraged to consider the impact of cultural mores or social discrimination on a patient's psychological and interpersonal

functioning. For example, in the case illustration that follows, cultural values and mores condemning homosexuality may indeed inform the patient's negative expectations and influence her behaviors in interpersonal interactions. What we may see as maladaptive behaviors or expectations (i.e., anticipating rejection if she discloses her lesbian relationship) may in fact be a cultural or social reality that needs to be accounted for in the case conceptualization.

Diversity factors inevitably influence the therapeutic encounter as well. When interacting with individuals whose cultural experiences and expectations differ from their own, therapists have an ethical obligation to bridge these differences through understanding. TLDP's approach to inquiry and dialogue offers a medium for such cultural sensitivity and responsivity, because it is a collaborative process driven by the patient's unique narrative. Specifically, the therapist's systematic inquiry to elicit patients' experiences conveys openness and a desire to fully understand their experiences. Furthermore, as a relational approach, the TLDP therapist can be attuned to the particular interpersonal dynamics that may be influenced by cultural dimensions. In this way, TLDP offers clients the opportunity for experiencing a healthier relationship by way of a corrective interpersonal experience that occurs in the context of a multicultural exchange. Thus, TLDP is well suited for patients who may have experienced rejection and discrimination based on minority status variables and, therefore, may find it difficult to trust others, including the therapist.

CLINICAL ILLUSTRATION

The following clinical case illustrates how to facilitate therapeutic inquiry and dialogue in order to track an interpersonal theme in TLDP. Identifying demographics and life experiences have been altered to disguise the identity of the patient. Heather is 28-year-old, Caucasian female who sought psychotherapy to address difficulties she experiences in her relationship with her parents, primarily her mother. She described being "tired" of carrying the burden of guilt, shame, and anger associated with her parents' disapproval of her romantic relationship with a woman. Heather indicates that she would like to have a more positive relationship with her family, as well as feel less guilt.

Heather reports significant, chronic conflict with her mother in particular. She describes her mother as highly critical, intrusive, and a "tyrant." Heather indicates that her mother controls the whole family, including two older brothers and her father, whom she describes as "henpecked." Heather conveyed that her mother is rather volatile and "rants, raves, and rages" when she is upset. Heather contends that her mother has been critical and disapproving her whole life, despite Heather's attempts to please her.

Heather has been in two long-term lesbian relationships. The first began in college and lasted 4 years. She is living with her current partner, Tracy, and they have been together for 2 years. Heather describes the relationship as mutually supportive and did not report the same expectations of criticism from Tracy as she does of others. She indicated that she experiences her current relationship as more "intimate" and mutually respectful than previous relationships. They have begun to discuss marriage, but Heather feels reluctant to move forward because of worries of "hurting" her parents. However, she feels she would be hurting herself if she "deprived [her]self of a relationship that makes [her] feel complete."

Heather appears to be functioning relatively well in her daily life. She is verbally fluent and intelligent. A college graduate, Heather works full-time as a project manager in a technology company. She enjoys the creative process of her work, but she feels discontent with her work environment and colleagues. She describes the company as extremely conservative and anticipates rejection if she were to disclose her relationship with Tracy.

Heather indicated she did not have a preference for a male or female therapist, and she began TLDP with a male therapist. The therapist opened the first session by inviting her to speak about her reasons for seeking psychotherapy. Heather spoke freely and was relatively open, although she tended to speak in generalizations, referring to situations without much elaboration of detail. Nonetheless, she conveyed her wish to address difficulties in her relationship with her family, which she described as "spilling over into personal life as far as work and interpersonal relationships." She indicated she is not open about her relationship with Tracy and, consequently, feels guilty and burdened. She also described feeling defensive and experiences her mother as "always trying to catch me in a lie."

P: That really irritates me. I feel like they have made me feel—well, what's the easiest way to say it—that I have to perform a certain way for their approval and love. Everything is contingent.

T: What is that certain way? *[Inquiry: The therapist avoids assumptions by encouraging the patient to elaborate what she perceives others expect of her.]*

P: I think they would like for me to tell them everything I do—which I wouldn't anyway, even if I were involved with someone else. They would like for me to be closer to them, where they could monitor everything I did. They would like for me to go back to school.

T: Sounds like they want you to lead your life in a way that is approved by them. And, to the extent that you depart from that, you feel you will be in trouble. *[Inquiry: Reflection conveys understanding and identifies an emerging interpersonal theme, which appears to focus on self-definition and acceptance. This invites her to elaborate the circumstances of the relationship.]*

Heather further describes always feeling disapproval and criticism from her mother, conveying her fear of her mother's "wrath" and emotional volatility. Later, in the session, the therapist asks what Heather would like to change. Noting that she is "hypersensitive to people" despite appearing self-confident to others, Heather indicates,

P: I would like to be able to not be so sensitive, and I would like to just build up my self-image of myself and not have to rely on those guidelines that my mother set for me, those guidelines that told me, "Yes, you do look nice, if you do this," and "You should feel good if you do this." I want my own guidelines. I don't feel all my standards are my own. It is what I've been raised with. I want something better for me. But I feel guilty about that.

T: Can you describe a situation, an experience with your mother that has contributed to that? *[Inquiry: The patient conveys several potentially important themes: lack of self-confidence despite others' perception that she is confident, hypersensitivity to others, a wish to define her own values and make her own decisions, and subsequent guilt. The therapist's choice to seek more specific examples of the interpersonal interaction with mother seems fitting because, in this first session, the patient has highlighted her relationship with her mother as the most salient concern that appears to underlie other interpersonal difficulties.]*

Commentary: In this first session, the patient initially focuses on expecting disapproval from her parents, and consequently feeling guilty, because she is in a lesbian relationship. However, she then describes long-standing experiences of her mother as critical, demanding, and fragile. In her stories of her mother, the patient conveys her expectations of disapproval, her subsequent fear of hurting her mother, and her efforts to repair their relationship by apologizing, followed by her anger and resentment. The patient suggests that the dynamic with her mother is an interpersonal pattern that affects other relationships. With inquiry, the therapist gathers interpersonal stories that begin to point to a salient interpersonal pattern revolving around a conflict between her wishes for autonomy and her fear of hurting others.

In the second session, Heather describes protecting herself by remaining private; in fact, she did not tell her partner about her therapy session. The therapist inquires about the previous session for an immediate example of this typical mode of relating. Yet Heather notes she was open and did not hold back. Curious about the inconsistency, the therapist inquired about her general expectations entering treatment. Heather described anticipating disappointment and "strained communication." The therapist continues to invite specific interpersonal narratives in order to develop a clear picture of the patient's interpersonal patterns. Here, we learn that the patient anticipates rejection in current relationships at work. It is curious that Heather does not describe the same experience of feeling criticized by her partner. We hypothesize that, early in treatment, Heather is

highly invested in protecting this romantic relationship from her negative feelings; this bears out when, later in treatment, Heather begins to express concern about feeling angry at home. *[Commentary: Heather protects herself by remaining private, but, consequently, experiences her relationships as superficial and presumably disappointing.]*

Heather adds another dimension to her interpersonal pattern in describing that it is difficult for her to be "assertive and candid" with other people. "I tend to cushion the blow—which I really regret later because I've built up a lot of animosity." *In a mode of inquiry, the therapist reflects her wish to stand up for herself and seeks specific interpersonal examples of her difficulty asserting herself.* Heather shares a story of helping others at work although she is under time pressure to complete a project. She also indicates that if she does assert herself, she then apologizes. Heather then describes her wish to be free of her sense of guilt and responsibility for her mother's emotional distress.

T: Feeling like you need to apologize for yourself is a familiar feeling. *[Dialogue: The therapist is highlighting that they are identifying a pattern across relationships, which sets the foundation for constructing and deconstructing her interpersonal narrative.]*

Cyclical Maladaptive Pattern

At this point, based on a number of interpersonal stories, we can follow a common theme and articulate the patient's CMP. It seems that the patient wants to be accepted and trusted for who she is. However, she expects that her mother, and now others, will criticize and reject her if she expresses her discontent or differences. She feels she is not getting love and approval and, consequently, feels chronically angry and resentful. To protect herself from further criticism, she withdraws and sulks in her anger. However, this leaves her feeling guilty, ashamed, and unhappy. One gets a sense that she is attempting to individuate by avoiding and withdrawing, but her guilt reels her back in. In addition, although her withdrawal, in part, protects others from her anger, it is also hostile (passive-aggressive) and alienating. Consequently, others likely feel frustrated with her, increasing the chances that she experiences them as critical. In addition, she experiences her relationships as superficial. Thus, the more she remains reticent and aloof, she misses out on feeling known and understood, thereby increasing her pain of feeling unloved and lonely. This feeds her anger, guilt, and discontent, which, in turn, perpetuates her maladaptive interpersonal style.

The CMP gets fleshed out in subsequent sessions, which leads to deepening dialogue about the patient's interpersonal expectations and patterns. For example, later in the treatment (session 10), the patient visited her parents and considered telling her mother of her relationship with Tracy. The therapist inquires about her current feelings, noting how upset she seems. Heather speaks of feeling "baffled" and like she has failed herself. Encouraging a dialogue about what occurred, the therapist points out that the patient may feel "a little out of sorts" because she expected a "bad scene" but nothing has changed. Heather described hoping for a confrontation, so "I would feel better, a little freer." *Facilitating a dialogue, the therapist articulates aspects of the patient's CMP by outlining how her expectation of disapproval and guilt leads to avoidance and feeling defensive. She then feels angry and despairs because her wish to have others' (mother's in this particular scenario) approval goes unfulfilled. She ultimately turns on herself, feeling like a failure.*

T: The cues for you that something big is going on are anger and guilt. *[Dialogue: The therapist highlights key emotional reactions perpetuating Heather's maladaptive interpersonal patterns.]*

P: Anger's not so bad. I have trouble differentiating between anger and just total bewilderment. I really do. I have a really hard time—sometimes something happens and I know I should be angry, but I'm just baffled. I don't get angry. As far as guilt—god, I just thrive on it. I guess I really wanted a confrontation. I still do. I need that, I think. I need to do something. I'm tired, I'm exhausted, I'm fed up! I don't care. So what? So what if it just blows their minds. I just need to get on; I need to get over this hump. I'm tired. I don't know, maybe I'll write them a letter. But, then I don't feel this is a fair time to unload on them. *[Commentary: Another element of the*

patient's CMP becomes clear in this passage: Her defensive stance of "I don't care" protects her momentarily from her pain of feeling she doesn't have others' approval.]

T: You take a lot of responsibility for your family, and it makes you feel guilty and angry a lot of the time. So, it is understandable that you wish you didn't care. *[Dialogue: The therapist highlights the patient's interpersonal pattern, couching her dominant feelings in her sense of responsibility to avoid hurting others. He also validates her key defensive strategy of withdrawal, but with a hint that in fact she does care and this keeps her mired in her pain.]*

Commentary: At an emotional level, the patient's tone is angry and defiant. At this point in her life, the patient acts as if she doesn't care and is living her own life. However, it is strongly apparent that she feels deep responsibility to others and desperately wants their approval. Her angst revolves around fending off her awareness that she wants approval. She protects herself by withdrawing and rejecting others, but she is left nursing her anger and resentment and feeling criticized, rejected, and alone.

P: I don't know why I take responsibility. [. . .] What is my mother's responsibility to me? I should obey, to the point of being unhappy? But what is my responsibility? Do I have a responsibility to them?

T: Well, I think you would probably believe that you do. But it seems like whatever they are, you feel offended. You haven't let them know, and the offense is that they would disapprove, wouldn't accept you. And you would be in a dilemma then. There's no way you could win—you would either fail by not being a good girl, or you would fail by not being able to stay true to yourself. And that dilemma—choosing between pleasing you and pleasing them—feels really unfair to you. *[Dialogue: The therapist frames the patient's interpersonal dilemma in terms of balancing attachment and autonomy needs. Intrapsychic conflict and anxiety emerge from the patient's belief that she must choose one or the other.]*

The therapist's articulation of a dilemma that keeps the patient mired in guilt and anger seems to trigger anger and defensiveness. In response, Heather describes her lifelong efforts to please her mother. The therapist returns to the patient's wish for approval, reflecting her sadness. Heather responds, "I feel sad. I won't ever get my mother's approval. *[Dialogue: The therapist's comment points out the other side of the patient's experience—the sadness and longing for approval that underlie the anger and defensiveness, thereby keeping her mired in her maladaptive interpersonal pattern. The therapist is working to keep her close to these feelings, because both sides of the dilemma need to be acknowledged and worked through.]*

In the subsequent sessions, the therapist and patient continue to engage in a dialogue in order to deconstruct the patient's interpersonal pattern and help the patient become more aware of the feelings and motivations that drive her to avoid confrontation with others. In this last excerpt, we provide examples where the therapist suggests an alternative mode of relating (in this case, asserting her needs and expressing her anger), and he cues the patient to practice catching herself in taking care of others' feelings by not expressing herself.

Speaking of feeling discontent at work because she wants more control over the creative process, Heather notes, "I've also found out that when I don't have control, I tend to alienate myself very easily, very quickly. I feel I get angry and I alienate myself from within."

T: That's a way you defend yourself from getting too angry—to pull away from the confrontation. I'm really asking that, not stating it. *[Dialogue: The therapist provides an understanding of her tendency to alienate by linking it to her interpersonal pattern of trying to avoid confrontation and expression of her anger.]*

P: The first thing I've always looked at, especially after a confrontation, I always feel like I must have done something. And then, if I know I didn't do anything to cause the confrontation, but I still don't say anything to the person, I start the alienation process. And ignore them and let them know that I'm pissed. Someone really pisses me off, I don't say anything. For a long time. The silent treatment. But that's what I used to get from my mother. She wouldn't say anything. She was pissed. She would just let it go—instead not talk to me, slam doors and things like that. (Sigh.)

T: Well, you know it would seem to me that anybody you dealt with for a while in whatever setting, there would invariably be some reason to be upset with them, some way they've disappointed you. So, I would assume that would happen with the two of us. We have had hours of talking seriously about you, and I've said lots of things. In the course of that, can you get in touch with any feeling I might produce with my behavior—irritation, frustration, not being understood, angry? *[Dialogue: The patient confirmed her tendency to criticize herself and withdraw from others. The therapist turns to their relationship as a potentially immediate example to bring the pattern into greater relief.]*

P: I have felt frustrated—never during the session. But, after, when I try to recreate what we talked about—when I can't remember or can remember, but I don't feel any better, I feel frustration. I feel anxious because I feel doomed to a life of feeling like this. If I am, then it's not worth it. I don't want to go through life feeling like this.

T: And, if you can think of particular times, what would you like me to do? What should I do to help you feel that less, those times you don't feel you can remember or organize the thoughts? *[Inquiry: The therapist is attempting to learn about the patient's interpersonal wish.]*

P: Maybe I'm expecting too much. Maybe I want something handed to me, the answer. But I don't know what to expect. I've never been in therapy. When my friends asked how's it going, I say, "It's great. One hour a week where I can live, feel free." But what do I do when this is over? I guess what I want to be able to do is to feel like this 2 to 3 hours/day. To feel comfortable, to relax. To release the anger. If I could ask for help with anything now, it would be that. Yoga, meditation, something tangible I can take with me.

T: Well, what you're saying makes sense. I want to ask, though, did you feel you wanted to choose your words carefully? In expressing this area of discontent, did you want to be careful that you didn't blame me? Were you aware of wanting to be sensitive? *[Dialogue: The therapist chooses to emphasize the interpersonal process—*how *she responded, rather than the content. Although her wish to get more direction is important, the objective here is to point out how she plays out her interpersonal pattern of protecting others by diminishing her self-expression.]*

P: I'm always sensitive in what I say. Nothing comes out of my mouth—if it does, I retract it quickly and make amends for it.

T: Were you taking care of me?

P: Yes, it's automatic. It's how I talk to people. I can't help that. I wouldn't know any other way to be. I would have been embarrassed and I would have felt bad afterwards.

T: Well, break it down a little—do you think that it was important to be so sensitive with me?

P: No. I think you can hear how I feel.

T: Perhaps this gives you a spot to challenge your automatic response and to try something different. You have an idea that you could express yourself honestly with me, but you still try to tone down your thoughts. The thing for you to try to do is to practice noticing when you have that automatic response to take care of the other person at your own expense. The next step would be to not respond in that automatic way. The more you can see yourself taking steps toward unloading that burden, I believe that could give you more freedom to grow. You would feel less angry and anxious. *[Dialogue: Here is the example of cuing the patient to practice self-awareness during interpersonal encounters outside sessions.]* You may find, as you assert yourself more, you may find that your worst fears don't materialize. You've done some with me, testing the waters. The more you do it, in general, the more you feel you can do that; it's conducive to changing how you feel.

Commentary: The therapist provides a practice cue to the patient to catch herself enacting her maladaptive pattern of withdrawing and short-circuit its completion by asserting herself. He builds hope by assuring her that her way of relating, and therefore her feelings, can change. In this excerpt, the therapist works to foster her growing awareness of how her tendencies to protect others and suppress her own needs have become automatic and unwittingly perpetuate her anger and anxiety. The excerpt also highlights making explicit the potential for having a corrective interpersonal experience in the therapeutic relationship. In inviting the patient to explore why she feels differently with

the therapist than with others, it opens the door for understanding how she might have more positive relationships with others as well.

CONCLUSIONS/KEY POINTS

- TLDP draws on psychodynamic/interpersonal theory that regards relationships at the core of understanding psychological functioning. Negative relational experiences early in life can adversely impact an individual's sense of self, expectations of others, and ways of behaving.
- Psychological distress and dysfunction emerge when rigid interpersonal schemas limit one's capacity for adaptation and flexibility in interpersonal interactions. Self-protection is a key unconscious motivating factor in rigidly maintaining negative, painful modes of relating.
- The primary goal of TLDP is to change ingrained patterns of interpersonal functioning in order to expand a patient's possibilities for relating to others and self-expression. Key principles of change in TLDP involve facilitating a patient's awareness and insight, enhancing reflective functioning, providing a corrective interpersonal experience, and encouraging practice of alternative ways of perceiving and/or reacting to interpersonal experiences.
- TLDP emphasizes a narrative approach to describing fundamental interpersonal themes that perpetuate the patient's difficulties in life. The CMP case conceptualization model provides a narrative framework for capturing an enduring, repetitive pattern of engaging in relationships. The CMP includes the person's expectations of others, problematic modes of relating with others, self-protective efforts, experience of others' responses, and consequent negative experiences of self.
- TLDP involves a systematic process of therapeutic inquiry and dialogue that focuses on constructing and deconstructing the patient's experiences in primary relationships. In the process of inquiry and dialogue, the TLDP therapist fosters a collaborative, positive working relationship with the patient. Inquiry and dialogue enable the therapist to (1) draw out the patient's narratives through respecting, listening, and conveying empathy and understanding; (2) foster a patient's agency, self-reflection, and involvement in the therapeutic process through collaborative questioning and observation; and (3) create possibilities for changing dysfunctional cognitive/affective processes and corresponding maladaptive modes of relating.

REVIEW QUESTIONS

1. According to the psychodynamic/relational approach in TLDP, what are the primary origin, cause, and motivating factors of an individual's difficulties?
2. What are the components of the CMP case conceptualization model?
3. What are the primary change principles in TLDP?
4. What is the main goal of the inquiry phase of TLDP?
5. What are the primary objectives during the dialogue phase of TLDP?

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5

Cognitive-Behavioral Therapies in Historical Perspective

Michelle G. Newman
Lucas S. LaFreniere
Ki Eun Shin

Abstract
This chapter provides a historical and descriptive perspective on the theoretical bases of cognitive-behavioral psychotherapy. A definition and broad historical summary of cognitive-behavioral therapy (CBT) practice and research is first provided, followed by a description of its many variations. The main body of the text then elaborates on the model's six foundational theories associated with change: classical conditioning, operant conditioning, cognitive principles, modeling/skills training, developmental factors, and biological factors. Lastly, the authors cover the efficacy and effectiveness of CBT, concluding with a synopsis of studies addressing human diversity within cognitive-behavioral treatment.

Keywords: cognitive-behavioral therapy, CBT, classical conditioning, operant conditioning, cognitions, modeling/skills training

Since the inception of its most antecedent forms, cognitive-behavioral therapy (CBT) has been a discipline grounded in empirical science. CBT is a collection of problem-focused, empirically derived cognitive and behavioral treatment techniques designed to diminish maladaptive behaviors and cognitions, reduce symptoms, promote functional conduct and thought, and teach skills for ensuring the self-maintenance of therapy gains. Rooted in the science of learning and cognition, CBT leads clients to enhance their ability at accurate *data collection and analysis* regarding their environment, experiences, and internal states.

CBT aims to lessen symptoms and improve well-being by teaching adaptive patterns of cognitive and behavioral responding, facilitating skill development, and fostering novel learning experiences. Almost all CBT techniques share similar core features. It is generally shorter in term, focuses on current issues in the client's experience, and targets specific problems. Additionally, the therapist–client relationship is one of collaboration. Both individuals share responsibility for addressing clients' concerns, whereas clients are expected to attain a sense of agency as they acquire and practice newfound abilities. CBT boasts several common hallmark *tools* for treatment, such as homework, psychoeducation, transparency, and functional analyses of causal relations between environmental stimuli and client responses. It also capitalizes on the individual strengths clients bring to treatment. Furthermore, CBT places a crucial emphasis on establishing efficacy and effectiveness via rigorous scientific research. With 45.4% of randomly surveyed American Psychological Association (APA) members defining themselves as predominantly CB in their theoretical orientation—the orientation of highest

prevalence—it is clear that CBT makes a massive impact on the field (Stewart & Chambless, 2007).

HISTORICAL BACKGROUND

CBT arose from merging disciplines. Basic research on behavioral learning in the first half of the 20th century sparked a strictly behavioral approach in the 1950s, which carried through the 1970s. The initially independent development of cognitive therapy in the 1960s progressively melded with the prevailing behavioral perspective, until cognitive-behavioral integration approaches grew to predominance in the 1980s and beyond. At present, a new generation of CBT techniques is surfacing—an array of perspectives that include mindfulness, integrated treatments, and more behaviorally focused techniques.

Before the 1950s, the theoretically driven psychoanalytic approach dominated the field of mental health treatment. Yet early in the 1900s behaviorism began laying the ground from which a novel, empirically driven treatment perspective could spring. Led by learning scholars such as James B. Watson (1878–1958) and B. F. Skinner (1904–1990), the behaviorists employed an uncompromising reliance on direct, controlled observation of well-defined, measurable constructs. With this strong commitment to scientific inquiry, as well as a robust base of proposed theory, post–World War II behavioral theorists developed therapies from two fundamental learning theory concepts: *classical* and *operant conditioning*.

It was Ivan Pavlov (1849–1936) who first recognized that a reflexive response to an innately evocative stimulus could be transferred to another, nonevocative stimulus if the two stimuli were repeatedly paired (1927). Pavlov termed this type of learning *classical conditioning*. In another sphere of research, Edward Thorndike (1874–1949) had discovered that the future occurrence of a behavior could be shaped by the nature of the consequence it generated (1898). With significant extensions by Skinner (1938), this learning process came to be known as *operant* (or *instrumental*) *conditioning*. Although Pavlov and Thorndike did not apply their theories to the study and treatment of human dysfunction, others did. For instance, Watson and Rayner (1920) determined that they could use classical conditioning to instill an irrational fear reaction in an infant, and Mary Cover Jones (1897–1987) devised techniques for diminishing fear in children (1924). Yet with psychoanalytic theory holding reign, such research did not influence clinical practice until the 1950s.

With the psychological ravages of World War II all too apparent, the demand for therapists and effective psychological interventions multiplied. Such burgeoning need opened the mental health community to new ideas on how symptoms might be allayed. Moreover, Hans Eysenck (1916–1997) raised strong criticism toward the effectiveness of existing treatments by arguing that traditional therapies achieved no better results than natural remission or placebo (1952). In an atmosphere ripe for change, Skinner led the charge on developing behavioral treatments by translating the findings of learning researchers who had preceded him. Skinner (1953) offered a novel means for treating undesirable behaviors by reshaping and/or extinguishing previously learned maladaptive associations via the reinforcement of newly taught adaptive behaviors. By the end of the 1950s the first standardized behavioral intervention for emotional disorders had arisen. Joseph Wolpe (1915–1997) in South Africa drew on incentive and conditioning research to invent a procedure for fear reduction termed *systematic desensitization*: incremental exposure to increasingly feared situations combined with relaxation. By the early 1960s many such behavioral treatments began to emerge, as well as studies that put them to the test.

Yet as the 1960s progressed, concern began to arise not only around the adequacy of analytic treatments but of learning-based approaches as well. Many started to view classical and operant conditioning as rote and overly facile; empirical findings cast doubt on response generalization and clinical utility for complex problems (e.g., marital discord); and some began to argue that the nature of many problems was not merely behavioral but also resided in the realm of thought (e.g., depressive self-beliefs). Furthermore, experimental psychology was developing an array of mediational models of thoughts influencing one's behaviors and behaviors influencing thoughts. From these dissatisfactions and developments emerged several pioneers of cognitive therapy. Albert Ellis (1913–2007) first introduced his *rational-emotive behavior therapy*, emphasizing direct disputation of irrational thinking as the ideal treatment (1957). Yet it was not until Aaron Beck (1921–) coined his

cognitive therapy for depression (and later, other emotional disorders), theorizing a connection between a person's information processing faults and deep-rooted maladaptive core beliefs, that behavioral approaches truly found their counterpart (1979). Beck made great impact on the field with his outspokenness and several foundational works, while other clinical cognitive theorists such as Albert Bandura (1925–) with *social learning theory* (1977) and Donald Meichenbaum (1940–) with *self-instruction training* (1977), helped the domain to flourish.

As scientist-practitioners like Ellis and Beck produced more active and directive treatments that aligned with their theories, and as promising efficacy studies came to light, notable scientists and clinicians began to identify themselves as cognitive-behavioral in orientation. In the late 1970s several crucial texts on cognitive-behavioral modification became available (Kendall & Hollon, 1979), and CBT as a defined approach began to solidify. This new orientation emphasized both behavior *and* cognition and employed interventions from both domains based on which treatments would likely be most effective for a client's targeted issue. Within this combined perspective clinicians guided clients to address the relationships between their maladaptive behaviors and maladaptive cognitions, often involving the disputation of automatic thoughts and appraisals both through talk therapy and behavioral experience. By the close of the 1990s the cognitive and behavioral camps were highly associated with one another. Currently, various new forms of CBT are taking shape and gaining a significant following. Many of these new interventions emphasize work on the client's impact on the therapist, interpersonal problems, emotion regulation, acceptance, mindfulness, and behavioral activation, as well as the integration of methods from different domains.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS WITHIN COGNITIVE-BEHAVIORAL THERAPIES

A plethora of models and interventions for behavioral and cognitive change have been developed across the aforementioned timeline. The number is too great to be expanded on in this chapter, but the principal ways in which CB approaches differ from one another can be traced along one primary and one secondary dimension: method (behavioral to cognitive) and, within cognitive therapies, philosophical stance (rational to constructivist). In general, CBT varies along one major dimension: the degree to which a technique is either behavioral or cognitive (or both). Predominantly behavioral approaches include *applied behavior analysis*, which wields operant principles to design reinforcement and punishment procedures for change; the neo-behavioristic *stimulus-response approach*, which pays special heed to mediational variables such as anxiety in describing and directing behavior; classical conditioning informed approaches (such as exposure treatments); and Bandura's *social learning approach*, which draws on modeling. *Cognitive therapies* comprise the complementary perspective.

Cognitive therapies vary along a secondary dimension: whether they take a *rational* or *postrational* (*constructivist*) philosophical stance. *Rational therapies* proceed from the assumption that there is an objective, stable reality external to the client that can be known through experience and cognitive processing. In contrast, *postrational* or *constructivist therapies* assume that reality is constructed by each person's subjective experience, not having a grounded standard for objective knowledge. The majority of influential cognitive approaches are rational therapies, such as Beck's *cognitive therapy*, Ellis's *rational emotive therapy*, and Goldfried's *systematic rational restructuring*. Others hold the rational assumption but with less emphasis, such as *problem-solving therapy*, Rehm's *self-control therapy*, *self-management therapies*, or Meichenbaum's *self-instructional training*. Constructivist therapies include *personal construct therapy* and *structural-developmental cognitive therapy*, among others.

THEORY OF CHANGE

CB researchers and therapists have emphasized well-defined, specific *procedures* such as case conceptualization, functional analysis, and manual-informed treatments, among others. Yet underlying these methods one can find six core theories of change and etiology, of which a thorough knowledge and understanding is vital to the practice of CBT: classical conditioning, operant conditioning, cognitive principles, modeling/skills training, biology, and development.

Classical Conditioning

Historically, the first theoretical foundation of CBT to arise was *classical* (or *respondent*) *conditioning*: learning via associations between response-eliciting stimuli and nonevocative stimuli. Pavlov (1927) first demonstrated classical conditioning with his experiment on canine salivation. When a neutral stimulus (the sound of a bell) is repeatedly paired with an inherently evocative stimulus eliciting a certain response (food causing salivation), the neutral stimulus becomes associated with the response. In technical terms, the inherently evocative stimulus (food) is known as an unconditioned stimulus (UCS), which produces an unconditioned response (UCR). The neutral stimulus that becomes associated with the UCR (the bell sound) is known as a conditioned stimulus (CS), which elicits a conditioned response (CR)—the same response as the UCR. These are the fundamental components of classical conditioning.

Classical conditioning was first applied clinically to experimentally induced fear responses. Watson and Rayner (1920) conditioned little Albert, an infant, to fear a white rat (CS) by producing a loud noise (UCS) while presenting the rat. After seven pairings of the rat and the noise, Albert started crying and withdrew even when the rat was presented alone without the noise. The conditioned fear persisted for over a week, transferring to similar stimuli, including a white rabbit and cotton wool. In another experiment, Jones (1924) used counterconditioning to extinguish a fear of rabbits from Peter, a 3-year-old boy. While Peter ate, Jones brought a caged rabbit gradually closer to him. The repeated pairing of a response to pleasant stimuli (eating food) with the feared stimulus (rabbit) eliminated the fear response. At the end of the experiment, Peter did not show a fear reaction to the rabbit roaming freely outside the cage. In fact, he was able to hold it closely without crying.

Several theories have been proposed to explain the mechanism of the conditioned fear response. Mowrer's (1947) *two-factor theory* links anxiety (fear) with avoidance. According to this theory, anxiety is acquired via fear conditioning: Once the neutral stimulus becomes conditioned to elicit fears, it motivates avoidance behaviors. Avoidance behaviors are reinforced by reduced anxiety because they preclude confrontation of the fear-provoking CS. Wolpe and Rachman (1960) also proposed a conditioning theory of fear acquisition. A neutral stimulus acquires fear-provoking qualities through classical conditioning, and the conditioned fear reaction generalizes to other stimuli resembling the conditioned stimulus.

Since their original development, theories on conditioned fear acquisition have been modified and refined. For example, Seligman (1971) challenged the *equipotentiality assumption* held by previous theories: the assumption that all stimuli have an equal chance of becoming a fear signal. Seligman noted that research on prevalence of phobias revealed a nonrandom distribution of fears, in which only certain types of stimuli (e.g., reptiles, heights) were associated with intense fear reactions. Seligman proposed that animals and humans were biologically prepared to fear stimuli that were evolutionarily linked to survival of the species. As a result, certain stimuli are more readily conditioned to provoke fears and more resistant to weakening of the conditioned fear response.

Elaborating further on conditioned fear theory, Rachman (1977) noted that fears may be acquired and removed without direct contact with stimuli. Experimental and survey studies showed that vicarious social contact or instruction alone was sufficient to cause or attenuate a fear response (e.g., Hagman, 1932). Based on these findings, Rachman proposed three pathways to fear acquisition: classical conditioning, vicarious acquisition, and informational transmission. The inclusion of the latter two pathways incorporated cognitive factors into the conditioning model of fear acquisition. Rachman (1977) also pointed out individual differences in propensity to develop fears. Based on the biological and genetic basis of personality, he proposed that people differ in their general level of fearfulness and are thus differentially susceptible to acquiring fears. In addition to temperamental factors, Rachman also identified situational factors (e.g., physical illness or nausea) as predisposing factors for fear acquisition.

In addition to fear and anxiety, classical conditioning can be applied to the understanding of other psychological problems, including eating disorders, sleep disorders, and addictive behaviors. For example, addiction involves appetitive conditioning in which situational cues (e.g., drug administration rituals) are associated with the effect of a substance and resulting pleasure (UCR). Exposure to conditioned cues increases an individual's urge to consume the substance; if the substance goes unused, cues cause withdrawal symptoms by eliciting physiological

effects opposite to the effects of the substance as a result of a physiological homeostatic process (Poulos, Hinson, & Siegel, 1981).

Treatment approaches based on the conditioning model utilize principles of extinction, counterconditioning, and stimulus control. *Extinction* refers to presenting the CS without the UCS repeatedly, and *counterconditioning* involves pairing the CS with a behavior or response opposite to the CR. *Stimulus control* requires the retrained pairing of the CS with a desired response (e.g., bed with sleep) and simultaneously extinguishing previously paired stimuli (e.g., no TV, work, or worry in the bedroom) by creating new associations with the latter stimuli (e.g., TV in living room, work in the study, worry outside the bedroom). One common treatment based on principles of extinction and counterconditioning is *exposure*. The goal of exposure is to weaken the conditioned association between a stimulus and an unwanted response. Exposure is primarily used for treating anxiety disorders, but it is also applied in the treatment of addictive disorders, eating disorders, sleep disorders, and sexual deviance.

Exposure is practiced in different forms. One example is Wolpe's (1958) *systematic desensitization*. Desensitization is the graduated presentation of increasingly aversive stimuli, starting with the least anxiety-provoking stimulus and progressing to stimuli that provoke greater anxiety. Clients are instructed to imagine an event that provokes anxiety, and then to engage in relaxation. The pairing of anxiety-provoking images and relaxation is repeated until the client no longer feels anxious. Systematic desensitization is based on the principle of *counterconditioning* (or *reciprocal inhibition*). The pairing of a response incompatible with anxiety (relaxation) and anxiety-provoking stimuli results in the suppression of the anxiety response. As an alternative to systematic desensitization, both *imaginal* and *situational exposure* have also been conducted without using paired relaxation. In this type of intervention, clients are exposed to feared stimuli and asked to persist until their anxiety level eventually subsides.

Aversion therapy—coupling pleasurable acts with displeasure—targets addiction and sexual deviance. To eliminate or decrease the unwanted behavior, the stimuli associated with an addictive or sexually deviant behavior is repeatedly paired with an aversive event. For instance, electrical shocks are paired with images of sexually deviant stimuli to reduce sexual arousal to the stimuli. *Chemical aversion*—using nausea-inducing drugs—has also been applied to the treatment of alcoholism (e.g., Lemere & Voegtlin, 1950). In another type of aversion therapy, *covert sensitization*, therapists use imaginal exposure in which clients imagine aversive consequences of engaging in the target behavior instead of experiencing actual aversive events.

One of the purported mechanisms of exposure therapy is *habituation*, the decline in response to a stimulus upon repeated presentation of the stimulus. According to the habituation model of fear reduction (e.g., *emotional processing theory*; Foa & Kozak, 1986), successful exposure depends on activation of a fear structure (a network of propositions about the fear stimulus, response to the stimulus, and its meaning) and within- and between-session habituation. The reduction of fear within and between therapy sessions is theorized to indicate corrective learning, during which the initial fear structure is integrated with information that challenges elements of the structure, transforming it into a nonfear structure. For instance, in the case of panic disorder, people fear that they will not be able to cope with the panic-inducing situation and may die or go crazy. By pushing them to stay in the situation until their fears peak and pass, they learn that the probability of dying or going crazy is unlikely and that they can cope with the situation. The new information serves to challenge and modify the existing fear structure. *Emotional processing theory* (Foa & Kozak, 1986) suggests that therapists should continue exposure until habituation occurs in order to optimize corrective learning.

A more recent conceptualization of the mechanism of exposure is *inhibitory learning* (e.g., Craske et al., 2008). Rather than deleting the fear association of the CS, exposure therapy enables the development of a new safety association for the CS. The new inhibitory association is theorized to compete with the initial fear association (e.g., Spiders are not dangerous; I can cope with a spider crawling on my arm). The inhibitory learning model emphasizes enhancing salience and retrievability of the safety association relative to the fear association to maximize the therapeutic effects of exposure. For instance, instructing clients to mentally rehearse the exposure context and therapeutic materials they learned during exposure or providing varied exposure stimuli (e.g., multiple spiders vs. single spider for spider phobia) to create

more retrieval cues can enhance exposure outcomes (e.g., Craske et al., 2008).

Operant Conditioning

Classical conditioning is not the only CB theory to which learning theory gave rise. The concept of *operant* (or *instrumental*) *conditioning* takes a similar stance on treating dysfunctional conduct: an individual's maladaptive behaviors, emotions, and cognitions have resulted *from* learning, so they can be corrected *through* learning. Yet rather than describing learning that occurs via associations between evocative and neutral stimuli, operant conditioning occurs through the association of a behavior with an enjoyable or aversive consequence. In operant conditioning, a behavior elicits a pleasant or disagreeable outcome. When an association is learned between the behavior and the outcome, the likelihood of future engagement in the behavior is either increased or decreased based on the nature of the outcome.

A precursor to contemporary operant conditioning was first theorized by Thorndike (1932). Thorndike's *law of effect* posited that stimuli-response associations followed by "satisfying" effects would be strengthened, whereas associations followed by "annoying" effects would be weakened. Skinner (1938) drew on Thorndike's research to found "operant" theory: Behaviors "operate" on the environment to generate particular outcomes, which influence the frequency that such behaviors will recur.

Skinner devised several categories for the consequences of behavior, defining each by the effect it causes. *Reinforcers* are consequences that increase frequency of a behavior (e.g., praise for correct answers), whereas *punishers* are consequences that decrease frequency of a behavior (e.g., shocks for incorrect answers). These consequences are labeled either *positive* or *negative*. If the consequence is delivery of some experience following a behavior, it is labeled *positive*, but if the consequence is removal of some experience following a behavior, it is *negative*. Accordingly, a *positive reinforcer* is a delivered consequence that promotes future occurrence of its antecedent behavior, such as euphoria following drug use for those with addictions. A *positive punisher* is also a delivered consequence, but it reduces the likelihood that the antecedent behavior will occur again, such as getting reprimanded for oppositional behavior. In contrast, a *negative reinforcer* is a consequence that increases future frequency of a behavior by removing an aversive state. For example, negative reinforcement occurs when individuals with social phobia steer clear of classmates to diminish their own anxiety. A *negative punisher* also alters the likelihood of a behavior's reoccurrence by removal (usually of something enjoyable), but it decreases that likelihood, such as when aggression by a child with conduct disorder results in a loss of video game privileges. Lastly, *extinction* in operant conditioning is a zero correlation between a behavior and a consequence. When a behavior does not predictably elicit any consequence—desirable or undesirable—it is likely to decrease in frequency.

Later research revealed that the degree of effectiveness of different reinforcers and punishers can vary greatly based on several factors. The *magnitude* (how large) and *rate* (how frequent) of rewards and penalties matter, with greater, more frequent consequences having more pronounced effects. Furthermore, the more quickly a consequence occurs following the behavior, the more impact it has, a phenomenon known as *immediacy*. *Contingency* describes the reliability that a given behavior will result in a particular reinforcer or punisher; more certain-to-occur consequences have greater influence than less dependable consequences. The extent to which an individual's desire or need has already been satisfied—*satiation*—holds sway as well, with greater satiation weakening the reinforcing or punishing power of a consequence.

Operant conditioning is crucial in the etiology of cognitive and behavioral issues. Reward and penalty consequences create learning experiences that can establish maladaptive behavior patterns. For example, Patterson and Cobb (1971) described the common occurrence of simultaneous mutual mediation in dyads, where *coercive* interpersonal exchanges lead to entrenched dysfunctional patterns of interaction. In a *positive reinforcement trap*, two people provide rewards to one another (e.g., attention for a clinging child, affection for a parent), often creating inflexible dependency. In a *coercive exchange* (a *negative reinforcement trap*), one person produces an aversive experience for another person, stopping only when the first receives a desired positive reinforcer from the second (screaming child, toy-giving parent). Such cycles are only broken when punishers are received instead of the expected reinforcers (and vice versa). The abundance of opportunities

for the outside-of-therapy environment to reinforce dysfunctional behaviors and punish productive ones poses a challenge for the use of operant conditioning in CBT. Moreover, reinforcers can be intrinsic as well as extrinsic (e.g., autistic self-stimulation), behaviors can be difficult to extinguish when delivered on variable time schedules (a phenomenon known as *Humphrey's paradox*), and failures to recognize relationships between adaptive behaviors and consequences (i.e., learned helplessness) make reconditioning a sizable task.

Yet despite these challenges, CB theorists have used the core concepts of operant conditioning to fashion effective approaches to assessment and treatment. Operant conditioning is an important part of *functional analysis of behavior.* A clinician uses a functional analysis to identify the causal relations between antecedents to a problematic behavior, the behavior itself, and its consequences. The idea behind a functional analysis is that people will engage in behaviors to serve basic needs. A goal is to determine what function a maladaptive behavior serves, such as socially mediated positive (receiving attention, activities, intimacy) or negative (avoiding demands, evading conflict) reinforcement. Once the functions and consequences of behaviors are established, the behaviors can be modified and replaced with adaptive behaviors that serve the same function. Note that punishment alone is constrictive, not constructive; punishment may eliminate behaviors temporarily, but without replacing the behavior with another behavior that serves the same function, the maladaptive behavior may recur.

The therapist is equipped with many more instrumental techniques for treatment. Reinforcers and punishers used for behavior change can be individually tailored to the client. Konarski and colleagues (1981) suggested the following principles for choosing a reinforcer to combat dysfunction: (1) *trial and error* of different reinforcers; (2) apply already known reinforcers from research or client history; (3) let the client choose from a varied *menu* of reinforcers; and (4) present a combination of many reinforcers for the same behavior (e.g., food, praise, smile). Emotions play a central role in operant conditioning. Positive emotions such as happiness or relief can signal reinforcement, whereas emotions such as frustration or sadness often mark punishment. Factors other than reinforcers and punishers can be used for change as well. *Establishing operations*, or conditions/events that influence the impact of consequences, can be manipulated so targeted behaviors change in frequency and severity. One example is altering *setting events*—the environmental stimuli of a context in which a behavior occurs (e.g., make a spouse aware of the ways in which he or she is reinforcing maladaptive behavior). Operant behavior change can be so intricate that it reaches the degree of *shaping*, a detailed step-by-step process whereby a behavior is first broken down into its constituent parts, followed by the alteration of the reinforcers that work on each part to modify how the behavior transpires.

Lastly, it is obviously not sufficient for instrumental conditioning to change behavior solely within one context. Novel behaviors must *generalize* to different stimuli/contexts and have a system for *maintenance* over time. Locating and eliminating stimuli that facilitate dysfunctional behaviors, increasing consistency of adaptive reinforcement, garnering reinforcing social support, and teaching new function-focused behaviors are a few ways to approach this task.

Cognitive Principles

The CB principle of cognition suggests that strictly behavioral perspectives overlook a crucial element of human endeavors: the influence of thinking on mood and behavior. Cognitive principles posit that distorted thinking about one's experiences drives dysfunctional behaviors and disordered moods. It is therefore a *mediational model* of behavior. Under this view, purely external events do not directly cause a person's responses; it is also the person's *perceptions* and *interpretations* of events that determine how he or she reacts (Beck, 1979; Ellis, 1980). Dobson (2001) outlines three fundamental propositions for cognitive principles: (1) cognitions affect behavior; (2) cognitions may be monitored and altered; and (3) behavior change may be affected through cognitive change. However, studies also show that behavioral change may affect cognitive change; thus, mediation can work both ways. Ultimately, the adaptive quality of a person's life is dependent on her or his way of mentally processing personal experiences. Cognitive therapy takes a skills-based approach in which rational, adaptive means of thinking are taught and practiced in session for continued use in daily life. The goal of therapy is to supplant skewed, dysfunctional

appraisals of life experiences with realistic, adaptive assessments.

Contemporary cognitive therapy arose from the work of Ellis and Beck. Discouraged by psychoanalytic methods and experimenting with more directive interventions, Ellis developed *rational-emotive behavior therapy* to combat irrational beliefs. Ellis (1962) argued that one's maladaptive emotional reactions result from irrationally labeling the situations one has experienced. Dysfunctional responses to events reflect faulty self-statements that have morphed into unrealistic global labels. According to Ellis, irrational beliefs are extreme, rigid, illogical, inconsistent with reality, catastrophizing, demanding, and full of "musts" and "shoulds." Via powerful learning from repeated use, such beliefs become ingrained as automatic and seemingly involuntary. In contrast, rational beliefs result from gathering accurate evidence from one's environment. In accordance with this view, Ellis set forth an *ABC Model* of psychological functioning and disturbance. When an (A) activating event occurs, a person forms a (B) belief about the event that is either rational or irrational, which manifests an emotional (C) consequence, whether appropriate or inappropriate.

Although Ellis's model has certainly impacted the field, Aaron Beck anchored cognition at the forefront of clinical psychology in the 1960s and 1970s. After conducting numerous interviews with depressed patients, Beck grew dissatisfied with psychoanalytic explanations for depression. He instead turned to the content of cognitions for a potential cause. Beck noticed automatic streams of thought, negative biases, and systematic distortions in reports of his depressed subjects—distortion patterns that proved debilitating in a way directly related to patient symptoms. Moreover, these automatic thoughts appeared to be rooted in maladaptive systems of belief about the self and world—"schemata"—that forced a negative framework on a patient's situational appraisals. Such findings led Beck to theories about content and processes of cognitions distinctive to emotional disorders. He went on to produce a typology of systematic cognitive errors (e.g., overgeneralization, arbitrary inference, personalization) and designed a "common-sense" approach to altering self-defeating thinking patterns via questioning, psychoeducation, and guidance. He termed his approach *cognitive therapy* and, along with his classic texts such as *Depression: Causes and Treatments* (Beck, 1967), his contribution strongly continues to influence clinical practice today.

Much of the cognitive element of contemporary CBT remains close to Beck's cognitive therapy and the mediational model. The basic model's assumption—beliefs and thoughts can intervene between stimuli and response to determine emotions and behavior—has been well established (Hollon & Beck, 1994). A person's experience constructs deep cognitive frameworks for organizing and interpreting information, known as *schemas*. When activated by stimuli or thoughts, the components of schemas—mental representations, encoding selection frames, affective content—direct one's perceptions of the world heuristically. Yet schemas can bias informational processing and retrieval or even create completely false—though schema-consistent—perceptions. For example, Roth and Rehm (1980) found that depressed patients rated their videotaped behavior as containing about twice as many unskilled behaviors as skilled behaviors, whereas more objective raters saw these behaviors as nearly equal. To treat cognitive distortions in psychopathology, the deep structures of schemata can be challenged over time by teaching reframing, objective evaluation, and counterschema evidence searching.

Other cognitive theories have made great impact. Bandura contributed to the acceptance of cognitive mediation by criticizing noncognitive conditioning models on empirical grounds. His *self-efficacy theory* (Bandura, 1977) posits that a person's expectations for success mediate the relationship between stimuli and behavior. The degree of one's *efficacy expectations* (beliefs that one can perform a certain behavior) and *outcome expectations* (beliefs that the behavior will produce the desired outcome) can determine the actual performance of a set task. Skillful CBT increases self-efficacy so that clients gain a sense of agency over their behavior change. *Attribution theory* suggests that the causes one ascribes to life outcomes (i.e., explanations) contribute powerfully to one's emotions, thoughts, and behaviors. *Internal* (within-person elements), *stable* (unchangeable), and *global* (consistent across contexts) attributions for negative events characterize a pessimistic explanatory style. Such a lens works against positive behavior, healthy emotionality, and the maintenance of change.

The cognitive therapist has an array of strategies for building constructive thinking where poorly wrought appraisal frames once stood. For most

approaches, the key process is the substitution of distorted thought content with alternative, evidence-based content less dominated by irrational core beliefs. First, therapist and client must attain a thorough understanding of which irrational thoughts the client holds, as well as the contexts in which they occur. For instance, in Meichenbaum's *self-instructional training* (SIT) the client's internal dialogue is closely examined for how it influences and is influenced by events and behaviors. Emotional content is crucial to cognitive work as well, and it should be addressed accordingly. Beck (1979) himself has written that effective changes in core cognitions occur in the presence of emotional arousal. Aversive emotions are sometimes the consequence of distorted cognitive interpretations; they often must be assessed and processed in therapy along with thoughts. Assessment of cognitions and emotions is done via discussion in session and by the client's *self-observation*—directing focused awareness to thoughts and feelings, or even keeping a record of activities, cognitions, and emotions outside of session. As the client's illogical thoughts are fleshed out, the therapist and client begin to target the client's signature schemata so they can be challenged. Afterwards, disputation of irrational thoughts and logical discussion of evidence ensue. Here clients initiate cognitions and behaviors that interfere with dysfunctional ones. The cognitive therapist assists clients to step back and regard their cognitions not as set-in-stone facts, but as hypotheses open to debate, known as *distancing*. Furthermore, to test their automatic "hypotheses," clients are taught to engage in *behavioral experimentation*—the experiential collection of evidence for the establishment of more realistic appraisals. When clients' incorrect perceptions are repeatedly pit against reality, the warped nature of the biases eventually erodes. Additionally, erroneous conclusions are challenged through Socratic questioning and guided discovery, defined as the use of leading questions to engender new perspectives and teaching clients to reflect on how they process information, respectively. Clients are led to contemplate the evidence for and against beliefs, alternative interpretations, and their implications. Clinicians instruct clients to think flexibly by taking multiple perspectives as well. Lastly, cognitive restructuring skills must be taught to clients to target maladaptive schemata, underlying core beliefs, and efficacy beliefs.

Modeling and Skills Training

Modeling is learning through observing and imitating the behavior of others. Modeling differs from classical and operant conditioning because it does not require engaging in overt behaviors for learning to occur. For instance, infants aged 12 to 21 days can produce new facial expressions by observing the facial expressions of adults (Meltzoff & Moore, 1977). Although modeling does involve aspects of operant conditioning, the experience of reinforcement and punishment occurs vicariously through observation, rather than directly. Individuals observe and evaluate the consequences of a modeled behavior, and then mentally represent the consequences to make a decision on whether to perform the behavior or not.

Bandura's "Bobo doll experiment" (Bandura, 1965) is one of the most well-known demonstrations of modeling. In this study, children viewed a film of an adult aggressively beating a large inflatable doll; following the assault, the children witnessed the model get either rewarded, punished, or no consequence. At the initial testing, children who watched the model receiving punishment imitated the behavior much less than those who watched the model receiving a reward or no consequence. At a later testing, children in all conditions received an offer of positive reinforcement for beating the doll. The introduction of incentives led the three groups to engage in a similar level of imitative aggression despite the initial group difference. Results of this experiment demonstrated that learning could occur via modeling with witnessed reinforcement. In addition, the study showed that acquisition and performance of a behavior are separate processes. Exposure to modeled aggression generated the potential for producing the aggressive behavior in all children (acquisition). However, only a subgroup who perceived the consequence of the behavior to be positive actively carried out the behavior (performance).

Rosenthal and Bandura (1978) proposed four types of learning that can occur through modeling. *Observational learning* refers to acquiring novel behaviors that did not previously exist in the person's repertoire. Infants' imitation of the gestures and facial expression of adults is one example. Another effect of modeling is to inhibit or disinhibit a response that is already in the person's repertoire. *Inhibitory modeling* occurs when an individual reduces the rate of a response as a result of observing another

person performing the act and getting punished. *Disinhibitory modeling* occurs when an individual increases the rate of a previously inhibited behavior after observing a model performing the act without aversive consequences. Inhibitory and disinhibitory modeling can be applied clinically to reduce undesirable behaviors (e.g., antisocial behavior) or elicit inhibited behaviors (e.g., approaching a feared object). The third function of modeling is known as *response facilitation*: When people observe others performing a behavior that is already a part of their behavioral repertoire, the rate of performing that behavior increases. Response facilitation is differentiated from disinhibitory modeling because the modeled behavior has not been previously restrained. Examples of response facilitation include increased laughing and yawning after witnessing others do so. In addition, modeled behaviors provide a template for evaluating the adequacy and appropriateness of one's own behavior. For instance, observing models who are tolerant of shocks was found to reduce the perceived painfulness of the shocks. As a result, participants chose to endure higher intensity shocks for a longer time (Craig & Neidermayer, 1974).

Effects of modeling can vary depending on characteristics of the model and the observer, as well as consequences to the model (Rosenthal & Bandura, 1978). Observers are more likely to perform behaviors modeled by specific populations, depending on the context. For instance, fearful adults who watched children approaching their feared object were more likely to perform the approach behavior than fearful children who watched adults modeling the behavior (Thelen, Fry, Fehrenbach, & Frautschi, 1979). Furthermore, observers are more likely to imitate models who are similar to them. When phobic children watched a model who was initially fearful, but later overcame the fear, they exhibited a greater attitudinal change than when they watched a model who was fearless from the beginning (Kornhaber & Schroeder, 1975). For modeling to be effective, the observer also needs to attend to the model's behavior. Thus, the modeled behavior should be presented conspicuously. In addition, modeling is enhanced when the observer systematically organizes the modeled information for memory retention (e.g., using imagery) and motorically rehearses the behavior. Lastly, response-reward contingencies also influence the observer's participation in the processing of the modeled information (attention, retention, and rehearsal) as well as the performance of the modeled behavior.

There is an abundance of ways in which therapists can employ modeling to facilitate positive change in a CBT context. One clinical application of modeling is *skills training*. Skills training can include any type of skill building for the client to overcome specific deficits or develop a more extensive behavioral repertoire. Targeted skills range from social and communication skills to general problem solving, study skills, or time management. Any life skill that can assist functioning is open to intervention. Because of its flexibility, skills training can be applied to a number of issues, including physical conditions, marital conflicts, and stress.

The first step in skills training is an assessment of the client's abilities. Clients' skill levels and areas of deficiency are evaluated through clients' self-reports, role-plays with the therapist, and observations of clients' behaviors in the natural environment. After identifying areas of deficiency, therapists teach skills through instruction, behavioral demonstration, and rehearsal. Therapists can exemplify the target skills directly or present examples through another medium such as a film clip. Once skills are learned, clients rehearse the skills through role-plays with the therapist in session and with others outside therapy sessions. Throughout the process, therapists provide reinforcement to clients to facilitate learning. Examples of skills training include communication training and problem-solving therapy (D'Zurilla & Goldfried, 1971).

Biology and Development

Although less conducive to the direct application of therapies, biological and developmental factors are vital to a CBT perspective. No understanding of the etiology, maintenance, and presentation of psychopathology would be complete without knowledge of how one's biological processes and developmental stage contribute to symptoms and dictate the optimal treatment.

Contrary to common perception, it is not only biological processes that influence psychological ones; psychological influences can strongly affect biology. For example, perceptions of pain are influenced by learning, behavior, and muscle tension. Learned factors (e.g., smoking, food choices) also cause or

exacerbate biological issues such as allergies, cancer, diabetes, heart disease, and preventative health behaviors, or manifest secondary problems that complicate medical conditions. Furthermore, many disorders and symptoms are best understood under a *diathesis-stress model*. In such a model a biological *diathesis*—or aspect of one's constitutional makeup such as genes, health, and so on—interacts with stress—upset from an aspect of environment such as trauma, interpersonal discord, and so on. These interactions are complex and different for different people at different times, and it should be recognized by clinicians.

Additionally, clients' current developmental stage directly influences treatment design and application. Scarr (1982) outlined five domains where developmental principles can impact clinical practice: an awareness of developmental norms (at what age is a behavior normative?); comprehending the role of parental and/or influential figures; describing and cultivating resilience; determining a prognosis (what early factors predict later maladjustment); and the use of developmental concepts to create a curriculum or treatment plan (what to teach, when, and in what order). Developmental stage can also inform an understanding of what may be maintaining a behavior (e.g., strength of parent vs. peer influence changes across the lifespan).

RESEARCH ON EFFICACY AND EFFECTIVENESS OF COGNITIVE-BEHAVIORAL THERAPIES

Throughout its history CBT has upheld empirical research as a core value. Currently, several meta-analyses as well as reviews of meta-analyses on efficacy of CBT exist. For example, Butler and colleagues (2006) reviewed 16 meta-analyses published up to 2004, and Hofmann and colleagues (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012) reviewed 106 meta-analyses published between 2000 and 2012. In most of the studies reviewed, CBT was compared to no-treatment, wait-list, or placebo controls such as nondirective supportive therapy.

A recent review (Hofmann et al., 2012) supported the efficacy of CBT, but revealed a nuanced picture. CBT demonstrated most efficacy for anxiety disorders, somatoform disorders, bulimia, insomnia, anger and aggression, and general stress, with medium to large effect sizes. Effect sizes also ranged from medium to large for depression and dysthymia. Effect sizes for addiction and substance use disorders ranged from small to medium. For schizophrenia and other psychotic disorders, CBT had medium effect sizes for positive symptoms and secondary outcomes, but it showed lower efficacy for relapse prevention and chronic symptoms. CBT also demonstrated efficacy for personality disorders, but it did not appear to be superior to other psychosocial treatments.

Meta-analyses revealed that treatment gains from CBT maintain over time, from 6 to 24 months (e.g., Butler, Chapman, Forman, & Beck, 2006). The effects of CBT tend to be most enduring in depression and anxiety disorders (Hollon, Stewart, & Strunk, 2006). However, even in the case of depression and anxiety disorders, relapse is not uncommon. A meta-analysis on relapse rates in depression (Vittengl, Clark, Dunn, & Jarrett, 2007) showed that 29% of depressed individuals treated with CBT relapsed within 1 year, and 54% relapsed within 2 years. Similarly, one study (Brown & Barlow, 1995) showed that 27% of individuals successfully treated for panic disorder relapsed and received additional treatment within 2 years. Nonetheless, CBT tends to have superior long-term outcomes relative to pharmacotherapy. In both depression and panic disorder, relapse rates of CBT are almost half the rates of those occurring with pharmacotherapy (e.g., Butler et al., 2006). Studies are also beginning to show that the effect of CBT for primary anxiety disorders generalizes to comorbid disorders (e.g., Newman, Przeworski, Fisher, & Borkovec, 2010).

Compared to research on efficacy of CBT in controlled clinical trials, there is less research on effectiveness of CBT—treatment outcomes in naturalistic settings. One recent meta-analysis (Stewart & Chambless, 2009) examined 56 effectiveness studies of CBT for adult anxiety disorders excluding specific phobias. Uncontrolled effect sizes (pre- to post-changes) were large across disorders, and comparison with control groups yielded favorable effect sizes. Treatment outcomes in effectiveness studies were also similar to those obtained in clinical trials. The authors coded clinical representativeness of each study to determine how well the given study reflected actual clinical practice. There was a significant but small negative relationship between clinical representativeness and CBT outcome. Other effectiveness studies examined effects of CBT in

community settings and samples (e.g., primary care) and demonstrated effectiveness (e.g., Roy-Byrne et al., 2005). Individual factors also affect treatment responses. CBT results in worse outcome in the presence of greater symptom severity, comorbid personality disorders, medical conditions, and life stressors (Newman, Crits-Christoph, Connelly Gibbons, & Erickson, 2006).

DIVERSITY

Despite the efficacy of CBT, ethnic minorities have been underrepresented in study samples (Miranda et al., 2005). Even when minority samples were included, studies often lacked sufficient power to examine minority treatment response and failed to conduct relevant analyses.

However, with growing demand for and emphasis on culturally competent mental health care (Miranda et al., 2005), there has been a recent increase in research on multicultural applications of CBT (Hays, 2006). Hays (2006) suggested that one of the strengths of CBT is its recognition of the uniqueness of the individual. Multiple therapeutic tools in CBT allow for flexibility to accommodate different clients' needs. CBT also promotes client empowerment via individual competence and skill building. Given that many minorities have experienced discrimination, the emphasis on client empowerment may be especially beneficial for minority clients. Another strength of CBT is its focus on concrete (e.g., conscious cognition and behaviors) rather than abstract processes (e.g., unconscious cognition). Such a focus can reduce misunderstandings, particularly when the client is not a native English speaker. In addition, CBT integrates assessment throughout therapy, encouraging clients to provide feedback. Active client participation can both facilitate therapy progress and contribute to a collaborative therapeutic relationship.

Potential limitations of CBT in serving culturally diverse groups include an emphasis on Euro-American values. The rationale and goals of CBT are based on Euro-American values of rational thinking, assertiveness, change, independence, and self-disclosure (e.g., Hays, 2006). Such values may conflict with values of spirituality, harmony, patience, and collectivism—more highly emphasized in other cultures. In addition, CBT places a limited focus on clients' developmental history. However, when working with minority clients, it would be essential for therapists to assess clients' developmental history and family environment to incorporate the information in conceptualizing the case and planning treatment.

To enhance cultural sensitivity, researchers and therapists have proposed culturally adapted versions of CBT as well as general frameworks for adapting CBT to different populations (e.g., Hwang, Wood, Lin, & Cheung, 2006). Cultural adaptations include providing therapy in clients' native language, receiving supervision in the language in which the services are being provided, using culturally relevant examples, consulting with professionals from clients' culture, training staff in cultural sensitivity, and providing additional services such as transportation and child care when needed. Furthermore, specific changes to treatment may need to be considered; for example, assertiveness training can be modified for Asian and Latina/o clients to incorporate their values of respect for elders. Therapists can also take a more balanced and dialectic approach to cognitive restructuring—instead of directly contradicting clients' beliefs—to be more consistent with the worldviews of East Asian cultures (e.g., Hwang et al., 2006). In addition, culturally sensitive CBT requires therapists to be culturally self-aware and knowledgeable as well as mindful of contextual factors impinging upon clients' presenting complaints such as racism, discrimination, oppression, and microaggressions, and, at times, to be clients' advocates. Moreover, comprehensive assessments of clients' cultural background should include both positive and negative aspects (e.g., Hays, 2006; Miranda et al., 2005).

Unfortunately, there is limited research on the efficacy of CBT with diverse populations. However, one review (Miranda et al., 2005) showed that both standard and culturally adapted CBT were effective with ethnic minority populations. For instance, CBT was as effective with African American and Latina/o youths as with White youths experiencing anxiety, depression, attention-deficit/hyperactivity disorders, and disruptive behavior disorders. CBT was also effective with African American and Latina/o adults experiencing depression, anxiety, and schizophrenia. A more recent review yielded similar results, supporting effectiveness of culturally modified and standard CBT with African, Hispanic/Latina/o, and Asian Americans experiencing depression and anxiety disorders (Horrell,

2008). Studies also have been conducted on culturally adapted CBT with refugee populations (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012) and patients in non-Western countries (Horrell, 2008) and showed that the interventions were effective.

Despite some positive results, several limitations of existing studies should be noted. In most studies, data on certain minority populations (e.g., American Indians, Alaskan natives, LGBT populations, and people with disabilities) was not available. In addition, some of the studies had small sample sizes, making it difficult to draw valid conclusions. Overall, current evidence indicates promise for the development of culturally responsive CBT. However, further research is clearly warranted to examine effects of CBT in different populations and compare benefits of culturally adapted interventions relative to standard interventions.

CONCLUSIONS/KEY POINTS

- The empirically focused cognitive-behavioral perspective arose in the 1980s, fusing mid-century clinical applications of basic learning research with later, independently developed cognitive therapies. Currently, many next-generation approaches are in development and use.
- Classical conditioning involves repeated pairing of an inherently evocative stimulus with a neutral stimulus to associate the neutral stimulus with the response elicited by the evocative stimulus. Exposure therapy is based on the principle of classical conditioning.
- Operant conditioning results from the association of a behavior with the consequences that follow it, either increasing (reinforcing) or decreasing (punishing) the behavior. CBT uses rewards and punishments for client behaviors to assess and treat symptoms.
- In modeling, individuals learn new behaviors by observing the behaviors of others. As a part of skills training in CBT, therapists demonstrate target skills through role-plays, and clients learn the skills by emulating therapists' behaviors.
- Cognitive principles assert that distorted, detrimental thinking about one's experiences causes maladaptive behaviors and dysfunctional moods, mediating stimuli-response chains.
- CBT has ample empirical support for its efficacy. However, more research is needed to examine its effectiveness in real-world settings and with culturally diverse populations.

REVIEW QUESTIONS

1. Explain the differences and similarities between classical and operant conditioning.
2. Discuss how each of the following four principles of CBT (classical and operant conditioning, modeling, and cognitive therapy) can be applied to treating spider phobia.
3. Outline three major developments throughout the history of CBT that led to its current form.
4. Name and describe the work of one important founding figure of CBT.
5. What are the strengths and limitations of CBT with minority groups (e.g., ethnic minorities, LGBT, low-income populations, the elderly, etc.)?

RESOURCES

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6

Cognitive-Behavioral Therapies in Practice

Amy Wenzel

Abstract

Cognitive-behavioral therapy (CBT) is an active, strategic, collaborative, and time-sensitive approach to the treatment of a host of mental health disorders and related conditions. Since its initial conceptualization in the mid-20th century, countless outcome studies have demonstrated CBT's efficacy for many populations and formats. The core of CBT is the cognitive case conceptualization, or the application of cognitive-behavioral theory to the patient's individualized clinical presentation. Standard CBT strategies include cognitive restructuring, behavioral activation for depression, exposure for anxiety, problem solving, and skills training. However, many strategic interventions can be implemented in CBT, including those that might not seem like typical cognitive-behavioral techniques. This focus on conceptualization is especially important in working with diverse populations, as it incorporates cultural influences and individual difference factors.

Keywords: cognitive-behavioral therapy, cognitive case conceptualization, efficacy, effectiveness, collaborative empiricism

Cognitive-behavioral therapy (CBT) is an active, problem-focused approach to treatment that centers on the modification of maladaptive or otherwise unhelpful cognitions (e.g., thoughts, beliefs) and behavioral patterns (e.g., avoidance). One aim of CBT is to make an impact on patients' lives as immediately as possible; thus, much cognitive-behavioral work is present focused. However, cognitive-behavioral therapists are also cognizant of the fact that many problematic cognitions and behavioral patterns are long-standing and have roots in key life experiences from the past. Thus, cognitive-behavioral therapists also help patients to (a) understand the factors that maintain these long-standing cognitive and behavioral patterns, (b) recognize when these patterns are activated, and (c) commit to healthy cognitive and behavioral habits that will prevent relapse and promote resilience. The fundamental tenets of CBT practice are as follows:

CBT is time-sensitive. Many CBT protocols that have been evaluated in the research literature are 12 or 16 sessions in length, which is much shorter than the length of some other types of psychotherapies (e.g., psychoanalytic psychotherapy). However, it is important to note that CBT as practiced outside of research protocols is not bound to any particular number of sessions. Some patients might end therapy after only a few sessions, reporting that they acquired valuable tools and got what they needed from the experience. Other patients, often those with complex problems and comorbid mental health disorders, might remain in therapy for a year or more (J. S. Beck, 2005; Brown, Newman, Charlesworth, Crits-Cristoph, & Beck, 2004). Regardless of the number of sessions that patients attend, the idea is that when they begin therapy, they know that there is an eventual end to treatment and that the goal is for them to be able to implement cognitive and behavioral tools and principles in their own lives without the need of a therapist.

CBT is collaborative. Cognitive-behavioral therapists assume a *teamwork* approach with their patients,

such that both the therapist and the patient are expected to have some expertise that is relevant to the life problems that the patient hopes to address in therapy. Thus, both the cognitive-behavioral therapist and the patient contribute to the development of treatment goals, the focus of sessions, and the type of work that the patient completes in between sessions. In addition, CBT is a transparent process, meaning that therapists provide an understandable rationale for the therapeutic interventions that they are using so that the patient can develop knowledge about cognitive and behavioral principles of change.

CBT is strategic. While interacting with patients authentically in order to build and maintain a therapeutic alliance, cognitive-behavioral therapists are mindful of strategy. According to Wenzel (2013), when CBT is delivered strategically, the therapeutic intervention (a) emerges from a coherent conceptualization of the patient's clinical presentation that is rooted in cognitive-behavioral theory, (b) is determined in collaboration with the patient, (c) is linked directly to the patient's treatment goals in order to move treatment forward, and (d) is seen through in its entirety without getting sidetracked in order to evaluate its effectiveness. In other words, the activities that occur during a CBT session are thoughtful, intentional, and linked with a clear mechanism of change.

CBT sessions assume some structure. To maximize the effectiveness of therapy, cognitive-behavioral therapists implement tools to structure the session. At the beginning of the session, they often do a mood check and bridge from the previous session. They collaboratively develop an agenda for the session with their patients, so that both parties are clear about the topics that will be covered during the session. They work with their patients to develop homework that will be completed between sessions and review homework that had been completed previously. At the end of the session, cognitive-behavioral therapists and their patients summarize what was discussed and accomplished in order for patients to consolidate their learning and maximize the likelihood that they will remember key points from the session when they leave. Although some therapists are hesitant to implement session structure for fear that it is too rigid or that it stifles spontaneous discussion, skilled cognitive-behavioral therapists implement session structure in a fluid, conversational manner that is responsive to patients' cues.

CBT requires a sound therapeutic relationship. Although a commonly held stereotype about CBT is that it places little emphasis on the therapeutic relationship, in actuality, cognitive-behavioral therapists have stated the importance of a sound therapeutic relationship since its inception (A. T. Beck, Rush, Shaw, & Emery, 1979). Moreover, there is a small but high-quality body of research examining the association between the therapeutic relationship and patient outcome in CBT. Interestingly, this literature provides some evidence that symptom change precedes improvement in the therapeutic relationship, particularly the bond between the client and therapist (see Newman, 2007, for a review), although the opposite direction of effect has been found in research designed to evaluate models of change processes in psychotherapy (e.g., Kolden et al., 2006). Thus, cognitive-behavioral therapists attend carefully to developing the therapeutic relationship when they begin treatment, but they also build momentum in treatment using the therapeutic relationship as patients begin to show improvement.

As discussed by Newman, LaFreniere, and Shin (this volume, Chapter 5), CBT emerged in the context of rich theoretical traditions such as classical conditioning, operant conditioning, cognitive theory, and modeling and in the context of many concurrent lines of innovative research that evaluated treatment protocols developed on the basis of these theoretical traditions. At present, there are countless scholar-clinicians who are adapting CBT for specific populations (e.g., women with postpartum depression) and for specific settings (e.g., primary care practice). Thus, in many ways, the term *CBT* could more accurately refer to a family of psychotherapies. However, if there were to be one prototype, it would be Aaron T. Beck's cognitive therapy, which was developed on the basis of Beck's clinical observations in the 1950s and 1960s, evaluated for the treatment of depression in the 1970s, and adapted for the treatment of other mental disorders in the 1980s through the present. This chapter describes the practice of the "Beckian" approach to CBT.

Aaron T. Beck, M.D. (1921–) started his psychiatric career as a trained psychoanalyst who not only practiced psychoanalysis but also conducted research with the intention of providing empirical validation of key constructs in psychoanalytic theory. While treating his patients, Dr. Beck noticed that they made quick, evaluative judgments that were

often self-deprecating in nature. He theorized that these self-statements were exacerbating his patients' depression and that if they were corrected, his patients' depression would improve. He began to test this hypothesis with his patients, and he found that they, indeed, improved significantly and completed treatment much more quickly than his patients had been when he was delivering psychoanalytic psychotherapy (A. T. Beck, 1976; J. S. Beck, 2011). Dr. Beck assimilated his observations into several key books (A. T. Beck, 1967, 1976; A. T. Beck et al., 1979) and evaluated the efficacy of his treatment in clinical trials.

Although the greatest amount of research that has evaluated the efficacy of the Beckian approach to CBT has focused on depression, this approach has been expanded to other mental health disorders, modalities, and settings (Butler, Chapman, Forman, & Beck, 2006). Specifically, it has since been adapted for the treatment of anxiety disorders (A. T. Beck & Emery, 1985), substance abuse (A. T. Beck, Wright, Newman, & Liese, 1993), eating disorders (Fairburn, 2008), personality disorders (A. T. Beck, Davis, & Freeman, 2015), and suicidal behavior (Wenzel, Brown, & Beck, 2009). More recently, it has been developed as an adjunctive treatment for serious psychiatric conditions, such as bipolar disorder (Basco & Rush, 2005) and schizophrenia (A. T. Beck, Rector, Stolar, & Grant, 2009). CBT's versatility is also evident by the fact that it can be delivered in formats other than individual psychotherapy, such as in groups (Bieling, McCabe, & Antony, 2006) and with couples and families (Dattilio, 2010).

Over the past 15 years, cognitive-behavioral therapists have been increasingly influenced by mindfulness and acceptance-based frameworks and strategies. Although there is much debate about whether mindfulness and acceptance-based approaches are fundamentally different than CBT or new packages for similar frameworks and strategies, they have undergone significant theoretical development and have been subjected to scientific scrutiny, and many cognitive-behavioral therapists have eagerly adopted these new approaches into their practices (Herbert & Forman, 2011). This development reflects the notion that it is very likely that new techniques will be acquired as the technology of psychotherapy advances and becomes more refined. However, regardless of the specific techniques that are implemented with patients, the "heart" of CBT is the cognitive case conceptualization (A. T. Beck, personal communication, July 23, 2014), described in the next section.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION IN COGNITIVE-BEHAVIORAL THERAPY

A fundamental principle that underlies CBT is that maladaptive or otherwise unhelpful thinking plays a role in the development, maintenance, and exacerbation of mental health problems. This notion is incorporated into the cognitive-behavioral model, presented in Figure 6.1. According to this model, people are characterized by underlying beliefs that are shaped on the basis of an array of factors, including biological predispositions (e.g., a family history of depression, signifying a genetic predisposition), psychological tendencies (e.g., the intolerance of uncertainty), and environmental factors that provide the scaffolding for learning (e.g., raised in poverty, witnessed parents with unhealthy means of coping). The confluence of these factors sets the stage for people to internalize messages about themselves, others, and the world around them when they experience notable formative events (e.g., experienced the ending of a romantic relationship, introduced to a first alcoholic drink).

Most people are characterized by both helpful (e.g., "I'm a good person") and unhelpful (e.g., "I'm a failure'") beliefs. According to cognitive-behavioral theory, in times of relative calm, the helpful beliefs predominate. However, in times of stress, unhelpful beliefs are activated. When unhelpful beliefs are activated, and a person experiences a situation that is perceived as stressful, challenging, or disappointing, it is likely that she will experience cognition that is negative, overstated, or otherwise unhelpful. These cognitive reactions are called *automatic thoughts* to reflect the fact that these thoughts are experienced so quickly that people often do not realize their presence, or if they do acknowledge them, they are taken as fact without further reflection. When people experience these negative automatic thoughts, the likelihood increases that they will experience negative affect (e.g., depression, anxiety, anger) and uncomfortable physiological responses (e.g., racing heart, shortness of breath), as well as respond behaviorally in a manner that is self-defeating or unhelpful (e.g., angrily confronting a perceived injustice without

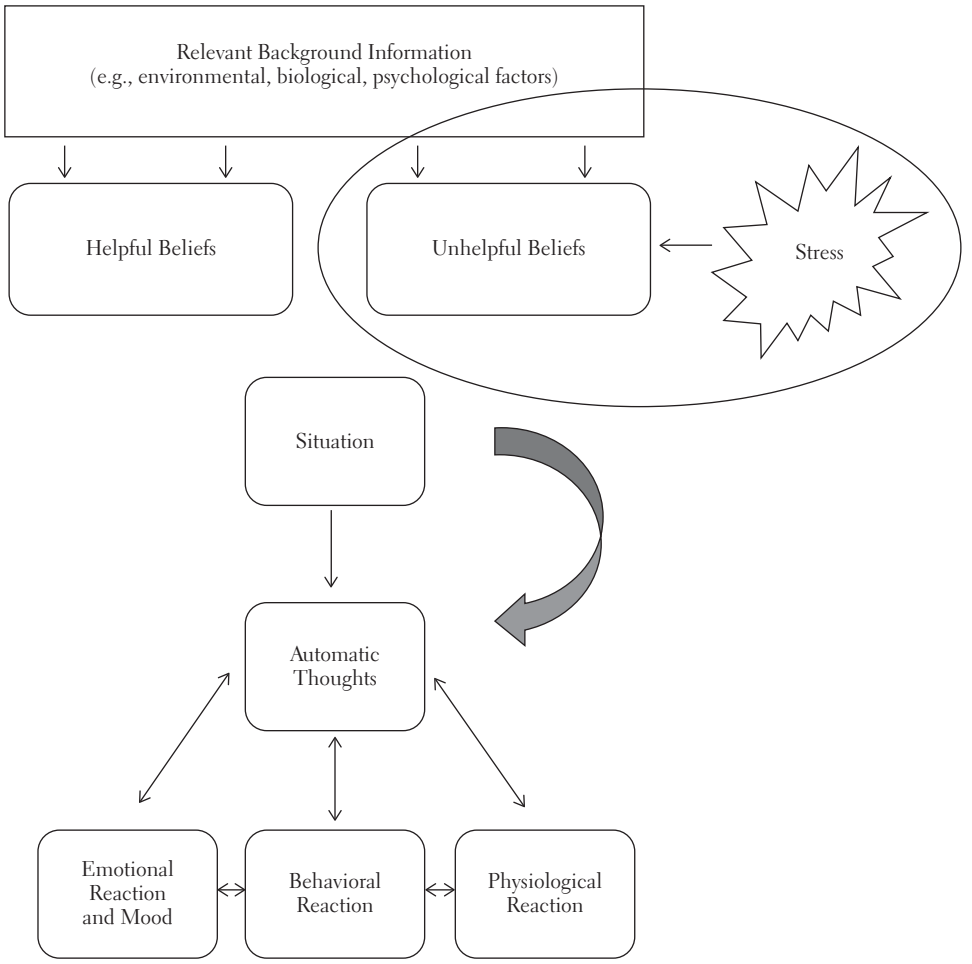

FIGURE 6.1 Cognitive-behavioral model.

Adapted with permission from Greenberg, L. S., McWilliams, N., & Wenzel, A. [2013]. *Exploring three approaches to psychotherapy.* Washington, DC: APA Books.

first gathering all of the facts). However, notice the bidirectional arrows between automatic thoughts and emotional, behavioral, and physiological reactions. These arrows are included in the figure because it is simplistic to say that unhelpful cognition simply causes unhelpful emotional, behavioral, and physiological reactions. Rather, it is often the case that these reactions influence the content and intensity of unhelpful cognition to a similar degree. Thus, two basic principles of change associated with CBT are that (a) change in cognition, whether at the level of automatic thoughts or at the level of beliefs, is associated with emotional and behavioral change; and (b) change in behavior is associated with cognitive and emotional change. As will be seen in greater detail in this chapter, many cognitive-behavioral interventions are designed to intervene at the levels of unhelpful cognition and unhelpful behaviors.

Cognitive-behavioral theory is the basis for the development of cognitive case conceptualization. *Cognitive case conceptualization* is defined as the application of cognitive-behavioral theory to the individual patient (J. S. Beck, 2011; Kuyken, Padesky, & Dudley, 2009; Persons, 2008). It organizes information about patients' clinical presentations (i.e., descriptive level; cf. Kuyken et al., 2009), as well as the factors that precipitate, maintain, and exacerbate patients' clinical presentations (i.e., cross-sectional and longitudinal levels). The cognitive case conceptualization captures underlying cognitive and behavioral

patterns that can explain the symptoms and life problems with which patients present at the beginning of treatment. As patients proceed with treatment, they share more information about their backgrounds and describe current stressors and challenges, and cognitive-behavioral therapists weave this information into the cognitive case conceptualization. In other words, the cognitive case conceptualization is dynamic, such that it is ever-evolving on the basis of new information that patients provide and real-time interactions between the therapist and patient. Moreover, the cognitive case conceptualization is integral for treatment planning, such that it points to modifiable psychological factors (e.g., beliefs, automatic thoughts, behavioral patterns) that can be targeted for change using cognitive and behavioral strategies.

Because unhelpful cognition is such a central construct in the Beckian approach to CBT, many investigators have sought out to establish empirically the mediational role between the severity of symptoms of mental health disorders and treatment outcome. At present, there is mixed evidence, at best, for the premise that change in unhelpful cognition mediates the relation between severity of symptoms and treatment outcome (Ilardi & Craighead, 1994; Kazdin, 2007; Longmore & Worrell, 2007). For example, DeRubeis et al. (1990) demonstrated that changes in unhelpful cognition at mid-treatment were associated with a reduction in depression at the end of treatment in patients who received cognitive therapy, but not in patients who received pharmacotherapy, though scores on measures of unhelpful cognition decreased to a similar degree in both groups at posttreatment. In contrast, Jacobson et al. (1996) found no association between early scores on some of the same measures of unhelpful cognition and reductions in depression. However, more recent research using sophisticated methodological and statistical approaches and measuring precise cognitive constructs have indeed found evidence for mediation, including reductions in estimated social cost in the cognitive-behavioral treatment of social phobia (Hofmann, 2004) and reductions in anxiety sensitivity and increases in self-efficacy in the treatment of panic disorder (Gallagher et al., 2013). Thus, at least in the treatment of anxiety disorders, evidence is beginning to accumulate that targeting specific, disorder-relevant cognitions in treatment has importance for outcome. The field is evolving in the manner in which mediation is conceptualized and tested (Hofmann, 2008; Kazdin, 2007), so it is expected that future research will continue to shed light on this issue.

RESEARCH ON EFFICACY AND EFFECTIVENESS OF COGNITIVE-BEHAVIORAL THERAPY

In the first outcome study examining cognitive therapy for depression, Rush, Beck, Kovacs, and Hollon (1977) compared cognitive therapy with the tricyclic antidepressant, imipramine, for unipolar depression. Results indicated that almost 80% of participants who received cognitive therapy showed marked improvement or complete remission of symptoms, relative to approximately 23% of the participants who received imipramine. Not only was the imipramine condition associated with a significantly higher dropout rate than the cognitive therapy condition, but it also was associated with fewer enduring gains over time, as 68% of the participants who had received imipramine later reentered treatment for depression, relative to 16% of the participants who had received cognitive therapy. This study created controversy because its results challenged widely held beliefs in psychiatry that medications are the first-line treatment for depression. However, it also facilitated widespread interest in cognitive therapy for depression.

Perhaps the most well-known study that evaluated the efficacy of cognitive therapy is the Treatment of Depression Collaborative Research Program (TDCRP; Elkin et al., 1989), which compared cognitive therapy, interpersonal psychotherapy (IPT), imipramine plus clinical management, and placebo plus clinical management at five different sites around the United States. Contrary to the findings reported by Rush et al. (1977), results for cognitive therapy were disappointing; only 36% of clients receiving cognitive therapy met study criteria for recovery post treatment, relative to 43% and 42% for IPT and imipramine, respectively. Although recovery rates in the IPT and imipramine plus clinical management conditions were significantly higher than recovery rates in the placebo plus clinical management conditions, the recovery rate of the cognitive therapy group did not differ significantly from that in the placebo plus clinical management condition. Moreover, all treatments, including placebo plus clinical management, performed similarly for less severely depressed clients,

and imipramine plus clinical management outperformed the other conditions for severely depressed clients. On the basis of these findings, it was widely concluded that psychotherapy, including cognitive therapy, was appropriate for people with mild to moderate depression, but that antidepressant medication was necessary for moderate to severe depression. This attitude persisted for many years, despite the preponderance of outcome studies that began to accumulate that demonstrated the efficacy of cognitive therapy, and the concern raised about the quality of cognitive therapy that was delivered in some of the sites included in the TDCRP (Jacobson & Hollon, 1996).

This attitude shifted after the publication of research by DeRubeis, Hollon, and their colleagues (DeRubeis et al., 2005), in which patients with moderate to severe depression were randomly assigned to receive antidepressant medication (paroxetine, with the possibility of augmentation with lithium or desipramine in cases in which clients did not meet established response criteria by week 8), cognitive therapy, or pill placebo. At the 8-week assessment, both the medication (50%) and cognitive therapy (43%) groups had higher response rates than placebo (25%), and at posttreatment, both the medication and cognitive therapy groups had achieved response rates of 58%. Even more compelling are the results from their 12-month follow-up period (Hollon et al., 2005). Patients who had completed cognitive therapy had much lower relapse rates than clients who had completed their medication trial (31% vs. 71%, respectively), and they were no more likely to relapse than patients who were continuing to take medications (47%). These results suggest that cognitive therapy is indeed efficacious for moderate to severe depression and that their effects are much more enduring than the effect of taking medications.

Moreover, scholar-practitioners are devoting increasing attention to the *dissemination* of CBT, or the study and application of transporting CBT from academic institutions where it is developed to "real-life" therapists in "real-life" settings for use with "real-life" patients. The idea behind this movement is to address the discrepancy between the large body of research supporting CBT's efficacy and the paucity of available cognitive-behavioral therapists in the community. In the United States, large dissemination movements have been initiated to implement CBT programs in Veterans Affairs Hospitals (Wenzel, Brown, & Karlin, 2011) and community mental health agencies (Stirman, Buchhofer, McLaulin, Evans, & Beck, 2009). Research conducted in the context of such movements will provide data on the effectiveness of CBT, which will supplement the research described previously on CBT's efficacy.

ASSESSMENT AND SELECTION OF PATIENTS

Cognitive-behavioral therapists rely heavily on assessment in order to develop the cognitive case conceptualization and facilitate treatment planning. There are several components of a typical assessment. Many cognitive-behavioral therapists administer structured clinical interviews in order to arrive upon diagnoses of mental health disorders. They also administer well-established self-report inventories to assess severity of symptoms like depression and anxiety. Although some self-report inventories, like the Beck Scales (e.g., Beck Depression Inventory-II; www.beckscales.com), must be purchased from publishing houses, others are freely available (see, for example, Antony, Orsillo, & Roemer, 2001, for a compilation of freely available measures of anxiety). In addition to the assessment of symptoms of mental health disorders, cognitive-behavioral therapists gather information about patients' current lives (e.g., employment, relationship status), medical history, and key developmental events in order to understand important stressors, as well as strengths, that are relevant to the cognitive case conceptualization. During the assessment, cognitive-behavioral therapists take note of things their patients express that provide information about the way in which they view themselves and their world, as well as of modifiable psychological factors that might be contributing to their patients' clinical presentations (e.g., the intolerance of uncertainty, perfectionism).

The information described in the previous paragraph is typically gathered across the course of one or two appointments with a mental health professional. However, cognitive-behavioral therapists believe that it is equally important to gather information about patients' cognitive, emotional, and behavioral responses in their lives outside of the professional office. Thus, many cognitive-behavioral therapists ask their patients to complete a self-monitoring form, on which patients prospectively track triggers for emotional responses, as well as associated cognitions, behaviors,

and outcomes of those triggers. Data obtained from self-monitoring facilitate functional assessment, or the gathering of idiographic information about the factors that contribute to and maintain negative emotional experiences (cf. Abramowitz, Deacon, & Whiteside, 2011).

Although there is a high likelihood that CBT would be an appropriate treatment for most patients, either alone or as an adjunct to other interventions, there are, of course, individual differences in the degree to which any one patient will respond to CBT's structure and process. Over two decades ago, Safran and Segal (1990) identified criteria to characterize the suitability of prospective patients for CBT. These criteria include characteristics such as the accessibility of automatic thoughts, awareness and differentiation of emotions, acceptance for personal responsibility for change, and optimism about therapy. Although Safran and Segal provided precise operational definitions of these criteria, as well as guidelines for measuring the criteria, it is also recognized that these criteria are ideal and that most clinicians will not have the luxury of choosing patients who are perfectly suited for CBT. Thus, much work has been done to develop guidelines for working with difficult patients (e.g., J. S. Beck, 2005) or to apply motivational interviewing (i.e., a therapeutic approach that helps patients increase their motivation for and commitment to change) to address ambivalence in patients who express skepticism or pessimism about treatment (e.g., Westra, 2012).

TREATMENT

The implementation of CBT roughly follows through three phases—an early phase, a middle phase, and a late phase. The aims of the early phase of treatment are to (a) conduct the conceptualization; (b) educate patients about the model, structure, and process associated with CBT; (c) identify clients' readiness for treatment and address any negative attitudes or expectations that might interfere with treatment, (d) instill hope that change is possible, (e) establish a sound therapeutic alliance, and (f) develop a treatment plan. Although treatment manuals often describe the early phase of treatment as lasting between one and three sessions (e.g., Wenzel et al., 2011), in reality, it lasts as long as it takes for the patient to resolve ambivalence about treatment and invest in the model.

In the middle phase of treatment, the cognitive-behavioral therapist works with the patient to apply strategic therapeutic interventions to the problems that were identified for the patient's treatment plan. As A. T. Beck had observed early in his career, many patients can benefit from the modification of maladaptive or unhelpful thinking, a process called *cognitive restructuring*. Cognitive-behavioral therapists who use cognitive restructuring help their patients acquire skill in (a) identifying negative automatic thoughts, (b) evaluating the accuracy and the helpfulness of those automatic thoughts, and (c) if necessary, reframing the automatic thoughts into thoughts that are more adaptive and balanced. Many clinicians refer to this process as *challenging* automatic thoughts. Indeed, Albert Ellis, the renowned psychologist who developed a related treatment, rational emotive behavior therapy, was known for being especially challenging with his patients to help them to see that they were thinking irrationally. In contrast, A. T. Beck took a stance of *collaborative empiricism* with his patients in examining their automatic thoughts, such that together (i.e., in a collaborative manner), therapists and patients withhold judgment and carefully examine the evidence that supports and refutes the thoughts, only drawing a conclusion or making a judgment after evaluating the evidence in a nonbiased manner. Thus, cognitive-behavioral therapists use Socratic questioning with their patients, such that they pose questions that stimulate critical thinking so that their patients can grapple with answers to these questions and draw their own conclusions, rather than being told what to think. It is also important to acknowledge that the goal of cognitive restructuring is not simply to think positively, but rather to acknowledge the full range of information associated with a particular situation—that which is negative, positive, and neutral.

Cognitive-behavioral therapists use many tools to achieve the aims of cognitive restructuring. A *thought record* is a log in which patients prospectively record instances in which they experience emotional distress, their corresponding automatic thoughts, and more adaptive, balanced responses to those thoughts. Not only does this tool allow patients to see vividly how the cognitive model applies to their personal circumstances, it gives them practice in catching and evaluating negative automatic thoughts as they arise in the moment. In the age of technology, many patients prefer to keep a thought record electronically,

either in a computer file or by using an application on their smartphone. In addition, some patients find that they develop compelling adaptive responses in session with their therapist to recurrent automatic thoughts that are distressing to them. They can write their adaptive response on a *coping card* (i.e., a 3.5 x 5 inch index card) that they can keep with them and consult whenever they notice that the automatic thought has been triggered.

As mentioned previously, automatic thoughts are not random, but they can be explained by underlying beliefs that have been developed and reinforced throughout patients' lives. It is sensible, then, that some of the greatest cognitive change would occur when these underlying beliefs are shifted from being overly negative (e.g., "I am worthless") to being more balanced (e.g., "I'm just as good as the next person"). The cognitive restructuring techniques that are used with automatic thoughts can be applied to the restructuring of underlying beliefs. However, because these beliefs are usually quite painful and deeply entrenched, they are not shifted with one attempt at cognitive restructuring; rather, they are modified over time. For example, clients who are trying to shift toward a belief of "I'm a worthwhile person" might keep a *positive data log*, recording specific instances that occur in their lives suggestive of being a worthwhile person. A cognitive-behavioral therapist working at the level of these beliefs might take an experiential approach, having the patients use mental imagery to vividly reexperience a key event in their lives that shaped a negative core belief, and having them walk through what they would tell their younger selves using their cognitive restructuring tools. Additional belief modification techniques are described in J. S. Beck (2011), Dobson and Dobson (2009), and Wenzel (2012, 2013).

In addition to these cognitive strategies, there are many behavioral strategies that are just as appropriate to incorporate into treatment. *Behavioral activation* is a strategy that helps patients, particularly those with depression, overcome avoidance and reengage in activities that they would find pleasurable and meaningful. Patients will typically monitor the manner in which they are spending their time in between sessions, recording what they are doing, how much pleasure and/or sense of accomplishment they get from the activities, and how it relates to their overall depression level. It is expected that patients will see that the days in which they attain the lowest levels of pleasure and/or sense of accomplishment from their activities are the days in which they experience the highest levels of depression. On the basis of this monitoring, patients work with their therapist to schedule activities that would be expected to be associated with pleasure and/or a sense of accomplishment. Over time, patients work on engaging in more of these activities, as well as integrating some of these activities into their daily routine so that they experience their benefits on a regular basis.

Another behavioral strategy is the *behavioral experiment*, such that patients try out in their lives something that they have previously avoided, withholding judgment until they have completed the experiment so that they can evaluate whether any awful predictions were realized. For example, patients with panic disorder who avoid cardiovascular activity for fear that it would induce a panic attack might be asked to increase their heart rate by running up and down a flight of stairs. The goal of the experiment is for patients to learn that the catastrophe they are predicting does not occur, or if it does occur (e.g., they have a panic attack), they learn it is not as bad as they had expected and that they can tolerate the distress associated with it. Notice that although this intervention is behavioral because it requires patients to *do* something that they have been avoiding, it achieves powerful cognitive change because patients acquire new learning that is inconsistent with previously held expectancies. Another way of conceptualizing behavioral experiments is from an *exposure* perspective, such that patients (particularly those with anxiety disorders) systematically have contacted with feared and avoided situations and stimuli in order to develop new learning (cf. Abramowitz et al., 2011; Craske et al., 2008).

Because nearly all patients are experiencing some sort of problem in their lives, cognitive-behavioral therapists assist patients in acquiring and practicing problem-solving skills. An entire cognitive-behavioral treatment package has been developed that focuses on problem solving (D'Zurilla & Nezu, 2007), and broader cognitive-behavioral approaches are heavily influenced by this approach, incorporating specific problem-solving techniques that are appropriate in light of the cognitive case conceptualization (e.g., J. S. Beck, 2011; Wenzel, 2013). Roughly speaking, problem-solving deficits are addressed in two ways. Some

patients lack the necessary skills to approach problems adaptively. Cognitive-behavioral therapists help them to acquire skill in problem definition and formulation, the generation of alternative solutions, decision making, and solution implementation and verification (cf. D'Zurilla & Nezu, 2007). Alternatively, other patients have adequate problem-solving skills, but negative attitudes about problems or their ability to solve them (i.e., a *negative problem orientation*) that interfere with the execution of these skills. Cognitive restructuring techniques are used to identify and modify a negative problem orientation. In addition, cognitive-behavioral therapists encounter many instances in which patients are skilled at arriving upon solutions to problems, but they lack skills to enact the solution effectively. In these cases, cognitive-behavioral therapists work with their patients to acquire and practice these skills, such as effective communication skills.

Throughout the middle phase of treatment, cognitive-behavioral therapists track their patients' progress. A straightforward approach to tracking progress is to administer one or more self-report inventories at every (or select) sessions and to track the manner in which those scores change over time. Another way of tracking progress is to observe the degree to which patients are implementing homework exercises in between sessions, as well as the degree to which the implementation of those homework exercises is achieving its desired results. When patients' mood has improved, and when it is clear that they are effectively using cognitive and behavioral tools in their own life, they can move into the late phase of treatment. The goals of the late phase of treatment are to (a) encourage the consolidation of learning, (b) collaboratively develop a relapse prevention plan, and (c) address any concerns about the end of treatment. The relapse prevention plan is a summary of warning signs that indicate that patients might be experiencing a relapse or recurrence, the cognitive and behavioral tools that they would use when they recognize these warning signs, and people to contact (both professionals and nonprofessionals) for help (Wenzel, 2013). In most instances, treatment does not end abruptly; more typically, patients decrease the frequency of their sessions to once or twice a month before ending treatment, even though such practice is not a part of most trials evaluating the efficacy of CBT.

Although the strategies described in this section are some of those that are the most typically incorporated into CBT, in reality, any intervention can be used by cognitive-behavioral therapists, provided that they are done so in a strategic manner and are indicated on the basis of the cognitive case conceptualization. In fact, some of the most powerful cognitive-behavioral work is done experientially, either through role-playing or imaginal exercises that promote affective experiencing (J. S. Beck, 2005).

DIVERSITY

CBT is well suited for use with diverse populations, as cultural forces serve as an important contextual factor that shapes the cognitive case conceptualization. Thus, it is critical that cognitive-behavioral therapists acknowledge contextual factors, as contextual factors shape the formative experiences that people have, as well as the meaning that they make from those experiences. According to Hays (2009), CBT and multicultural approaches to therapy share many core assumptions, including the importance of tailoring therapeutic interventions to the needs and strengths of the individual, the importance of empowerment, a focus on conscious processes that are more easily articulated than unconscious processes, and continual assessment throughout treatment that communicates respect for patients' viewpoints. The following are some guidelines that cognitive-behavioral therapists use in practice when working with clients with diverse backgrounds.

Cognitive-behavioral therapists check their own assumptions about the patient's background. Modeling the process of gathering evidence before arriving upon a conclusion, cognitive-behavioral therapists gather "data" before arriving upon a case formulation. Clinicians who are unfamiliar with a patient's cultural background ask open-ended, nonjudgmental questions to learn about the role that culture played in the development and maintenance of his/her long-standing cognitive and behavioral patterns. Cognitive-behavioral therapists also take care to use language that is inclusive and does not reflect assumptions about patients' backgrounds, such as "partner" rather than "husband" or "wife."

Cognitive-behavioral therapists respond flexibly to patients' needs and wishes. Cognitive-behavioral therapists are sensitive to patients' preferences that can

stem from their cultural backgrounds (e.g., a desire to involve the entire family in therapy), regularly inquire about these preferences, and make adjustments as necessary.

Cognitive-behavioral therapists do not pathologize culturally driven cognitions and behaviors. Cognitive-behavioral therapists consider the degree to which cognitive and behavioral reactions are to be expected in light of patients' cultural backgrounds before concluding that the reactions are "diagnostic." They take care to validate patients' perceptions of oppression, and they refrain from attempting to change core cultural beliefs (Hays, 2009).

Cognitive-behavioral therapists use outside resources when necessary. When cognitive-behavioral therapists are working with patients who have a background with which they are not familiar, they read quality published work to educate themselves. When necessary, they seek supervision from a mental health professional who possesses the necessary expertise and background.

Although there is a paucity of large randomized controlled trials that have evaluated culturally relevant adaptations of the Beckian approach to CBT, much literature has described adaptations for specific cultural groups that have been examined in the context of smaller pilot studies. To take but one example, Interian and Díaz-Martínez (2007) described culturally competent CBT for depression with Hispanic patients. They emphasized the importance of making available Spanish language services. They pointed to many dimensions associated with acculturation that will influence the case conceptualization, such as dominant language, foreign versus US education, and adoption of American values. They also showed the manner in which many key values held by Hispanic individuals could affect their perception of a therapist's interpersonal style, which could in turn affect the therapeutic alliance. For example, they encouraged therapists to be mindful of *formalismo* (the expectation of formality in interactions) and *respeto* (the notion of respect toward people who are older, in positions of authority, parents, and relatives) when they address their patients. They introduced the concept of *dichos*, or sayings or proverbs in Spanish language, and demonstrated how *dichos* can illustrate the rationale for cognitive and behavioral techniques. This treatment package was evaluated in a pilot study of 15 patients (Interian, Allen, Gara, & Escobar, 2008), which found that mean depression and anxiety scores decreased by 57% and 67%, respectively, from pre to post treatment. Larger scale research of this nature would be a welcomed addition to the literature.

CLINICAL ILLUSTRATION

"Jake" is 50-year-old man who identifies as gay and who was diagnosed with persistent depressive disorder of moderate severity. Although his depression did not affect his ability to be productive at work, he often isolated socially and spent time vegetating at home on the evenings and weekends, rather than engaging in activities that, in the past, had brought him pleasure. He admitted to passive suicidal thoughts (e.g., "What's the point of me being here?") and hopelessness but denied a desire or intent to kill himself.

Jake sought out CBT after having been in supportive psychotherapy for the previous year. He first presented for supportive psychotherapy after his close friends banished him from their tight-knit group, remarking that he was a "downer" and that he created too much "drama" during their weekend activities. Jake admitted that he was easily hurt when he perceived that his friends were closer with one another than with him, and as a result, he would either give them the "cold shoulder" or make self-deprecating remarks. However, at the same time, he thought their reaction to him was extreme and that he was being treated unfairly. Jake had few friends outside of this group. He was active on social media sites, and he often saw photos of his friends enjoying dinners and vacations, which further exacerbated his depression. After a year of supportive psychotherapy, Jake did not believe that he was handling the loss of his friends any more effectively than he had when he started psychotherapy, and he began looking for other options for mental health treatment.

Thus, Jake pursued CBT upon the recommendation of his psychiatrist. The early phase of CBT was devoted to socializing Jake into the CBT structure, process, and model; addressing negative attitudes toward treatment; gathering information to formulate a cognitive case conceptualization; and developing a treatment plan. On the one hand, education about CBT's structure, process, and model was straightforward for Jake, as he was bright and had done much research about CBT prior to his first appointment. On the other hand, Jake readily expressed skepticism about treatment, remarking, "I'm 50 years old. I've

always been this way. I can't change how I think." In response to this sentiment, Jake's therapist educated him about the manner in which negative self-fulfilling prophesies can decrease the degree to which patients embrace treatment and implement strategies in their own lives. She also proposed that he commit to four additional sessions, keeping an open mind and withholding judgment until they evaluate progress at the end of those four sessions. Jake agreed to do this, continuing to say that he was skeptical, but, at the same time, committing to regular attendance and completion of homework. At the end of the first session, Jake solidified his goals for treatment, including (a) reducing the frequency and intensity of self-deprecating thoughts; (b) reducing the time spent tracking his former friends on social media, and conversely increasing the time spent engaged in pleasurable activities that he had been foregoing; (c) developing skill and practice in negotiating awkward social situations in which he encountered his former friends; and (d) achieving a sense of acceptance of the loss of his close-knit friendship group and forgiveness.

Jake's therapist used two primary strategies when he transitioned into the middle phase of treatment. First, she taught him the steps of cognitive restructuring, in which he learned to identify automatic thoughts (usually those that were self-deprecating, such as "I'm a loser" and "No one wants to be around me"), evaluate their accuracy, and modify them on the basis of that evaluation. Jake's therapist encouraged him to rate the intensity of negative affect associated with his automatic thoughts and with his balanced responses. In general, he typically rated the negative affect associated with his automatic thoughts at an intensity of 8 or 9 on a 10-point scale (0 = none; 10 = highest level), and his balanced responses at an intensity of 5 on the 10-point scale. Thus, Jake was having some success with cognitive restructuring, although he continued to experience moderate levels of negative affect when he was faced with reminders of the loss of his friends.

The second strategy that Jake's therapist used as Jake entered the middle phase of therapy was behavioral activation, with the idea that Jake was spending his time outside of work consumed with checking on his former friends' activity on social media at the expense of engaging in other activities that, historically, had brought him much pleasure and meaning. Jake indicated that he, indeed, had many interests in the past, including gardening, attending jazz concerts at small venues, and antiquing. He also acknowledged that he lacked energy and motivation over the past year and that it was much easier to stay indoors on the couch than engage in these activities. Thus, Jake and his therapist embarked on activity scheduling in order to gradually work some of these activities back into his time outside of work.

After four sessions of treatment that was focused on cognitive restructuring and behavioral activation, Jake and his therapist evaluated his progress. Although Jake remained unconvinced that CBT would be fully effective, he indicated that he saw more progress than he did in his previous course of therapy and that he was interested in continuing. The most significant problem that Jake perceived in treatment was that he understood, intellectually, that his automatic thoughts were characterized by all-or-nothing thinking and were overstated, which worsened his mood. However, he continued to believe, emotionally, that these thoughts were true and that he was destined to be alone for the remainder of his life. Throughout the four sessions of their work in the middle phase of treatment, Jake's therapist had noticed him mention in passing several invitations to go on outings with other friends and acquaintances, many of which he would dismiss (e.g., "They're just inviting me because they feel sorry for me."). She asked if Jake would be willing to keep an *evidence log*, in which he would prospectively record any positive gestures from others, such as invitations to social gatherings, emails or text messages that checked in to see how he was doing, or compliments. Jake was intrigued and agreed to do this for homework.

When Jake returned for his subsequent session (his sixth session), he expressed great surprise about the number of people who made gestures of friendship toward him. He had gone out to dinner twice with two different friends, he had chatted via text message with two other friends, and he noticed that many people commented on his social media postings. During the course of discussion, Jake realized that he carried the core belief, "I am unlovable," which manifested itself in self-deprecating automatic thoughts whenever he was faced with a social interaction in which there was the possibility of rejection. He tracked the development of this belief to growing up in a conservative small town, where he did not feel comfortable expressing his sexuality and assuming that he would always be different than other

people, thus not having a chance to have a romantic relationship with another man. He indicated that he feared prejudice and discrimination, which he anticipated would bring shame upon his family and further reinforce the belief that he was unworthy of being loved. When he finally embraced his sexuality in his early 40s, he believed that it was too late to have a romantic relationship because he had missed critical developmental experiences that would have taught him how to function in relationships. In fact, when he presented for CBT, he had never had a romantic relationship that lasted longer than a couple of weeks. Although this background only gave him the vague sense that he was unlovable, the rejection of his close group of friends fully activated this core belief.

For the next several sessions, treatment consisted of (a) practice with cognitive restructuring of automatic thoughts so that this tool was well practiced and available to him when he needed it in the moment; and (b) core belief work to shift Jake's belief from "I'm unlovable" to "I'm just as loveable as everyone else, and I have something to offer." To achieve this belief shift, Jake continued to keep his evidence log, and each week, he recorded more and more attempts at contact, invitations to social gatherings, and kind gestures from others. He also implemented some behavioral experiments, such that he proactively reached out to friends and acquaintances outside of his former circle of friends to get together for coffee, lunch, or a movie. The aim of these behavioral experiments was to test the prediction that he would be rejected, which was associated with the belief that he was unlovable. He was also prepared with strategies for coping with worst-case scenarios (e.g., someone telling him that he was not interested in getting together with him) and ensuring that he viewed worst-case scenarios in a balanced manner (e.g., "If someone doesn't want to get together with me, it doesn't mean I'm unlovable. It could be that the other person has a lot on his plate. And, even if he truly doesn't care for me, the opinion of one person is not equivalent to everyone's opinions."). Fortunately, every behavioral experiment that he implemented was a positive learning experience, as either the people to whom he reached out readily accepted his invitation, or they declined for a valid reason and expressed remorse that they could not get together.

A special challenge that arose during the course of CBT was the city's annual gay pride weekend festival, which Jake very much wanted to attend but was sure that he would encounter his group of former friends. At this point in treatment, Jake was adept at using cognitive restructuring and no longer viewed himself as wholly unlovable, but he worried that seeing these friends would activate the negative belief and automatic thoughts and that he would be back to "square one." Jake and his therapist spent two sessions planning for this event, such that they (a) prepared balanced responses to negative automatic thoughts in advance and wrote them on coping cards that Jake could consult in moments of emotional distress, and (b) practiced appropriate social skills for politely and nonjudgmentally acknowledging these friends should the opportunity arise to interact with them. Jake indeed attended many events at the gay pride festival and saw many members of his former group of friends. Although he was disappointed that the person who he viewed as his closest friend did not acknowledge him, he was pleasantly surprised to see that several other people from this group of friends hugged him and expressed a desire to get together in the future. Jake also indicated that he had urges to fall back into his old patterns of behavior (e.g., giving the cold shoulder, making self-deprecating comments), but that he refrained and instead used the interpersonally effective communication skills that he had practiced in session. When he presented for his subsequent session, he pronounced that he no longer believed that the rejection of his friends meant that he was unlovable, but that it was an unfortunate confluence of the consequences of his persistent depression and the influence of his closest friend, who had grown tired of him.

At session 15, Jake moved into the late phase of treatment. He reviewed what he had learned in therapy, described the manner in which he would have used his new cognitive and behavioral tools to manage his distress associated with the rejection of his group of friends, and anticipated the application of these tools to future challenges and disappointments. Interestingly, he began to date someone who he had met online, and he believed that he was approaching the relationship in a much different manner than he had in the past. Jake contacted his therapist approximately 3 months after the completion of treatment to provide an update, and he indicated that he was in the early stages of a satisfying romantic relationship and that he had cultivated a few close friendships with people whom he had previously dismissed as not providing support.

CONCLUSIONS/KEY POINTS

- CBT is a strategic, collaborative, time-sensitive approach to treatment in which clinicians work with their patients to (a) identify, evaluate, and if necessary, modifying unhelpful cognition; and (b) overcome avoidance and engage in behaviors that are pleasurable and meaningful.
- CBT was originally developed on the basis of the clinical observations of Aaron T. Beck, and its efficacy for the treatment of depression was established in the 1970s. Since that time, CBT's efficacy has been established for a wide range of mental health and related conditions, including anxiety disorders, substance abuse, eating disorders, personality disorders, suicidal behavior, bipolar disorder, and schizophrenia. It has been adapted for treatment in groups and with couples and families.
- A central component of CBT is the development of the cognitive case conceptualization, or the application of cognitive-behavioral theory to the patient's clinical presentation.
- Cognitive-behavioral therapists often use structured diagnostic interviews, self-report inventories, and self-monitoring to aid in the assessment process in order to develop a cognitive case conceptualization.
- Although every course of CBT is different because every patient's case conceptualization is different, typical strategies used in CBT sessions include cognitive restructuring, behavioral activation (for depression), exposure (for anxiety), problem solving, and skills training.
- Cognitive-behavioral therapists practice from a stance in which they are sure to verify the assumptions that they are making about their patients, especially patients from diverse backgrounds; model respect for individual differences; and seek consultation when necessary.

REVIEW QUESTIONS

1. What are the main features of CBT that make it unique?
2. Describe the main components of cognitive-behavioral theory.
3. What is the purpose of cognitive case conceptualization?
4. Identify the important features of three main CBT intervention strategies.
5. What are the important principles that cognitive-behavioral therapists keep in mind when they are working with diverse populations?

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7

Existential, Humanistic, and Experiential Therapies in Historical Perspective

Orah T. Krug

Abstract
Existential therapy is not a singular therapy but rather a rich aggregate of many therapeutic practices that organize around a shared concern: the lived experiences of human beings. This chapter focuses primarily on contemporary existential-humanistic (E-H) therapy, the prevailing American model of existential therapy, as well as other experiential approaches such as gestalt and emotion-focused therapy. The first section of the chapter provides a historical context for E-H therapy. The second section highlights those psychological pioneers of E-H therapy who have contributed to its theoretical development. Gestalt therapy and emotion-focused therapy are discussed as variations on the existential-humanistic approach and then illustrated with a few different examples. The last two sections review research on the efficacy of E-H and other experiential therapies and their sensitivity to the particular issues of diverse populations.

Keywords: existential-humanistic therapy, experiential therapies, phenomenological method, experiential reflection, meaning

It takes outward courage to die; but inward courage to live.

—Lao Tzu

How shall we live? How are we living in this moment? What really matters to us? How can we pursue what really matters? Existential-humanistic (E-H) therapy is an experiential therapy, which assumes that if life-limiting blocks are dissolved, more joy, satisfaction, meaning, and purpose will emerge. As Lao Tzu suggests, awareness of our existence requires an inward courage to face life—not avoid it. Existential therapy aims to help clients, through experiential reflection, understand how they miss a fuller life by constricting their living. Consciousness, personal freedom, and responsibility take root in this reflective process, supporting the incorporation of previously abandoned ways of being. A reclaiming of one's life is the ultimate goal, but this cannot be achieved until one knows what has been disowned. This type of change is not primarily concerned with symptom removal, although symptom removal often occurs. Rather, this type of change is in the core of one's being; it is "whole bodied" and transformative.

What is meant by E-H therapy? Existentialism is concerned with the living experience of becoming and originates from the Latin root *ex-sistere*, which literally means "to stand forth" or "to become." Humanism comes from the Greek tradition of "knowing thyself" (Schneider & Krug, 2010). Thus, "existential-humanism," although a seemingly static name, actually references the dynamic process of becoming and knowing oneself.

E-H therapy came into being in the early 1960s in the United States with the publication of Rollo May's edited book *Existence* (1958). *Existence* arrived at a time when humanistic psychology, founded by Abraham Maslow and Carl Rogers, was gaining popularity by challenging the more prevalent therapeutic approaches of behaviorism and psychoanalysis. The book's themes expanded the focus of American humanistic psychology by introducing "gloomier" existential concerns, such as death, limited freedom, and uncertainty into the "sunnier" humanistic landscape, flush with possibilities and potentialities. Perhaps, even more significant was the authors' challenge to an accepted "way of knowing" when they introduced a radical epistemology for understanding human beings, drawn from the European existential philosophers. This phenomenological epistemology valued knowing the person directly as opposed to projecting onto the person abstract models of human behavior, be they behavioral or psychoanalytic.

Thus, existential-humanistic therapy developed as an amalgam of American and European perspectives, uniting existential accents on limited freedom with humanistic accents on potentiality. Added to this distinctly American mix is a radical method of understanding human beings, not through a lens of abstract theories but through a direct encounter with the person's experiential world. Consequently, E-H therapy emphasizes (a) an experiential way of knowing oneself and others, (b) freedom to become within one's given limitations, (c) experiential reflection on one's personal meanings about becoming, and (d) responsibility to respond to what one becomes.

E-H therapy has its origins in the existential and humanistic philosophies that trace back to Greek, Renaissance, Romantic, and even Asiatic sources. However, the formalization of existential philosophy came about in the mid-19th century with Soren Kierkegaard (1813–1855). One day while sipping coffee and musing on his lackluster life, he had a flash of insight. Unlike his successful friends, who made life progressively easier by developing the railways and steamboats, he decided, given his "limited capacities, to undertake to make something harder" (as cited in Yalom, 1980, p. 15). Kierkegaard reasoned that ease could be dangerous in its excessiveness—better to look for difficulties. He didn't have far to look. As he considered his own existence, he encountered "his own dread, his choices, his possibilities and limitations." Kierkegaard devoted his life to exploring his existential situation and in 1844 published *Concept of Dread*. Kierkegaard worried that science was becoming a new god. He maintained that objective and rational perspectives were insufficient to explain how and why we do what we do. He advocated passion and inwardness. He was not a subjectivist, however. He believed that both objectivism, with its emphasis on the measurable, and subjectivism, with its emphasis on internal experiencing, were needed to fully inform our understanding of ourselves.

Kierkegaard believed that human beings exist on many levels, some contradictory and many unknowable; nevertheless, all levels must be included so we may fully grasp what it means to be human—human in the abstract, but more important, human in the particular, whether it be ourselves or another. He also suggested that human beings have a capacity to limit and to extend themselves, and that problems ensue when one capacity is emphasized to the exclusion of the other. Thus, the emotionless objectivist can be understood as too limited or contracted, while the passionate subjectivist may be understood as too extended or expanded. A healthy individual moves between both polarities (see Schneider & May, 1995, for an expanded explanation). Kierkegaard's perspectives on human functioning with regard to inclusiveness and complementary polarities form the foundation of E-H therapeutic theory and have influenced subsequent experiential therapies such as gestalt and emotion-focused therapies.

Drawing from the perspectives of the pre-Socratic philosopher, Heraclitus, the iconoclastic Friedrich Nietzsche (1844–1900) challenged the dominant European view that valued rationality and order over spontaneity and abandon. In *Twilight of the Idols* (1889/1982), Nietzsche predicted the demise of European culture if what he called "Apollonian consciousness" (reason and logical thinking) eventually excluded "Dionysian awareness" (emotions and instincts). Similar to Kierkegaard, Nietzsche understood how cultural problems would ensue if people embraced only one way of being, to the subordination or exclusion of its complementary opposite. Nietzsche believed our lives would be more balanced, natural, and dynamic if we acknowledged not only our need for order and discipline but also for spontaneity and abandon.

With science and technology ascending to greater heights in the early part of the 20th century,

coupled with the shock of World War I, the writings of Kierkegaard and Nietzsche found new supporters in Edmund Husserl (1859–1938), Martin Heidegger (1884–1976), and Jean Paul Sartre (1905–1980). Each objected to the increasing objectivism of the day to the exclusion of subjectivism and responded by formulating in different ways the structure of subjective experiencing.

Husserl introduced a radically new method to study human functioning that he called phenomenology, outlined in his book, *Ideas: General Introduction to Pure Phenomenology* (1913/1962). Husserl contended that the imposition of scientific attitudes on the study of humans reduced the human experience. It only provided a surface understanding of deeply complicated human behaviors such as smiling. An understanding of smiling could not be arrived at by using a simple stimulus-response paradigm, as in the "smile muscles" contract in response to a certain stimulus. Husserl posited *the person* on whose face the smile has manifested must be studied—the smile originates from the person's subjective feelings and/or thoughts—and not from the "smile muscles" contracting. Husserl's method valued experiential immediacy of the subject, arrived at because the researcher has bracketed (*epoché*) his or her presuppositions about the phenomenon. This phenomenological mode of knowing blends aspects of art and science and has had a profound influence on E-H therapeutic theory and other experiential therapies.

Heidegger was primarily concerned with exploring what it means "to be" or to exist. What if we could transcend our role-dominated lives and exist in our fullness, he wondered? These musings became Heidegger's project, combining a phenomenological inquiry of himself with Western philosophy that culminated in the publication of *Being and Time* in 1962. In this landmark work, Heidegger developed a philosophy of being. Heidegger contrasted "being-in-the-world" with "being-in-the-midst of the world." The former refers to an authentic self who is separate, centered (i.e., a self in contact with one's subjective experience), and related to the world. The latter refers to an inauthentic self, an uncentered self—a self that lives and does for others. The authentic self is present and responsive to self and the world; the inauthentic self is unresponsive to self and responds from habit and custom. Moreover, Heidegger's unusual phrasing "being-in-the-world" was his attempt to illustrate that no person or "dasein" could be separated from the world he or she lived in, because from the perspective of experience "dasein" is always contextualized; that is, a person is continually being influenced by the external world, and continually understanding this world from the context of his or her personal world. Finally, "dasein" refers to the fact that a person is a constituted object, and at the same time people (i.e., persons) constitute or create their world.

Sartre (1905–1980) was deeply affected by his experiences as a soldier during World War I and by Heidegger's views on human beings. In *Being and Nothingness* (1956), Sartre pointed out an increasingly worrisome practice: Even though peoples' experiences of being were radically different than those of things, people persistently confused *being* with their *roles*—be it a truck driver, a nurse, or a factory worker. Consequently people treat themselves and others as things or objects. To live authentically, said Sartre, one must constantly free oneself from this frozen "thing" identity and declare oneself a "no-thing." Sartre's extreme view of "no-thingness" meant a constant negating of one's past identities and the creation of new ones, to ward off the potential objectifying of oneself.

Maurice Merleau-Ponty (1908–1961) brought a more balanced perspective to existential philosophy and phenomenology. In *The Phenomenology of Perception* (1962), Merleau-Ponty updated Husserl's quest to find all knowledge in subjectivity, with a more balanced goal of "revealing the indeterminate intersubjectivity of viewpoints—always open to revision" (Schneider & May, 1995, p. 63). While he argues against essences, he challenged Sartre's view of nonessentialism, suggesting that Sartre diminished the potent contextual influences such as culture, history, and the subconscious on human functioning. Merleau-Ponty reclaimed the balanced perspectives of Kierkegaard and Nietzsche, challenging the notion that human experience was one sided.

Martin Buber (1878–1965) is best known for his work *I and Thou* (1958), in which he describes two basic levels of interaction: the "I-it" and the "I-thou." If one is treating a person as a thing, or an object to be manipulated, then one is interacting on the "I-it" level. Most interactions take place, as Kierkegaard pointed out, on this level. But if one assumes that the human being is complex and

unique, then one will cultivate an attitude of surprise and interact on the "I-thou" level. Buber's emphasis on the "I-thou" level of connecting known as "the between" space became a foundational principle of E-H therapeutic theory.

While earning his graduate degree at Columbia University, Rollo May met professor Paul Tillich (1886–1965), a brilliant philosopher and theologian, exiled from Nazi Germany in the early 1930s. Tillich's philosophy of human beings exerted significant influence on May's thinking. Tillich mentored May, and eventually they became good friends and colleagues. Tillich's best known work entitled *The Courage to Be* (1952) explores the challenges of being human, a reflection on the courage we need to face life full on, without contracting to avoid our *finite freedom*, just one of the realities of existence. Tillich maintained that the goal of therapy was to help people accept the unacceptable.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS

E-H therapeutic theory developed when cries of protest arose from various corners of the European therapeutic community—objecting to the reigning behavioral and psychoanalytic models of human beings. Rollo May, influenced by Alfred Adler in Europe and Paul Tillich in the United States, was the initial shaper of E-H therapeutic theory. Others followed with their own variations on his theme. This section reviews these theorists and their theories.

The Phenomenological Method—A Way to Enter the Person's Experiential World

Existential psychology developed in Europe as a rebellious response to behaviorism and psychoanalysis, the two major psychological movements of the 20th century. Ludwig Binswanger and Medard Boss, among others in the existential-analytic movement in Europe, contended that neither behaviorism, spearheaded by Watson and Skinner, nor psychoanalysis, developed by Freud, had a theory of human beings that truly explained a person as he or she really was. They worried that the theories postulated by behaviorism and psychoanalysis obfuscated the real, living persons whose worlds are unique and concrete. To help clients, the therapist must truly know them, which means the therapist must find ways to enter into and exist in their clients' experiential worlds—not merely project onto them some theoretical notions of human functioning. This radical, experientially oriented method of understanding the lived experience of human beings challenges the assumption that humans can be adequately understood in terms of some theory, whether it be mechanistic, biological, or psychological. E-H therapy as well as its variations (e.g., gestalt and emotion-focused therapies) was founded on this new phenomenological method of understanding human beings and the world they live in.

By the late 1960s, E-H therapy became a recognized therapeutic orientation. Rollo May's edited book *Existence* (1958) and James Bugental's *The Search for Authenticity* (1965) allowed E-H therapy a place at the table alongside the two major psychotherapeutic orientations: behaviorism and psychoanalysis. But E-H therapy differed from these orientations in that it was not offering the field of psychology a new therapeutic system. Rather, it offered a new understanding of the structure of human existence and a new method to enter into the personal worlds of human beings that could serve as a foundation "on which all specific therapeutic systems could be based" (Schneider & May, 1995, p. 85).

E-H therapy was met with a good deal of resistance when May introduced the approach to the United States, even though it was widely accepted in Europe. To some extent, the E-H approach still suffers from a lack of support from the academic community, in part because the academic community overvalues quantitative empirical research as a way to validate knowledge. The basic principles of E-H therapy do not lend themselves easily to quantitative empirical study. And yet, the phenomenological method is intuitively understandable to all therapists. To understand the inner world of their clients, therapists must encounter their clients without standardized instruments or preconceived notions. As Yalom (1980) suggests, "so far as possible one must 'bracket' one's own world perspective and enter the experiential world of the other" (p. 25). There is nothing esoteric or highbrow about this method. All good therapists engage in this way of being with the client—it simply means being present, accepting, empathic, and attuned to the meanings clients have made about themselves and their experiences.

Human Beings Make Meaning From Experiences in the Objective World to Create Their Personal Worlds

In *Existence* (1958, p. 11), Rollo May defined existentialism as the "endeavor to understand man by cutting below the cleavage between subject and object which has bedeviled Western thought and science since shortly after the Renaissance." What did May mean by "cutting below the cleavage between subject and object"? Existential theory challenges the Cartesian notion of a world made up of objects, and subjects who perceive those objects. Individuals, according to existential theory, do more than simply perceive and experience reality; they, in fact, participate in constituting their realities by making meanings of their perceptions and experiences as they relate to the objective world. Thus, they are not simply aware; they are conscious—aware of being the ones who makes meanings from experiences. This is a core concept across all existential, humanistic, and experiential therapies. Within this definition of existence lies (a) we are centered in our being and create meanings about our world and our selves; (b) *freedom*: we choose how we define our perceptions and experiences; (c) *responsibility*: we are responsible for the choices we make, and d) *change*: we have agency to create new meanings about our world and our selves.

The Process of Shaping Consciousness Results in a Sense of Self

E-H therapy assumes that the process of constituting or shaping one's reality results in the creation of self and world constructs (i.e., how we understand our nature and our experiential world). Rollo May (1975) called this shaping of reality or consciousness *passion for form* that results in, as he called it, an "I am" experience. May's concept, while clearly informed by the existential philosophers, was also informed by process philosophy's great thinker, Alfred N. Whitehead. Whitehead's understanding of human beings as part of nature and therefore a matter of process was helpful to May's formulations about human beings. Whitehead's philosophy is part of a philosophical tradition going back to Heraclitus that focuses on *process*. Reality is not an assortment of material things, which is the Aristotelian notion, but one of process. Nature is a process, not a thing. A river is not a thing but a continuing flow that only exists if it has two complementary parts: water and a riverbed. Therefore, a human being, being a part of nature, is also not a thing but a continuing flow or process that exists with two complementary parts: constancy and change. In every moment (or "actual occasion"), the past (constancy) flows into the present (change) and orients the organism (us) to the future. In other words, our past is alive in the present moment (we have embodied memory) influencing how we are aware of the present moment and how we will project ourselves into the future (we have embodied anticipation). We are never simply aware of bare existence or thought. Awareness is our subjective reaction to our present moment derived from our past experiences and the external world. As May posits: "I can shape feelings, sensibilities, enjoyments, and hopes into a pattern that makes me aware of myself as a man or woman. But I cannot shape them into a pattern as a purely subjective act. I can do it only as I am related to the immediate objective world in which I live" (May, 1975, p. 135). Whitehead's perspective provides May (and existential psychotherapy) with a sound philosophical position from which to explain how a sense of identity is created—identity is created not as a purely subjective act but only as a dialectical process with the objective world.

Human Beings Are Both Free and Determined

A corollary to the dialectical process of identity formation is the assumption that human beings are both free and determined: a paradoxical premise with roots tracing back to the Greek philosopher Heraclitus. Humans are free because they make meanings from their experiences, and they are determined because these meanings are limited by natural and self-imposed limitations. In other words, our subjective freedom—that is, our freedom to form attitudes, meanings, and emotions about an experience—is limited by the objective facts of the experience and our personal, cultural, and historical context. We have the capacity to be aware of ourselves objectively, for example: "I have a cold with the symptom of a stuffy nose"; conversely, we can experience ourselves subjectively: "My head feels like its full of cotton and I feel rotten." Objective awareness pertains to measurable facts; subjective awareness pertains to

feelings and experiences. They are not in opposition; rather, they form a paradoxical unity of human experience. Human beings, unlike most organisms, have the remarkable capacity to make meaning and create an experiential world that is unique and personal, a world that includes both subjective and objective awareness.

May (1980) considers this paradox of human experience as the human dilemma—one that should not be resolved because choosing to emphasize one pole to the exclusion of the other can result in behavior that is either too expanded or too limited. Many people come to therapy suffering from an overemphasis of one pole, such as the emotionally repressed, objectively focused intellectual (too limited) or the pleasure-seeking, subjectively focused risk-taker (too expanded). E-H therapists are sensitive to this human dilemma, so they encourage a way of being that supports the development of both—objective and subjective awareness. The ability to move between the subjective and the objective pole is the source of human creativity and energy, but it is also deeply challenging.

In *The Courage to Be* (1952), Tillich brilliantly articulates this fundamental challenge of living courageously—to face the reality of our "finite freedom," without avoidance, denial, or repression. It takes courage to be fully present in life, to face the "givens" of life and of one's personal experiences and limitations. The choices we make determine who we become. Often an internal battle develops between those parts of self seeking consciousness and the protective life stance, created to block those parts from consciousness. This psychological split often results in self-alienation or estrangement. Illuminating and holding the client's internal battle is a major focus for E-H therapists. In *Escape From Freedom* (1941), Eric Fromm describes how people have tended to resolve this internal battle by relinquishing personal freedom for the safety and security of authoritarian governments or, in the more modern version, by conforming unconsciously to cultural, societal, or mass media norms, thus avoiding the burden of personal responsibility.

Variations on Existential-Humanistic Therapeutic Theories

An E-H understanding of healthy functioning rests on three interdependent dimensions: engagement in experiential reflection, exercise of personal freedom, and the assumption of personal responsibility. Although E-H theorists almost invariably highlight all three of these dimensions, they do so in unique and varied ways. For example, Rollo May (1981) gives primary attention to freedom and that which he terms "destiny." By freedom, May means the capacity to choose within the natural and self-imposed (e.g., cultural) limits of living. Freedom also implies responsibility, for, as he challenges: If we are conferred the power to choose, is it not incumbent upon us to exercise that power?

James Bugental (1915–2008) gave primary attention to the client's subjective lived experience. Bugental's life project was to deconstruct the process of E-H therapy. Bugental made it knowable by inviting his readers into the therapy room to illuminate the therapeutic encounter with pristine clarity. His theory emphasized the self as a matter of process yet embodied, separate but related to the world. The person who comes to therapy is usually self-alienated because of a psychological split. This person experiences an internal battle between a tyrannical boss who drives an untrustworthy worker to do more and to prove himself or herself worthy against unreasonable expectations. This characterization is akin to the overly constricted person who objectifies himself or herself and is bound by excessive rules. Bugental aims for internal wholeness and authenticity by recovering the person's lost sense of being. Specifically, "being" is recovered when the person's awareness of what he or she feels and wants becomes clearer, often resulting in behavior more congruent with his or her feelings and wants. A sense of internal wholeness and authenticity is experienced as: "I have agency, I am in charge of my life." This reclaiming of self occurs by heightening the client's immediate subjective awareness—an awareness that implies freedom, choice, and responsibility.

Bugental's therapeutic perspective illustrates the close ties between existential therapy and humanistic therapy. His emphasis on individual subjective experiences and the need for human beings to be true to their own needs rather than conform to the needs of others shows the influence of humanistic psychologists such as Abraham Maslow (1968) and Carl Rogers (1961). On the other hand, his emphasis on the individual as a freely choosing, self-aware, and meaning-making being draws more from the existential approach.

Irvin Yalom is probably the most famous existential psychiatrist practicing today. In his widely read "teaching novels," academic textbooks, and

intriguing case studies, existential theory and practice become not only understandable but also intuitive. A gifted storyteller, Yalom has brought an awareness of existential concepts to people in every corner of the globe. Early in Yalom's career at Stanford University, he wrote *Existential Psychotherapy* (1980), in which he outlines, using vivid case histories to illustrate, the existential therapeutic perspective. In it he describes four "givens" of human existence: death, freedom, isolation, and meaninglessness. Yalom asserts that the extent to which we are able to confront these givens will determine the extent of the dynamic conflict. If we need, for example, to deny the reality of death, we may cope by developing overexpanded, extreme risk-taking behavior, or we may cope with overconstricted, excessive rule-bound behavior. But if we are able to face these givens sufficiently, our lives will be more balanced, free, honest, and congruent.

Thus, the central aim of therapy is to "de-repress" and reacquaint the individual with something she or he has known all along. This consists of two parts. The first part involves encouraging the individual to engage in experiential self-reflection and attend to his or her existential situation. Although painful but healing, this confrontation allows the individual to accept responsibility for shaping one's life. But responsibility assumption is only the first step. For real change to occur, the person has to behave differently. This happens when the therapist asks the client implicitly and sometimes explicitly if he or she is satisfied with how his or her life is unfolding. When the likely negative response arrives, the therapist embarks with the client on a difficult journey to transform personal dissatisfaction into constructive action.

Kirk Schneider (1999, 2008) has elaborated on a constrictive/expansive continuum of conscious and subconscious personality functioning. According to Schneider, this constrictive/expansive continuum of personality functioning has a capacity that is both freeing and yet limiting. We have a capacity to "draw back" and constrict thoughts, feelings, and sensations, as well as an equivalent capacity to "burst forth" and expand them. For Schneider, it is the interplay among constrictive and expansive capacities that constitutes personal and interpersonal richness and health.

As a result of Orah Krug's long association with two brilliant existential practitioners: James Bugental and Irvin Yalom, existential-humanistic therapy is now understood as a therapy with a subjective and a relational focus (Krug, 2009, 2010, 2016). This wider focus illuminates varied patterns of being, be they intrapsychic or interpersonal. Moreover Krug's research on the effectiveness of E-H supervision and training (Krug & Schneider, 2016; Pierson, Krug, et al., 2015) has aligned with recent findings calling for an emphasis on the personal dimensions of training, including therapeutic presence and responsiveness (Fauth et al., 2007).

E-H therapy also evolved further in the form of an integrative methodology. In their 1995 book, *The Psychology of Existence* (updated by Schneider in 2008), Schneider and May set about to reinvigorate E-H practice by drawing inspiration from May's original perspective: E-H therapy offered the field of therapy an understanding of the structure of human existence that could serve as a foundation for all specific therapeutic systems. With the advent of existential-integrative (EI) therapy, Schneider and May developed one way to utilize a variety of therapeutic modalities within an overarching existential or experiential context. Thus, E-H therapy has become a new bridge to both mainstream and existentially oriented therapies. Schneider and Krug expanded on this new perspective of E-H therapy in their textbook, *Existential-Humanistic Therapy* (2010). They proposed that E-H therapy could possibly serve as a foundation for all effective treatments by offering mainstream and existentially oriented therapies a phenomenological method of understanding the experiential world of the person. As a result, today's E-H therapy has become for many an increasingly integrative therapy.

Currently three variations on the E-H approach exist. They are gestalt therapy, emotion-focused therapy, and client- or person-centered therapy. Because client- or person-centered therapy is essentially a rebranding of humanistic therapy, the principles of which have been explained in the preceding sections, only gestalt and emotion-focused therapies will be discussed as they chronologically originated.

Gestalt therapy was founded by Frederick "Fritz" Perls (1893–1970) and flourished during the 1960s. It continues as a therapeutic system because of its focus on the lived experience of the whole person. Existentialism informs many aspects of gestalt therapy. The existential viewpoint that Western societies have exalted intellectual reasoning over subjective experience was turned into the challenge by Perls to "lose your mind and come to your senses" (Truscott, 2014, p. 189). Other existential influences are seen in

its emphasis on choice and responsibility and its focus on *how* a person lives, not on *why* the person behaves in a certain manner. Illuminating the present subjective experience is most important—the "what is." The causes are assumed to be irrelevant. Contact with one's immediate experience in the present moment results in healthy functioning by allowing an awareness of how one is thinking, feeling, and doing.

Leslie Greenberg (Elliott & Greenberg, Chapter 8, this volume), whose training included gestalt and humanistic therapies, developed emotion-focused therapy (or EFT) as a guide to working systematically with emotions. Emotions according to EFT are "fundamentally adaptive ... providing our basic mode of information processing ... automatically appraising situations for their relevance to our well-being and producing action tendencies to meet our needs" (Greenberg, 2014, p. 117). Greenberg posits that "emotion schemes," which are internal memory structures, form the foundation of a person's emotional response system. "They are internal emotion memory structures that synthesize affective, motivational, cognitive, and behavioral elements into internal organizations that are activated rapidly, out of awareness, by relevant cues" (Greenberg, 2014, p. 119). The similarities of existential concepts to that of emotion-focused concepts are notable. Specifically similar is the concept of self and world construction to the concept of emotional schemes construction. In both theories, people (i.e., persons) do more than simply perceive and experience reality; they, in fact, participate in constituting (or in EFT language "synthesizing") their reality by making meaning of their perceptions and experiences as they relate to the objective world. In E-H therapy this "constituting" results in the creation of self and world constructs, and in EFT this "synthesizing" results in emotional schemes. The two theories interrelate further by understanding experiencing as an amalgam of feelings, thoughts, and behaviors which are present in the living moment but often "unregarded" in existential terminology and "out of awareness" in EFT terminology.

THEORY OF CHANGE IN EXISTENTIAL, HUMANISTIC, AND EXPERIENTIAL THERAPIES

E-H and other experiential practitioners base their conception of human change processes on their suppositions about human nature, human experience, and human functioning. Human beings are understood to be always *in the process of becoming*, situated as a being-in-the-world—related to the physical, personal, and social worlds. Human beings are not simply a collection of drives and behavior patterns within encapsulated selves—human beings are more than the sum of their parts. Human beings continually shape their experiences because they are capable of self-reflection and subjective meaning making; thereby they participate in continually constructing personal worlds from their unique perceptions of the objective world (in EFT terms "synthesizing" experiences into emotional schemes). This is the meaning of consciousness: "I can be aware that I am a being who has a world." Personal identity making is thus an ongoing, dialectical process of self and world, two poles united and always relating. Hence, human beings have agency: free to change, to make new meanings—yet are bound by the givens of existence and their unique personal, cultural, and historical contexts. We are both free and determined.

The meanings made from lived experiences create a set of self and world constructs that allow individuals to understand their nature and their experiential world. These constructs about self and world constitute an individual's context that varies, influenced by the personal, cultural, historical, and cosmological experiences of each individual. An individual's context acts as a "lens" from which one sees and makes sense of one's world and oneself. One person, for example, may see himself as loveable and perceive his world as kind and accepting, whereas another may see herself as unworthy and perceive her world as judgmental and critical. The present, objective world is continually influencing the individual's context—simultaneously one's context is continually influencing one's perceptions and experiences of the objective world; that is, *perception and experience are always contextualize*d. As Bonnie Raitt, the philosophical singer-songwriter suggests, "no matter if our glasses are on or off, we see the world we make."

One's context inevitably limits one's capacity to be fully free, fully open, or fully responsible. Most people have developed some type of limiting or constricting pattern of protection. These protection patterns or life stances can be understood as overemphasized or polarized ways of being (e.g., excessive rationality, excessive emotionality, excessive giving, or excessive withholding). E-H practitioners (as well

as other experientially focused practitioners) believe that if polarized protection patterns are experientially embodied in therapy, then clients will be more willing and able to reclaim disowned or undeveloped aspects of self in the future. Put another way: The path to greater freedom is paradoxically found through an encounter with the ways in which one is bound. Moreover, clients' symptoms are understood not as problems to eliminate but rather as methods to maintain selfhood by shutting out disavowed feelings or experiences.

The road to a fuller, more vital sense of being is to help clients experience and attune to their polarized, limiting protection patterns and their underlying fears and anxieties. In so doing, E-H therapists help clients to reflect upon, as opposed to react against, evocative material. This work typically results in clients appreciating the "functionality" of their symptoms and experiencing their polarized protection patterns as restrictive or self-limiting. Thus, by encouraging clients to experientially embody their restrictive patterns, clients can face and accept the givens of existence that may have been avoided, denied, or repressed. However, for the E-H practitioner, responsibility assumption is not sufficient—it is simply preparatory for substantive change evidenced when clients first make new meanings about themselves and then choose more life-affirming patterns for themselves and with others.

E-H therapists aim to know the person who comes for therapy at a deep structural level of being so as to illuminate the blocks and limiting polarized patterns. They wonder: "How is this person, in this present moment coping with his/her awareness of being alive?" They attune deeply (as do other experiential therapists) to the client's implicit experiences and process (a way of relating to self and others) underlying his or her "story." Being present, in this way, will illuminate the client's subjective self and world constructs (or in EFT terminology, emotional schemes) because the client's past is alive (embodied) in the present moment. People (i.e., persons) make meaning of their experiences not as dry abstractions but as embodied memories richly laden with emotions and opinions about self and others, which then manifest concretely in vocal tones, affect, body postures, language, dreams, and relational behavior patterns. Experientially oriented therapists know they don't have to go on a treasure hunt to understand the client's past—it's right in front of them! If therapists bring a full and genuine presence to the encounter, they can empathically enter their clients' experiential worlds and know them as they are and the meanings they have made about themselves and their lives.

The Latin root for presence is *prae* (before) + *esse* (to be)—presence means "to be before." Consequently, presence can be understood as the capacity "to be before" or to be with one's self and/or "to be before" or to be with another human being. Presence involves aspects of awareness, acceptance, availability, and expressiveness in both therapist and client. Presence implies that the encounter is real. For Martin Buber (1958), it means that the person who is before one has ceased being an "it" and has become a "thou"; it means that we are all humans who include each other in each other's recognition. If one can be truly present with another, then a genuine encounter has occurred. *Hence, presence is both the ground for a genuine encounter and a method for effecting transformational change.*

Given this background, it may be clearer why E-H therapists and other experiential therapists cultivate a presence to the client's immediate and implicit experience and process. They attune to what is most alive in the moment and respond accordingly: whether it is a focus on the interpersonal space or on the client's subjective experiencing. Whereas discussions can help clients incorporate a specific event, for example, a memory of abuse, deep attunement or presence can help clients experience the self-limiting stance created to protect their selves from overwhelming feelings. The process of illuminating the life stance that both echoes and transcends the event and then helping one to reclaim the disowned feelings hidden behind the stance is the life-changing work of E-H therapy. The deepest roots of trauma cannot be talked about or explained away; they must be discovered, felt, and lived through. Change is evidenced when new meanings about self are made; for example, "I no longer feel damaged—I feel loveable." These new meanings about self typically result in a construction of more functional patterns of living and relating to others.

E-H therapists attend to three dimensions of experience and process: (a) the personal or subjective dimensions of both client and therapist (i.e., a focus on "self"); (b) the interpersonal or relational dimension (i.e., a focus on the "in-between" field of client and therapist); and (c) the ontological or cosmological dimension (i.e., an existential focus on "the world").

Being present to all three dimensions of experience and process is crucial—all three dimensions are "actual" in the present moment and provide entry into the feelings and world of the client (for a case illustration, see Schneider & Krug, 2010, p. 69). Moreover, E-H therapists and other experiential therapists work to facilitate change in clients by cultivating therapeutic presence, activating deep experiential reflection, identifying and illuminating polarized protective patterns, and supporting the reclamation of disowned experiences, thus allowing for the creation of new meanings and more constructive ways of being. Said briefly, the net result for clients is an expanded sense of self.

To sum, E-H theorists and other experiential therapists share four core aims: (1) to help clients to become more present to themselves and others; (2) to help them experience the ways in which they *both mobilize and block themselves from fuller presence*; (3) to help them take responsibility for the construction of their current lives; and (4) to help them choose or actualize ways of being in their outside lives based on facing, not avoiding, the existential givens such as finiteness, ambiguity, and anxiety.

RESEARCH ON THE EFFICACY AND EFFECTIVENESS OF EXISTENTIAL, HUMANISTIC, AND EXPERIENTIAL THERAPIES

Recently therapeutic outcome research, using meta-analytic methods, found that the most significant factors responsible for therapeutic effectiveness were a healing environment, the therapeutic relationship, and the therapist and client's personal styles—and not specific techniques or treatment modalities (Elkins, 2007; Norcross, 2002; Wampold, 2001). These common or contextual factors, as they have come to be called, are the foundational principles of E-H therapy and other experiential therapies. According to Elkins (2007), these meta-analytic findings support what existential and humanistic practitioners have assumed: Techniques and particular modalities have their usefulness, but change and healing occur in the human dimension, characterized by qualities of safety, honesty, and acceptance as therapist and client work together.

Leading therapy researcher Bruce Wampold (see Schneider & Krug, 2010, p. 89) in a review of Kirk Schneider's edited book *Existential-Integrative Psychotherapy* (2008) asserts that the existential-integrative approach meets the criteria as a scientific psychological treatment. Even more important, he agrees with Schneider's supposition that an understanding of the principles of existential therapy may be needed by all therapists and could help form the basis of all effective treatments.

Unfortunately, contextual factors research has only had a limited impact on the field in the areas of orientation and training (Cooper, 2004; Elkins, 2007). Most mainstream practitioners still believe that empirically supported treatments (ESTs) are the treatments to employ and the training to learn (Elliott, 2002; Westen, Novotny, & Thompson-Brenner, 2004). The EST movement has relied on readily quantifiable forms of practice (e.g., cognitive-behavioral)—while neglecting or overlooking the contextual factors (and meta-analytic findings) mentioned earlier (see Cain & Seeman, 2002, and Wertz, 2001, for comprehensive reviews).

Nonetheless, there has been a shift that has given E-H therapy a good deal of momentum. The randomized controlled trial, once considered the "gold standard" of measurable psychotherapy, has been criticized from many quarters (see Bohart, O'Hara, & Leitner, 1998; Schneider, 2001). Conversely, qualitative research, once shunned by academic psychology, has recently received greater acceptance, while mainstream conceptions of outcome research have undergone significant changes (APA Taskforce on Evidence-Based Practice, 2006; Wertz, 2001). Existential and experiential therapies have been gaining a small but substantial foundation of empirical support (Elliott & Greenberg, 2002; Walsh & McElwain, 2002). As previously mentioned, there is growing support for the existential principles of practice in the area of systematic quantitative research, which is worthy of elaboration. The so-called context or common factors research consistently points to the relationship as opposed to technique as the factor responsible for change (Wampold, 2001). This research is reinforced in the growing research on expressed emotion (Gendlin, 1996; Greenberg, Rice & Elliot, 1993). Another interesting area of quantitative inquiry for E-H practice is the neuroscience of emotional regulation. Greenberg (2007) posited that in order for emotional regulation to endure, it must be worked through with nonverbal (embodied) approaches and not with those that stress cognition. Existential therapy has produced rich and expressive qualitative

case studies (e.g., Binswanger, 1958; Bugental, 1976; May, 1983; Schneider & Krug, 2010; Yalom, 1989). These expressive cases convey the lived experiences of therapist and client, vividly illustrating the healing powers of the therapeutic relationship. Finally, there is more research in the area of clinical training (Fauth et al., 2007; Pierson et al., 2015; Krug & Schneider, 2016), which supports the principles of E-H practice by calling for an emphasis on the personal dimensions of training, including presence and responsiveness.

Related to these shifts is the publication by the American Psychological Association of a textbook on E-H therapy (Schneider & Krug, 2010), and a companion video series called "Psychotherapy Over Time" (Schneider, 2009). Most recently, the American Psychological Association has published a textbook that focuses on the training and supervision of students from an E-H perspective (Krug & Schneider, 2016) with a companion video (Schneider, 2016). Increasingly, there has been an integration of existential and humanistic principles into modalities like cognitive-behavioral approaches (Schneider & Langle, 2015).

Empirical investigation of E-H and other experiential psychotherapies is at an early but promising stage. Studies, from therapy outcome to neurology to psychiatric care, show convincingly that all experiential therapies have something important and helpful to offer our profession. Certain conceptual dimensions related to experiential practice such as the value of the therapeutic relationship over technique, the significance of the personality of the person who delivers the therapy, client's capacity for self-healing, and the value of emotional regulation have been confirmed by both quantitative and qualitative research while other areas need further clarification (Bohart & Tallman, 1999; Greenberg, 2007; Greenberg et al., 1993; Wampold, 2001). Empirical investigation of experiential practice is at an early but propitious stage. It may soon become a model evidence-based modality that stresses four crucial variables: experiential reflection, the therapeutic relationship, the therapist's presence or personality, and the active self-healing of clients.

DIVERSITY IN EXISTENTIAL-HUMANISTIC THERAPY

The following section examines the value and limitations of employing E-H therapy with a diverse population of clients. Although the other experiential therapies such as gestalt and emotion-focused therapies are not specifically referred to in this section, one can appropriately generalize from the discussion about E-H therapy and diverse populations, given that all value understanding the lived experiencing of the individual over treatments delivered to the individual. Consequently, E-H therapy, and other experiential therapies lend themselves to use with a variety of populations. There are case studies reporting successful use of E-H therapy with children, adults, and couples from a wide variety of cultural, religious, and ethnic communities (for an expanded explanation, see Schneider, 2008; Schneider & Krug, 2010).

Strengths From a Diversity Perspective

E-H therapy can be useful for a diverse population of clients because it does not demand a particular way of viewing reality. On the contrary, E-H therapists want to enter their clients' worlds and learn how they view reality. With its emphasis on presence and the I-thou relationship, clients from differing backgrounds, age brackets, and sexual orientations are provided with an accepting space to express their particular perspectives, values, and cultural norms. For example, E-H therapists would attune to the lived experience of a religious person in the same way they would attune to the lived experience of an atheist because attunement to lived experience is foundational to E-H practice. Consequently, E-H therapy can be effectively applied with diverse client populations, with a range of specific problems and in a wide array of settings.

The research on the effectiveness of common factors or contextual dimensions of therapy detailed earlier also supports the efficacy of E-H therapy with diverse populations. The issue for the E-H therapist is not so much the cultural background of the client but rather the meaning of that background for the client. How is that meaning manifesting in the client's present unfolding experience? A person's unfolding experience may not conform to his or her demographic profile; and to understand a person simply on his or her demographics is a diminution of his or her vital, lived experience. The E-H therapist's task is to assess the client's desire and capacity for change and how to best mobilize, support, and release that desire and capacity.

That being said, much more research is needed to understand the value of E-H therapy with clients from diverse backgrounds. Specifically, we need to know how the principles of E-H practice, like presence or the cultivation of meaning, impact clients from different backgrounds with different needs.

Vontress and Epp (2001) suggest that existential counseling is the most useful approach for clients of all cultures because of its focus on common concerns which all humankind faces: concerns related to love, death, anxiety, and meaning. These concerns transcend separate cultures. They further believe that therapists-in-training would benefit from an education that initially focuses on the commonalities between people from different cultures and secondarily on the areas of differences. It is more important to infuse the therapist-in-training with a tolerant and sensitive perspective than teach specific interventions for each culture.

Shortcomings From a Diversity Perspective

E-H therapy does have specific shortcomings. One of them is its tendency to invite depth and intensity when that invitation may not be appropriate. For example, if a client's desire or capacity for change is limited due to psychological, cultural, or intellectual factors, he or she may not benefit from or be capable of engaging in deeper experiential reflections. By contrast, a client who wants symptom-reducing therapy will probably not find intensive explorations into his or her life concerns particularly useful, at least not initially. That being said, most E-H therapists are unlikely to display such insensitivity to clients' needs. The sine qua non of E-H therapy is to meet clients where they are, and not where therapists want clients to be. E-H therapists have developed a high degree of sensitivity to the world of the other. Because of their skilled presence, most are quite effective at responding appropriately and effectively to the needs of their clients. E-H therapists understand that every client demands a new therapy that is unique to his or her needs and ways of relating. For example, E-H therapists working with children will listen and communicate empathically, using each child's special language to convey an understanding of and empathy for that child's unique and personal experiences.

In sum, there is no cardinal rule about for whom or in what circumstances E-H therapy will prove most effective. In keeping with the E-H practice philosophy, each connection, each setting, and indeed, each moment must be thoughtfully and attentively evaluated. Again, we cannot say enough about the value of "presence" for assessing the appropriateness of E-H (or any other kind of) therapy for struggling, panicking lives. To the extent that therapists can draw on their whole-bodied experience in therapy, they will be in an enhanced position to relate to, assess, and serve the clients they engage.

CONCLUSIONS AND KEY POINTS

The challenge of living courageously means one must face the reality of our "finite freedom," without avoidance, denial, or repression. It takes courage to be fully present to life, to face the "givens" of existence and of one's personal experiences and limitations. If one is able to be fully present to life, then according to existential thought one will not be psychologically split, but whole, living authentically, being the author of one's life. The choices we make determine who we become. Often an internal battle develops between the parts of self that want to become conscious with the protective life stance erected to keep those parts from consciousness. This "split in self" can cause a sense of estrangement and alienation from self. Illuminating and holding the client's internal battle is the primary focus for E-H therapists, a focus that often leads to an incorporation of these denied parts, which results in "whole-bodied" transformative change in the client.

Key Points

- The foundation of E-H therapy unites existential accents on limited freedom with humanistic accents on potentiality. In addition, it introduces a radical phenomenological epistemology concerning how one understands human beings—not by projecting onto the person abstract models of human behavior but by entering the person's experiential world.

- E-H therapy differed from the psychoanalytic and behavioral orientations, in that it was not offering the field of psychology a new therapeutic system; rather, it was offering a new understanding of the structure of human existence, to serve as a foundation on which specific therapeutic systems could be based.
- Human beings make subjective meanings from experiences in the objective world to create their personal world. A person is not simply aware; he or she is conscious, aware of being the one who makes meaning from experiences.
- Humans are free because they make meanings from their experiences, and they are determined because these meanings are limited by natural and self-imposed limitations.
- E-H therapy assumes that the process of constituting one's reality, or to put it another way, shaping consciousness, results in identity formation, for example, a sense of self. Often an internal battle develops between the parts of self that want to become conscious with the protective life stance that keeps those parts from consciousness. Illuminating and holding the client's internal battle is a major focus for E-H therapists.
- The road to a fuller, more vital identity is to help clients appreciate their polarized, limiting protection patterns; assist them to "embody" those patterns and their underlying fears and anxieties; and help them attune, at the deepest levels, to the implications of what has been discovered.
- E-H therapists (and other experiential therapists) cultivate a "presence to implicit experience or process" (process refers to an implicit way of relating or being, a life stance that manifests in body posture, vocal tone, etc.) over content, that is, discussions about the past.
- E-H therapy and other experiential practices may soon become models of evidence-based modalities that stress four crucial factors: (1) experiential reflection, (2) the therapeutic relationship, (3) the therapist's presence or personality, and (4) the active self-healing of the client.
- E-H therapy and other experiential therapies can be useful for a diverse population because they do not demand a particular way of viewing reality; instead, they value understanding the lived experiencing of human beings.

REVIEW QUESTIONS

1. Who were the key people responsible for the historical development of E-H theory and what were their contributions?
2. What are the distinguishing aspects of E-H theory?
3. What are the distinguishing aspects of subsequent experiential therapies?
4. How does an E-H therapist facilitate the change process?
5. How does current research support or challenge the efficacy of the E-H approach and other experiential therapies?

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8

Humanistic-Experiential Psychotherapy in Practice: Emotion-Focused Therapy

Robert Elliott
Leslie S. Greenberg

Abstract
In this chapter, we provide an overview of emotion-focused therapy (EFT), a contemporary humanistic psychotherapy that integrates person-centered, gestalt, and existential approaches. After sketching its history and main theoretical concepts, we outline a set of emotion change principles. These guide an emotional deepening process in which therapists help clients move from undifferentiated distress to secondary reactive emotions to primary maladaptive emotions to core pain and thence to primary adaptive emotions and emotional transformation. To do this, the therapist responds to key markers offered by clients, proposing appropriate therapeutic tasks such as unfolding problematic reaction points or two-chair work for internal conflicts. In addition, we briefly summarize the relevant outcome data, review the EFT case formulation process, lay out treatment principles, consider its application to diverse client populations, and provide a brief case example.

Keywords: humanistic-experiential psychotherapy, emotion-focused therapy, emotion, therapeutic tasks, social anxiety

Emotion-focused therapy (EFT) is an integrative, humanistic, empirically supported treatment based on a program of psychotherapy research going back into the 1970s (Elliott, Watson, Greenberg, Timulak, & Freire, 2013; Rice & Greenberg, 1984). Drawing together person-centered, Gestalt, and existential therapy traditions, EFT provides a distinctive perspective on emotion as a source of meaning, direction, and growth.

When developed in the late 1980s and early 1990s, this approach was referred to as process-experiential (PE) therapy (Greenberg, Rice, & Elliott, 1993), to distinguish it from related experiential therapy approaches, in particular, those of Mahrer (1996/2004) and Gendlin (1996). Emotionally focused therapy was reserved for a closely related form of couples therapy (Greenberg & Johnson, 1988). However, since the late 1990s, the term "emotion-focused therapy" (EFT), has come to be applied to the individual therapy (Greenberg & Paivio, 1998) and some versions of the couples therapy (Greenberg & Goldman, 2008).

Like other humanistic therapies, EFT is based on a set of core values (Elliott, Watson, Goldman, & Greenberg, 2004), which it strives to foster; these values have been updated in light of contemporary emotion theory (Greenberg, 2002) and dialectical constructivism (Elliott & Greenberg, 1997):

- *Experiencing* is central and emerges out of an evolving, dynamic synthesis of multiple emotion processes (emotion responses and schemes).
- At the same time, human beings are fundamentally social and have strong attachment needs,

which require human contact in the form of *presence* and *authenticity*.
- *Agency or self-determination* is an evolutionarily adaptive motivation to explore and master situations.
- *Pluralism/diversity* within and between persons is unconditionally accepted, validated, and even celebrated, leading to relationships based on equality and empowerment.
- A sense of *wholeness* is adaptive and is mediated by emotion. Instead of an overarching, singular executive self, however, wholeness stems from friendly contact among disparate aspects.
- *Growth* is supported by innate curiosity and adaptive emotion processes, and it tends toward increasing differentiation and adaptive flexibility.

EFT originated as an individual treatment for depression and a couples intervention for relationship problems, organized around a set of emotion theory concepts, treatment principles, and in-session tasks. Since then, it has continued to evolve, driven by work with clients suffering first from complex trauma and abuse (Paivio & Pascual-Leone, 2010) and more recently with anxiety (Elliott, 2013) and eating difficulties (Dolhanty & Greenberg, 2007). Application to these new client populations has led to the development of new therapeutic tasks, which has in turn led to more general understandings of core change processes and the process of emotional deepening and change (Pascual-Leone & Greenberg, 2007). At the same time, organized EFT training has been developed in many parts of the world, which has also helped bring greater clarity to its theory and practice. Moreover, treatment manuals have been written addressing EFT overall (Elliott, Watson, Goldman, & Greenberg, 2004), as well as how to treat depression (Greenberg & Watson, 2005) and address complex trauma (Paivio & Pascual-Leone, 2010) with EFT.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION

We will describe two sets of guiding principles of change in EFT. First, we will present the original set of general treatment principles that provided the foundation from which EFT developed; after that, we will lay out a more specific set of emotional change principles.

General Emotion-Focused Therapy Practice Principles

The actual practice of EFT is based on a set of six general practice principles. These include principles focused on the relationship and those that emphasize task facilitation.

1. *Empathic attunement.* The starting point for EFT is always careful empathic attunement to the client's immediate and evolving experiencing. Empathy is an evidence-based therapeutic process (Elliott, Bohart, Watson, & Greenberg, 2011) and the foundation of EFT practice. From the therapist's point of view, empathic attunement grows out of the therapist's presence and basic curiosity about the client's experiencing. Empathic attunement also involves at different times, orienting toward the main meaning expressed by the client, what the client wants to work on in the session, his or her emotion or what is most poignant, what it is like to be the client more generally, and what is unclear or emerging.
2. *Therapeutic bond.* Following Rogers (1957) and consistent with current assessments of the research literature (e.g., Norcross, 2011), the therapeutic relationship is seen as a key curative element. For this reason, the therapist seeks to develop a strong therapeutic bond with the client, characterized by communicating three intertwined relational elements: understanding/empathy, acceptance/prizing, and presence/genuineness. Empathy or understanding of client emotions and meanings can be expressed in many ways, including reflection and exploration responses and appropriate tone of voice and facial expression. Acceptance is the general "baseline" attitude of consistent, genuine, noncritical interest and tolerance for all aspects of the client, while prizing goes beyond acceptance to the immediate, active sense of caring for, affirming, and appreciating the client as a fellow human being, especially at moments of client vulnerability (Greenberg et al., 1993). The therapist's genuine

presence (Geller & Greenberg 2002) to the client is also essential, and it includes being in emotional contact with the client, being authentic (congruent, whole), and being appropriately transparent or open in the relationship (Lietaer, 1993).

3. *Task collaboration*. An effective therapeutic relationship also entails involvement by both client and therapist in developing overall treatment goals and immediate within-session tasks and therapeutic activities (Bordin, 1979), aiming to engage the client as an active participant in therapy. In general, the therapist accepts the goals and tasks presented by the client, working actively with the client to explore the emotional processes involved in them (Greenberg, 2002). In addition, the therapist offers the client information about emotion and the therapy process to help the client develop a general understanding of the importance of working with emotions and to provide rationales for specific therapeutic activities, such as two-chair work.
4. *Emotional deepening through work on key therapeutic tasks*. In EFT, therapists begin by working with clients to develop clear treatment foci and goals, and then track clients' current tasks within each session, particularly those tasks associated with their treatment goals. For example, given a choice of what to reflect, therapists emphasize experiences associated with treatment foci; in addition, therapists gently persist in offering clients opportunities to stay with key therapeutic tasks or to come back to them when distractions, sidetracks, or blocks occur. In doing so, therapists are partly guided by their knowledge of the natural resolution sequence of particular tasks, and so gently offer clients opportunities to move to the next stage of the work (for example, giving the critic in two-chair dialogue an opportunity to soften), if they are ready to do so. It is also important for therapists to be flexible and to follow their clients when they switch to an emerging task that is more alive or central for them.
5. *Self-development*. EFT therapists emphasize the importance of clients' freedom to choose their actions, in therapy as well as outside therapy. Beyond their general stance of treating clients as experts on themselves, the therapist supports the client's potential and motivation for self-determination, mature interdependence with others, mastery of difficulties, and self-development, including the development of personal power (Timulak & Elliott, 2003). For example, the therapist might hear and reflect the assertive anger implicit in a depressed client's mood, or the therapist might offer a hesitant client the choice not to go into exploration of a painful issue. We have found that clients are more willing to take risks in therapy when they feel they have the freedom to make therapy as safe as they need it to be.
6. *Emotional processing*. A key insight in EFT is the understanding that clients have different ways of working productively with their emotions at different times. We refer to these different ways of working as modes of engagement or emotional processing modes (Elliott et al., 2004; Greenberg et al., 1993). Client emotional processing modes include the following: mindful receptive focus on immediate perceptual experiences or specific memories; careful attention to immediate bodily experience and felt meaning; awareness and symbolization of immediate emotional experience; expressing wants or needs or the actions that go with them; and reflecting on the meaning, value, or understanding of experience. A common sequence is for clients to start by attending to external events, and then move back and forth between reflection on meaning and accessing and expressing emotions (Angus & Greenberg, 2011). This general principle will next be elaborated in the form of a further set of emotion change principles.

Emotion Change Principles

From the EFT perspective, change occurs by helping people make sense of their emotions through awareness, expression, regulation, reflection, and transformation (Greenberg, 2011), all in the context of the more general EFT change principles, including a therapeutic relationship characterized by a therapist who is actively engaged, emotionally present, and empathically attuned, and it offers positive regard and unconditional acceptance.

1. *Awareness*. Increasing awareness of emotion and its various aspects is the most fundamental overall goal of treatment and involves accessing and becoming aware of one's emotions. Once people know what they feel, they reconnect to their needs and are motivated to meet them. Emotional awareness involves accepting emotions rather than avoiding them; it also involves feeling the feeling in awareness rather than simply thinking about it. Lieberman et al. (2007) have shown that naming a feeling in words helps decrease amygdala arousal. EFT therapists thus work with clients to help them access, approach, tolerate, accept, differentiate, and symbolize their emotions.
2. *Expression*. Expressing emotion in therapy does not involve the venting of secondary emotion but rather overcoming avoidance to strongly experience and express previously constricted primary emotions (Greenberg & Safran, 1987; Greenberg, 2002). Doing this can also help clarify and focus attention on central concerns and needs, which in turn promotes pursuit of important goals. The role of emotional arousal and the degree to which this can be useful in therapy and in life depends on what emotion is expressed, about what issue, how it is expressed, by whom, to whom, when, and under what conditions, and in what way the emotional expression leads to other experiences of affect and meaning. Greenberg, Auszra, and Herrmann (2007) found that it was the manner of processing aroused emotions, rather than arousal alone, that distinguished good from poor outcome cases. They defined productive emotional expression as occurring when a client was aware of emotion in a "contactful" way.
3. *Regulation*. The awareness and expression principles are useful when emotion is absent or overregulated; however, when emotional arousal is too high, it no longer informs adaptive action (Pascual-Leone & Greenberg, 2007). Underregulated emotions that require downregulation are generally either undifferentiated or secondary distress emotions, such as panic, despair, or automatically generated primary maladaptive emotions such as the shame of being worthless or the anxiety of basic insecurity. EFT uses a range of methods for helping clients regulate these emotions: The most basic of these and generally the first step is offering a safe, calming, validating, and empathic presence. Emotion regulation processes also involve identifying and avoiding triggers, identifying and labeling emotions, allowing and tolerating emotions, establishing a working distance, increasing positive emotions, enhancing resilience in the face of painful emotions, self-soothing, breathing, and distraction; these are all useful coping skills. In particular, the ability to regulate breathing, to develop a working distance from intense emotions, and to observe one's emotions are important processes to help regulate emotional distress. Another important aspect of regulation is developing clients' abilities to self-soothe. Physiological soothing involves activation of the parasympathetic nervous system to regulate heart rate, breathing, and other sympathetic functions that speed up under stress. Promoting clients' abilities to receive and be compassionate to their emerging painful emotional experience is a key step toward tolerating emotion and self-soothing. Soothing of emotion can be provided by individuals themselves, reflexively or from another person, including the therapist, in the form of empathic attunement, acceptance, and validation.
4. *Reflection*. In addition, promoting self-reflection on emotional experience helps people make narrative sense of their experience and promotes its assimilation into their ongoing self-narratives (Angus & Greenberg, 2011). Reflection helps make sense of aroused experience. In this process, feelings, needs, self-experience, thoughts, and aims are all clarified and organized into coherent narratives, and different parts of the self and their relationships are identified. The result of this reflection based on aroused emotion is deep experiential self-knowledge. Situations are understood in new ways and experiences are reframed, which leads to new views of self, others, and world.
5. *Transformation*. Probably the most important way of dealing with emotion in therapy involves the transformation of *emotion by emotion* (Greenberg, 2002, 2011). In EFT an important goal is to arrive at maladaptive emotion in order to make it accessible to transformation. The coactivation of the more adaptive

emotion and the maladaptive emotion, in response to the same eliciting cue, helps transform the maladaptive emotion. Change in previously avoided primary maladaptive emotions such as core shame or fear of abandonment is brought about by the activation of an incompatible, more adaptive experience such as empowering anger and pride or self-compassion, which undoes the old response. This involves more than simply feeling or facing the feeling in order to diminish it. Rather, for example, the withdrawal motivated by a primary maladaptive emotion such as fear and shame is transformed by activating the approach tendencies that stem from anger or contact/comfort seeking. A key method for accessing new more adaptive emotion involves *focusing on what is needed* (Greenberg, 2002, 2010). New emotional states enable people to challenge the validity of perceptions of self/others connected to maladaptive emotion, weakening its hold on them. These states provide new, *corrective emotional experiences* with the therapist, which undo old patterns of maladaptive interpersonal experience (Greenberg & Elliott, 2012). Thus, experiences that provide interpersonal soothing, disconfirm pathogenic beliefs, or offer new success experience can correct patterns set down in earlier times. For example, an experience in which a client faces shame in a therapeutic context and experiences acceptance, rather than the expected disgust or denigration, has the power to change the feeling of shame.

Case Conceptualization

In keeping with the intervention and emotion change principles described earlier, EFT case conceptualization focuses more on process than content and relies primarily on a set of emotion theory concepts, such as emotion schemes and emotion response types.

Emotion Schemes

In EFT, emotions are conceptualized as organizing networks of interrelated experiences known as emotion schemes. These networks consist of many elements, among them: (a) *situational-perceptual* experiences, including affectively tinged memories and immediate appraisals (e.g., noticing that one is alone and isolated from others and remembering oneself as a lonely child); (b) *bodily sensations and expressions* (e.g., a sinking feeling in the chest accompanied by quivering lips); (c) *implicit verbal-symbolic* representations, including stock phrases and self-labels (e.g., "Unlovable"); and (d) *motivation-behavioral* elements, including needs and action tendencies (e.g., needing another person's affirming presence, while at the same time withdrawing from contact). When activated and attended to, this produces a conscious emotional experience, which can be considered as a fifth emotional element (e.g., an old familiar sadness at feeling abandoned and unloved).

Emotion Response Types

Four types of emotion responses are distinguished in EFT (Greenberg et al., 1993). *Primary adaptive* emotion responses are our first, natural reactions to the current situation that would help us take appropriate action. For example, if a person is being violated by someone, anger is an adaptive response because it helps the person to take assertive action to end the violation; sadness, on the other hand, indicates loss and motivates the need for connection. *Primary maladaptive* emotion responses are also initial, direct reactions to situations; however, they involve overlearned responses based on previous, often traumatic, experiences. For example, a client with borderline processes may have learned when he or she was growing up that caring offered by others was usually followed by physical or sexual abuse. As a result, the therapist's empathy and caring are responded to with anger, as a potential violation of boundaries. With *secondary reactive* emotional responses, the person reacts to his or her initial primary emotional response (which can be either adaptive or maladaptive), so that it is replaced with a secondary emotion. For example, a client who encounters danger and begins to feel fear may become angry about the fear, even when angry behavior increases the danger. Finally, *instrumental* emotion responses are strategic displays of an emotion for their intended effect on others, such as getting others to pay attention to or to approve of the person. Common examples include "crocodile tears"

(instrumental sadness), "crying wolf" (instrumental fear), and intimidation displays (instrumental anger).

Case Conceptualization Process

To promote a focus during brief treatment, EFT has developed a context-sensitive approach to conceptualizing clients, referred to in EFT as *case formulation* (see Goldman & Greenberg, 2014; Greenberg & Goldman 2007). In this approach, however, *process is privileged over content, and process diagnosis is privileged over person diagnosis*. In other words, EFT case formulation focuses primarily on developing a shared understanding of the client's core painful emotion, key in-session presenting issues, and recurring task markers, and only secondarily on their character structure or patterns of relating to self and others. In a process-oriented approach to treatment, case formulation is an ongoing process, as sensitive to the moment and the in-session context as it is to developing a more global understanding of the person.

Case formulation is helpful in facilitating the development of a treatment *focus* and in fitting the therapeutic task to the client's goals, thereby aiding in the establishment of a productive working alliance. In our view, formulations are always co-constructions that emerge from the relationship, rather than being formed by the therapist alone. The establishment of a problem definition is tantamount to the agreement on treatment goals in the formation of the initial alliance (Bordin, 1979). Table 8.1 depicts the steps that have been identified to guide clinicians in the development of case formulations (Greenberg & Goldman, 2014).

The first steps in developing a case formulation involve the identification of the presenting problems, listening to the related narratives, and gathering information regarding attachment and identity histories as they pertain to current relationships. In parallel with these initial steps and throughout the process, therapists attend to the manner in which clients process emotions from moment to moment. As therapists build the relationship, they begin to formulate the person's characteristic emotional processing styles. As therapy progresses, therapists continue to attend to momentary fluctuations in emotional processing style to make process diagnoses about how best to intervene. On the one hand, therapists note whether the client is emotionally overregulated or underregulated, or is engaged in restricted emotional processing such as purely conceptual or externalized; on the other hand, therapists track the client's experiential processing, noting whether emotion is accessed through personal memories or bodily sensations, expressed in action or reflected upon, and whether and

TABLE 8.1 Steps and Stages of Emotion-Focused Therapy Case Formulation

Stage 1: Establish relationship while unfolding the narrative and observing emotional processing style:

1. Listen to the presenting problems (relational and behavioral difficulties).
2. Listen for and identify poignancy and painful emotional experience.
3. Attend to and observe emotional processing style.
4. Unfold the emotion-based narrative/life story (related to attachment and identity).

Stage 2: Co-create the case formulation emphasizing focus and core emotions (MENSIT):

5. Identify recurrent markers (M) for task work.
6. Identify underlying core emotion (E) schemes, adaptive and maladaptive.
7. Identify needs (N).
8. Identify secondary (S) emotions.
9. Identify interruptions (I) or blocks to accessing core emotion schemes.
10. Identify themes (T): self-self relations, self-other relations, existential issues/interrupted life projects.
11. Co-construct the formulation narrative linking presenting relational and behavioral difficulties to triggering events and core emotion schemes.

Stage 3: Apply the case formulation by identifying emerging task markers, micromarkers, and new meanings:

12. Identify emerging task markers.
13. Identify micromarkers.
14. Assess how emerging new emotions and meanings create new narratives and connect back to presenting problems.

how new experience is emerging. Cues for emotional processing style include not only content but also the depth of experiencing by clients, their vocal quality, and the degree of emotional arousal. Attention thus is paid to *how* clients are presenting their experiences in addition to *what* they are saying.

To aid in the formulation of momentary states, therapists also distinguish between primary, secondary, and instrumental emotional responses (Greenberg & Safran, 1987; Greenberg et al., 1993). In order to formulate successfully, EFT therapists also develop *a pain compass*, which acts as an emotional tracking device for following their clients' experience (Greenberg & Watson, 2006). Therapists focus on the most painful aspects of clients' experience and identify clients' chronic enduring pain; this leads to identifying core maladaptive emotion schemes, which become the center of the formulation. Painful events provide clues as to the source of important core maladaptive emotion schemes that clients may have formed about themselves and others. For example, in working with a client presenting with social anxiety, the therapist and client will identify markers (M in Table 8.1) such as self-criticism and unresolved experiences of abuse and may come to share the understanding that underlying the secondary hopelessness and anxiety (S) is a core maladaptive emotion scheme (E) of shame. This core shame points to the client's need (N) for validation. In response, the therapist offers the validation needed to counter the painful sense of shame; however, the client initially interrupts (I) the process through in-session states of numbing. The theme (T) of the therapy focuses on lack of self-worth.

RESEARCH ON THE EFFICACY AND EFFECTIVENESS OF EMOTION-FOCUSED THERAPY

EFT is an empirically supported psychotherapy. It is the product of extensive psychotherapy process-outcome research, which has been reviewed in several publications (Elliott, Greenberg & Lietaer, 2004; Elliott et al. 2013; Greenberg et al., 1994). Rice and Greenberg (1984) first adapted the method of task analysis from research on cognitive problem solving and used it to develop and test microprocess models of the steps clients go through to resolve key therapeutic tasks such as internal conflicts or puzzling personal reactions. Similarly, Elliott's research on therapist response modes (Elliott, Hill, Stiles, Friedlander, Mahrer, & Margison, 1987) and client within-session helpful experiences (e.g., Elliott, James, Reimschuessel, Cislo, & Sack, 1985) provided the descriptive basis for key elements of EFT. For the past 20 years, however, much of the research on EFT has been on outcome, complemented by process-outcome prediction studies, qualitative research, and case studies (reviewed in Elliott et al., 2013).

The larger meta-analytic data set used by Elliott et al. (2013) includes data from almost 200 outcome studies on humanistic-experiential therapies. This overall data set shows large pre-post client gains and controlled effects, along with equivalent outcomes for humanistic-experiential therapies and other therapies, including cognitive-behavioral therapy. Table 8.2 summarizes 34 studies on EFT taken from this data set. The uncontrolled pre-post effects are even larger than for the larger data set (weighted ES = 1.16; n = 1124). Twelve studies compared EFT to no-treatment or waiting-list controls, for a very large weighted, controlled ES of 1.05 (n = 255). Finally, in 11 studies comparing EFT to some other nonhumanistic therapy, a medium weighted, comparative ES of .57 (n = 183) was found, favoring EFT. However, a limitation of the existing research is that it is predominated by research carried out by advocates of EFT.

ASSESSMENT AND SELECTION OF CLIENTS

Assessment

Formal assessment and diagnosis are not essential to the practice of EFT; however, quantitative and qualitative outcome and change process research instruments are frequently used for assessing client's presenting issues, for tracking client's progress, and for monitoring the state of the therapeutic relationship and helpful and hindering factors. In focus group research (Elliott et al., 2004), our students reported that doing research on EFT was helpful for learning the approach and deepening their practice. Assessment/research tools that are particularly compatible with EFT include the *Personal Questionnaire* (Elliott et al., 2015), an individualized, weekly outcome measure consisting of 10 problems identified by the client for work in therapy, used to

TABLE 8.2 Summary of Overall Pre-Post Change, Controlled and Comparative Effect Sizes for Emotion-Focused Therapy Outcome Research

	n	*m*	*SD*
Pre-Post Change ES (mean *g*)			
By assessment point:			
Post	34	1.22	.59
Early follow-up (1-11mos.)	15	1.50	.62
Late follow-up (12+ months)	4	1.63	.48
Overall (mES):			
Unweighted	34	1.20	.55
Weighted (d_w)	1124	1.16	.42
Controlled ES (vs. untreated clients)[a]			
Unweighted mean difference	12	1.29	.75
Unweighted mean difference RCTs only	8	*1.31*	.72
Experiential mean pre-post ES	11	1.58	.75
Control mean pre-post ES	10	.21	.22
Weighted	255	1.05	.70
Weighted mean difference RCTs only	*116*	*1.31*	*.67*
Comparative ES (vs. other treatments)[a]			
Unweighted mean difference	11	.67	.50
Unweighted mean difference RCTs only	9	.68	.56
Experiential mean pre-post ES	10	1.40	.60
Comparative treatment mean pre-post ES	10	.74	.71
Weighted mean difference	183	.57	.46
Weighted mean difference RCTs only	*156*	*.57*	*.50*

Note: Hedge's *g* used (corrects for small sample bias). Weighted effects used inverse variance based on *n* of clients in experiential therapy conditions.

[a]Mean difference in change ESs for conditions compared, except where these are unavailable; positive values indicate prohumanistic therapy results.

ES, effect size; RCT, randomized controlled trial.

identify presenting problems and potential therapy tasks and to monitor outcome; the *Working Alliance Inventory* (Horvath & Greenberg, 1989; see revised 12-item short form: Hatcher & Gillaspy, 2006), a brief client measure of the therapeutic relationship as it is conceptualized in EFT; the *Client Task Specific Change—Revised* Form (Watson, Greenberg, Rice, & Gordon, 1997), a client postsession impact rating scale; the *Resolution Scale* (Singh, 1994), a client outcome measure assessing perceived resolution of EFT tasks; and the *Self-Relationship Scale* (Faur & Elliott, 2007), a measure of client-perceived treatment of self (e.g., self-attack, self-control).

Selection of Clients

As noted in the earlier discussion of case formulation, assessment in EFT is collaborative and emphasizes the emotion processes implicit in client presenting problems. EFT has now been applied to a wide range of clients, including those presenting with depression (Greenberg & Watson, 2005), couples difficulties (Greenberg & Johnson, 1988), attachment injuries and unresolved relationships (Paivio & Greenberg, 1995), complex trauma (Paivio & Pascual-Leone, 2010), anxiety (Elliott, 2013; Shahar, 2014), and eating difficulties (Dolhanty & Greenberg, 2007).

TREATMENT

In EFT, what the therapist actually does can be described at two levels: therapist responses modes and EFT tasks and markers.

Therapist Response Modes

Some of the key therapist experiential response modes used in EFT (Elliott et al., 2004) include the following:

1. *Empathic understanding.* Consistent with its person-centered heritage, the foundation of therapist responding in EFT is empathic reflection and following, using responses that try to communicate understanding of the client's message, including simple *reflections* and brief *acknowledgments* ("uh-huh's"). For example, when Carol, one of our clients with severe social anxiety said,

   C: This is what I've never had, is the feeling of being OK.

   her therapist reflected with:

   T: To be seen as OK, to be regarded as good enough.

2. *Empathic exploration responses.* The most characteristic EFT response, however, is empathic exploration (Elliott et al., 2004). These responses both communicate understanding and help

clients move toward what is difficult or painful to say. Empathic exploration responses take many different forms, including *evocative reflections* (which use imagery or metaphor), *exploratory questions* ("What comes up inside when you hear that?"), "fit" questions ("Does that fit your experience?"), and *empathic conjectures*, or guesses about what the client is experiencing but has not yet said out loud. Here is a brief excerpt from the same socially anxious client exploring her sense of being left out of ordinary social life:

T: So what happens when you feel that wall against you? [exploratory question]
C: I just want to go, to bed [crying], because I can't work it out now, I don't know, where to take it, I don't know where to go.
T: So when you get faced with that kind of being pushed out and judged, you just are paralyzed. [evocative reflection]
C: I don't know where to go.
T: The feeling is really, really painful? [empathic conjecture]
C: It's just really *sad*, I just feel sad that I'm not belonging anymore, do you know what I mean, it's just . . .
T: Because you really *want* to belong [empathic conjecture]

3. *Process guiding*. In support of the different therapeutic tasks in EFT, therapists also offer various process-guiding responses. These include *process suggestions*, offering opportunities for clients to engage in particular in-session activities, such as speaking to an imagined self-aspect in the other chair. EFT therapists also sometimes provide *experiential teaching*, for example giving orienting information about the nature of emotional experience, or they offer gentle support, orienting suggestions, or encouragement for working on the task at hand (*task-structuring* responses). At other times, they may tentatively offer an *experiential formulation* of a process or self-aspect for the client ("unfinished business," "critic") in the service of work on a therapeutic task. Finally, at the end of the session EFT therapists may offer *awareness homework*, encouraging them to continue work from the session on their own. Many of these are illustrated in this segment from session 4 with Carol as she began to work with the process by which she makes herself afraid of other people:

T: So come over here and be them [the other students in your counseling skills practice group]. [process suggestion]
C: Ohh [C gets up and moves to other chair]
T: [With enthusiasm:] This is this chair stuff we do! [experiential teaching]
C: Oh dear! Is it?
T: So be them as you are afraid they are responding to you. [process suggestion]
C: Be them?
T: She's just lost you, right. She just lost you, right? [task structuring]
C: Oh, OK. What's up with you? Who do you think *you* are? You're not a tutor.
T: "You have no right to say this to us." (C: No) Say that to her: "You have no right to tell us." [process suggestion]
C: You don't have any right to tell us to do anything.

4. *Experiential presence*. In EFT, therapist empathic attunement, prizing, genuineness, and collaborativeness are largely communicated through the therapist's genuine presence or manner of being with the client. There is a distinctive, easily recognized EFT style: For example, when offering process guiding, the therapist typically uses a gentle, prizing voice (and sometimes humor), while empathic exploration responses often have a tentative, pondering quality. Presence is also indicated by direct eye contact at moments of connection between client and therapist. Therapist *process* (in session) and *personal* (more general) *disclosures* are really explicit forms of experiential presence, in that they are commonly used to communicate relationship attitudes. For example, the therapist began the first session of Carol's therapy with a process disclosure of his own anxiety:

T: I don't know how it is for you, but I'm a bit nervous, because we are just starting out.

Markers and Tasks

A defining feature of the EFT approach is that intervention is *marker guided*. Research has demonstrated

that clients enter specific problematic emotional processing states that are identifiable by in-session statements and behaviors that mark underlying affective problems and that these afford opportunities for particular types of effective intervention (Elliott et al., 2004; Greenberg, Rice, & Elliott, 1993; Rice & Greenberg, 1984). Client markers indicate not only the type of intervention to use but also the client's current *readiness* to work on this problem. EFT therapists are trained to identify markers of different types of emotional processing problems and to intervene in specific ways that best suit these problems.

Each of the tasks has been studied both intensively and extensively, and the key components of a path to resolution and the specific form that resolution takes have been specified. Thus, models of the actual process of change act as maps to guide the therapist intervention. Many task markers and their accompanying interventions have now been identified and described; here are some of the most common ones (Elliott et al., 2004; Greenberg et al., 1993):

Problematic reactions expressed through puzzlement about emotional or behavioral responses to particular situations. For example, a client saying, "On the way to therapy I saw a little puppy dog with long droopy ears, and I suddenly felt so sad and I don't know why." Problematic reactions are opportunities for a process of systematic evocative unfolding. This form of intervention involves vivid evocation of experience to promote reexperiencing the situation and the reaction in order to establish the connections between the situation, thoughts, and emotional reactions, thus helping the client to finally arrive at the implicit meaning of the situation that makes sense of the reaction. Resolution involves a new view of self-functioning.

An *unclear felt sense* occurs when the person is confused about something or unable to get a clear sense of his or her experience ("I just have this feeling, but I just can't put my finger on it"). This marker calls for *focusing* (Gendlin, 1996) in which the therapist guides clients to approach the embodied aspects of their experience with attention and curiosity in order to experience them and to put words to their implicit, often subtle feelings. A resolution involves the creation of new meaning along with a release of bodily tension.

Conflict splits involve one aspect of the self being critical, coercive, or interruptive toward another aspect. For example, a woman quickly becomes hopeless and defeated but also angry at the prospect of being seen as a failure by her sisters: "I feel inferior to them: It's like I've failed and I'm not as good as them." Self-critical conflict splits like this offer an opportunity for two-chair work, in which two parts of the self are put into live contact with each other. Thoughts, feelings, and needs within each part of the self are explored and communicated in a real dialogue to achieve a softening of the critical voice. Resolution involves an integration of the two sides. Self-interruptive conflict splits arise when one part of the self interrupts or constricts emotional experience and expression: "I can feel the tears coming up, but I just tighten and suck them back in, no way am I going to cry." In this case, the therapist helps the client to enact and make explicit how the interrupting part of the self does this, for example by physical act (choking or shutting down the voice), metaphorically (caging), or verbally ("shut up, don't feel, be quiet, you can't survive this"), so that the client can experience himself or herself as an agent in the process of shutting down and then can react to and challenge the interruptive part of the self and express the previously blocked experience.

An *unfinished business* marker involves the statement of a lingering unresolved feeling toward a significant other, such as the following said in a highly involved manner: "My father, he was just never there for me. I have never forgiven him. Deep down inside I think maybe I'm grieving but then I just tell myself, 'What's the point, there's no use dwelling on the past.'" Unfinished business toward a significant other calls for an empty-chair intervention. The client imagines the other present in the other chair in order to activate his internal view of a significant other and then to experience and explore his emotional reactions to the other and make sense of them. Shifts in views of both the other and self occur. Resolution involves holding the other accountable or understanding or forgiving the other.

Stuck, dysregulated anguish is a marker that occurs in the face of strong emotional pain or a powerful existential need (e.g., for love or validation) that has not or cannot be met by others: "No one will ever understand me. I'm all alone." Anguish calls for compassionate self-soothing (Goldman & Zurawic, 2012; Ito, Greenberg, Iwakabe, & Pascual-Leone, 2010; Sutherland, Peräkylä, & Elliott, 2014). Expressing compassion toward oneself is a way of changing painful emotions (e.g., shame, fear, sadness) by internally confronting them with a different emotion. In

this task, the therapist first helps the client deepen her sense of anguish so that she can access her core existential pain and express the unmet need associated with it. Then, the therapist offers a two-chair process to the client in which she enacts providing what is needed (e.g., validation, support, protection) to herself. This can be done either directly or with the needy part symbolized as a child or close friend experiencing the same things that the client is. The comforting aspect is represented either as a strong, nurturing aspect of self or as an idealized parental figure.

A number of additional markers and interventions, such as alliance rupture and repair, confusion and clearing a space, high distress and meaning making, and more, have been added to the original six markers and tasks identified earlier (see Elliott et al., 2004). In addition, a new set of narrative markers and interventions combining working with emotion and narrative, such as same old story, empty story, untold story, and healing story have been specified (Angus & Greenberg, 2011).

DIVERSITY

EFT is routinely offered to a diverse range of clients of all persuasions, origins, and abilities. EFT training and practice are carried out successfully, with appropriate cultural sensitivity, in most parts of the world. While EFT might seem to most naturally fit clients from individualistic Western cultures who enter therapy with emotion processing styles that allow them to engage almost immediately in the empathic exploration and experiential search, it is also true that some clients in Northern European cultures (especially male clients) can struggle with the focus on exploring and expressing emotion, as opposed to working with cognition or action. Such clients nevertheless typically respond well to a relational offer that is both no-nonsense and genuinely empathic and caring, especially when accompanied by clear structure and experiential teaching about the nature and importance of emotion.

In addition, EFT can be used successfully with clients whose styles are generally external or interpersonally dependent, which can be associated with more collectivistic as opposed to individualistic cultural backgrounds (Kitayama, Markus, & Kurokawa, 2000). For these clients, it is essential for the therapist to provide solid empathy for client experiences grounded in different cultural values, such as the need for social harmony, respect for elders, or traditional religious beliefs and practices. In these situations it is still important to work with clients to gradually create an internal focus through consistent empathic exploration of their inner experience and by occasional experiential teaching. In addition, treatment with these clients may emphasize the use of the more process-guiding tasks such as focusing and empty-chair work.

As it is currently formulated, EFT is as not well suited for clients with psychotic processes, impulse control, or antisocial personality patterns, or those in need of immediate crisis intervention or case management (e.g., acutely suicidal or experiencing current domestic abuse). In addition, we are not inclined to utilize this approach with those few clients who develop strong negative reactions to its internal exploration and self-determination aspects or who find the therapist's relatively nondirective stance of not advising or interpreting to be unacceptable. It is best to refer such clients on to other treatments.

CLINICAL ILLUSTRATION

Carol (see MacLeod, Elliott, & Rodgers, 2012) was a single Scottish working-class woman in her mid-50s; some of the work with her has already been illustrated in the earlier section on therapist response modes. She had been unemployed for 10 years after she became overwhelmed with anxiety and depression while working at a stressful job. At the beginning of therapy she was very socially isolated and spent most days hiding in bed. She met the diagnostic criteria for severe social anxiety, centering on fears of social situations, especially weddings and parties. She had a history of alcohol misuse but had been sober for at least 15 years and had had previous unsuccessful cognitive-behavioral therapy. She had a childhood history of emotional and sexual abuse. At the end of therapy she "confessed" that she had been severely suicidal when she started and had planned to kill herself if the therapy failed.

In terms of EFT case formulation (see Table 8.1), Carol's main presenting problems were extreme social isolation and hypervigilance in social situations (Step 1); she was able to describe these painful experiences quite clearly and poignantly (Step 2).

Despite her external focus on others' potential reactions to her, she was also able to turn her attention inward and to express her emotions in sessions openly and unguardedly (Step 3).

In the early stage of therapy, Carol described her history (Step 4) and explored her current and past experiences of social anxiety, which was a secondary reactive emotion, under which there was core primary maladaptive shame about her appearance, awkwardness, and being unwanted (Steps 6 and 8). In terms of themes (Step 10), her main treatment of self was one of self-attack/blame/neglect, while her view of others was that they were critical and rejecting; and she found herself unable to work or to form meaningful, close relationships with others. The key markers (Step 5) that she presented were unclear feelings (pointing to focusing), anxiety, and self-critical splits (pointing to two-chair work), unresolved relational issues with her mother and father (pointing to empty-chair work), and unregulated anguish (pointing to the need for compassionate self-soothing).

Carol's distress started at high levels through the first half of the therapy as she began to work with her anxiety splits and then moved into work with the deeper self-critical split, where her attempts to change led to harsh reprisals from her terrified inner critic, which interrupted her attempts to change and led to a sense of impasse and anguish (Step 9).

Through the use of these tasks (Steps 12 and 13), she and her therapist began to co-construct a useful formulation of the different emotion processes described earlier and their connection to her life narrative and presenting difficulties (Step 11); at the same time, she began to access a range of primary adaptive emotions and, through these, important unmet needs (Step 7). Thus, she more fully experienced her connecting sadness about the time and relationships she had lost, and with this the need to connect with other people, which motivated her to seek out social situations (Step 14). Gradually over time she also began to access protective anger about the abuse she had suffered (and the associated need for better boundaries) and self-compassion for all she had been through, along with the need to comfort and support herself. Ultimately, she was able to feel pride for who she was and what she had been able to accomplish in her therapy. Her ability to access, symbolize, and regulate her painful emotions improved, and her sense of self was strengthened, to the point where the critical aspect became less afraid and diminished in power so that she was able to move past the impasse. She was largely improved by session 16; at that point her recent changes still felt fragile, so the last four sessions took place at monthly intervals providing an ad hoc consolidation phase to her treatment, as she began attending social events and working in the profession that she had long trained for but never practiced. A consolidation phase is not a formal part of EFT, but in this case one emerged spontaneously out of Carol's change process. Her large post-therapy gains were maintained at 6- and 18-month follow-up assessments.

After session 16 and before her four monthly consolidation sessions, Carol was interviewed by a researcher, and reported:

> When I think back from very, very early on in working with him, it's been so powerful, experiencing things and in the session going into how I'm feeling. And I've been amazed that I have felt so much. . .. I'll tell you what I think is the most, the greatest thing that I'm feeling: It's that I'm feeling a sense of belonging . . . Just this sense of general belonging.

CONCLUSIONS/KEY POINTS

Emotion-focused therapy (also known as process-experiential therapy) is a contemporary, evidence-based humanistic psychotherapy that integrates person-centered, gestalt, and existential approaches. It is based on contemporary emotion theory, and it posits that human experience is organized around key emotion schemes and that emotion processes are essentially adaptive. Emotions can become problematic, however, through under- or overregulation or when the primary adaptive emotion response is replaced by secondary reactive, primary maladaptive, or instrumental emotion responses. EFT is guided by a set of emotion change principles, including awareness, symbolization, regulation, expression, reflection, and transforming emotion with emotion. It is organized around an emotional deepening process in which therapists help clients move through the following sequence of emotion responses: undifferentiated distress; secondary reactive emotions;

primary maladaptive emotions; core pain; and primary adaptive emotions. To do this, the therapist responds to key markers offered by clients, proposing appropriate therapeutic tasks such as unfolding problematic reaction points or two-chair work for internal conflicts. EFT has been applied to a wide range of clients, especially those presenting with depression, anxiety, and interpersonal difficulties, as well as eating difficulties and other self-damaging activities. Finally, as EFT training has spread to different parts of the world, especially East Asia and South America, it has increasingly embraced clients from different cultures. We have found that although cultures vary in terms of what emotions (especially anger, shame, and sadness) are seen as appropriate to express in which situations and what key human needs (e.g., social harmony vs. independence) are particularly culturally valued, basic human emotion processes and the needs associated with them are universal.

REVIEW QUESTIONS

1. What is the EFT understanding of how working with emotion brings about change?
2. What kinds of emotion response are there in EFT and how do they differ from one another?
3. Describe what a therapeutic task is and give an example of one.
4. What kind of client presenting problems has EFT been found to be effective with?
5. Name three emotion change principles.

RESOURCES

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Videos

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Websites

Emotion-Focused Clinic: http://www.emotionfocused-clinic.org [Les Greenberg's website].

Experiential Researchers. http://www.experiential-researchers.org [Contains information on EFT-friendly research instruments].

International Society for Emotion-Focused Therapy: http://www.iseft.org

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9

Interpersonal Psychotherapy in Historical Perspective

Scott Stuart

Abstract
In 1967, a discussion group began meeting at Washington University in St. Louis. Though what later became known as the Feigner criteria were not published until 1972, the diagnostic criteria the group was developing were soon to be widely cited and would be rapidly incorporated into psychiatric research. Ultimately the criteria served as the foundation for the Research Diagnostic Criteria (Spitzer, Endicott, & Robins, 1978) and later the third edition of *The Diagnostic and Statistical Manual of Mental Disorders*, third edition (*DSM-III*). Also in 1967, a group at Yale University began collecting data to determine how well antidepressant medications worked to prevent depression relapse. What developed from their research became interpersonal psychotherapy (IPT). It is in this historical context that the development of IPT can best be understood. It is a fascinating story reflecting controversies between biomedical psychiatry and the psychoanalytic community, and it is also intertwined with the development of the concept of empirically validated psychotherapy.

Keywords: Interpersonal Psychotherapy, IPT history, IPT evolution, manualized psychotherapy, interpersonal triad

> Science is totally dependent upon philosophical opinions for all of its goals and methods, though it easily forgets this.
>
> —Nietzsche, 1979, p. 58

History, like science, is best begun by stating the facts. Interpretation of the facts then follows. High-quality psychotherapy, in which the clinician and patient work together to collect the facts and then create an interpretation, a story, or a deeper meaning from them, follows this trajectory, too. Psychotherapy is a combination of history and science. History, science, and psychotherapy are always interpretive.

One of the primary source interpretations regarding the development of Interpersonal Psychotherapy (IPT) was written by Myrna Weissman, one of the individuals involved in the first IPT studies (Weissman, 2006). In brief, Paykel joined Klerman at Yale in 1967 to work on research regarding the efficacy of tricyclic antidepressants alone and in combination with psychotherapy as a maintenance treatment for depression. Weissman, who was a practicing social worker at the time, was recruited to help write a manual for the psychotherapy intervention.

The psychotherapy developed for the project was conceptualized as a placebo treatment—it was one that incorporated the nonspecific Rogerian aspects of psychotherapy but had no "active" ingredients. As Weissman put it, the psychotherapy was "high quality

supportive psychotherapy as it might be delivered by social workers" (www.iptinstitute.com/about-ipt). Given Klerman's views about psychotherapy generally, there is little doubt that the trial was originally designed to demonstrate that psychotherapy was not efficacious; Weissman herself notes that "There was not an assumption that psychotherapy would be efficacious" (www.iptinstitute.com/about-ipt). The original "social work/supportive" therapy was subsequently more fully developed and was renamed "Interpersonal Psychotherapy." The original IPT textbook, *Interpersonal Psychotherapy of Depression* (Klerman, Weissman, Rounsaville, & Chevron, 1984), was published in 1984 as a manual for the National Institute of Mental Health Treatment of Depression Collaborative Treatment Program (NIMH-TDCRP).

As a result of the academic efforts of many investigators, there is an impressive array of studies demonstrating the efficacy of IPT for a variety of affective, anxiety, eating, and personality disorders, as well as for populations including geriatric patients, adolescents, and perinatal women. Yet IPT has been poorly disseminated in the community. In 2006, for example, nearly 40 years after IPT was first described, Weissman et al. (2006) found that across psychiatry, psychology, and social work, there were far fewer graduate programs requiring training in IPT than those requiring behavior therapy, cognitive-behavioral therapy (CBT), or dialectical behavior therapy (DBT); IPT also trailed training in couples, family, group, psychoanalytic/psychodynamic, and supportive therapies.

Given that the first IPT manual was published in 1984, only 5 years after Beck's seminal text *Cognitive Therapy of Depression* (Beck, 1979), the difference in dissemination and usage between IPT and CBT is striking. More recently developed therapies such as DBT (Linehan, 1993), motivational interviewing (Miller, 1991), and acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999) have been disseminated and practiced much more widely than IPT (Weissman et al., 2006). Understanding why this might be so requires a return to the early history of IPT.

Gerald Klerman (1928–1992) was without doubt the seminal figure in the development of IPT. Klerman was 63 years old when he died from complications of diabetes; his protégés include many individuals who have contributed greatly to research in IPT such as his second wife Myrna Weissman, John Markowitz, Katherine Shear, Ellen Frank, and Laura Mufson. Klerman's early writings include articles about interpersonal dynamics and psychoanalytic concepts as well as epidemiology and pharmacology. Though not a practicing analyst, early in his career Klerman had psychoanalytic training.

Klerman's greatest impact, however, was as an apologist for biomedical psychiatry. Klerman was a major figure in the cultural shift in American psychiatry to empiricism and the biomedical model, and he championed treatment based on diagnostic specificity. This shift continues to impact the development and dissemination of IPT, which, following Klerman's lead, was established as a diagnostically specific medical treatment based explicitly on the biomedical model. His protégés have continued to strictly adhere to that model of IPT.

Klerman's legacy has also been, at least among those with allegiance to his original model, that IPT has been in large part defined by what it is not—namely that it is not psychodynamic or behavioral. That IPT was not psychodynamic was crystalized in Klerman's writing regarding the Osheroff case. This case was one of the most influential in the history of American psychiatry and, in retrospect, can be seen as the last major battle between biomedical psychiatry and the psychoanalytic community.

In 1979, Raphael Osheroff, a nephrologist, beset by yet another episode of depression, admitted himself to Chestnut Lodge for psychiatric care. Chestnut Lodge was considered to be "state of the art" for psychoanalytic treatment. There has been little disagreement about the basic elements of Osheroff's treatment; he had been treated for a chronic anxious depression by three different psychiatrists, and it was widely agreed that Osheroff had been poorly compliant. At Chestnut Lodge, Osheroff was diagnosed with a depressive illness borne of a narcissistic personality. During his stay, he was treated with intensive psychoanalytic psychotherapy, during which he made no improvement.

After 7 months, Dr. Osheroff's mother and stepfather convinced him that he should transfer to the Silver Hill Foundation. At Silver Hill, he was diagnosed with a psychotic depressive reaction, agitated type. He was prescribed psychotropic medication and "supportive" therapy, and he was reported to have recovered within 2–3 weeks. Aggrieved by his treatment at Chestnut Lodge, Osheroff instituted a

malpractice suit in 1982. He alleged that Chestnut Lodge negligently failed to diagnose his biological depression and failed to treat it by appropriate biological means. Osheroff was awarded $250,000 by the Maryland Health Claims Arbitration Board, which found Chestnut Lodge liable. Both sides appealed, but before any additional action was taken, a settlement was reached. Osheroff's star expert witness before the Arbitration Board was Gerald Klerman.

The case became a "cause célèbre" with the publication of an article in the *Philadelphia Inquirer* with the provocative title, "An improper diagnosis case that changed psychiatry" (March 24, 1988). Many high-profile psychiatrists enthusiastically concurred that the psychoanalytic treatment provided to Osheroff lacked any empirical support, whereas the treatment with antidepressant medication was, in contrast, replete with evidence of efficacy. What followed was a firestorm of arguments about the utility of psychoanalysis, the nature of science and empiricism, and the ethical and legal rights of patients to effective care.

Klerman first wrote about the case in 1990 (Klerman, 1990), arguing that Osheroff was misdiagnosed and inappropriately treated. He described the case as an egregious example of malpractice, using it as an exemplar to argue that clinicians had a legal duty to provide only those psychiatric treatments that had been shown to work. According to Klerman, treatments "shown to work" included only those which had been proven efficacious using randomized controlled trials and which were specific to diagnoses generated by the *The Diagnostic and Statistical Manual of Mental Disorders*, third edition (*DSM-III*). He listed the treatments he considered to be empirically validated at the time: antidepressants, Beck's CBT, and Klerman et al.'s own IPT.

Alan Stone, a professor of psychiatry and law at Harvard University, was chosen to respond to Klerman. Stone agreed with Klerman that the continued use of intensive psychoanalysis in the face of Osheroff's deterioration was not warranted, and that additional consultation should have been sought. Much of Stone's response, however, was a well-reasoned and highly technical discussion about the legal implications of the case (Stone, 1990). He noted that there was no legal precedent established since the case had been settled out of court, and he described the potential malpractice difficulties that might ensue if a legal right to any specific treatment was accorded to a patient. He reproached Klerman for using the legal system to promote Klerman's views about the diagnostic system and the validity of treatments (Stone, 1990). Stone also elaborated on the legal concept of the "respectable minority," namely that a treatment was reasonable if there were a respectable minority of clinicians (such as psychoanalysts) in whose opinion the treatment (such as psychoanalysis) was appropriate.

Klerman's view of the opinions of the "respectable minority" had already been set out in fiery terms in his original paper:

> With regard to the treatment of the patient's DSM-II diagnosis of psychotic depressive reaction, there was very good evidence at the time of his hospitalization for the efficacy of two biological treatments—ECT and the combination of phenothiazines and tricyclic antidepressants. The combination pharmacotherapy was the treatment later prescribed. There are no reports of controlled trials supporting the claims for efficacy of psychoanalytically oriented intensive individual psychotherapy of the type advocated and practiced at Chestnut Lodge. It should not be concluded there is no evidence for the value of any psychotherapy in the treatment of depressive states. . . . The psychotherapies for which there is evidence include cognitive-behavioral therapy, Interpersonal Psychotherapy, and behavioral therapy. However, no clinical trials have been reported that support the claims for efficacy of psychoanalysis or intensive individual psychotherapy based on psychoanalytic theory for any form of depression. (Klerman, 1990, p. 413)

Klerman summarized his position with this scathing indictment: "The issue is not psychotherapy versus biological therapy but, rather, opinion versus evidence. The efficacy of drugs and other biological treatments is supported by a large body of controlled clinical trials. . . . Psychoanalysis is on the scientific and professional defensive. This situation is, in part, a consequence of the failure of psychoanalysis to provide evidence for the efficacy of psychoanalysis and psychodynamic treatments for psychiatric disorders" (Klerman, 1990, p. 415).

A direct connection can be made between this statement by Klerman and the movement of both American psychiatry and psychology toward

empirically validated treatments. The creation of the American Psychological Association Presidential Task Force on Evidence-Based Practice in 2006 (APA Presidential Task Force on Evidence-Based Practice, 2006) and the subsequent listing of "approved" psychological treatments (Society of Clinical Psychology APA Division 12, 2012) stands as a testimony to the impact of Klerman's arguments. On that list are a variety of manual-based therapies; the list is restricted to those that are diagnostically specific and empirically validated. Klerman's arguments in the Osheroff case and his beliefs generally shaped not only IPT but all of psychotherapeutic and psychiatric practice. Klerman was by no means a lone voice, but he was a loud and persistent one.

Klerman's argument was clear, articulate, and simple in its appeal. Treatments must be based on a medical model and must be diagnostically specific. Clinicians were obliged to use treatments that work. What worked was what science proved efficacious in randomized trials. His position was virtually unassailable—it appeared to be a prima facie statement describing good clinical care. What reasonable clinician would argue that he or she wanted to provide a treatment that *didn't* work?

Klerman's views have continued to influence the development and practice of IPT to this day. IPT was developed as a concrete manifestation of his biomedical empiricism. The direct result was that the original version of IPT, and its subsequent descriptions by his protégés, were based explicitly and exclusively on the biomedical model. IPT was a treatment for a specific diagnosis. The therapist was instructed to "give" the patient the "sick role"—literally to tell the patient that he or she was suffering from a medical illness. The implication was that the patient, just as he could take an antidepressant, could take some IPT and become asymptomatic. And IPT, according to the biomedical model, was only to be used for approved indications (i.e., those for which empirical evidence had been produced, such as major depression). Patients who were "only" seeking help for adjustment disorders, or grief, or marital disputes, or any of the other myriad interpersonal issues for which people seek therapy, were not candidates for IPT. No off-label prescribing of IPT was permitted. Though other specific diagnoses were added to the list of "approved indications" over time, this diagnostically specific approach limited the appeal of IPT for many practitioners and greatly hindered dissemination.

Based on their belief that only treatments that were empirically validated and manualized should be provided to patients, the Yale group further insisted that IPT was not valid or efficacious unless it was delivered exactly as it had been used in the empirical treatment trials. Just as an antidepressant medication had reliably reproducible and exact ingredients no matter which individual patient swallowed it, so too in the biomedical model was the IPT therapist to deliver reliably reproducible and exact treatment to each and every patient. Because IPT had to be delivered reliably in order to be empirically valid, the manual had to be followed precisely. The manual was not a guide—it dictated treatment. Because the original manual specified that treatment had to be terminated, then it had to be terminated. Because the manual specified that there were only four interpersonal problem areas that could be discussed, then only those four could be discussed, and they had to be defined exactly as they were in the manual. Empirical validation bred reliable and reproducible treatment, but it was treatment that was completely inflexible.

INTERPERSONAL PSYCHOTHERAPY AND THE NIMH-TDCRP

In 1977, planning began in earnest for one of the largest and most influential psychotherapy outcome studies ever conducted. Following the model used in previous psychopharmacologic treatment trials, a randomized placebo-controlled efficacy methodology was applied to psychotherapy in a comparison of IPT, CBT, Imipramine, and placebo for the treatment of *DSM-III* major depressive disorder. The NIMH-TDCRP results (Elkin et al., 1989), in a nutshell, were that imipramine, IPT, and CBT were all superior to placebo, with imipramine superior to IPT and CBT for more severe depression. None of the four interventions were efficacious in preventing relapse after they were terminated.

Two psychotherapeutic approaches were included in the TDCRP. According to the investigators (Elkin, Parloff, Hadley, & Autry, 1985), the psychotherapies had to have been developed or modified specifically for use with depressed outpatients; have been standardized (i.e., manualized); and have some evidence of efficacy. The choice of CBT as one of the psychotherapies was obvious. CBT was well established; there

was a manual (Beck, 1979), there were reliable symptom measures, and there were data (Rush, Beck, & Kovacs, 1977). CBT even had a specific and well-developed theory.

IPT, in contrast, had a paucity of theoretical support—it had simply been described as "good social work practice." IPT had, however, already been tested in comparison to imipramine, there were efficacy data (Weissman et al., 1979; Weissman, Klerman, Prusoff, Sholomskas, & Padian, 1981), and there was an unpublished manual that had been used to generate that data (Klerman, Rounsaville, Chevron, Neu, & Weissman, 1979). The methodology that had been used in the IPT studies was nearly identical to that which was adopted by the NIMH-TDCRP, and the IPT studies were symptom based, diagnostically specific, and based on *DSM-III* criteria. One additional factor may have influenced the final decision to include IPT: Elkin et al. (1985) documented the decision-making process, which began in 1977, noting that the "research plan was developed and approved in an internal NIMH and Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) review process" (p. 306). Klerman was director of the ADAMHA in 1977, a post he held until 1980.

It was imperative to ensure that the two psychotherapies were distinguishable (Elkin et al., 1985). CBT and IPT had to have different (presumed) mechanisms of action, different techniques, and different theories explaining their effect. CBT had already been codified in Beck's 1979 manual, which placed a heavy and obvious emphasis on cognitive and behavioral techniques. IPT was left in the position of having to adjust, so to speak, to CBT. The techniques and tactics that were already associated with CBT, in essence, were no longer available for use in IPT. The upshot was that the 1984 IPT manual—the codification of the IPT used in the NIMH-TDCRP—explicitly prohibited a variety of techniques. These exclusions included but were not limited to behavioral techniques known to be helpful for depression such as behavioral activation, and structural tactics such as the assignment of homework and setting an agenda for sessions, in part because they were already subsumed by CBT. They were also excluded because these techniques and tactics were not considered a part of the "good social work practice," upon which IPT was founded. That relaxation, the assignment of homework, and other techniques could easily be integrated within an interpersonal framework, and that their inclusion may have increased the efficacy of IPT, was not relevant. Reliable replication, complete separation from CBT, and the requirements of the TDCRP protocol were prioritized.

Because the techniques that were subsumed by CBT were explicitly excluded, IPT became defined to an even greater extent by what it was not. IPT did not permit behavioral or cognitive interventions, and it most certainly was not psychoanalytic—the Osheroff debate had ensured the exclusion of psychoanalytic techniques and theory. IPT was described as relying largely on "nonspecific" techniques such as nondirective exploration and clarification in order to distinguish it from the behavioral and cognitive components of CBT. Thus, the exclusion of homework specified in the early IPT manuals, for example, was the result of research expedience rather than being supported by a specific theoretical rationale or by clinical experience. Without a well-defined theory of change, there was also no theoretical basis for expanding the array of techniques and tactics that could be used in IPT. The lack of techniques specific to IPT, and the lack of techniques derived from a theoretical base, actually led some critics to describe IPT as nothing more than a "time-limited psychodynamic psychotherapy," or a sophisticated means of encouraging social support (Markowitz, Svartberg, & Swartz, 1998).

The development of IPT was also affected in other ways by the rigorous study design, which dictated that it be adapted to the TDCRP research protocol, rather than adapting the research protocol to reflect good clinical practice. For instance, the protocol required termination of treatment, so the IPT manual was written requiring termination. This was a change that was actually contrary not only to good clinical care but to the data, since Klerman et al.'s own research had strongly suggested that maintenance therapy with IPT reduced risk of relapse (Weissman et al., 1981).

In sum, the inclusion of IPT in the TDCRP was without question a great boon. The TDCRP provided IPT tremendous visibility and publicity, and it also provided very favorable data supporting IPT. But the TDCRP further concretized the concept that IPT was diagnostically specific and that IPT was a biomedical treatment. Moreover, the interpretation of the TDCRP data by the Yale group and its adherents was that in order to be empirically valid, IPT had

to be delivered exactly as it was described in the 1984 manual. The rigidity of the manualized approach had a profound impact on the implementation and dissemination of IPT. Rather than being conceptualized as a dynamically developing treatment which should incorporate new clinical observations and clinical experience, the way IPT was manualized in the NIMH-TDCRP became for many years the singular and "correct" way to conduct it.

THE DISSEMINATION OF INTERPERSONAL PSYCHOTHERAPY

IPT spread slowly in the United States despite extensive evidence of efficacy, and for many years it was restricted largely to a few academic departments of psychiatry. The dissemination was so slow that by 2000 only four training sites were listed in the *Comprehensive Guide to Interpersonal Psychotherapy* (Weissman, Markowitz, & Klerman, 2000) (Cornell Psychotherapy Institute in New York, Western Psychiatric Institute and Clinics in Pittsburgh, the Interpersonal Psychotherapy Clinic at the Clarke Institute in Toronto, and the University of Iowa).

IPT was slowly disseminated in Europe as well. The first early adopters (1996) were within the Scottish National Health Service (NHS). Dissemination ultimately proceeded more rapidly in Europe, however, particularly in the United Kingdom and in The Netherlands, where IPT was recognized by the National Health Service in both countries as an empirically supported treatment and included on a list of approved treatments for depression. Australia and several other European countries soon followed suit.

Chris Freeman and colleagues at the University of Edinburgh were instrumental in developing the first IPT training guidelines, which were driven largely by the need to document training within the Scottish NHS. These standards have been the basis for widely accepted guidelines around the world. IPT within the United Kingdom expanded further in 2008 with the initiation of the Increasing Access to Psychological Therapies (IAPT) program in England and Wales. The Netherlands also has a flourishing IPT network that is headed by Marc Blom (Blom et al., 2007); there are now over 1,000 IPT therapists within the Dutch system. There are IPT groups in France, Turkey, Italy, and Israel, as well as Sweden, Norway, Iceland, Ireland, Portugal, and Spain. Small groups are active in New Zealand, Malaysia, Singapore, Hong Kong, Germany, Greece, Korea, Japan, and Brazil.

In North America, IPT has been disseminated primarily through university training programs. In Canada, the University of Toronto, Dalhousie University, the Universitè Laval in Quebec, and the Universitè de Montrèal are notable. In the United States, IPT training sites include the large groups in New York and Pittsburgh as well as the University of Iowa, University of Washington, Washington University (St Louis), University of Michigan, Florida State University, the University of Wisconsin, University of Rochester, and Brown University.

Several large-scale training projects are underway in the United States, including work within the Veterans Administration system led by Kathleen Clougherty and Greg Hinrichsen (Stewart et al., 2014), in which 124 therapists have been trained. In Los Angeles County, Scott Stuart, Jessica Schultz, and colleagues (Schultz & Stuart, 2013) have developed a community-based training program in which over 1,500 therapists have been trained and are practicing in community mental health agencies.

Among the most creative dissemination efforts are several projects in which IPT has been used in rural settings in Africa and India. In many of these projects, non–mental health professionals, and in some cases lay individuals, have been trained to conduct IPT for depression individually or in groups. These projects include work in Uganda and Haiti by Helena Verdeli and colleagues (Bass et al., 2006; Verdeli et al., 2008), in Ethiopia by Paula Ravitz and colleagues, and in India by Vikram Patel and colleagues (Chatterjee et al., 2008).

The International Society for Interpersonal Psychotherapy (ISIPT) was founded by Michael Robertson and Scott Stuart in 2000. Since 2005, the ISIPT has held an international meeting, most recently in 2015 in London. In 2009 Stuart and colleagues founded the IPT Institute as an international organization devoted to IPT training and certification. In contrast to the academic orientation of the ISIPT, the mission of the IPT Institute is to establish IPT training standards and to develop highly trained and certified IPT clinicians, supervisors, and trainers around the world. Certification in IPT is completely voluntary, though there are a number of countries and organizations that currently require certification in order for therapists to be reimbursed for services

or to delivery therapy within their NHS or regional health system.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS IN INTERPERSONAL PSYCHOTHERAPY

The IPT that was developed for the NIMH-TDCRP remained quite static and did not attempt to claim or utilize any additional techniques or tactics for nearly two decades after the NIMH-TDCRP was completed. Over time this rigidity had an impact on dissemination and usage. For instance, many IPT trainers insisted on a strictly delivered course of exactly 16 sessions of IPT for all patients, because 16 sessions was used in the NIMH-TDCRP protocol and was thus the "empirically validated" way to deliver IPT. The attempts to introduce IPT to community-based clinicians with these types of rigid limits simply did not fit clinical practice, and as a consequence, therapists did not utilize IPT broadly.

More than a decade after the publication of the 1984 manual, John Markowitz, a protégé of Klerman's, described this rigidity in his method of teaching IPT (Markowitz, 1995), noting that in IPT, "no agendas are set, and there is no formal homework" and that addressing distorted cognitions was not permitted. He also insisted that IPT required therapists to give the patient the "sick role" following a biomedical model, and that IPT required that all therapists terminate treatment. Markowitz also reiterated that IPT must follow the biomedical model of diagnostic specificity, noting that IPT had a limited scope and that the therapist must adhere to the "differential therapeutics of its prescription." He went on to emphasize that IPT therapists must be diagnostically specific, and that they literally must "offer themselves as antidepressant therapists."

This biomedical diagnostically specific model was used by many other investigators, including Ellen Frank and David Kupfer and their colleagues at the University of Pittsburgh, who have had a major influence on the development of IPT since the early 1980s. Kupfer, Frank, and colleagues, like Klerman, were also interested in the prevention of depression relapse. In their elegant series of studies, which followed the Yale model of diagnostic specificity and manualized treatment, they found that IPT was effective in preventing depression relapse (Frank, Kupfer, Wagner, McEachran, & Cornes, 1991; Kupfer, 1992). The impact of the research from the Pittsburgh group is hard to overstate; their work has continued for nearly four decades (Frank et al., 2000, 2007) and has heavily influenced psychiatry worldwide.

An underappreciated side effect of the Pittsburgh IPT research, however, was the way in which investigators described and labeled the adaptations of IPT that they developed and validated. Frank et al.'s practical solution to avoid contesting the hegemony of the 1984 manualized approach was to label their version of IPT "IPT-M," with the "M" standing for maintenance. Thus, it did not challenge the 1984 IPT manual, but was a new variation of IPT for a diagnostically distinct form of depression. IPT-M was for major depressive disorder, recurrent; it was *not* for major depressive disorder, single episode. Moreover, it was not for the acute treatment of depression, but only for maintenance. It was a distinct therapy. Reynolds et al. (1992) followed suit with geriatric patients, labeling their variation IPT-LL for "late-life" depression. This was, of course, consistent with the biomedical model and diagnostic specificity, which dictated that there should be a completely distinct treatment for each *DSM-III* disorder. But it made it very difficult for community clinicians interested in learning IPT to determine what training to seek. Did one need to learn IPT, IPT-M, IPT-LL, and all of the other IPT subtypes that emerged, or was it sufficient to learn the principles of IPT and apply them transdiagnostically? The answer from the Yale-Pittsburgh group was consistent: a different form of IPT was needed for each diagnosis.

The Yale-Pittsburgh approach—labeling IPT with modifiers for each adaptation—was adopted by many subsequent IPT investigators. The term "investigators" is appropriate because the new adaptations of IPT literally always came in the form of randomized treatment trials for diagnoses or subgroups for which it was previously untested. The biomedical approach used to adapt IPT was obvious: new indications, based on *DSM* specific diagnoses, were sought for IPT just as they were being sought for antidepressant medications. The 1993 textbook by Klerman and Weissman, *New Applications of Interpersonal Psychotherapy* (1993), epitomized this approach. In the section on adaptations of IPT, one finds IPT-M (maintenance), IPT-LLM (late-life maintenance), IPT-CM (conjoint IPT for depressed patients with marital disputes), IPT-A (adolescents), IPT-HIV (HIV for seropositive

patients), IPC (interpersonal counseling in a primary care setting), and IPT-D (dysthymic disorder).

IPT-CM stands as a particular exemplar within that group. Described by Klerman and Weissman, it was for patients with depression with marital disputes. It was specifically and exclusively for treatment of an individual with major depressive disorder. IPT-CM was explicitly *not* a couples or systemic therapy, but one for an individual with *DSM-III* major depressive disorder whose spouse accompanied them to treatment. The IPT-CM approach, mirrored in all of the other early adaptations of IPT, impeded theoretical development by placing the patient outside of his or her dyadic relationships, family system, and social environment by conceptualizing the problem as a biomedical disorder or disease intrinsic to the individual patient.

A great deal of research funding and scholarly prestige were gleaned by academics modifying and alphabetizing IPT for specific disorders. But the net result was a longstanding balkanization of IPT, in which it appeared that each diagnosis required a different and specific IPT treatment. Moreover, the diagnostic specificity limited the breadth of patients to whom IPT could be applied. As a consequence, there has been, until recently (Stuart & Robertson, 2003), little discussion about what constitutes the general principles of IPT and the way it can be used transdiagnostically, not to mention the ways it can be used to treat people who simply suffer from interpersonal problems but do not have a specific diagnosis.

THEORY OF CHANGE: THE DEVELOPMENT OF THEORETICAL SUPPORT FOR INTERPERSONAL PSYCHOTHERAPY

That the early and later biomedically oriented manuals described IPT as a specific treatment rather than a general approach to therapy contrasted strikingly with other psychotherapy approaches. One can, for instance, speak of a cognitive approach to psychotherapy, or to a behavioral or psychodynamic approach. The principles of these therapies are generally held to be helpful transdiagnostically (Barlow, Allen, & Choate, 2004; Fairburn, Cooper, & Shafran, 2003). It was not common until the last decade to hear one describe an "interpersonal approach" to treatment. Moreover, doing what "good social workers do" was perceived by many in academia as poorly delivered therapy lacking a credible theoretical base. IPT was not aesthetically appealing for this reason to many academicians or clinicians; this also hindered dissemination and investment in theoretical development.

The unique way in which IPT was originally developed heavily influenced the limited theoretical support for its use. Other modalities developed quite differently, with theory and detailed clinical observation preceding codification of the therapy. Behavioral therapy, for example, evolved over time, beginning with careful clinical observation, refinement of hypotheses, and explicit empirical testing; cognitive therapy evolved in the same fashion. IPT, on the other hand, was first developed as a control or placebo treatment, which, for obvious reasons, needed no theoretical support. Only after it was found to be efficacious was an explanation sought for why it might be so. The IPT manual was literally written first, and then theory was appended. In short, that IPT worked was most important; how it worked was of secondary interest.

A critical question raised in any review of psychotherapy is what is "required" for a theory of psychotherapy to be legitimate, valid, or sufficient. There is certainly no universal agreement; it is a philosophical question and, frankly, an aesthetic one as well. Most would agree, however, that at the least, a coherent theory should provide an explanatory model for psychopathology and support for the general approach of the therapy. Without question, there is this level of theory supporting IPT. The essential theoretical premise in IPT is that disruption of interpersonal relationships is associated with depression, and that talking about and doing something about those relationships leads to improvement. What is lacking in the biomedical model of IPT is a more sophisticated explanation of causation (i.e., an understanding of what causes depression and psychological distress).

A close read of the 1984 textbook and its subsequent revisions reveals what is best described as a survey of interpersonal and attachment research. *Associations* between interpersonal functioning, social interactions, and depression are described in detail, but there is no linkage or explanatory model. Associations are established, but mediators are not. In the 1984 and subsequent biomedical model texts, Adolf Meyer is credited with much of the theory supporting IPT. Meyer is usually described as eclectic, though he did emphasize the need to understand

social context and relationships and their impact on psychopathology. Harry Stack Sullivan is also mentioned in the 1984 and subsequent manuals. Sullivan hypothesized that maladaptive interpersonal relationships lay at the root of severe mental illnesses, and he developed a theory to explain causality—in fact, his book was entitled *An Interpersonal Theory of Psychiatry* (Sullivan, 1953). In contrast to the biomedical model of IPT, however, Sullivan's model was transdiagnostic and psychodynamic. The clinical treatment he developed focused on understanding individuals in the context of their relationships, though his was largely a long-term and transference-based approach (and needless to say, very different from IPT). Ironically, Sullivan had been a prominent psychoanalyst at Chestnut Lodge and was practicing the very type of analytic psychotherapy that Klerman so forcefully rejected in the Osheroff case.

The work of John Bowlby, who is best known for his description of attachment and its association with psychopathology (Bowlby, 1969, 1988a), is also reviewed in the 1984 and subsequent biomedical manuals. Bowlby was also an analyst; like Sullivan, he developed his own method of treatment based upon his theoretical understanding of psychopathology (Bowlby, 1988b). It too was largely transference based and long term. Like Sullivan, Bowlby focused primarily on understanding the childhood antecedents of psychopathology.

Myrna Weissman and colleagues (Weissman & Paykel, 1974) also contributed heavily to the empirical support for the association between social environment and depression, and also demonstrated that social functioning improved following treatment with IPT (Weissman, Klerman, & Paykel, 1974). But how it improved, and the specific mechanisms of IPT that might lead to improvement, were not elucidated nor described theoretically.

The biomedical model of IPT does not provide a bridge between theory and specific therapeutic techniques. That social factors are important no one would deny, but what to do about them in therapy is not clear. What the biomedically oriented IPT therapist is expected to do (i.e., follow the treatment manual) is clear, but why the therapist should do so is not so apparent. Of course, for Klerman, the "why" was obvious: The therapist should follow the manual because the randomized treatment trial outcome data instruct that adherence to the manual leads to better outcome.

Without clear mediators, however, it is difficult if not impossible to provide a rationale for specific techniques. For instance, that the experience of grief is linked to changes in mood is an obvious association. But it is not clear, based on the biomedical model, what mediates the link between them, nor what interventions might be helpful. How, for example, does talking about grief in an IPT session help with mood? Is it catharsis? Behavioral change? Support from the therapist? A working through of conflict and emotions? A change in neurochemistry? Without understanding mediators, both theoretically and through empirical research, it is not clear how specific interventions work, which ones are necessary, nor what additional interventions might enhance IPT further.

A recent approach to IPT theory (Stuart & Robertson, 2003) advocates that a theory of change should be linked to specific interventions designed to address distress generally, and that those techniques or tactics should be empirically tested. IPT should then be revised based on the theory, clinical experience, and empirical data. Without this coherent theoretical linkage and approach to therapy development, much of IPT simply devolves into interpersonal problem solving using nonspecific techniques, and the therapy remains static.

Stuart and Noyes (1999) began tackling the lack of theoretical linkages in IPT conceptually in a paper on somatizing disorders, in which they hypothesized that interpersonal communication was directly linked to attachment style and mediated attachment and social support. Combining the attachment work of Bowlby and interpersonal theorists such as Kiesler (1996) and Horowitz (2004), they hypothesized that attachment style was manifest in moment-to-moment interpersonal communications, and that maladaptive interpersonal communication led to difficulties in eliciting support from others during times of distress, difficulties in resolving interpersonal problems, and problems in generating needed social support. This theoretical approach is shown in Figure 9.1 (Interpersonal Triad).

In brief, the combination of an interpersonal stressor with biopsychosocial, cultural, and spiritual vulnerabilities and inadequate social support lead to psychological distress. The patient's communications to others mediate his or her ability to resolve the interpersonal crisis and to enlist social support. This model led Stuart and Robertson (2003) to suggest focusing IPT much more extensively on examining

FIGURE 9.1 Interpersonal Triad.

and modifying interpersonal communication, using techniques they developed such as elaborating interpersonal incidents.

Stuart and Robertson (2003) argued that since IPT was brief, change in attachment style should not be a goal of therapy, whereas modification of communication and increase in social support were realistic goals. Their IPT model was both transdiagnostic and readily combined with other therapeutic approaches. Stuart et al. (Stuart, Noyes, Starcevic, & Barsky, 2008), for instance, proposed that combining interpersonal and cognitive approaches with well-delivered reassurance from the therapist would be even more effective for somatizing disorders than either of the approaches in isolation. Nancy Grote and colleagues have done similar work combining ethnographic interviewing and IPT for depression (Grote et al., 2009). This, too, was a new development in IPT, which had heretofore been conceptualized as a stand-alone treatment not to be combined with other therapies or techniques.

Stuart and Robertson (2003) elaborated on the theoretical connection between attachment, interpersonal, and social theory, again emphasizing that interpersonal communication mediated the relationship between attachment style and distress, and also impacted social support. Their book was also a departure from the IPT literature to that point, as it was the first IPT textbook designed for general clinical use rather than as a research manual for a specific disorder, and it was also the first to advocate moving from a biomedical model to a biopsychosocial model.

The second edition of *The Clinician's Guide* (Stuart & Robertson, 2012) included several notable changes. Among those was a change to the biopsychosocial/cultural/spiritual model of IPT, reflecting the importance of culture and spirituality in understanding individuals and in developing a formulation or explanation for why they were distressed. There was an intentional presentation of IPT as transdiagnostic, emphasizing that it could and should be used for a variety of interpersonal situations and distress rather than being relegated solely to use with specific diagnoses. In contrast, for example, to Klerman and Weissman's use of IPT-CM as a specific treatment for an individual suffering depression in the context of marital conflict, Stuart and Robertson advocated using IPT for marital disputes generally, whether or not one or both of the individuals was depressed. Further, they advocated that marital disputes (and other social conflicts) were in part a function of the dyadic relationship rather than being the result of a biomedical disorder in one of the individuals.

Stuart and Robertson (2012) also provided a theoretical and data-driven rationale for not terminating treatment. The work of Frank et al. (1990) demonstrated that maintenance therapy was helpful for many patients; moreover, it was well known from the TDCRP and many other studies that patients frequently relapsed. Those two well-established facts, when combined, led to the obvious conclusion that IPT should not be terminated, since it was impossible to provide maintenance treatment if termination occurred. Theoretically, the therapist was seen as an attachment figure for the patient, and Stuart and Robertson hypothesized that disrupting that attachment by terminating was actually harmful in short-term therapy. Instead, they proposed structuring IPT as an acute treatment for distress with a dosing range of 8–20 weekly or biweekly sessions followed by maintenance treatment for patients that would benefit from it.

Though the theory supporting IPT has been elaborated in more detail over time, it remains largely untested. Ravitz, Maunder, and McBride (2008) as well as McBride, Atkinson, Quilty, and Bagby (2006) have provided what little empirical data there is regarding attachment and outcome. There have been no empirical studies focusing on other potential mechanisms of change in IPT.

There are strong differences of opinion about whether IPT should be applied transdiagnostically or should only be used for specific diagnoses. The contemporary view is that although symptom-based diagnostic systems are an important way to understand patients, they should not be used as the sole basis for conceptualizing patients' distress, nor should a specific diagnosis be required for treatment with IPT. IPT can be used clinically with

patients who present with interpersonal problems whether or not they have a diagnosable disorder. The question of whether IPT should be applied in a clinical setting if the patient does not meet strict diagnostic criteria is of secondary importance; it is the individual's unique problems, distress, and social context that should be used to make a determination regarding suitability for IPT.

Moreover, the contemporary view contends that while symptom relief is a highly desirable goal, and that a multitude of efficacy studies demonstrate that IPT does lead to reduction in symptoms, this narrow focus has displaced attention from the other benefits of IPT. These include feeling more fully understood by others, being less isolated, increases in insight, improvement in social relationships, improvement in general life satisfaction and well-being, and a better match between the patient's attachment style and his or her social milieu. Though these concepts are very difficult to quantify and to measure, neglecting them and focusing narrowly on symptomatic outcome alone runs the risk of missing some of the most powerful and beneficial aspects of IPT—aspects that are unique to psychotherapy as opposed to treatment with medication.

At the foundation of all of these important differences of opinion is a metaconflict that has yet to be resolved. This metaconflict is, very simply, a disagreement about who gets to determine whether there is a "correct" perspective, and if so, which one it is. The traditional view is that the original developers of IPT have intrinsic authority to make that determination; the contemporary view is that there should not be a single model of IPT and that encouragement of differences of opinion will enhance creativity and iteratively enhance IPT over time.

RESEARCH ON EFFICACY AND EFFECTIVENESS OF INTERPERSONAL PSYCHOTHERAPY

IPT has been demonstrated to be an efficacious treatment for a range of psychological disorders in adolescent, adult, and geriatric populations. Meta-analyses have found IPT to have a moderate to large effect in treating depression, at least equivalent to CBT (Cuijpers, van Straten, Andersson, & van Oppen, 2008; Cuijpers et al., 2011). IPT has also been shown to be effective in treating posttraumatic stress disorder (Bleiberg & Markowitz, 2005; Krupnick et al., 2008; Robertson, Rushton, Batrim, & Ray, 2004), bulimia nervosa (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000), binge eating disorder (Wilfley et al., 2002), and social phobia (Lipsitz et al., 2008), as well as borderline personality disorder (Bateman, 2012; Bellino, Rinaldi, & Bogetto, 2010) and with women with histories of abuse (Talbot et al., 2011). IPT is also an effective maintenance treatment for depression.

In addition to the individual format originally described, IPT has been adapted to group formats (Reay et al., 2006; Wilfley, MacKenzie, Welch, Ayres, & Weissman, 2000). Empirical research has yet to be developed regarding the efficacy of IPT in a couple's format; however, partners or significant people in the client's life are often integrated into treatment (Brandon et al., 2012). There is also substantial evidence demonstrating the efficacy of IPT for a variety of affective disorders with different populations of patients. A sampling of these populations includes depressed adolescents, the elderly, perinatal women, and patients with dysthymia and those with HIV.

While empirical research regarding the efficacy of a treatment is essential, the effectiveness of a treatment is the ultimate measure of its clinical utility. Though quantitative effectiveness research regarding the effectiveness of IPT is not well developed at present, there is a great deal of clinical wisdom and experience that addresses its use in the community. This clinical experience is critical in the further development of IPT. The practice of IPT should be based on both empirical data gathered from randomized trials and from the qualitative data derived from clinical experience. Clinical judgment can and should influence the conduct of IPT.

DIVERSITY

IPT studies have been conducted with patients in every continent. Many of the cultural adaptations that have been made in these settings are described in the research protocols utilized. Schultz and Stuart (2014) have reviewed cultural adaptations of IPT generally; Brown, Conner, and McMurray (2012) have described use of IPT for African Americans; and Rossello, Bernal, and Rivera-Medina (2008) have done so with Puerto Rican youth. Furthermore, Budge has utilized

IPT with transgendered clients (2013), while Grote et al. (2009) and Swartz et al. (2007) have done work utilizing ethnographic interviewing to make IPT more culturally relevant with diverse clients.

In addition to its international applications, there is evidence of IPT's effectiveness for use with a variety of populations. Specifically, IPT has been used successfully with patients of low social class and low incomes (Grote, Swartz, & Zuckoff, 2008). As previously noted, Budge (2013) has worked with transgendered clients and has suggested that IPT might be an ideal treatment for those who are in the midst of transitioning, especially when working within the role transitions problem area. IPT is also an effective treatment for adolescents and adults from a variety of ethnic backgrounds (Blom et al., 2010; Cassidy et al., 2013; Markowitz et al., 2009). As Schultz and Stuart note (2014), "IPT transcends culture: people are people across the globe. Though the structure of families and individual social roles varies greatly across culture and geography, people relate to one another. They become distressed when they have problems with conflict, change, and loss of relationships. The foundation of IPT, attachment theory and interpersonal theory, lead[s] it to be relevant and useful for all human beings" (p. 12).

CONCLUSIONS AND KEY POINTS

Erik Erikson's psychoanalytic theory would characterize IPT as being in middle adulthood and wrestling with a conflict over generativity versus stagnation, with many questions about the therapy still unanswered. Will IPT evolve, or will it remain static? Will IPT be conceptualized as a medical treatment, or will it transcend that view? Will IPT be relegated to a niche treatment for diagnosed affective disorders, or will it be utilized transdiagnostically for interpersonal problems? Is IPT "defined" by its founders, or is it an "open-source" therapy? Time will tell how these questions are answered.

Should IPT be applied to specific diagnoses or be applied transdiagnostically? The trend is clearly a movement toward a broader conceptualization of IPT and the use of the biopsychosocial/cultural/spiritual model. Across psychotherapy generally, it has been noted that the diagnostically specific approach has resulted in an ever-expanding and increasingly unwieldy and impractical list of various brand-named psychotherapies, each for different discrete conditions which make them difficult to implement (Deacon, 2013). This situation has led Rosen and Davidson (2003) to argue that it would be far more useful to focus on empirically supported principles of change rather than individual reified therapy approaches.

Psychotherapy researchers are increasingly focusing on treatment process (Castonguay & Beutler, 2006), and guidelines have been offered for incorporating process research into efficacy trials (Hayes, Laurenceau, & Cardaciotto, 2008). The transdiagnostic approach to therapy has been widely advocated (Barlow et al., 2011), and the NIMH has tied funding for research to the newly developed research domain criteria (RDoC), which are also transdiagnostic.

What defines IPT, and what are its critical elements? This question is still being debated, but there is consensus that IPT rests on at least three principles: (1) that interpersonal transition, conflict, and loss lead to psychological distress; (2) that addressing this distress leads to improvement in symptoms; and (3) that treatment should be time limited and generally focused on external relationships rather than the patient–therapist relationship. The details are extensive and extremely important, and include disagreement about whether IPT should be terminated or not, about whether it rests on a biomedical model or a biopsychosocial/cultural/spiritual model, and about the mediators of change and goals of treatment. More research along with attention to clinical experience will be needed to further refine the understanding of what is necessary from a theoretical standpoint, and what are the necessary components of the therapy as it is delivered in practice. The clear trend, however, is a shift away from the biomedical model toward a more comprehensive conceptualization.

Who gets to decide what the critical elements of IPT are and how those elements are determined? Erikson would have recognized another of his stages of development (i.e., trust vs. mistrust) operating within the IPT community. Much of the conflict about IPT boils down to this: How much value should be given to clinical experience? While researchers argue over protocols and adherence, clinicians in the community have always modified psychotherapies to fit their own personal style, cultural needs, and their unique patients. They will continue to do so. Psychotherapies evolve—it is far better to embrace and encourage change than to resist it. Despite resistance from those

with allegiance to the original model of IPT, modifications and changes made by clinicians using it in the community are inevitable.

REVIEW QUESTIONS

1. What factors influenced the dissemination of IPT?
2. What was the impact of the Osheroff case on American psychiatry and psychology?
3. What was the impact of the NIMH-TDCRP on IPT?
4. What are the currents models of IPT in use?
5. What are the limitations of the biomedical model?

RESOURCES

Videos

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World Canvass. (2013). *Interpersonal Psychotherapy overview*. Iowa City: University of Iowa. [http://www.youtube.com/watch?v=fcGlTXAb4tE]

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Websites

International Society for Interpersonal Psychotherapy: http://www.interpersonalpsychotherapy.org

Interpersonal Psychotherapy Institute: http://www.iptinstitute.com

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10

Interpersonal Psychotherapy in Practice: Working With Depressed Adults

Hui Qi Tong
Leila Zwelling
Jeremy Doughan

Abstract
In this chapter we first present a brief historical perspective on interpersonal psychotherapy (IPT). We then examine its case conceptualization and how it reflects the principles of human behavioral change as defined by the American Psychological Association's Task Force on Principles of Therapeutic Changes. We also provide a brief overview of the efficacy and effectiveness of IPT when applied to the general adult population with unipolar depression. The phases and procedures of this treatment are included as well, followed by a discussion on how this approach addresses matters pertaining to patients' diverse backgrounds. Furthermore, we provide a clinical case which illustrates the procedure of this approach. Finally, we provide some conclusions, key points, review questions, resources, and references to help consolidate the understanding of IPT.

Keywords: interpersonal psychotherapy, depression, interpersonal disputes, role transitions, grief, interpersonal deficits

Interpersonal psychotherapy (IPT) is a time-limited, attachment-informed, present-oriented form of psychotherapy originally developed by Klerman and colleagues in the 1970s to treat adult unipolar major depressive disorder (Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974; Klerman & Weissman, 1993). It has three theoretical underpinnings: attachment theory, communication theory, and social skills theory. It emphasizes the important role human relationships and social communication play in the development, maintenance, and exacerbation of depressive episodes. Its main goal is to reduce depressive symptoms and improve social functioning by building social support and addressing issues related to four common areas of human relationships, including *interpersonal disputes*, a conflict with a significant other; *role transitions*, a major life change; *grief*, depression due to unresolved bereavement; and *interpersonal deficits*, difficulties forming or maintaining relationships. IPT is deeply rooted in attachment theory (Bowlby, 1977), as evidenced in the therapist's awareness of the client's attachment style from the initial contact; in-session, moment-to-moment interactions; and the prediction of prognosis and outcome of the therapy. Although it has its roots in attachment theory, the goal of IPT is not to change an individual's attachment style over the course of a limited number of sessions, but rather work in a more symptom-focused and present-oriented manner. Unlike therapies that began with anecdotal client stories of effectiveness as shared by the providers, IPT was derived from an empirical study where IPT was a "high-contact" control condition. This condition included a diagnostic evaluation, the gathering of a

psychiatric history, psychoeducation about depression, an interpersonal inventory of important people currently in the patient's life, the assignment of the sick role, the linkage of symptoms to interpersonal situations, and the choice of problem areas. IPT was compared to antidepressants in a maintenance treatment trial for adult unipolar depression (Klerman et al., 1974). The developers of IPT paid particular attention to its reproducibility before its dissemination through clinical training and supervision, first in the United States and, more recently, globally.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION IN INTERPERSONAL PSYCHOTHERAPY WITH DEPRESSED ADULTS

APA's Task Force on Principles of Therapeutic Change has identified a total of 48 principles of change related to the treatment of depression and dysphoria. These principles are categorized into four clusters to help guide clinicians in understanding the patient's experiences and in treatment planning (Beutler, Castonguay, & Follette, 2006). The first cluster pertains to the patient's characteristics and emphasizes the selection of patients who are most likely to respond to psychotherapy. The second cluster of principles focuses on the therapist–client relationship, which emphasizes the salience of a working relationship and guides the therapist in the development of a beneficial working alliance. The third cluster of principles lists technique factors that can be used by the clinician to increase compatibility between the patient and an intervention. The fourth and final cluster of principles emphasizes the value of developing a treatment plan, monitoring progress and change, and reinforcing changes as they occur, stressing the importance of acknowledging negative emotions and of developing positive, adaptive responses to replace maladaptive coping patterns.

Within the approach of IPT for adults with depression, the IPT case formulation and its implementation encapsulates a number of principles of change for treating patients with depressive disorders. We first provide an overview of IPT case conceptualization and its implementation and then discuss those principles of change that are represented in the case conceptualization and procedure of IPT.

The Interpersonal Psychotherapy Case Conceptualization

The IPT case conceptualization or interpersonal formulation is built upon the foundation of the biopsychosocial model, which asserts that biological, psychological, and social factors coalesce within an individual to produce a unique diathesis and response to stress (Stuart & Robertson, 2003). When confronted with a sufficient interpersonal crisis, vulnerable individuals are likely to experience psychological difficulties. In addition, IPT interpersonal formulation places a strong emphasis on both attachment and communication theory (Stuart & Robertson, 2003). The interpersonal formulation is decided on collaboratively and serves as a tentative hypothesis for predisposing, precipitating, and perpetuating factors in the development or exacerbation of depressive episodes. It is not meant to be static; instead, it should be modified as new data become available (including information from progress monitoring). The IPT case formulation also plays a central role in treatment planning, where one of the four common areas of interpersonal difficulties is identified as the focus of treatment, and appropriate techniques and strategies are applied to address that problem area. The IPT case formulation and the interventions that have been developed based on the interpersonal formulation represent the following principles of change, some common, some IPT specific, for treating depressed patients.

Principles of Change Related to Patient Characteristics

In general, the patient's attachment/interpersonal style interferes with the process of change and/or outcome. Patient prognosis is best among those with social approach or nonavoidant styles. Similarly, the perceived level of social support is a positive predictor of treatment benefit, while the absence of either actual or perceived social support may be indicative of the severity of the problem and the degree of experienced impairment. In the case of depressed adults, improving social support adds some benefit to the effects of treatment, suggesting that it may be a specific treatment factor. Severity and chronicity are likely to be negative outcome predictors: The more impaired or severe and disruptive the problem, the fewer benefits are noted for time-limited treatments.

The IPT case formulation entails an integrative assessment of a patient's biological, psychological, and social information, which forms the predisposing factors for the onset or exacerbation of depression. Attachment is considered an integral part of the patient's psychological factors. In IPT, attachment style is evaluated by asking open-ended questions about the patient's relationships; more specific inquiries into how a patient communicates when distressed, ill, or otherwise seeking care; and examining the patient's quality of narratives as well as the patient–therapist relationship (Stuart & Robertson, 2003). A patient's interpersonal relationship patterns as well as his or her communication styles in the initiating, maintaining, and terminating of relationships both inside and outside of therapy help shed light on how attachment styles are manifested in these relationships. A relatively secure attachment is likely the most important factor in determining which patients are most suitable for IPT (Stuart & Robertson, 2003). Attachment style is also an important outcome predictor for psychotherapy in general. In addition, IPT emphasizes a maintenance phase of treatment beyond the acute phase when available and necessary, while paying close attention to the recontracting process during which the goals of this phase of treatment, that is, maintaining functioning and relapse prevention as well as the differences in both frequency and intensity of treatment from the acute phase, are discussed.

Social theory is one of the underpinning theories of IPT, and social factor is another integral part of the IPT case formulation. Social theory emphasizes the importance of the social milieu in which a person develops interpersonal relationships and asserts that deficits in social support in the current circumstance play a causal role in the genesis of psychological distress (Henderson, Byrne, Duncan-Jones, Scott, & Adcock, 1980).

In the initial evaluation phase of IPT, it is critical to take the severity and chronicity of a patient's psychological difficulties into consideration when evaluating whether or not IPT is the most appropriate approach for the patient. IPT as a time-limited psychotherapy may not serve well patients with severe and chronic conditions (e.g., comorbid personality disorder) due to the time limitations. Additionally, the structured and prescriptive nature of IPT may not serve patients with high trait resistance that might be more prevalent in certain personality traits (e.g., narcissistic).

Common Principles Related to the Therapeutic Relationship

A number of common principles related to the therapeutic relationship have been encapsulated in IPT. Like all other psychotherapies, the first and foremost task of IPT is to create a therapeutic environment in which there is high degree of inclusion and affiliation. A positive working alliance is essential in IPT, and the responsibility for creating one lies with the therapist (Stuart & Robertson, 2003). IPT therapists must pay attention to the nonspecific Rogerian elements that are necessary to bring about therapeutic change: warmth, empathy, affective attunement, and positive regard (Rogers, 1951). Due to time constraints, it is critical that the IPT therapist strives to establish a therapeutic alliance as quickly as possible. Furthermore, since IPT is a therapy about interpersonal relationships, the way in which the therapist forms the therapeutic relationship could serve as a model for patients who are experiencing psychological difficulties due to interpersonal issues.

In IPT case formulation, therapist and client collaboratively identify a problem area as the focus of the treatment. The therapist educates the client on the diagnosis and symptoms of depression, assigning a sick role to the patient and presenting the IPT model, including the interpersonal formulation, to the client in a caring and collaborative way. Relational information between the therapist and the client is used from the initial contact. Therapists must be aware of their own reactions, especially while working with patients with insecure attachment.

Common Principles of Selecting Techniques and Interventions

Although good therapeutic relationship is essential, a laissez-faire approach to therapy, that is, one in which the therapist fails to confront the patient, fails to direct the patient's efforts, or avoids raising the patient's distress has limited effects. The IPT approach followed a number of principles of techniques and interventions. A key element of early sessions of IPT is validation of the depressed client's emotions as absolutely understandable when viewed in the context of his or her life situation (Stuart & Robertson, 2003). In addition, during the initial phase of treatment, the IPT therapist socializes the client on depressive symptoms and the diagnosis. Therapists also guide their clients

in deciding on a problem area to work on and provide the rationale for addressing interpersonal issues that have precipitated the depressive symptoms. Clear and explicit goals and the structure of IPT are discussed. Ongoing assessment is conducted by weekly symptom measures and mood checks.

In summary, a number of principles of change manifest in IPT from alliance building, case formulation, treatment planning, and implementation. IPT therapists attempt to help patients decrease depression and improve social functioning by focusing primarily on interpersonal issues and closely monitoring treatment progress in a collaborative therapeutic relationship.

RESEARCH ON EFFICACY AND EFFECTIVENESS OF INTERPERSONAL PSYCHOTHERAPY

IPT for depression is an empirically based treatment protocol grounded in studies attesting to its efficacy, as well as its effectiveness (Craighead, Hart, Craighead, & Ilardi, 2002; Stuart & Robertson, 2003; Weissman, Markowitz, & Klerman, 2007). In brief, efficacy research involves stringently controlled conditions, using rating instruments and well-trained clinicians to administer the protocol. Highly defined inclusion and exclusion study criteria are established to limit heterogeneity among the sample in efficacy trials (Markowitz & Weissman, 2010). Once efficacy is established, it must be determined if the treatment is effective in less rigorous or well-controlled environments and applicable in a clinical setting (e.g., medical centers, outpatient clinics, community programs). The research in support of IPT as an efficacious treatment focuses mostly on randomized controlled trials (RCTs) as a treatment for unipolar, nonpsychotic depressive disorders (Craighead et al., 2002).

A myriad of studies have demonstrated the efficacy of IPT in regard to depressive symptomatology. IPT was initially researched as an acute treatment for depression and began with Klerman and Weissman in the 1970s (Stuart & Roberston, 2003; Weissman, 2006). One of the initial studies for IPT began in 1973 as the New Haven-Boston Collaborative of the Treatment of Acute Depression (Klerman & Weissman, 1993). This study compared IPT, amitriptyline, a combination of the two treatments, and a control treatment for 81 outpatients with major depression. The results showcased no significant difference in symptom reduction between the antidepressant and IPT at 16 weeks; however, the active treatments all demonstrated symptom reduction compared to the control, and the combination trial of amitriptyline and IPT was more efficacious than either monotherapy. The study concluded that in comparison to amitriptyline for treating major depression, IPT was just as efficacious (Craighead et al., 2002; Klerman & Weissman, 1993). Additionally at 1-year posttreatment follow-up, Klerman and Weissman (1993) found that IPT therapeutic benefits (i.e., social functioning) were sustained by a number of the patients.

One landmark study, in particular, considered the gold standard for psychotherapy efficacy outcome studies, furthered IPT in research settings (Stuart & Robertson, 2003). The National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH-TDCRP) examined the efficacy of IPT in comparison to imipramine, cognitive-behavioral therapy (CBT), and a clinical management-placebo (i.e., support) trial (Craighead et al., 2002; Elkin et al., 1989; Stuart & Robertson, 2003). This was the first national study of its kind to compare IPT to CBT. This multisite clinical study concluded that patients in all three experimental conditions demonstrated symptom reduction and improvement in functioning, and that IPT was not only superior to the placebo but also equally effective as CBT for mild to moderate depression. Furthermore, Klein and Ross (1993) stated that in comparison to IPT, CBT was inferior for patients with scores at or above 30 on the Beck Depression Inventory. Reanalysis of the data concluded that IPT was comparable in efficacy to imipramine (Craighead et al., 2002). Additionally, Luty and colleagues (2007) conducted a study that examined IPT in comparison to CBT. They also concluded that IPT was equally efficacious when compared to CBT for mild to moderate symptoms of depression.

Other large-scale randomized controlled studies have also demonstrated empirical support for IPT in treating depression. From the University of Pittsburgh and Western Psychiatric Institute and Clinic, Frank and colleagues examined maintenance treatment trials for depression at 3-year outcomes to explore the high relapse rates and recurrent episodes (Frank et al., 1990; Markowitz & Weissman, 2010). They

conducted a maintenance trial on 128 outpatients assigned to five treatment protocols: imipramine, imipramine and monthly IPT, monthly IPT, monthly IPT and placebo, and placebo. The researchers reported that monthly IPT (maintenance) was both clinically and statistically superior to the placebo. Additionally, Frank and colleagues (1991) indicated that monthly sessions of IPT were of significant benefit when there was an interpersonal focus in patients with recurrent unipolar depression.

Further support for the efficacy of IPT has also been obtained through meta-analysis research. Several key reviews have validated empirical evidence for IPT as a first-line treatment for depression. Cuijpers and colleagues (2011) examined 38 studies, 33 for acute depression and 5 for maintenance, consisting of 4,356 patients in differing treatment conditions (e.g., control, pharmacotherapy, and other psychotherapy modalities). Results indicated moderate to large effect sizes for IPT in the treatment of acute depression when compared to control groups. Additionally, combination treatments of IPT and pharmacotherapy were more efficacious than pharmacotherapy alone. Cuijpers et al. (2011) also concluded that IPT was equally effective to CBT, and maintenance IPT, when combined with pharmacotherapy, also reduced relapse rates.

Another meta-analytic review by de Mello et al. (2005) summarized findings from 13 studies that examined the efficacy of IPT for the treatment of depressive spectrum disorders. Their findings supported IPT as superior to a placebo condition and more efficacious than CBT. Furthermore, their findings suggested IPT was equally as efficacious as antidepressants but did not support a combination of IPT and antidepressants, in comparison to antidepressants alone for acute depression.

While the empirical evidence in support of IPT as a treatment for depressive disorders has been thoroughly established, the clinical utility or effectiveness of IPT, albeit not as widely reported, has also demonstrated benefit in clinical settings, with future work to be done in this arena (Stuart & Robertson, 2003). Hinrichsen (2008) and colleagues (Hinrichsen & Clougherty, 2006) observed in their clinical work with older adults, or geriatric population, that 74% of patients showed clinically significant improvements in affect and reported reductions in depressive symptoms over the course of IPT for late-life depression. Clinical effectiveness or outcomes in a group psychotherapy format have also garnered evidence for utility in the community. Mackenzie and Grabovac (2001) discussed their experience by illustrating a case study using IPT to treat patients with depressive symptoms. The study reported 5 out of 8 group members experienced marked symptom reduction over the course of 14 weeks. They posited that IPT in a group setting is "a promising, cost effective treatment modality for patients suffering from depression" (p. 51). Additionally, Scocco, De Leo, and Frank (2002) reported that IPT for depressed older adults in a group setting was clinically relevant.

ASSESSMENT AND SELECTION OF PATIENTS

Before deciding to treat a patient using IPT, it is important to do a careful assessment to determine whether the patient can benefit from this approach. IPT for depression is for adult patients with moderate to severe unipolar depression. As IPT focuses on depression in relation to interpersonal issues in four problem areas, patients with depression related to difficulties in one or more of these four areas are most suitable for IPT.

As with other time-limited psychotherapies, patient characteristics such as motivation, commitment, and ability to form a therapeutic alliance are crucial in patient selection for IPT. The ability to trust the therapist, be honest and forthcoming, and establish a working alliance is paramount. Level of autonomous motivation and the strength of the therapeutic alliance are especially important predictors of IPT treatment outcome (McBride et al., 2010). Also, similar to other time-limited therapies, IPT requires the patient to make a commitment—in the case of IPT for depression, the commitment is 12–16 weekly sessions—and to make adjustments in their schedules (e.g., for work, school, child care, etc.) to accommodate the treatment commitment.

There are other patient characteristics specific to IPT that increase the likelihood that patients will benefit from the treatment. Patients who are able to see others' perspectives and take responsibility for their own actions will generally fare better in IPT. Relatedly, a qualitative study (Crowe & Luty, 2005) identified the following patient characteristics that were good prognostic indicators for IPT: an ability to engage in multiple perspectives, an awareness

of others' feelings, a desire to make change, a sense of self-responsibility, an ability to use a range of communications strategies, a desire to act cooperatively, and an ability to engage with the therapist. In addition, Stuart and Robertson (2003) cited patient characteristics that increase the likelihood of benefiting from IPT, which include a relatively secure attachment style, the ability to relate a coherent narrative, a specific interpersonal focus for distress, and a good social support system.

Conversely, certain patient characteristics are related to poorer IPT treatment response, including social isolation, self-critical perfectionism, and high levels of attachment avoidance (Ravitz, McBride, & Maunder, 2011). Marshall and colleagues (Marshall, Zuroff, McBride, & Bagby, 2008) hypothesized that depressed individuals with higher levels of self-criticism do not benefit as much from IPT as CBT because these individuals are less preoccupied with interpersonal issues; they are usually instead struggling with depression related to cognitive distortions, which is treated more successfully with CBT. In another study examining anxiety and avoidance dimensions of adult attachment insecurity as moderators of treatment outcome for IPT and CBT (McBride et al., 2006), those with elevated levels of attachment avoidance responded less favorably to IPT than they did to CBT.

In addition to patient characteristics, it is helpful to use objective assessment measures in patient selection for IPT. Usually the Beck Depression Inventory (BDI) is used to measure depressive symptoms. Patients who score in the moderate to severe depression range on the BDI are most likely to benefit from IPT for depression. The abbreviated World Health Organization Quality of Life measure (WHOQOL-BREF) is also frequently used. It measures the patient's perception of his or her quality of life in domains including physical health, psychological state, personal beliefs, and social relationships. Patients with moderate to high scores on the social relationship subdomain will likely benefit most from IPT.

In summary, all patients should be uniquely assessed for which treatment can best address their presenting concerns. Generally, IPT for depression tends to be more effective for moderately to severely depressed patients with a specific interpersonal problem area related to their depression, who are motivated for treatment, have the ability to form a strong therapeutic alliance, and who are open to working on improving their social relationships and communications skills.

INTERPERSONAL PSYCHOTHERAPY TREATMENT WITH DEPRESSED ADULTS

The goals in the IPT treatment with depressed adults include reducing depressive symptoms and improving interpersonal functioning through work on interpersonal problems related to change, loss, isolation, or conflict in relationships. Simultaneously, IPT aims to assist patients in better utilizing available social support or developing new social supports. IPT is typically delivered in a course of 12 to 16 weekly sessions, divided into three distinct treatment phases: the initial phase, the intermediate phase, and the termination phase. Some providers may choose to offer an optional maintenance phase of treatment, after the acute phase is complete. Regular symptom monitoring is conducted on a weekly basis using the Beck Depression Inventory and verbally with a subjective mood check (rating depression level on a scale of 1–10) at the beginning of the session.

The Initial Phase

The initial phase takes place over the first several sessions, and its focus is primarily on assessment versus intervention. The initial phase includes reviewing the patient's symptoms of depression, making the diagnosis of depression explicit to the patient, and providing the patient with psychoeducation about depression as a medical illness. The patient is also given the "sick role" to reduce the self-blame that frequently accompanies depression.

One of the most important tasks in the initial phase is to complete the interpersonal inventory, a structured review of the most salient people in the patient's life. The interpersonal inventory is useful in identifying the patient's relational patterns, interpersonal issues that may be a focus of treatment, potential sources of support, and the patient's interpersonal strengths and weaknesses. For example, after exploring a patient's relationship with her spouse, her friend, and her boss in the interpersonal inventory, the therapist may notice that the patient is conflict avoidant and could use help developing assertiveness skills. This will be important information to guide interventions later in the treatment.

Once the inventory is complete, the therapist integrates information obtained in the patient's history and the inventory and presents the patient with the

interpersonal formulation. The interpersonal formulation is essentially the therapist's hypothesis about what is causing and/or maintaining the patient's depression, and the interpersonal focus of treatment that is considered to be most helpful in alleviating the depressive symptoms. By the end of the initial phase, patient and therapist should reach an agreement on the formulation, treatment contract, and selection of one or two of IPT's interpersonal problem areas to focus on during treatment.

For example, a formulation for a patient with a role transition problem area after a move out of state may be phrased as:

> Like we've discussed, you are suffering from depression. Your primary symptoms are depressed mood, insomnia, loss of appetite, and frequent crying spells. Your depression began when you graduated from college and then moved from your home state of Virginia to California last year. It's been harder to make friends than you expected and difficult to find a good job, and the loneliness and stress you're feeling have worsened your depression. In IPT, we call this a "role transition," or major life change: You've gone from being a university student to working full-time, moved from one coast to another, and then moved in with your boyfriend, Adam. I think that if we can work together on helping you get involved in new activities and meeting new people here in California, that this will really improve your mood. Do you agree?

Note the importance of ending the formulation with an inquiry about the patient's agreement. If the patient does not agree, the therapist and patient should work together to modify the formulation before moving forward. For instance, using this example, if the patient disagrees, stating that the issue most contributing to her depression is her constant fighting with her boyfriend, the formulation should be modified to something like this:

> You said you became depressed when you moved to California and moved in with your boyfriend, Adam. Since the two of you moved in together, you have been fighting daily about money and chores, and these fights really worsen your mood. In IPT, we call this an "interpersonal dispute." I think that if we can work together on helping you with your relationship with Adam and get the two of you communicating more effectively, your mood will likely improve. Do you agree?

The initial phase of treatment is only complete when the therapist and the patient are in agreement about the formulation and focus of treatment.

The Intermediate Phase: Problem Areas

The intermediate phase consists of focused work on the one or two of IPT's four interpersonal problem areas (i.e., interpersonal disputes, role transitions, grief, interpersonal deficits), of which the therapist and patient have mutually agreed upon to focus. For each problem area, there are specific goals, strategies, and interventions to guide the treatment.

In the *interpersonal disputes* problem area, the patient has a major conflict in a significant relationship, usually involving the two parties having differing expectations—or "nonreciprocal expectations"—about the relationship. Examples of interpersonal disputes are conflicts such as the following: disagreement with a spouse about money management styles, a conflict with a boss about work performance, or a conflict with an elderly parent about whether to move into a retirement home. In the dispute problem area, goals include (1) identifying the stage of the dispute, (2) making a choice about a plan of action, and (3) putting the action plan into practice by modifying maladaptive communication patterns and/or reassessing expectations.

In the *role transitions* problem area, the patient's depression is associated with difficulty adjusting to a major life change. Examples of role transitions are major life changes, such as getting married or divorced, going back to school, moving to a new city, or retirement. Goals in the intermediate phase for a role transition problem area include (1) acknowledging and expressing ambivalence regarding the role transition, (2) mourning the loss of the old role, (3) developing a more balanced view of the new role, and (4) developing new skills and social supports in the new role.

The *grief* problem area is selected when the patient's depression is associated with the death of a significant person. Patients with a grief problem often have become stuck in the bereavement process, sometimes due to feelings of guilt or "unfinished business" in the relationship. Examples include an adult daughter who was not on speaking terms with

her mother at the time of her death, a father who lost his military son to war, or a friend who didn't intervene when a friend drove home drunk and had a fatal accident. Goals in the grief problem area include (1) grief work, including describing events leading up to and immediately following the death, (2) exploring both positive and negative feelings about the deceased, and (3) either re-establishing interests or developing new interests and relationships.

Finally, the *interpersonal deficits* problem area is used when the patient's depression relates to a long-standing difficulty forming or maintaining relationships. Examples of the interpersonal deficits problem area are a patient who is very socially isolated and lonely, or a patient who is able to make friends, but the relationships usually end after several months. Goals in the interpersonal deficits problem area include (1) reducing social isolation, (2) building relationships, and (3) learning and practicing communications skills.

The Intermediate Phase: Interventions

In the intermediate phase, a variety of interventions are flexibly used, depending on patient characteristics and the selected problem area. Some of the interventions in IPT are common to many types of therapies, such as clarification, exploration, eliciting affect, and encouraging the patient to tolerate painful feelings. There are also interventions that are more structured, or more specific to IPT, such as the communication analysis, decision analysis, role-play, communications skills building, and work at home. Several of these interventions are detailed later. For more detailed information about IPT interventions, see chapter 8 entitled "Specific Techniques" in the *Comprehensive Guide to Interpersonal Psychotherapy* (Weissman et al., 2000).

Communication Analysis

One frequently used IPT technique is the communication analysis, which is used to help the patient identify maladaptive communication styles and assist in teaching the patient how to communicate more effectively. The communication analysis is a very detailed, structured review of a recent conversation the patient had with a significant person, which affected the patient's mood positively or negatively. Instead of having the patient tell the therapist *about* the conversation, in an IPT communication analysis the therapist facilitates the patient reciting the conversation as close to a word-for-word "transcript" as possible. For example, if the patient comes to session after having had a fight with his wife the previous evening, the therapist will ask the patient to replay the conversation verbatim, saying something like "I want to hear the fight as if I was a fly on the wall during your argument. What would I see? What would I hear?" The therapist asks the patient where he was when the argument began and how it started. The therapist will then instruct the patient to repeat as closely as possible the exact words he said (for example, "I said, 'You always come home late' "), followed by the response of the other party (for example, "Then she said, 'That's crazy, this is the first time I've been home late all month' "). The therapist guides the patient in relating the entire conversation in this manner. During the communication analysis, the therapist elicits the affect during important parts of the conversation ("How did you feel when she said that?" "How do you think she was feeling?" "How could you tell?"). Additionally, the therapist listens for any assumptions that the patient or the other party may have made during the conversation. Finally, the therapist assists the patient in examining the effectiveness of the patient's communications in this specific conversation and the ways the patient could have been more effective in communicating his or her message.

Decision Analysis

Another frequently used IPT intervention is the decision analysis. The decision analysis is used to help the patient decide on a course of action regarding an interpersonal problem. As it is often difficult for depressed patients to see the range of options available to them, this technique helps highlight and explore options of which the patient may not be fully aware. To begin the decision analysis, the therapist has the patient generate a list of options he or she could select to handle the interpersonal problem. Then each option is reviewed one by one, with a thorough examination of the pros and cons of that option. After all options are reviewed at length, the patient selects one option on which to act. For example, if a patient and his wife are not speaking after an argument about his drinking, the therapist could use a decision analysis

to help the patient decide how to proceed. The therapist will help the patient generate options, such as (1) telling his wife he is sorry, (2) acting as if the argument didn't happen, (3) asking his wife to revisit the issue when they are both calmer, or (4) continuing the silent treatment. After weighing the pros and cons of each of these options, the patient selects one option. In this example, perhaps the patient decides to approach his wife when they are both calm and ask to discuss her concerns about his drinking.

Role-Play

Role-play is another intervention that is often used in IPT. Frequently, following a decision analysis, a role-play may be used to practice before proceeding with the option selected. The role-play highlights the patient's communication style and gives the patient the opportunity to practice new ways of interacting with others. In the earlier example, perhaps the therapist will next facilitate a role-play, to allow the patient to practice what exactly he will say to his wife when they revisit her concerns about his drinking. The therapist may play the role of the patient's wife, while the patient plays himself, or vice versa. After the role-play, the therapist gives feedback about the patient's communications and may offer suggestions for communicating more effectively. The therapist may then teach the patient new interpersonal communications skills (such as using "I" statements, "putting yourself in the other person's shoes," and carefully selecting the right time to have an important conversation).

The Termination Phase

The last several sessions of the IPT treatment protocol are termed "the termination phase." In IPT, termination is explicitly discussed, and the patient is encouraged to explore both positive and negative feelings about therapy ending. During the termination phase, the patient and therapist review changes in symptoms and interpersonal functioning over the course of the treatment. Symptom change is measured using the weekly scores from the Beck Depression Inventory, as well as comparing the numbers given by the patient in the subjective mood check (rating depression level on a scale of 1–10) over the course of treatment. Additionally, comparing the WHOQOL-BREF scores from the first session to the final session of treatment is a useful way to measure improvements. The therapist highlights new skills the patient has learned and interpersonal successes the patient has had during the treatment. Most important, any improvements are attributed to the patient's efforts (for example, if after reviewing significant mood improvement over the course of treatment the patient says, "I couldn't've done this without you," the therapist should highlight the patient's work in therapy by saying something like "We've worked really well together. You've worked hard to make some pretty big changes in your life, and because of this, you are no longer depressed. I've helped guide the way, but you're the one who's done the hard work."). The termination phase also includes relapse prevention planning and an optional discussion of maintenance treatment, when indicated and available.

The Maintenance Phase

Maintenance IPT treatment can be offered after an acute course of treatment ends, provided that the initial course of treatment was helpful. The goal of the maintenance phase is to prevent the recurrence of depression, enhance the skills, and strengthen the competencies achieved in acute IPT. In the maintenance phase, the patient is encouraged to take responsibility for preventing future episodes of depression while continuing to cope with interpersonal life events as they emerge. Maintenance IPT may focus on the same problem area as the acute treatment, a different problem area if one becomes more prominent, or a broader relapse prevention focus in an interpersonal context. Maintenance sessions are typically provided on a biweekly or monthly basis (Frank et al., 2007).

DIVERSITY

IPT has proven to be effective with a number of diverse groups, including differing ages, genders, ethnicities, and cultures, as well as special populations (i.e., veterans). Originally, IPT was targeted for an adult outpatient with nonbipolar depression (Weissman et al., 2000). However, Weissman and colleagues (2000) understood that psychosocial variables might ultimately need to be adapted to work with differing treatment populations. The strong

empirical support for the clinical applications of IPT has been substantially stated in other sections of this chapter. Therefore, it remains important to examine the role of IPT on race, gender, culture, age, and specialized cohorts, as well as the research that supports the treatment within these populations.

Culture and Ethnicity

IPT has been recognized in many countries as an efficacious treatment for depression. International organizations and branches of IPT abroad have been established and garnered growing attention to this particular treatment (Interpersonal Psychotherapy Institute, 2016; Weissman et al., 2000, 2007). In fact, the IPT manual has been translated into Italian, German, Japanese, and French. Additionally, training curriculums have been designed in Brazil, Canada, China, Germany, India, New Zealand, and the United Kingdom, to name a few (Weissman et al., 2007). Several studies and investigations worldwide have taken part in RCTs to establish IPT's efficacy within specific cultures, as well as its clinical utility (Weissman et al., 2000, 2007).

IPT has been culturally adapted and researched in several developing nations. Two notable research projects evaluating cultural perspectives were conducted in Uganda and Ethiopia (Stuart, Robertson, & O'Hara, 2006; Weissman et al., 2007). The Ugandan project was conducted by Bolton and colleagues (2003) to address the high prevalence (i.e., approximately 21%) of depression in this country. Those increased rates were presumably associated with skyrocketing rates of HIV infection, a lack of local methods to effectively treat depression and the rural setting limiting access to care. An adaptation of IPT was conducted with male and females in separate groups, consisting of eight to ten patients per group. Sessions lasted 90 minutes and took place weekly over the course of 16 weeks. Adaptations included a group format versus individual due to the value placed on community and family within the Ugandan culture (Weissman et al., 2007). Additionally, interpersonal problem areas or foci were given culturally specific descriptions (i.e., deficits were termed "loneliness" and "shyness"). Investigators reported depression rates significantly reduced from 86% prior to treatment to 6.5% post intervention (Bolton et al., 2003; Verdeli et al., 2003). They concluded that despite minor adaptations to the original protocol, IPT still yielded significant results with non-Western populations.

According to Weissman et al. (2007), the four problem areas previously described are represented in many cultures and can be viewed as universal. Another culturally adapted IPT protocol was again used in Africa. In 2003, Ravitz and colleagues out of the University of Toronto, Department of Psychiatry, established an adapted IPT psychiatry resident training program between the University of Toronto and Addis Ababa University in Ethiopia as a way to expand, train, and apply the context of the IPT framework to another culture (Weissman et al., 2007). Given IPT's four problems model and the application of this model to differing cultures and settings, researchers posited that Ethiopian patients had relevant adverse life events for which IPT could be utilized. Ethiopian psychiatric residents were trained in a month-long didactic, focusing on IPT application and theory. While researchers found less frequent and shorter sessions to be more feasible, Ravitz and colleagues concluded that experiences of conflict, loss, and change were applicable as well to this ethnic group and determined IPT to be an effective adjunctive treatment (Weissman et al., 2007).

Regarding other cultures and ethnicities where IPT has been utilized, Weissman and colleagues (2000) reported that Dutch researchers have adapted a protocol from the IPT manual, following the announcement by the Dutch Consensus Conference in 1994 that listed IPT as a proven efficacious treatment for depression. Furthermore, Weissman and colleagues (Weissman et al., 2007) report some successful clinical trials in the United States with non-Anglo groups such as African American and Latina/o populations; however, more research is needed with these and other populations (i.e., Asian Americans).

Older Adults

In addition to adaptation for other cultures and ethnic backgrounds, IPT has been used with older adults. Depression can affect patients in later stages of life (Hinrichsen, 2008). IPT for older adults has shown strong evidence as an effective and efficacious treatment for late-life depressive symptoms (Reynolds et al., 1999; Hinrichsen & Cloughtery, 2006; Miller, 2009; Weissman et al.,

2007). Rothblum and associates (1982) were some of the first to report the effectiveness of IPT with an older adult cohort with grief and role transitions as the treatment focus. Adaptions consisted of longer sessions than the traditional 50- or 60-minute sessions and included more case management, such as arranging transportation and connecting patients with community services or more contact with the patient's primary caregiver. The research group concluded approximately 61% of depressed geriatric patients showed a decrease in symptoms after 6 weeks of IPT and antidepressant pharmacotherapy (Hinrichsen & Clougherty, 2006). Miller and colleagues (1998) noted that grief, contrary to popular intuition, was not the most common problem area for this elderly group; in fact, approximately two fifths of the participants demonstrated role transition problems, followed by role disputes. Furthermore, Miller (2009) proposed adapting IPT to older adults who have mild cognitive impairment. He stated that late-life depression can be further complicated by cognitive impairment, leading to the modification of an IPT protocol to address memory loss, impairments in executive functioning (i.e., insight, judgment), and incorporating the role of the caregiver. Subsequently, Miller and colleagues developed an IPT-CI (cognitive impairment) framework that addresses depressed geriatric patients with mild cognitive difficulties (2007).

Gender

When considering gender issues, most research has been conducted with women who experience pregnancy, postpartum depression, or a miscarriage. According to Weissman et al. (2007), due to complications (i.e., illness, stress) during pregnancy, 10% of pregnant women may be diagnosed with a major depressive disorder. Adaptations for IPT to address women during this time have been minimal, but Weissman and colleagues (2007) reported at least one RCT for IPT during pregnancy and postpartum, as well as encouraging findings in small sample pilot studies for miscarriages. A fifth problem area has been identified for women in this group: complicated pregnancy (Spinelli, 1999). This area may encompass specific situations such as rape, HIV infection, infants born with abnormalities, and unwanted or unplanned pregnancies.

Special Populations

Other considerations regarding diversity pertain to specific subgroups of the population. One group in particular that has been of interest to the US Department of Veterans Affairs (VA) is postmilitary service members or veterans. According to the Veteran Health Administration (VHA) National Registry for Depression, approximately 2 million veterans have been diagnosed with a depressive disorder since 1997 (Smith et al., 2011). Furthermore, depression accounts for over 14% of health care costs in the VHA (Rodrigues et al., 2014). Recognizing the need to treat military veterans who suffer with depressive disorders, the VHA has embarked on a national dissemination training program to address this issue. Stewart and colleagues (2014) conducted a review of IPT-trained VA health care clinicians to assess the utility of IPT for a veteran population. They reported large reductions in depression scores and improvement in overall quality of life with IPT, further supporting the feasibility and effectiveness of IPT for a veteran population (Clougherty et al., 2014). Consequently, the IPT for depression protocol has been implemented throughout the VHA system.

CLINICAL ILLUSTRATION—AN INTERPERSONAL ROLE DISPUTE: THE CASE OF LINDA

Linda is a 51-year-old, divorced, perimenopausal Caucasian female with a son and a daughter, both of whom are adults. She relocated to San Francisco from the Midwest about a year ago. For the past 8 months, she has been attending an ongoing women's group for substance abuse (in sustained remission) and was referred by her group therapist for individual psychotherapy for recurring depressive symptoms, including depressed mood, loss of interest, isolation, fatigue, loss of appetite, crying, and sleep disturbances.

Assessment

Before initiating IPT, a thorough evaluation that included current and past history of depression and other comorbidities, treatment history, current stressful life events, severity of the current depressive episode, attachment style, motivation for treatment, and ability

to form a relationship was conducted to determine if IPT might be a good fit for the patient. Throughout the interview, the patient demonstrated the capacity of trusting a new therapist, and her recurring depressive symptoms were largely attributable to the conflicts in her relationship with her daughter, who broke up with her boyfriend lately and "has been taking out her frustrations" on her mother. Linda found it difficult to be "respected and heard." Meanwhile, she stated that she has a satisfactory relationship with her son. She has remained in touch with a few old friends in the Midwest after her relocation and has made a couple of new friends in the neighborhood. She is committed to making changes in her relationship with her daughter. Based on this information, the therapist conveyed to Linda that IPT is likely to be a good fit to address her depression. Toward the end of the first session, the practical aspects of treatment such as length of sessions, frequency, termination date, appointment times, and missed sessions policy were discussed and agreed upon, and an explicit treatment contract was stated: "I'd like to meet with you once a week for twelve to sixteen more sessions for fifty minutes each session, to try to understand with you your current life stressors, your depressive symptoms, and how they might be related to salient interpersonal issues. We will also figure out how to address interpersonal issues so as to alleviate depression."

Initial Phase (Sessions 1–4)

In the initial phase of IPT, an interpersonal inventory was conducted. Several important relationships were discussed in detail, including her ex-husband, daughter, son, grandparents, a couple of old friends, as well as her parents, who, although deceased, still have a sizable impact on Linda's interpersonal patterns. Linda grew up in a chaotic environment with an alcoholic father and an often depressed and emotionally absent mother. She was able to get some care and support from her maternal grandparents until her teenage years. Linda learned to "hide" and "be quiet" at a young age so as not to get any attention when her father got drunk. Her mother "seemed to be chronically depressed" and "emotionally unavailable." She started to consume alcohol around 15 years old with a few high school friends after school "to numb the pain." Linda started to work as a bartender after high school and married in her early 20s and continued to abuse alcohol after work. Her ex-husband reminded her of her own father. Both were veterans. Both appeared to be nice when sober. However, when drunk, both would become verbally and emotionally abusive toward family members. Linda divorced at age 47 when her son was 20 and her daughter was 18. She has not been in touch with her ex-husband for a number of years and has no desire to speak to him. She reported having a fine relationship with her son, who is a man "who does not drink or yell" and, at a young age, acted as Linda's protector when her ex-husband was drunk and yelling. He seemed to appreciate Linda's situation but "was probably depressed on and off as well." Linda and her son used to talk to each other at least once a week, but she had a difficult relationship with her daughter, Jasmine. Jasmine "hates" Linda for being "emotionally checked out" often in the past and for being unable to provide adequate care as a mother. Linda feels guilty toward Jasmine and tries to do whatever her daughter asks of her so as "to please and appease her." The two got along quite well until Jasmine's breakup. Linda has a few old friends back in the Midwest from childhood with whom she had been in contact at least once a month until she became depressed. Linda expressed the desire to resume contact with them.

Following the interpersonal inventory, Linda and her therapist collaboratively developed an interpersonal formulation and identified a problem area as the focus of the treatment:

> Linda, based on the symptoms you've described, I believe that you have developed an episode of major depression. From going through your history, we know you have experienced and been treated for depression before, and it seems to be recurring again now. Depression is a complex illness that is influenced by a number of factors. There seem to be some biological factors that may serve as risk factors, such as the fact that your mother had depression. You are perimenopausal and have been experiencing some mood swings that may be related to hormonal change. There also appear to be psychological factors at play. You grew up in a chaotic environment where you did not have adequate support from your parents and coped with it by stuffing your emotions,

avoiding conflicts, or numbing by drinking. While confronting your daughter, who has become rather abusive by blaming, belittling, and yelling at you, you were at a loss for words to express your hurt feelings and assert yourself for respect. You started to experience depressive symptoms again, like crying, isolating, and you said you noticed that you stopped calling your son and friends. The risk factors we discussed earlier, combined with the increased tension between you and your daughter, and your decreased social support since you are new to the area, all contributed to the recurrence of your depression. Since this episode of depression is closely related to the increasing conflict between you and your daughter, we will choose this conflict—in IPT we call it a "role dispute"—as the focus of our work.

Intermediate Phase (Sessions 5–8)

During the intermediate phase, Linda's relationship with Jasmine was explored further. In IPT, the stage of role dispute is defined in three phases: negotiation phase, impasse, and dissolution. It was determined that the role dispute between Linda and Jasmine is in a "negotiation" stage, as Linda intended to put effort into changing the relationship. Linda stated that after she became sober about 10 years ago, she had been feeling guilty about being unavailable as Jasmine grew up. She felt that she was a "bad" mother just like her own. Jasmine left home after high school and enrolled in a college in San Francisco.

It was Linda's hope to rekindle the relationship when Jasmine asked if she might consider moving to the Bay Area. Linda moved in to live with Jasmine and took over the rent. Although there were incidents during which Jasmine would yell at Linda and send Linda "mean messages," Linda kept "quiet" and hoped that Jasmine would change if she did enough for Jasmine. However, following the breakup with her boyfriend, Jasmine became increasingly irritable and rude to the point that she called Linda names and slammed doors behind her. Linda felt "fearful, small, and discouraged." She did not know how to communicate with Jasmine and started to cry in her own room and stopped contacting her son and friends. The therapist and Linda role-played assertive communication, but Linda instantly felt "depleted and fearful" when she saw that she and Jasmine were unable to work on communication directly.

At the therapist's suggestion, Linda initiated family therapy, to which Jasmine agreed to try. However, Jasmine discontinued the family sessions after two meetings, blaming the therapist for taking sides with her mother. The conflict between Linda and Jasmine continued to escalate verbally. After a few more unsuccessful attempts at asserting herself, Linda and her IPT therapist redefined the stage of the role dispute as an "impasse." Frustrated and discouraged, Linda decided to move back to the Midwest. She started to call her son and old friends again and her decision was warmly supported. One of her friends offered to fly to San Francisco and rent a car to drive back together. Toward the end of session eight, Linda increased contact with her son and friends and actively planned for the move. Her mood became brighter. At the same time, Linda role-played with the therapist how to convey her decision to Jasmine and speculated what might happen. To her surprise, Jasmine accepted the news calmly.

Termination Phase (Sessions 9–12)

In the termination phase, Linda's depression continued to lift. She was in regular contact with her son and friends. She started to say goodbyes to her new friends and group members. Meanwhile, Jasmine started to make more efforts at improving their relationship. Jasmine also disclosed to Linda that she was addicted to pain medications and her addiction was getting out of control, which was the reason why her ex-boyfriend broke up with her. Jasmine started to attend a support group in the community and began to soften and be kinder to Linda.

Linda and the therapist conducted a decision analysis and weighed her options in terms of moving or staying. After looking at the pros and cons, Linda decided to stick with her plan and move back to the Midwest. At the same time, her relationship with Jasmine steadily improved, and the two went to a music festival together in celebration. "I guess I accomplished my mission of coming here in the first place: to rekindle the relationship with my daughter. Now things have come full circle and I really miss my son and my friends in the Midwest." She expressed some anxiety about separating from the group and

the therapist but said she intends to reconnect with resources in the community she will be moving back to.

After the 12th session, Linda stopped in-person individual therapy and group therapy to prepare for the move. She received two weekly telephone check-ins from the individual therapist until the week before she moved back to the Midwest. During her phone calls with the therapist, Linda sounded upbeat and hopeful.

CONCLUSIONS/KEY POINTS

- Interpersonal psychotherapy (IPT) is a time-limited, attachment-informed, present-oriented psychotherapy originally developed in the 1970s by Gerald Klerman, Myrna Weissman, and John Markowitz to treat adult unipolar major depressive disorder.
- Goals of IPT are to decrease depressive symptoms and improve interpersonal functioning through work in one of four specific interpersonal problem areas: role dispute, role transition, grief, and interpersonal deficit. These identified problem areas may be the precipitant and/or consequences of depression.
- Patient characteristics increasing the likelihood of benefitting from IPT include a relatively secure attachment style, a specific interpersonal focus for distress, the awareness of others' feelings, and the willingness to try new communication strategies.
- IPT consists of three distinct treatment phases: the initial phase, intermediate phase, and termination phase. Additionally, there is an optional maintenance phase, which can be used after the termination of the acute phase of treatment.
- IPT for depression in adults usually consists of 12–16 weekly individual psychotherapy sessions, lasting 50–60 minutes each.
- IPT has been applied to diverse non-Western cultures and among populations who have experienced natural disasters or intense political conflict in countries such as Uganda, Ethiopia, and China.

REVIEW QUESTIONS

1. What are the three central theories that comprise IPT?
2. What principles of change are readily identifiable in IPT case conceptualization?
3. How efficacious is IPT in research trials when compared with other therapy modalities and psychopharmacology?
4. What are the four main problem areas associated with IPT, and how are they relevant in patient selection process?
5. Please discuss how IPT was utilized in the case of Linda.

RESOURCES

Websites

The Interpersonal Society of Interpersonal Psychotherapists (ISIPT): http://Interpersonalpsychotherapy.org

National Center for Veterans Analysis and Statistics. *Quick Facts*. http://www.va.gov/vetdata/quick_facts.asp

American Psychological Association. (2014). *Interpersonal therapy for depression*. Retrieved February 2016, from the Society of Clinical Psychology Division 12 website: http://www.div12.org/PsychologicalTreatments/treatments/depression_interpersonal.html

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11

Systemic Therapies in Historical Perspective

Harlene Anderson

Abstract
This chapter describes the development of systemic therapy from a historical perspective. It first discusses the significant epistemological shift in the field of psychotherapy that became the foundation and inspiration for the development of systemic therapy. It addresses the main contribution by the Palo Alto group, credited as being the first to introduce the shifts that became the foundation for what was later referred to as systemic therapy. It then discusses later iterations within systemic therapy, including a discussion of the Milan team now the most widely acknowledged for introducing the term "systemic therapy." The philosophical and theoretical concepts that influenced systemic therapy and its practice, particularly the concepts of language and reality, are also discussed.

Keywords: systemic therapy evolution, systemic therapy pioneers, Bateson, MRI, Milan team, systemic therapy epistemology

During the 1950s and 1960s, some pioneers in family therapy began to notice and study the individual within the family context and to develop a therapy in which family members were included. They were particularly interested in the family's role in relationship to development and maintenance of symptomatic behavior in a family member and the usefulness of that information in the treatment of the symptomatic member or the family system. These pioneers included Nathan Ackerman (1908–1971), Gregory Bateson (1904–1980), Ivan Boszormenyi-Nagy (1920–2007), Murray Bowen (1913–1990), Donald Jackson (1920–1968), Jay Haley (1923–2007), Virginia Satir (1916–1988), and Lyman Wynne (1923–2007) among several others. The therapies developed were called family therapy. It is largely acknowledged, however, that the Palo Alto, California, collegial group composed of Gregory Bateson, Donald Jackson, Richard Fisch (1926–2011), Jay Haley, Paul Watzlawick (1921–2007), and John Weakland (1919–1995) were the first to consider the notion of a systemic understanding while explaining and treating human behavior, particularly within the context of the family. Their transdisciplinary composition, a primary interest in research, and the influence of contemporary developments in literature outside the psychotherapy disciplines distinguished them from the other pioneers. This chapter first discusses the developments and contributions of the Palo Alto colleagues that significantly influenced what became known as systemic or systems therapy. A discussion of the contemporary iterations of their contributions follows.

Historically, the systemic movement in psychotherapy began in the family therapy field and was initially, and is still today, strongly influenced by Gregory Bateson's epistemological contributions. What is known as systemic therapy in psychotherapy, in general and family therapy specifically, cannot be separated from this early influence and its subsequent evolution. At the time, it represented a major epistemological shift in the way that therapists think about the people they work with, themselves, and what they do together. The work of the early Palo Alto colleagues is easy to forget because many of the ideas and practices that developed into a family or systemic

perspective in thinking and practice are so familiar in this day and age that it may be difficult to relate to the dramatic nature of the shifts at the time.

The significance of this epistemological shift warrants some words about epistemology. Epistemology is the study of knowledge, its nature, and how it is acquired. Classically, it refers to propositional knowledge: a focus on the nature of knowledge or "knowing that" rather than how-to knowledge or "knowing how to do something." Propositional knowledge is usually thought of as a justified true belief. For example, we believe the reality or correctness of our knowledge based on what is declared substantiated evidence (i.e., knowledge disseminated by academia and persons in authority that is believed to be the truth). A propositional view of knowledge is also reflexive: What we think we know and how we acquired the knowing also influence our realities, beliefs, and truths about the world and our experiences of it. Systemic therapists consider it important to have a clear sense of one's epistemology. One's epistemology authoritatively, whether subtly or not, affects one's words, actions, attitudes, and thoughts or, said simply, the ways that a therapist *is* in the world. What distinguishes systemic therapy from other therapies is that the perspectives or the epistemology on which systemic therapy stands is counter to many of the inherited traditions of psychotherapy theories and practices. These traditions include, for instance, the separation of the observer from what is observed, the belief that pathology is an internal psychological problem, the importance of history and etiology, and the notion of confidentiality.

The epistemological shift can be traced back to the 1950s and the collaborative research projects and conceptualizations of two transdisciplinary collegial groups in California. One group was founded by Donald Jackson as a behavioral research center and formally became the Mental Research Institute (MRI) in 1958 and it continues today. Initially the group also included Jules Riskin and Virginia Satir. The other group that became known as the Bateson Project (roughly 1952 to 1962) primarily focused on communication research and initially included Jay Haley and John Weakland. Critical to the innovative developments that emerged were the transdisciplinary characteristics of the two groups' membership and their nondisciplinary focus, including a lack of identification with psychology and psychiatry. Jackson, a psychiatrist, having just finished a lecture, was approached afterward by Bateson; Jackson said that the lecture and the conversation with Bateson so significantly influenced him that "From that moment on, I became more closely related to the social sciences than to medical psychiatry. I have never regretted this decision" (Jackson, 1968a, p. V). Critical to their innovations was a primary interest in research, the cross-fertilization of ideas and efforts, the influence of emerging contemporary theoretical developments mostly in the natural and social sciences, and the intellectual curiosity and background difference that each member brought to the collaborative efforts.

Jackson, Bateson, and colleagues' contributions challenged traditional psychotherapy thinking and practice and became the foundation for what became known as systemic therapy. Three primary contributions distinguished their conceptual contributions from the then current thinking about human behavior: a different comprehension of human behavior and change that was founded on the idea of understanding a person in his or her relational context and not in isolation; a focus on the present here-and-now interaction and communication instead of on the past; and a refusal to view people and their behavior as either normative or pathological. Their practice was also distinguished by some important innovative characteristics. For example, the same therapist would see family members or the members of an intimate relationship group all together (or at times in different combinations), rather than different therapists separately treating family members. Moreover, co-therapists or multiple therapists worked conjointly in the same session with the members of the family and at times its broader social system. Combined, their conceptualization and practice challenge the field to rethink some of its truths such as those mentioned earlier: the separation of the observer from the observed, pathology as an internal psychological defect, the importance of history and etiology, and the notion of confidentiality. These challenges were influenced by and represented advancements in the social and natural sciences. All early innovations remain characteristic of contemporary systemic therapy.

There is no single systemic therapy. Its different versions are known as problem-solving, brief, solution-focused, brief solution-focused, Milan systemic, systemic family therapy, and systemic therapy. The same epistemological assumptions influence the different versions; each is identified as

a family therapy; and each has evolved to a therapy in which therapists work with one or combinations of a social system: individuals, couples, groups, families, and members of larger personal and professional systems. However, there are variations among the methods they use. The present account of the development and influence of systemic therapies may differ from others' perspectives: Honoring multiple perspectives is coherent with the essence of systemic therapies.

Family therapies as well as individual therapies that are influenced by the epistemological shift historically have been identified as systems and systemic therapies. These include structural family therapy, strategic family therapy, and intergenerational family therapy, among others. Some therapists insisted on working with whole families or as many members of the family that they could access; others focused on working with the individual while keeping the family context and its influence in mind. Though the epistemological shift was appealing to many at the time, it was difficult to make the change. This is evidenced by some family system therapists who focus on the family system yet still view the individual and family members with a more traditional individual therapy lens and theoretical perspective. It is as if some therapists simply boosted the locus of the dysfunction or pathology and target of treatment from the individual to the family unit, while others boosted the locus to wider social systems such as communities, ecosystems, and so on. It was not until the advent and development of the Milan Associates systemic therapy, which we will turn to later, that the term "systemic" began to be widely used. Both expressions—systems therapy and systemic therapy—are used synonymously to refer to the numerous iterations and varieties of therapy that were influenced by the work of the early Palo Alto colleagues.

Influential developments from general and cybernetic systems, constructivist, evolutionary, and social construction theories are discussed in the following section. Separately and combined, these theories have had significant influence on systemic therapy historically and contemporarily.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS IN SYSTEMIC THERAPY

The major theoretical developments of the early Palo Alto colleagues and those of future generations of systemic therapists remain important foundational concepts. These foundational concepts include general systems, cybernetic, constructivist and social construction theories, and postmodern and poststructural philosophies. The early intent of the California pioneers individually and collectively was to study human behavior, particularly communication and interaction in intimate relationships (e.g., families with a member who had a diagnosed psychotic disorder, notably schizophrenia) and how these influenced the members' relationships with each other. Importantly, they were interested in communication in the here and now, not from a historical perspective. What they learned from their research led them to be strongly influenced by a series of innovations that evolved outside the mental health disciplines in the social and natural science disciplines from the 1940s through the 1970s. These concepts included general systems, cybernetic systems, and constructivist theories, among others that were developing in fields such as biology, mathematics, and neurophysiology (Ashby, 1947; Maturana, 1978; Russell, 1996; von Bertalanffy, 1968; von Foerster, 1982; von Glasersfeld, 1984; Wiener, 1948). These concepts provided a new perspective for understanding their research observations and experiences and subsequently their treatment approaches. The treatment approaches the Palo Alto colleagues introduced were first referred to as "interactional therapy" and "conjoint family therapy." Both terms referred to a focus on the interactions among the members of a system with as many members as possible being present in the therapy. Both represent a bold move away from the centrality of the insulated individual in the traditional psychiatric and psychotherapy literature and practice. The therapies developed by Fisch, Weakland, and Watzlawick would be called "brief therapy" and "focused problem resolution"; Haley would use the term "strategic therapy."

The Influence of General Systems and Cybernetic Theories

Early on, the Palo Alto colleagues turned to general systems theory, then to first-order cybernetics, and later to second-order cybernetics systems theory. General systems theory challenged traditional empiricism and reductionism and introduced the notion of the importance of understanding the whole system

rather than its separate parts. It focused on the study of the structure and function of an entity and the relationship and connection of its parts to the whole. This included how the parts communicate and share information with each other.

The development of general systems theory is attributed to biologist Ludwig von Bertalanffy (1968), who felt that there was a need for a universal framework in which to understand the relationships and connections of the elements and components of a system as a whole instead of the traditional framework of understanding, in which each individual part of a system was analyzed separately. In other words, von Bertalanffy provided a theory of how systems are organized that suggested the importance of studying their organization by looking at the whole system instead of their parts in isolation: a theory of wholeness. The new framework included conceptualizing living systems as open systems that are influenced by and influence their environment and that maintain a steady state or homeostasis while moving toward increased order and organization.

Closely related to general systems theory was the development of cybernetic theory, which was influenced by physics theories of relativity and quantum mechanics. Cybernetics is a theory of communication and control, which focuses on the importance of the relationship of everything to everything else. The word *cybernetic* refers to control in systems and translates to "steersman, guide, or governor" in English. Cybernetics is usually acknowledged to have been originally developed by mathematician Norbert Wiener and further developed during the Macy Conferences in the mid-1940s to 1950s. The Macy Conferences were designed to promote transdisciplinary thinking and focused significantly on the function of the communication pattern and exchange of information within a system and the relation of these to feedback and control. Human systems from a cybernetic perspective are considered feedback systems in which the feedback is the control mechanism (the steersman). A typical example of a self-correcting feedback system is a thermostat. Just as a thermostat maintains the stability of the temperature, a human system acts to maintain a balanced state. Early cybernetics was later referred to as "first-order cybernetics."

Bateson and his Palo Alto colleagues became particularly interested in Ross Ashby's development of the notion of stability and change within a system. Ashby conceptualized systems as self-correcting and striving toward maintaining a steady state and having a two-level or a bimodal capacity for dealing with change. This meant a system has two correcting processes, which he called first- and second-order change. First-order change referred to a system's responses to minor variations within it, and second-order referred to its responses to major ones. Bateson, in particular, found cybernetics offered a way to try to understand what he had observed some years earlier in his anthropological study of the Iatmul society of New Guinea and later in his study of families in Palo Alto. He had observed that escalating damaging behaviors in relationships somehow did not destroy the system. Cybernetics offered the idea of self-regulation. Symptoms in a family member therefore meant that a family was having difficulty meeting the demands of life, whether at natural transition points such as a development stage or during a crisis. Either meant that a family system was having difficulty moving toward greater complexity. The symptom was thought to maintain the family's equilibrium or homeostasis: its structure, organization, relationships, and continuity.

Second-order cybernetics, or cybernetics of cybernetics, emerged in the 1970s (Ashby, 1947; Maturana, 1978). A primary distinction between second- and first-order cybernetics is that in first-order cybernetics the observer is in an independent and neutral position from the observed (observed system). In second-order cybernetics the observer is part of what is observed (observing system). The *participant observer* is integral to *what* is observed. As such, the observer influences what is experienced and described, as well as being influenced by it. In other words, all observation is self-referential, meaning that the description and interpretation say something about the observer as well as the observed. This suggests that there cannot be objectivity or certainty in an observation, description, or interpretation.

Thus began a shift from the notion that a family system was an objective entity that could be impartially observed and described. Therapists, for instance, could not keep their biases and opinions from influencing what they observed and how they described it. Impartiality and objectivity are impossible. Regarding the observer, Bateson (1997) suggested that a universal feature of human perception and epistemology is that the observer perceives only the product of his perceiving act and does not perceive the means by which that product was created.

Bateson thus warned therapists to be aware of their involvement in the phenomenon studied and the seductive nature of wanting to cure. Looking back on Bateson's warning regarding this seduction as well as thinking one could cure, he was alerting therapists to avoid thinking in terms of dualistic, hierarchical, and expert–nonexpert, client–therapist systems.

The notion of the family system as a feedback system introduced a significant change in explaining its members' behaviors. Haley (1997) succinctly summarized that systemic theory offered a new perspective of human beings. The family, for instance, was not a collection of separate individuals but ongoing members who responded to each other in a homeostatic way, and so behavior had *present causes*. Self-corrective governing processes that were activated in response to an attempted change stabilized the family system. Family members thus were caught up in rigid repetitive communication patterns regardless of their desire and attempt to change. Haley further suggested that therapists likewise could be caught up in the same kind of repeating patterns with the family. As Hoffman (1981) suggests, cybernetic theory became the source for analyzing, identifying, understanding, and predicting a family's communication/interaction patterns and its structures/typologies. Hoffman (1979) introduced the notion of second-order cybernetic systems as "dynamic social fields" (pp. 37–66).

Constructivist Theory

Several people who were involved in the development of second-order cybernetic thinking were also major contributors to constructivist theory, a theory of the development of knowledge and the constructing individual (Maturana, 1978; von Foerster, 1982; von Glasersfeld, 1984). Knowledge refers to our expertise, truths, and beliefs—in other words, our realities—as well as to our descriptions, explanations, and interpretations. Constructivism challenges the Cartesian viewpoint of a tangible, external reality that can be known and described. From a constructivist viewpoint, knowledge is not passively communicated or absorbed but is constructed internally by the subject itself (e.g., within the mind of the cognizing person). In this view knowledge therefore is not representative, nor is there a subject-object duality. Humans construct or invent their worlds: The mind constructs; the mind "brings forth" knowledge and reality (Maturana, 1978). According to radical constructivist von Glasersfeld (1984), "all communication and all understanding are a matter of interpretive construction on the part of the experiencing subject" (p. 19). In other words, because we cannot have direct access to reality, we construct our realities by ordering and organizing our experiences. Likewise, Watzlawick (1984) purported that "Relationships are not aspects of first-order reality, whose true nature can be determined scientifically; instead, they are pure constructs of the partners in the relationship, and as such they resist all objective verification" (p. 238). The idea of the constructing individual suggested that knowledge cannot be passively received; it cannot be transferred from the head of one person to another. Instead, it is constructed by a person. In other words, as Maturana suggested, instructive interaction is not possible. People construct their own meanings, realities, and so forth. These are not and cannot be constructed by others for them.

Constructivist theory was followed by social construction theory (Berger & Luckmann, 1966). Even though both theories argue against knowledge as reflecting an ontological reality, there is a significant distinction between them. Social construction theory focuses on knowledge as created in social interchange and not within the mind of a person (Berger & Luckmann, 1966; Gergen, 1985). It is important to further clarify this distinction because some therapists who identify themselves as systemic hold a constructivist viewpoint while others hold a social constructionist viewpoint. A therapist's preferred viewpoint on the process of the construction influences how a therapist thinks about therapy theory and practice. We will return to this later.

Influence of General Systems, Cybernetic Systems, and Constructivist Theory on Clinical Practice

When the Palo Alto pioneers began microanalyzing and interpreting the organizational features of families and their communication and interactional patterns, they did not intend to develop a therapy approach for dealing with pathology. It became obvious to them, however, from their research and the theoretical concepts mentioned earlier that it would be imperative to include the family in the treatment. Not

including them would ignore the importance of the system context and its influence. From their research observations of family communication and interaction, they felt that it was important therapeutically to focus on the here and now because the symptom and dysfunctional communication were occurring in the present. The present was what they had access to. This demanded that they ascertain how to disrupt the pervasive pattern of incongruent messages within the family—in other words, the system's tendency toward homeostasis.

In Jackson's (1957) seminal paper on "family homeostasis," he affirmed the complex nature of family interactional patterns and how change in one family member could affect change in the others—mainly the effect of the schizophrenic behavior of a family member on the other members. He concluded that families were closed systems that maintained homeostasis. In other words, they were self-regulating. The self-regulating nature of families resulted in unspoken roles and rules that influenced the interactions of family members and thus the symptomatic member. In other words, families did not cause a member to have a problem. A symptomatic member's behavior was an adaptive mechanism for a family's difficulty adjusting to and moving through any threat to its stability. The symptomatic behavior was thought to be the corrective mechanism that prevented change. The goal of therapy became to disrupt the family homeostasis.

Jackson's theory of family homeostasis was important because it was perhaps the earliest reference to a move away from the individual and intrapsychic processes as focal points to an alternative focus on the interactional patterns and relational processes between family members. Jackson like Bateson thought that all behavior is communication: "Every message (communication bit) has both a content (report) and a relationship (command) aspect; the former conveys information about facts, opinions, feelings, [and] experiences, and the latter defines the nature of the relationship between the communicants" (Anderson, 1997, p. 8). This concept critically influenced two shifts. One was a shift away from thinking about the individual (i.e., a member diagnosed with schizophrenia) as separate from the "whole" to thinking about the system and the interactions among its members. The other was a shift away from thinking about so-called pathological or dysfunctional behavior (i.e., schizophrenia) as an internal characteristic of an individual to thinking of it as a response associated with a system's communication patterns, which were attempts to maintain equilibrium within the system. Both represented a significant move away from the notion of pathology and dysfunction altogether.

In the 1950s, Bateson was studying family communication patterns of persons diagnosed with schizophrenia, especially the relationship of these patterns to the nature of schizophrenia in one of its members. It was from these studies, combined with Jackson's notion of homeostasis and Bertrand Russell's notion of logical types, that the concept of the double bind as a hypothesis for the development of schizophrenic behavior within a family member was proposed (Bateson, Jackson, Haley, & Weakland, 1963). Oversimplified, Russell's theory of logical types refers to the paradoxical nature of confusing the content of a communication with the relational manner of the communication. The Palo Alto colleagues hypothesized that when this confusion is present in interpersonal communication, a paradoxical relationship is created in which pathology such as schizophrenia can develop. A classical oversimplified example is the "be spontaneous" paradox. You cannot tell or cause someone to be spontaneous. A frustrated parent cannot command a child to do his school assignments "spontaneously." If a child does succumb to the parent's command and does his or her homework, then he or she is doing it from an order and not spontaneously. The parent can remain frustrated because the child, though doing his or her assignment, is not doing it spontaneously. Of course, the content of this simple communication and interaction example would not be thought to cause schizophrenia because from the double-bind perspective both are much more complex.

Noteworthy is that Jackson and colleagues went so far as to say that therapists and therapeutic systems can unintentionally create double-bind situations for a patient. They suggested that, unfortunately, sometimes in hospitals "actions are taken 'benevolently' for the patient when actually they are intended to keep the staff more comfortable" (p. 51). On the other hand, they investigated the use of what they called therapeutic double binds: "using multiple—and often incongruent—messages therapeutically" (Jackson & Weakland, 1968, p. 242). The therapists or treatment teams purposely created double-bind situations in order to bring about change.

The double-bind development was followed by Jay Haley's (1963) theory of pathological systems in which

he focused on family triads. Haley first maintained that the symptomatic individual's behavior was the consequence of the social structure in which he or she lived. More specifically, there was frequently an alliance of two members of the family that negatively influenced the behavior of the third member. He also maintained that seemingly illogical behavior of a family member (e.g., psychosis) could be explained as the result of being caught in a loyalty bind between the other members. This and the double-bind research upheld the importance of the interpersonal and interactional nature of human communication and its circularity—self-referential nature—as critical to understanding human behavior. This was in contrast to a focus on an intrapsychic orientation such as distorted human affect and inappropriate emotions of the individual.

Also noteworthy is that neither the MRI nor the Bateson Project members in their study of schizophrenia focused on past events, individual characteristics, or psychic processes. They continually cautiously stayed away from thinking in terms of and trying to find individual and linear causality descriptions. Instead, they focused on concrete observable interpersonal communication and behavior of individuals within their relational context and circular explanations within the here and now. One person was not considered to *cause* another person to have a problem, nor was a problem thought to have a historical etiology. This was in contrast to the norms in the psychotherapy field at the time regarding the importance of history in a problem's etiology and its location as residing in a person's psyche or unconscious mind.

Evolutionary Paradigm

Some family therapists began to move beyond a focus on the notions of problems, pathology, homeostasis, and causality, including linear and circular causality, and became interested in an evolutionary epistemology (Dell & Goolishian, 1979; Elkaim, 1981; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). Most notable among these were Paul Dell and Harry Goolishian (Dell, 1982; Dell & Goolishian, 1979), who along with Mony Elkaim at the time were especially influenced by the concept in physics of evolutionary feedback, which described systems as evolving nonequilibrium, nonlinear, self-organizing, and self-recursive networks in a constant state of discontinuity (Briggs & Peat, 1984; Prigogine & Stengers, 1984). From this perspective a change or fluctuation in a system is random, unpredictable, and always leads to higher levels of complexity. That is, change in any part of a system, regardless of the size, can influence a new organization of the system and higher complexity. Translating this concept to human systems suggested that neither therapy nor therapist could unilaterally amplify one fluctuation over another or determine the direction of change (Dell, 1982; Dell & Goolishian, 1979). Process was emphasized over the system, its structure, and its flexibility, and change was emphasized over stability. Instead of the system determining the process, the process determines the system. The process between the family members or between a therapist and a client, for instance, determines the structure of their system. Anderson and Goolishian (1988) would later take a linguistic turn and extend this idea to systems and problems. They conceptualized human systems as linguistic systems. Problems are determined by people in conversation with each other about a concern or an alarm; the system does not create the problem.

Social Construction Theory

Some systemic therapists eventually became influenced by social construction theory, which was first introduced by P. L. Berger and T. Luckmann (1966). They suggested that a relationship exists between individual perspectives and social processes. In other words, the construction of what we think of as reality is a communal activity; therefore, there are multiple authors of a description and interpretation of a so-called reality. Kenneth Gergen suggests that knowledge is the product of relationships, emphasizing the "contextual basis of meaning, and its continuing negotiation across time" (Gergen, 1994, p. 66). The primary focus of Gergen's contributions is on the process of knowledge production as a relational activity and not an individual one. Gergen views constructivism as still rooted in the Western notion of the autonomous individual. John Shotter (1993) emphasizes the notion of "conversational realities." As the term suggests, the construction of reality is a dialogical process. We create our realties in conversation with others and with our selves, whether articulated verbally or otherwise. The creation of reality is a meaning-making process. We

create our meanings (our interpretations and understandings *with* each other). The creation of meaning is a joint activity or action: Meanings do not originate within an individual mind but in the social processes of people's interactions with each other. The meanings we attribute to others, ourselves, and the events in our lives influence our relationships and responses with others. A significant influence that social construction has on systemic therapists is a focus on the meaning-making process. In therapy, for instance, importance is placed on the local meanings that a client brings and working within these meanings. In such a process, newness in meanings that develop in therapy are co-authored by the client and therefore stay close to the client's meaning and have more relevance and thus sustainability. That is, staying close to the client's language allows therapist and client to mutually develop dialogically shared meanings and understandings. Such meanings and understandings thus have relevance and usefulness for the client. This is in contrast to the therapist bringing in already constructed meanings and understandings (i.e., therapist academic knowledge, expertise, experience) from the outside and in contrast to the notion that people's problems are similar and require similar solutions. This view of the meaning-making process and the creation of local understanding and knowledge places the therapist in a less hierarchical position via the client.

Postmodern and Poststructural Philosophy

Today some systemic therapists have been influenced by postmodern and poststructural philosophies. First introduced into family therapy in the 1980s (Anderson, 1997; Anderson & Goolishian, 1988), these philosophies invited interest in alternative perspectives of language and knowledge. They influenced a turn away from the mechanical explanatory metaphors of cybernetics and toward a new direction to what was called a linguistic turn. Instead of conceptualizing human systems as cybernetic systems, they were seen as linguistic systems (Anderson & Goolishian, 1988). Therapies most associated with this new direction are collaborative (Anderson & Goolishian, 1988; Anderson, 1997), narrative (White, 1995; White & Epson, 1990), open-dialogue (Seikkula, 1993; Seikkula & Olsen, 1995), and reflecting therapies (Andersen, 1987, 1991). For the most part, these therapists do not tend to refer to themselves as systemic, and thus a discussion of these developments is beyond the scope of this chapter.

This discussion would not be complete without mention of changes in the way that the self is conceptualized. Though an alternative notion of self is usually not identified with the early Palo Alto colleagues' thinking, Jackson (1968b) did approach the subject of self when he said that he and his colleagues emphasized that the self, the relationship, and the other are an indivisible whole. Though they did not, in theory or practice, isolate or extract the individual from their relational context, implicit in the ideas being developed by the Palo Alto colleagues was the question: Is there a core self or is the self, like other realities, a creation?

The developments in social constructionism and postmodernism would lead some systemic therapists to question familiar notions of self as static and discoverable. These developments introduced the notion of a social understanding of self or the self as a narrative self (Gergen & Davis, 1985; Goolishian & Anderson, 2002; Shotter, 1993). The narrative self is a constructed reality, a dialogically socially created self that therefore is not fixed. That is, the self is created in language through social interaction. The self therefore changes as people try to make sense of their lives and worlds through our ongoing narratives or stories. In other words, we are constantly revising ourselves. The notion of the linguistic, socially constructed self is contrary to the notion that a person with such a self and identity can have a deeper, truer understanding of his or her self and identity through various therapies. Likewise, it is contrary to the traditional Western concept that a person has an individualized contained self that is autonomous and a core identity that is discoverable.

The aforementioned contributors collectively challenged the status quo of therapy theory and practice. This included challenging the utility of the inherited familiar concepts of Cartesian dualism, objectivity, and linear causality as ways of thinking about and working with human systems. In so doing, they emphasized the importance of a shift from the notion of linear thinking and causality to a circular epistemology with an emphasis on the recursive nature of human behavior and interactions. They also called attention to the importance of moving away from thinking in terms of individuals or families or any system based on its membership

and working clinically from the same orienting perspective regardless of the systems' membership or the relationship of its members with one another.

These theories influenced the Palo Alto colleagues' and systemic therapists' evolving theory of problem formation and change. The notion that the components of a system are interconnected, that none are independent, and that change in one part of a system can effect change in another part of it is still a major theme in all. A discussion of theory of change follows in the next section. But first a caution. Contemporarily, an interesting caveat appeared on the systemic scene. Communication theorist Barnett Pearce (unpublished data) and psychologist John Shotter (2012) caution practitioners about what remains a primary challenge of systemic therapy for the therapist. They caution that "systemic thinking" and "thinking *about* systems" are very different. The main point is that thinking about systems is thinking as an observer from outside the system and as if the observer can have a metaposition in contrast to a position as a participant within the system or as a participant observer. "Thinking about" remains a lingering seduction of a Cartesian dualistic subject-object dichotomy and can risk certainty thinking. The notion of participant observer calls for practitioners to change the way they conceptualize and interpret the other person(s), themselves, their relationship with each other, and what they do together. In a "systemic" conceptualization the practitioner partly shapes the other and vice versa. Certainty is replaced with the possibility of what can develop from within the relationship. Important in this caveat is that the practitioner must walk the talk: congruency between how one thinks, talks, and acts. This speaks to the challenge of systemic thinking and therapy: Even though a practitioner may believe that he or she thinks and acts systemically, it is easy to slip into "about thinking." It is easy to let preunderstandings guide (e.g., as in "knowing" the person or problem before either is met) and thus to encounter the risks of generalizing and categorizing from these rather than from the here and now.

THEORY OF CHANGE IN SYSTEMIC THERAPY

It is important to keep in mind that there were variations among the members of the Bateson project and the MRI group regarding the focus and structure of practice, and thus variations in theory of change. Members of the MRI group (Watzlawick, Weakland, and Fisch) developed what they called an "interactional" approach in which the theoretical focus was on the process of communication within a family and its effects on them. The theory of change within the interactional view (Watzlawick & Weakland, 1977) was influenced by five principles drawn from communication and cybernetic theory: (1) one cannot not communicate; (2) every communication has a content and a relational aspect; (3) the nature of the relationship is contingent upon the punctuation of the communication processes on the part of the partners; (4) human communication uses digital and analogue modalities; and (5) communication is symmetric or complementary.

The focus of the MRI colleagues was on the maintenance or persistence of the problem and not on its etiology, cause, or history. They focused neither on normalcy nor pathology. Families were considered mechanistic entities that were resistant to change; they wanted the problem solved without having to change. Failure to solve a problem was considered to be due to the solution itself, usually repeating the same solution attempts that do not work over and over again. In other words, the problem is the solution. Why, because people get stuck in their realities and cannot change them. The interactional component was compatible with these colleagues' belief that problems do not reside inside a person, an individual, but rather between people.

Clinically, the specificity was on solving the problem, and hence as it was later developed by others (e.g., Haley, 1997), it was variously called problem-focused resolution, problem solving, brief problem-solving therapy, or brief therapy. The approach, though originally developed as a therapy for families, was soon applied across human systems regardless of number of members or their kinship relationship. Whether the client was an individual, a couple, or a family, the therapist always kept the relational context of the problem's development and maintenance in mind; that is, the importance of intimate relationships (e.g., families) and broader social contexts (e.g., other personal, work, and community relational systems). Following Jackson's lead, clinically it was no longer seen as necessary to have all family members present in the therapy. In other words, family therapy became a conceptualization, a way of thinking about

therapy and not a designator of the membership composition or numbers of people in therapy (Jackson & Weakland, 1968). The interactional perspective provided alternative understandings of symptoms as something other than internal phenomena such as anger, hysteria, or marital conflict and would lead to alternative understandings of treatment phenomena such as transference and resistance.

Perhaps the most well-known therapy to emerge from the MRI group was the work published by Watzlawick, Weakland, and Fisch in their 1974 book *Change: Principles of Problem Formation and Problem Resolution*. Therein they discussed the complimentarity of persistence and change. They suggested that problems could be associated with the paradoxical notion of how and why common sense and logical behavior were not always successful avenues to problem resolution and thus change. They suggested that such solution attempts were not only unsuccessful but could eventually escalate the problem and become more of the problem than the problem itself. Common sense and logical behavior were considered first-order change and usually worked with what might be thought of as less complex problems. This is not necessarily always the case because at times common sense and logic can exacerbate a difficulty into a problem, especially when persistently applied without the expected results. Take a simple example of a failed attempt to solve a difficulty and in which a problem is created. Often when a person is sad, eating less, sleeping more, or not being social because of a circumstance in his or her life, someone will try to cheer the person up by using common sense. For instance, someone might say, "It's not as bad as you think," "There will always be another love in your life," or "Don't worry; you'll find another job." Such efforts can be perceived by the person showing sadness as not being understood or his or her problem being minimized. Thus, the person can become sadder or even depressed. The Palo Alto colleagues considered it important to target failed solutions to the difficulty and not the difficulty itself.

From this perspective, the *what* of a problem is more important than the *why*: what is being done in the present that perpetuates the problem (Watzlawick et al., 1974). In other words, discovering and understanding the cause of a problem is not as important as what is maintaining it.

According to the MRI group, persistent and more complex problems that have not been resolved by first-order change require second-order change. Second-order change involves looking at the problem from a different frame, reframing the problem to allow a perspective or view that frees the client to entertain new solutions that intervene into the persistent common-sense solution, into the "more of the same."

The MRI group outlined four clinical steps associated with their view of change: The therapist must (1) have a clear definition of the problem in concrete terms; (2) thoroughly investigate the attempted solutions; (3) have a clear definition of the concrete goal; and (4) formulate and implement a plan to produce the change (Watzlawick et al., 1974). The most well-known interventions include paradoxes and reframing. The notion of paradox is just as important in the resolution of the problem as it is in the creation of the problem (as discussed earlier). A simple example of a paradoxical intervention would be requesting a client to do something that the therapist hopes the client will defy. An example would be "prescribing the symptom," telling the client to "go slow," suggesting the "situation is hopeless" and telling the client that the only thing the therapist can do is to help the person "live with" the problem. Reframing literally creates a new lens from which to view the problem. It changes the "conceptual and/or emotional" viewpoint and experience of the problem and places it in a new frame, which changes the meaning and experience of the problematic situation (Watzlawick et al., 1974, p. 95). It is important to note that systemic therapists do not think of reframing as an intellectual or cognitive intervention. It creates a different reality of the problem situation, and thus a new definition of it, and therefore it opens the door for different solutions. Most important is that the language of the new reality created must fit the client's language, worldview, and reality. Otherwise a new reality cannot be created. Once the reality shifts, it is usually impossible to go back to the old one.

In sum, the MRI groups' principles of change built on the communication principles of the interactive view mentioned earlier. This included the notions that the solution, not the symptom, is the problem; the solution that the client or system members have attempted creates and maintains the problem; the intervention target is the attempted solution; and the therapist's language and interventions must be placed in the client's language and fit the "facts" of the situation (e.g., the coherence mentioned earlier).

In their book they do not focus on skills or techniques but rather on a different epistemology of problem formation and resolution, which opens the door for the therapist to be creative. This refers to the ability to tailor interventions that are specific to the problem and it circumstances and that are coherent with the client's language (literally as well as beliefs, realities, etc.). Creating unique and fitting interventions is a challenge of many forms of systemic therapy, but not all. The most notable exceptions are brief-solution-focused therapy (de Shazer, 1985) and Milan systemic therapy (Selvini-Palazzoli et al., 1978). Both therapies are discussed next.

Iterations of Systemic Therapy and Variations in Theory of Change

The early development of systems or systemic therapy was a North American phenomenon and was followed by the development of a proliferation of family therapy practices and training programs across the United States and throughout Europe. The most well-known iterations of systemic therapy are brief solution-focused therapy and Milan systemic therapy.

Brief Solution-Focused Therapy

In the 1970s and 1980s, innovations in the conceptual perspectives and team practice structures of systemic thinking and practice began to develop. Within the United States the most notable is solution-focused therapy (SFT) developed by Steve DeShazer and Insoo Kim-Berg in the 1980s. Strongly influenced by the work at the Mental Research Institute and psychiatrist Milton Erickson, SFT simply turned problem-focused therapy on its head. Succinctly, as the name suggests, SFT is a goal-oriented therapy that focuses on the solution and not the problem, and it focuses on the present and the future. It aims to help clients identify and achieve goals by helping them to identify and build on resources, competencies, and successes. In other words, client behaviors that move in the direction of the client's goal are supported and encouraged. All therapist's questions and comments have these aims in mind and are carefully crafted to keep the client and therapy focused on the future and the positive. They aim to promote solution talk and to avoid problem talk. SFT has particular prestructured sequences and techniques. Techniques associated with SFT include miracle questions, exception questions, coping questions, and scaling questions. Homework assignments are used to help the client practice and build on competencies and successes. SFT, whether named brief or not, became known as a brief and parsimonious therapy (see solution-focused therapy link in the Resources section for a demonstration of structure and techniques).

Milan Systemic Therapy

Luigi Boscolo, Gianfranco Cecchin, Giuliana Prata, and Mara Selvini-Pallozoli, four psychoanalytic psychiatrists, formed the Institute for Family Studies in Milan, Italy, and developed a family therapy method that was based in the conceptual perspectives introduced by Bateson and his Palo Alto colleagues. The Institute soon simply became known as the Milan Associates or Milan team. Primarily influenced by Selvini-Pallozoli's disillusionment with her work with children with anorexia and her intrigue with experimenting with anorexia patients and including their families in the treatment, the team developed a method based primarily on cybernetic epistemology that they called "systemic family therapy." In addition to working with families, they continued the traditions of the early MRI and Bateson groups of abandoning a linear view and privileging a circular epistemology. Importantly, however, they introduced several variations and innovations uniquely fitting with their own histories and contexts. Influenced by their psychoanalytic training, they focused on the importance of having a systemic view of the evolution of the problem and its relationship to the treatment. It is important to note that evolution of the problem does not suggest a highlighting of history or cause; instead, a systemic understanding of a problem must include an understanding of its history or its evolution as well as the context in which it evolved. They developed a structured method and format for the therapy session and a set of interventions they applied across families. Maintaining focus on the method and interventions outweighed the importance of relationship. Though many therapists consider their work systemic, the Milan team introduced the term *systemic* when they gave that name to their therapy.

Several elements are characteristic of their method. They initially required everyone who lived

in the home to come to the sessions, though in later sessions they sometimes continued to meet with this constellation for the duration of the therapy and sometimes with smaller units or subsystems. Later, particularly Boscolo and Cecchin would agree to initially meet with smaller units of the family, even an individual, especially as they traveled and consulted in other countries. Prior to each session, the team would meet to discuss the session, both previous and immanent ones. Prior to the initial session they were interested in knowing about the referring person and his or her relationship to the family and the problem. Based on his or her experience, the referring person was an important part of the "family system" and often held a homeostatic position in the family with regard to the problem, its maintenance, and previously unsuccessful treatment. Therefore, it was not unusual for them to include the referrer in the therapy. The team members thoughtfully approached each family and each session. The team met before and after each session to investigate and consider every aspect of the family and the session to plan and execute the hallmarks of the approach. Well-known hallmark methods and interventions include hypothesizing, circular questioning, maintaining neutrality, positively connoting, prescribing the symptom, and prescribing rituals. The Milan method became the primary systemic family therapy practice in many places around the world, often with culturally influenced iterations.

RESEARCH ON THE EFFICACY AND EFFECTIVENESS OF SYSTEMIC THERAPY

A distinction of the Palo Alto colleagues is that they were first and foremost researchers. The clinical approaches that they developed were based in what they learned from their early research about human communication and interaction. Clinical outcome research on systemic therapies has been conducted on their early approaches and the iterations of contemporary developments. Keeping in mind that there is no single systemic therapy, in general, research documents that the various systemic therapy approaches are effective with individuals, couples, and families; with children, adolescents, and adults; and with a variety of presenting problems. Following is a summary of some of the research.

Of the systemic approaches, solution-focused therapy (SFT) appears the most researched. General discussions and documentations of its effectiveness with a range of clients and presenting problems are offered by De Shazer (1990), De Shazer and colleagues (1986), Franklin, Trepper, Gingerich, and McCullom (2001), and Miller, Hubble, and Duncan (1986). Studies that specifically demonstrate its effectiveness with children, adolescents, and adults include those by Carr (2009), Cottrell & Boston (2002), Franklin, Biever, Moore, Clemmons, and Scarmado (2001), and Wheeler (2001) among others. Gingerich and Eisenhart (2000) reviewed 15 controlled outcome studies of brief solution-focused therapy with clients in a variety of contexts, client ages, and presenting problems to determine the degree of empirical support. They divided the studies into "well-controlled" and "moderately or poorly controlled" studies. Of the well-controlled studies, they found that five had positive outcomes, four had outcomes that were better than no therapy or standardized institutional treatment, and the outcome of one was comparable to a widely used depression intervention. They concluded that all studies supported, though not definitively, the efficacy of brief solution-focused therapy. Rohrbaugh & Shohan (2001) also concluded the effectiveness of brief therapy.

In a longitudinal prospective study, Brezzi (2008) compared patients diagnosed with schizophrenia who received SFT with those who received what was referred to as "routine" psychiatric treatment. Patients in both groups were evaluated at the end of treatment and 12 and 24 months afterward. On the 12-month follow-up, patients who received SFT had significant clinical improvement and better pharmacological compliance. No significant difference was found in the 24-month follow-up.

There are several documentations of the effectiveness of systemic therapy with couples and families (Asen, 2002; Crane & Payne, 2011; Jones & Asen, 2000; Leff, et al., 2000). Jones and Asen focused on systemic couple therapy with depression as a presenting symptom. Davidson, Gordon, and Horvath (1997) studied brief therapy (i.e., three sessions) with couples. The study included couples who received immediate treatment and couples who were placed on a waiting list but who received the same treatment approach at a later time. They found a positive relationship between couples' improvement and compliance with treatment

objectives. From their results they concluded that therapy had a positive effect on the couples in both groups. Based on Christensen and Mendoza's (1986) definition of clinically meaningful improvement, they found that 39% of the couples had clinically meaningful improvement in their relationship complaints and conflict resolution. At a 6-week follow-up, these couples appeared to have maintained their improvement.

Studies have also been conducted in which a systemic therapy approach was compared with other psychotherapy approaches and treatments. Bennun (1986), for instance, compared Milan systemic therapy with problem-solving family therapy, specifically looking at first- and second-order change. The results showed positive change in both groups, although those families who received the Milan approach showed statistically significant improvement in second-order change as compared with those who received problem-solving therapy. In a randomized controlled study of older patients with depression and executive dysfunction, Alexopoulos and colleagues (2011) examined whether problem-solving therapy reduced depression and cognitive disability more than supportive therapy. They concluded that both therapies were equally effective for the first 6 weeks of treatment. At 9 and 12 weeks, however, participants receiving problem-solving therapy had a greater reduction in both areas. They also noted that after 24 weeks when treatment ended the advantage was retained, even though cognitive disability had increased. Littrell, Malia, and Wood (1995) in a combined qualitative and quantitative study with high school students compared three versions of systemic therapy: problem-focused task, problem-focused without task, and solution-focused with task. Their results indicated that the students' concerns were significantly reduced and their goals were significantly achieved.

The efficacy and effectiveness of systemic therapy (sometimes referred to as family therapy) is well documented by Peter Stratton of the Leeds Family Therapy and Research Centre in his review of numerous research studies and meta-analyses of studies (Stratton, 2011). Following are the conclusions of some of the studies that he included in his report.

In a meta-analysis of published psychotherapy studies, Shadish and Baldwin (2003) reviewed 140 studies. They concluded that marriage and family therapy was empirically documented to be effective in general and with a variety of problems. In a later "meta-content analysis" of 38 randomized controlled studies of systemic therapy with families, couples, groups, individuals, and multifamily groups where the identified patient was diagnosed with a mental disorder, Sydow and colleagues (2010) concluded that there was sound evidence after a minimum of 5 years follow-up for the efficacy of systemic therapy. Further efficacy is demonstrated by Shaddish, Montgomery, Wilson, Wlson, Brigt, and Okwumabua (1998).

Evidence for the efficacy of systemic therapy for children and adults was extensively reviewed by Carr (2009a, 2009b). He concluded that systemic interventions are effective for a wide range of child-focused problems. He likewise concluded that there was evidence for the effectiveness of systemic intervention with adults with a wide range of mental health and relationship problems. For both children and adult therapy, Carr highlighted that the therapy was brief (usually no more than 20 sessions), could be offered by professionals of various disciplines, and could be provided on an inpatient and outpatient basis. He cautioned, however, that most likely both child and adult interventions would be less effective if offered in settings where therapists were busy with large caseloads and did not have adequate supervision.

In another analysis, the About Families Evidence Bank (2012) included a review of the literature on systemic therapy from its early development through current meta-analysis and practice guidelines. The report suggested that there is substantial evidence that the various forms of systemic therapy are effective with child and adult disorders and with challenges of family life. They concluded that even given this evidence there is a need for further research.

The About Families Evidence Bank (2012) documents that systemic is effective for the conditions for which it has been properly researched. Though it echoes common concerns among other researchers regarding studies of the efficacy and effectiveness of systemic therapy. The concerns are mostly that there are few randomized controlled studies and that much of the research is qualitative. Moreover, there are multiple variations of systemic therapy, and, with few exceptions, there are no manuals of standardized procedures and interventions for the variations of systemic therapy. Finally, the therapy is interactional in the truest sense: It is conducted in response to what the client brings and within the client's language and reality. Its principles inform the therapist–client

relationship and the therapy process. Regarding the matter of qualitative versus quantitative research, some suggest that qualitative research is more compatible with systemic therapy. The importance of the client's voice in the therapy suggests the equal importance of the client's voice in determining its effectiveness and to what the client attributes it to. Combined, these matters create the challenge for researchers to conduct random controlled studies. A final note about research: Systemic therapists believe that it is important for client and therapist together to frequently evaluate the usefulness of therapy during its occurrence so that they can use what they learn to continually fine-tune the therapy to the client's needs. This includes self-reporting scales and anecdotal evidence. They also do the same evaluations at the conclusion of therapy. There are numerous publications that report on the client's evaluation of therapy, though these are beyond the scope of this chapter.

DIVERSITY

Matters of diversity such as age, gender, gender identity, sexual orientation, race ethnicity, culture, religion, and socioeconomic status as such are not given importance in the origins of systemic therapy or its contemporary iterations. These matters are considered to always be part of both the macrosocial and microsocial, political, and economic background in which problems develop and persist. They are not, however, necessarily considered critical to problem resolution. They are, therefore, not focused on unless they are introduced in the client's narrative and considered important by the client. This does not mean that a therapist would not ask about, talk about, or introduce any of these into the conversation. If a therapist were to do so, however, he or she would pay careful attention to the client's response. This is all in respect to the client as the expert on his or her life. It is also in respect to the risk of considering any of these matters as related to the cause or solution to a problem and to the risk of categorizing people and generalizing across problems and solutions.

CONCLUSIONS AND KEY POINTS

In conclusion, systemic therapy offered a new epistemology for therapists that challenged many of the traditional assumptions, both then and now, on which many family- and system-oriented therapies are based. Importantly, it was the interdisciplinary nature of the members of Jackson and his colleagues at the Mental Research Institute and those of the Bateson project and their insatiable curiosity and ability to think outside the traditional therapy box that laid the foundation for the new epistemology that they introduced. The new epistemology moved away from a focus on descriptions such as linear causality and objective interpretations, and internal attributes and characteristics of people and problems. These were replaced with contextual and recursive descriptions in which people were understood in terms of their relationship with and to each other, including their interaction and communication. It moved away from descriptions of dualistic and hierarchical systems in which the observer is separated from and meta to the observed. In contrast, the observer was viewed as part of the observing system and a participant in creating what was seen, heard, described, and interpreted. The new epistemology moved away from conceptualizing change as continuous and predictable to thinking of change as discontinuous and unpredictable. It moved away from a focus on the individual to a focus on the person-in-relationship and emphasized the contextual fields in which a person lives, including the various micro and macro multiple social systems and relationships.

The new epistemology influenced a dramatic shift in the way that therapists thought about patients, problem formation, and problem resolution and therefore the therapy methods. It moved away from observer punctuations and notions of symptom functionality, scapegoats, victims, and blame. It helped therapists to think of a human system as always striving for stability, rather than, for instance, needing a symptom or pathology to survive. This thinking shift invited a therapist to be more positive and benevolent toward the family and its members. It also invited a therapist to conceptualize that change in one part of a system can influence change in another part and that as a system adapts to a small change other changes become possible.

Conclusions and key points must return full circle to Bateson. Most would acknowledge that he significantly influenced the development of the new epistemology that became known as family therapy and systemic therapy. In sum, his contributions and

principles, whether thinking about an individual, a group of individuals such as a family, a society, or an ecosystem, include the following: Mind and body are not separate but form a necessary unity as do mind and nature; we create our perceptions and yet in doing so we are unconscious of the creating process; perception operates only upon difference; and information is news of a difference. Beginning with his research project on communication and thereafter, he continually challenged therapists to free themselves from what he considered muddled and constraining thinking. Though mostly described as an anthropologist, he stated, "I *am* the epistemology" (Bateson, 1977, p. 238).

What began decades ago holds promise and continues to flourish and change. This is evidenced as iterations of the theoretical and clinical contributions of the early Palo Alto colleagues continually maintain compatibility with its epistemology: Systemic therapists and therapy change in response to the changes in our contemporary worlds.

REVIEW QUESTIONS

1. Who laid the foundations for what would become systemic therapy?
2. What are the key elements of the epistemological shift that the systemic therapy pioneers introduced into psychotherapy?
3. What are some distinctions between systemic therapies and other therapies?
4. What are the key elements of the theory of change in systemic therapies?
5. What is the greatest challenge for a therapist who wants to practice systemic therapy?

RESOURCES

Websites

Dulwich Center Newsletter: http://www.dulwichcentre.com.au

Journal of Constructivist Psychology: http://www.constructivistpsych.org/jcp

Journal of Systemic Therapies: http://www.guilfordjournals.com/loi/jsyt

Mental Research Institute: http://www.mri.org

Solution-Focused Therapy: http://www.psychotherapy.net/video/insoo-kim-berg-solution-focused-therapy

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12

Systemic Therapies in Practice: Family Consultation for Change-Resistant Health and Behavior Problems: A Systemic-Strategic Approach

Michael J. Rohrbaugh
Varda Shoham

Abstract
This chapter describes a systemic-strategic approach to change-resistant health and behavior problems that evolved from a couple-focused treatment for alcohol problems (Rohrbaugh, Shoham, Spungen, & Steinglass, 1995) we outlined in the first edition of this volume. Subsequently simplified and adapted to help couples and families cope with problems ranging from nicotine addiction, anxiety, and depression to heart disease, cancer, and dementia, this family consultation (FAMCON) approach now offers a conceptual and procedural framework for addressing a variety of individual and relational complaints that do not respond to first-line interventions. FAMCON embodies a systemic (social-cybernetic) view of clinical problems and a team-based format for brief intervention based on that view. Because the FAMCON approach requires multiple professional participants and labor-intensive treatment planning, cost-effectiveness is a key consideration.

Keywords: family consultation, systemic-strategic family therapy, ironic processes, symptom-system fit, communal coping

The conceptual underpinnings of family consultation (FAMCON) date back more than 50 years to the beginnings of the family therapy movement (Hoffman, 1981). Borrowing ideas from cybernetics and systems theory, pioneers such as Bateson, Jackson, Weakland, and Haley observed that problems of health and behavior rarely occur in a vacuum, but persist as a function of ongoing close relationships, where causes and effects appear inextricably interwoven. In the 1960s, 1970s, and 1980s, groups of clinician investigators working independently in Palo Alto (Weakland, Fisch, Watzlawick, and others); Philadelphia (Haley and Minuchin); Italy (Selvini-Palazzoli and others); and elsewhere systematized these ideas into distinct but interrelated models of therapy. Today the common elements of these pragmatic approaches continue to embody a relatively pure-form systemic paradigm defined by the core themes of *context*, *circularity*, and *pattern interruption* (Rohrbaugh, 2014). The *context* theme means that, to understand a problem, we first look around it, to the social processes that keep the problem going; and when stuck, we add people—both conceptually and in the consulting room. *Circularity* refers to the assumption that a problem or symptom both maintains, and is maintained by, the sequence(s) of interpersonal behavior in which it occurs. When one person has (or better, *does*) a

problem, how do others respond—and how does this feedback help keep the problem going? The third core theme, *pattern interruption*, represents a necessary and sufficient condition for clinical change. Because patterns of social interaction maintain problems, identifying and interrupting those patterns should be sufficient to initiate change by altering the problem cycle and opening the way to progressive therapeutic developments. In contrast to most other therapy models, there is no assumption that pattern interruption requires insight, skill acquisition, or corrective emotional experience.

Taken together, these core themes imply that how problems *persist*—their maintenance and course—is more relevant to case formulation and intervention than is etiology or antecedent cause. Another implication is that what people *do* with each other is more relevant to therapy than internal processes such as what they think and feel. For example, internal or dispositional constructs like attachment style, biological temperament, trauma residue, or even social learning history do not fit well with this paradigm because they risk drawing the clinician's attention into the individual or back to the past.

A Systemic Couple Therapy for Problem Drinkers

In the early 1990s, for a research project comparing family-systems and cognitive-behavioral treatments for alcoholism, we attempted to integrate key ideas and techniques from then leading family therapy approaches to alcohol problems. Thus, from Steinglass and colleagues' alcoholic family model we drew the concepts of family-level detoxification, couple identity, and alcohol as an external invader of family life; from Fisch, Weakland, and colleagues' brief strategic therapy came an emphasis on interrupting ironic problem-solution loops and framing suggestions in terms consistent with clients' own preferred views; and from the solution-focused therapy of DeShazer, Berg, Miller, and colleagues we adapted techniques to identify and reinforce client strengths. As if this were not enough, the resulting systemic treatment manual also incorporated therapeutic neutrality, circular questioning, a brief family genogram, externalization tactics to build couple collaboration against alcohol, and structural/strategic family therapy techniques to counter resistance and restabilize the family system later in therapy (Rohrbaugh et al., 1995).

Ideally, this therapy occurs in three phases: In an initial *consultation phase* (sessions 1–6), the therapist conducts a systemic assessment, begins to intervene indirectly using circular- and solution-focused questioning, and in a carefully prepared feedback (opinion) session offers the couple "treatment" while remaining neutral about whether they should choose it. If both spouses accept, the *treatment phase* consists of "family detoxification" and therapist-initiated intervention to alter couple interaction patterns that help to maintain drinking. The final, *restabilization phase* aims to restabilize the family system without alcohol and prevent relapse. Throughout therapy, a key principle is to avoid confronting resistance or denial directly. Thus, if resistance arises during the treatment phase—or if the couple does not choose treatment in the first place—intervention shifts to strategic and structural tactics (framed as *continuing consultation*) such as prescribing a controlled drinking experiment, intensifying the restraint-from-change stance, seeing the spouse alone, or involving other family members or friends. The main goal of these tactics is to lead couples back to family detoxification, or failing that, to provoke change directly.

In retrospect, the implementation of this integrative treatment package was only partially successful, but lessons learned proved crucial to the evolution and broadened application of FAMCON (Rohrbaugh & Shoham, 2002). Although more than half of the 39 male-alcoholic couples who entered the systemic treatment completed the full 20-session regimen with at least moderately positive drinking and relationship outcomes, the fidelity of implementation by the master's-level clinicians we had trained proved quite uneven. For example, therapists implemented some components of the integrative model more effectively than others, and the accessibility of familiar and/or well-specified procedures (e.g., doing a genogram or contracting for family detoxification) sometimes seemed to undermine effective implementation of other, more central or exacting components (e.g., tracking and interrupting ironic problem-solution loops). In any case, analyses of case records and videotaped therapy sessions indicated that therapists' adherence to the manual and successful implementation of its main components predicted successful outcomes.

Fidelity difficulties also highlighted limitations of our integrative approach to treatment development. For example, because the models we drew upon call

attention to different clinical phenomena (e.g., hypotheses about adaptive consequences of drinking vs. descriptions of problem-solution loops) and prescribe starkly different therapeutic actions (e.g., neutrality, advocacy of family detoxification, strategic restraint from change) depending on the clinical situation, our manual-based rules governing which concepts and techniques to invoke in which circumstances were difficult for therapists to understand and apply. For subsequent applications of FAMCON, it therefore seemed imperative to simplify both the conceptual framework for understanding systemic problem maintenance and the associated clinical guidelines for promoting pattern interruption.

A final lesson was that developing a viable formulation of problem maintenance and using this to plan a successful feedback/opinion session and pattern interruption strategy proved very difficult for therapists to do independently. In almost all cases this required some degree of supervisory input, and the most compelling instances of feedback and treatment planning seemed to emerge from group brainstorming by multiple project therapists and at least one supervisor. We subsequently came to regard FAMCON as an inherently multiheaded clinical endeavor, discouraging attempts to implement the entire package on a solo basis. In addition to generating more coherent case planning, the team approach presents avenues for strategic management of resistance to change (e.g., reflecting team interventions, split opinions about the possibility or advisability of change), as the following case material should illustrate.

FAMCON for Other Health Problems

Later in the 1990s, and into the new millennium, we experimented with using FAMCON teams to address a variety of other problems, most of which referring clinicians considered "difficult" by virtue of not responding to other, often individually focused interventions. The organizational context for this was the University of Arizona's Psychology Department Clinic, where doctoral students and faculty could work together in a live-supervision (one-way mirror) setup with selected cases.

One particularly formative project involved a series of cases we saw in a family neuropsychological consultation clinic, where complaints concerned adjustment to neurological problems such as Parkinson's disease, Alzheimer's disease, traumatic brain injury, and surgical intervention for brain cancer. The complaints themselves ranged from aberrant patient behavior to relationship conflict and debilitating caregiver distress. The teams for these cases included two neuropsychologists, two family psychologists (MR and VS), and several neuropsychology graduate students interested in broadening their intervention skills. After conducting conjoint and sometimes individual interviews with relevant members of the client system, the team would construct and deliver a carefully prepared expert "opinion," with suggestions designed to interrupt or reverse some specific sequences of interaction we thought helped to maintain the complaint behavior. Case formulations typically centered on interpersonal *ironic processes*, which we identified by investigating family members' well-intentioned, repeated, but ultimately unsuccessful "solutions" to whatever the problem was (e.g., trying to reason with a demented loved one, over- [or under-] controlling the patient's living environment or daily activities, overfunctioning as a caregiver at the expense of self-care). An important piece of each opinion involved framing suggestions for change in a manner consistent with observations about indications and functional limitations imposed by the patient's neurological condition, as well as with family members' preferred views of themselves and the problem for which they sought consultation. Although opinion/feedback sessions were rarely sufficient in and of themselves to instigate "less of the same" solution behavior (and thus break the problem cycle), the usual result was at least some perturbation of problem-maintaining interaction patterns, which the team could then use to adjust intervention strategies and amplify incipient change over a limited number of follow-up sessions. Of the 10 cases we saw in this format, virtually all evinced at least modest improvement in the presenting complaint.

Unfortunately, due to competing commitments, the neuropsychology consultation project did not continue beyond the 1998–1999 academic year, but later in 1999 we began a NIDA-funded treatment development study of FAMCON for health-compromised smokers (Shoham, Rohrbaugh, Trost, & Muramoto, 2006). This open trial ultimately provided the most systematic data we were able to obtain on the process and preliminary outcomes of the FAMCON intervention. Later, when the smoking project was complete, we returned to investigating FAMCON with a

variety of other problems, albeit in a less systematic way (Rohrbaugh, Kogan, & Shoham, 2012).

FAMCON for Health-Compromised Smokers

The background for our interest in smoking was that evidence-based interventions for this pressing health problem, while only modestly successful, focused almost exclusively on the individual smoker, even though a substantial body of research indicated that social support from significant others, especially spouses, strongly predicts whether smokers will be able to quit and stay abstinent. Interestingly, however, clinical trials of behaviorally informed "social support" interventions based on teaching partners better support skills have yielded consistently disappointing results (Park, Tudiver, Schultz, & Campbell, 2004; Rohrbaugh et al., 2001), apparently leading the Public Health Service (PHS) Clinical Practice Guideline panel to exclude relationship-focused interventions from their best practice recommendations (Fiore et al., 2008).

From a systemic viewpoint, the failure of one-size-fits-all skill training or problem solving is not surprising and should not deter efforts to develop effective couple-and family-level interventions for change-resistant smoking. The main limitation is that these interventions did not typically address couple-specific relationship patterns that facilitate or hinder stable cessation (Shoham et al., 2006). For example, teaching skills and problem-solving strategies in group formats can easily detract attention from how particular support behaviors function in a particular couple. Thus, in one couple, a spouse's persistent positive encouragement to quit might provoke resistance, while in another a spouse's refusal to allow smoking in the house (counted as "negative" support in some studies) could actually function to help a smoker stay abstinent. In addition, some of the psychoeducational social support programs mixed dual- and single-smoker couples in the same treatment group, while others made little distinction between committed partners and other relatives or acquaintances.

Taking couple relationships as the primary focus of intervention—and drawing on accumulated experience with prior FAMCON projects—we proceeded to develop and pilot test a FAMCON intervention for couples in which one partner (the primary smoker) continued to smoke despite having or being at significant risk for heart or lung disease, and despite receiving repeated medical advice to quit. Based on social-cybernetic and family systems principles, the FAMCON approach to smoking cessation is substantially different in concept, format, and technique from the social support interventions that had been tested in the past. The preliminary results were promising in that 50% of the primary smokers achieved stable abstinence over at least 6 months, a rate that compares favorably to cessation benchmarks in the literature, especially for smokers initially unmotivated to quit. The results also suggested that FAMCON may be particularly well suited for female smokers and patients in dual-smoker couples, two groups at high risk for relapse (Shoham et al., 2006).

PRINCIPLES OF CASE CONCEPTUALIZATION AND CHANGE

As noted earlier, principles of case conceptualization follow from systemic and cybernetic assumptions about problem maintenance and change. Weakland, Fisch, Watzlawick, and Bodin (1974) stated the core assumption as follows:

> Regardless of their origins and etiology—if, indeed, these can ever be reliably determined—the problems people bring to psychotherapists persist only if they are maintained by ongoing current behavior of the client and others with whom he interacts. Correspondingly, if such problem-maintaining behavior is appropriately changed or eliminated, the problem will be resolved or vanish, regardless of its nature, or origin, or duration. (p. 144)

In other words, following our definition of "systemic" earlier, problems of health and behavior do not occur in a vacuum (context theme) but persist as an aspect of current close relationships in which causes and effects appear inextricably interwoven (circularity theme), with one person's behavior setting the stage for what another person does, and vice versa, in ongoing, circular sequences of interaction. It follows, therefore, that simply breaking these interactional circuits (pattern interruption theme) should be sufficient to change the problem.

The term *cybernetic* highlights the circularity of interpersonal systems in which the social effects of some problem behavior feedback to modify, control, or regulate that very same behavior. Because behavioral feedback circuits outside the skin are less familiar than internal, physiological ones (like homeostasis in clinical biology), we add the modifier *social* to underscore the primacy of feedback-control circuits operating between people rather than within them. A *social cybernetic* view thus takes relationships rather than individuals as a unit of analysis and attaches much more importance to problem maintenance than to etiology. Note, too, that this view departs from the familiar stress-vulnerability model by downplaying linear causality and blurring the conceptual boundary between an individual patient and factors such as stress or support in his or her social environment.

A key distinction in the cybernetic framework is between *positive and negative feedback* circuits, which in the clinical realm embody two patterns of problem maintenance we call *ironic processes* and *symptom-system fit*, respectively. In technical terms, a positive feedback cycle denotes enhancement or amplification of an effect by its own influence on the process that gives rise to it (e.g., an arms race, or amplifier gain in electronics), whereas negative feedback refers to the dampening or counteraction of such an effect (e.g., the operation of a simple thermostat, inhibition of hormone secretion by high levels of other chemicals in the blood). Importantly, cybernetic usage of the term *negative feedback* has little to do with giving or receiving criticism, and positive feedback relates only tangentially to reinforcement or praise. On the other hand, positive close relationships do matter: In fact, a crucial flip side of social-cybernetic problem maintenance is that positive, collaborative relationships not only confer health benefits but also provide a powerful resource for change. For this reason, in addition to pattern interruption, the FAMCON approach places special emphasis on cultivating *communal coping* by the people involved. In summary, case formulations take relationships rather than individuals as the primary unit of analysis and attach more importance to problem maintenance than to etiology. Interventions aim to interrupt two types of repeating interpersonal feedback circuits—*ironic processes* (when attempted solutions maintain problems) and *symptom-system fit* (when problems stabilize relationships)—as well as to mobilize *communal coping* by the people involved (when we-ness promotes change). The entire intervention format usually spans no more than 10 sessions over 2–5 months and consists of a semi-structured assessment phase, a focused feedback (opinion) session, and follow-up sessions designed to initiate, amplify, and solidify interpersonal change.

Ironic Processes

Ironic processes are deviation-amplifying positive feedback cycles that occur when well-intentioned, persistently applied solution attempts keep problems going or make them worse. Although social psychologist Dan Wegner first used the term "ironic process" to describe ironic *intra*personal effects of attempted thought suppression on mental control, this idea captures a much broader range of clinical phenomena, including interpersonal ones, described decades earlier by family therapists at Palo Alto's Mental Research Institute (Watzlawick, Weakland, & Fisch, 1974)—and from a systemic perspective, ironic processes occurring between people have greater clinical significance than those occurring within people (Shoham & Rohrbaugh, 1997). In couples, for example, urging one's partner to eat, drink, or smoke less may lead him or her to do it more; protective attempts to avoid conflict or hide negative feelings may lead to more partner distress; encouraging a depressed partner to cheer up can inadvertently promote more despondency; or attempting to resolve a disagreement through frank and open discussion may serve only to intensify conflict.

Ironic processes persist because problem and attempted solution become intertwined in a vicious cycle, or positive-feedback loop, in which more of the solution leads to more of the problem, leading to more of the same solution, and so on. Most important, specific formulations of ironic problem-solution loops provide a useful template for assessment and strategic intervention: They tell us where to look to understand what keeps a problem going (look for *more of the same* solution) as well as what needs to happen for the problem to be resolved (someone must apply *less of the same* solution). When pattern interruption happens, even in a small way, more virtuous cycles can begin to develop, leading to further positive change (Rohrbaugh & Shoham, 2001).

Interestingly, certain paradoxical interventions—injunctions in apparent opposition to therapeutic goals yet actually designed to achieve them—can help to interrupt persistent problem-maintaining solutions and cut ironic processes at their joint (Shoham & Rohrbaugh, 1997). Unfortunately, although featured in our earlier work, we came to view the term "paradoxical intervention" as problematic because it lumps together interventions based on different rationales (e.g., compliance and defiance), elevates technique over formulation, and tends to privilege processes occurring *within* people over what happens *between* them. The *ironic process* rubric is more compelling, both conceptually and pragmatically.

The following vignettes illustrate how ironic positive-feedback loops can help to maintain change-resistant smoking:

> A husband (H) smokes in the presence of his nonsmoking wife (W), who comments how bad it smells and frequently waves her hand to fan away the smoke. H, who had two heart attacks, shows no inclination to be influenced by this and says, "The more she pushes me, the more I'll smoke!" Although W tries not to nag, she finds it difficult not to urge H to "give quitting a try." (She did this when he had bronchitis, and he promptly resumed smoking.) Previously H recovered from alcoholism, but only after W stopped saying, "If you loved me enough, you'd quit": When she said instead, "I don't care what you do," he enrolled in a treatment program.
>
> H, who values greatly his 30-year "conflict-free" relationship with W, avoids expressing directly his wish for W to quit smoking. Although smoke aggravates H's asthma, he fears that showing disapproval would upset W and create stress in their relationship. W confides that she sometimes finds H's indirect (nonverbal) messages disturbing, though she too avoids expressing this directly—and when he does this she feels more like smoking. (Rohrbaugh et al., 2001, p. 20)

A central aim in FAMCON is to identify and interrupt ironic positive-feedback circuits such as these. To do this, the therapist-consultant must (a) accurately identify particular solution efforts that maintain or exacerbate the problem (here smoking), (b) specify what less of those same solution behaviors might look like (the strategic objective), and (c) persuade at least one of the people involved to do less or the opposite of what he or she has been doing (Fisch, Weakland, & Segal, 1982; Rohrbaugh & Shoham, 2001). As it turns out, most ironic patterns tend to involve either doing too much (commission), as in the first example, or doing too little (omission), as in the second. Thus, if the main thrust of a spouse's solution effort is to push directly or indirectly for change—and this has the ironic effect of making change less likely—doing less of the same might entail declaring helplessness, demonstrating acceptance, or simply observing. In contrast, if the spouse's main solution is to *avoid* dealing with the smoking, the consulting team will encourage more direct courses of action, such as gently taking a stand. Interestingly, compared to the alcohol-involved couples we studied earlier, our sample of couples with a health-compromised smoker tended to show more ironic patterns centered on avoidance and protection than on direct influence. Consequently, interventions with smoking couples more often aimed to *increase* partner influence attempts than to decrease them.

Symptom-System Fit

The second social-cybernetic pattern, *symptom-system fit*, refers to deviation-minimizing negative feedback cycles, where enactment of a symptom or problem appears to preserve some aspect of relational stability for the people involved. This form of problem maintenance, emphasized by family therapists such as Jackson, Haley, and Minuchin, relates to the interpersonal functions a problem may serve, not for the problem bearer as an individual, but for the current close relationships in which he or she participates. For example, a problem may persist because it provides a basis for the short-term preservation or restoration of some vital relationship parameter (e.g., marital cohesion, conflict reduction, engagement of a disengaged family member) in a kind of interpersonal homeostasis. Thus, in couples where both partners smoke, drink, or overeat, shared indulgences might create a context for mutually supportive interactions or help partners remain connected, even when they disagree—or cohesion in other relationships may depend on sharing concerns about health. Alternatively, a

young person's somatic symptoms (or misbehavior) could provide a focus for detouring parental conflict, activating a depressed caretaker, or justifying a grandparent's involvement. In each of these examples symptoms serve to regulate relationship patterns, and vice versa.

These vignettes illustrate symptom-system fit in couples where both partners smoke:

> H and W have an early morning ritual of smoking together in their garage on favorite lawn chairs. W says smoking together is the only thing H will let her initiate: "If we didn't smoke in the garage, I doubt we'd talk much—and he wouldn't even miss me." When the couple does talk, W feels that H calms her down—and they mostly talk when they smoke. W had quit smoking some years previously but resumed "because I felt such a distance between us."
>
> H and W have mostly nonsmoking friends but say, "We enjoy our forbidden pleasure together. We like being outside the mainstream." W says, "If one of us quits and the other doesn't, I think our relationship would change—and probably not for the better." (Rohrbaugh et al., 2001, p. 22)

The aim of addressing symptom-system fit in FAMCON is to help couple and family members realign their relationship in ways not organized around the symptom. For example, if partners anticipate relational difficulties will accompany giving up cigarettes (as expressed in the vignettes), they can practice exposing themselves to such situations before attempting to quit or work toward establishing substitute rituals and activities that do not involve smoking. In this way, they begin to make nonsmoking fit the system—a collaborative strategy that often pays special dividends in managing symptoms of nicotine withdrawal.

In general, however, patterns of symptom-system tend to be more difficult to conceptualize, operationalize, and target for intervention than ironic processes. This is because identifying a symptom's presumed homeostatic "function" (maintaining cohesion, reducing conflict, etc.) requires more inference than simply describing the behavioral components of an ironic problem-solution cycle. Formulations of symptom-system fit are nonetheless useful because they suggest approaches to pattern interruption that target this aspect of problem maintenance directly (e.g., by helping a couple to disagree or stay connected without smoking, drinking, or focusing on health concerns). These formulations often translate into graded relationship-level exposure interventions, through which the team helps clients experience approximations of whatever a symptom such as substance use, overeating, or anxiety helps them avoid as a couple or family, but without engaging in the symptom.

Communal Coping

FAMCON's third central construct is *communal coping*, which involves encouraging partners or family members to view a health problem as "ours" rather than "yours" or "mine" and to take cooperative action to deal with it (Lyons, Mickelson, Sullivan, & Coyne, 1998). This idea of building *we-ness* has been around a long time, and in fact it was an important component in our preliminary FAMCON treatment for couples coping with alcohol problems. For example, by defining alcohol as an external invader of the couple's relationship, we aimed to help partners develop a more collaborative approach to family detoxification and change. In current practice we routinely aim to promote communal coping both indirectly (e.g., by attending to and reinforcing partners' recollections of how they have successfully resolved difficulties together in the past) and directly (e.g., by requesting partner agreement and framing suggestions in terms of benefiting "you as a couple"). Although communal coping is not a particularly systemic or cybernetic idea—it actually comes from interdependence theory (Lewis et al., 2006) with individualistic trappings—we think it adds an important dimension to relationship-focused intervention. In fact, by mobilizing collaborative resources for change, it sometimes seems to provide an indispensable complement to social-cybernetic pattern interruption.

RESEARCH ON EFFECTIVENESS AND MECHANISMS

Although FAMCON has not yet received attention in randomized clinical trials, preliminary results

from the Shoham et al. (2006) open trial with health-compromised smokers show some promise. In that study, FAMCON was tested with 20 couples in which one partner (the patient) continued to smoke with heart or lung disease, and in 8 of these couples the other partner smoked as well (18 couples were heterosexual and 2 couples were homosexual). On average, couples participated in 8 FAMCON sessions and had quit rates approximately twice those of comparably intensive interventions: For the entire sample of 28 smokers, stable coverified cessation rates were 54% and 46% over 6 and 12 months, respectively. The results were especially encouraging for female smokers and patients whose partners also smoked. Although *n*s were small, virtually all cessation, health, and client satisfaction indices were in the direction of better outcomes for women than men (perhaps because FAMCON explicitly takes relationship dynamics into account). Similarly, dual-smoker couples were at least as successful as single-smoker couples, suggesting that FAMCON's emphasis on relational functions of smoking (symptom-system fit) may have helped to neutralize the powerful risk factor of spousal smoking status.

While it was not possible to document rigorously *how* FAMCON helped smokers quit and maintain cessation, our clinical observations were consistent with the family systems principles on which the intervention is based. For example, cessation was most successful when partners accepted the communal-coping frame and worked together in choosing and preparing for a quit date, not to mention finding satisfactory ways to protect their relationship after one or both had quit. It was also apparent that rather different patterns of couple interaction served to maintain smoking in different ways for different couples, and that correspondingly different intervention strategies (e.g., encouraging a spouse to back off vs. take a stand) helped to facilitate constructive change.

A broader base of research supports the relevance of FAMCON's three central constructs. *Communal coping* first caught our attention in a longitudinal study of couples coping with congestive heart failure, a chronic condition that makes complex demands on patients and their families. In an 8-year prospective study, dyadic measures of marital quality predicted how long the patient lived, regardless of baseline illness severity (Rohrbaugh, Shoham, & Coyne, 2006). The most predictive component of marital quality, related to communal coping, was the reported frequency of a couple's useful discussions about the patient's illness. Consistent with this, a follow-up study found that communal coping, measured unobtrusively by automatic text analysis of a spouse's first-person-plural pronoun use (*we*-talk) during a conjoint coping interview, predicted a favorable course of heart failure symptoms over the next 6 months (Rohrbaugh & Shoham, 2011).

Extrapolating this finding to intervention, we performed similar analyses of pronoun use by health-compromised smokers and their partners before and during the FAMCON treatment development study to determine whether *we*-talk during the course of treatment would predict clinical outcomes. To check this, we examined cessation outcome in relation to partners' *we*-talk during FAMCON session 4 (immediately following the opinion/intervention) and the final session, using word counts from a pretreatment marital interaction task as a baseline covariate. Similar to the heart failure results, *we*-talk by the patient's spouse at baseline predicted the patient's cessation success a year later. Even more striking was that *both* partners' *we*-talk in the later couple sessions predicted cessation success as well, after controlling for *we*-talk levels at baseline. This latter finding raises the possibility that communal coping marked by *we*-talk might function as a "common factor" change mechanism across some forms of couple-focused intervention (Rohrbaugh, 2014; Rohrbaugh & Shoham, 2011).

To investigate another FAMCON construct, *symptom-system fit*, we used a stimulated recall procedure with a larger sample of 25 couples in which one or both partners smoked. As noted earlier, symptom-system fit occurs when a problem such as smoking or drinking appears to have adaptive consequences for a relationship, at least in the short run. Thus, in couples where both partners smoke, shared smoking might create a context for mutually supportive interactions by helping partners stay positive, even when they disagree. In a laboratory demonstration of this phenomenon, dual- and single-smoker couples discussed a health-related disagreement before and during a period of actual smoking. Immediately afterward, the partners used independent joysticks to recall their continuous emotional experience during the interaction (from highly positive to highly negative) while watching themselves on video. Participants in dual-smoker couples reported increased positive emotion contingent upon lighting up, while in single-smoker

couples both partners (nonsmokers and smokers alike) reported the opposite. Strikingly, changes in individuals' emotional experience from baseline to smoking depended almost entirely on a couple-level variable (one vs. two smokers), with no apparent contribution from individual characteristics such as a participant's gender or psychological distress.

Still, this result left open the possibility that the reports of dual-smoker couples amounted simply to a surge of positive emotion in each individual partner, rather than something inherent in what the partners experienced *together* as a couple. To examine more directly the couple as a dynamic, interacting unit, we reanalyzed the same data to determine if the coordination or *synchrony* of partners' moment-to-moment emotional experience also changed coincident with active smoking. The results showed that a couple-level index of *affective synchrony*, operationalized as correlated moment-to-moment change in partners' reported emotional experience, in fact increased during smoking for dual-smoker couples and decreased for single-smoker couples—and this was independent of the parallel mean-level changes in emotional valence we found earlier. Thus, emotional correlates and consequences of change-resistant smoking appear to have an important social dimension, depending not only on biological or psychological characteristics of the individual smoker but also on the specific relational context in which smoking occurs (Rohrbaugh, 2014; Rohrbaugh & Shoham, 2011).

We have used a wider variety of self-report and observational methods to investigate *ironic processes* in couples coping with various health problems and addictions. Across the board, measures of the ironic process construct show strong concurrent and prospective associations with health outcomes and patient adherence to medical regimen. Many of these studies focus on ironic patterns of attempted influence, including variants of demand-withdraw couple interaction, where one partner criticizes, complains, and pressures for change, while the other resists, avoids, and withdraws. Another ironic pattern, common in chronic illness, occurs when one partner tries to protect the other from distress by hiding negative emotions and avoiding potentially upsetting topics. Studies of protective buffering in couples coping with heart disease and cancer suggest ironic associations with increased distress, not only for the person who tries to protect but also for the medically ill spouse. In fact, a daily-process analysis of covariation between protection and distress in heart failure couples found asymmetrical partner effects, where protection by the spouse predicted the patient's daily distress more than patient protection predicted spouse distress. Overall, our results in this arena have been consistent with a broader literature linking gender, relationships, and health—specifically, with evidence that women are generally more oriented to relationships than men, and that associations between relationship quality and health tend to be stronger for women than for men (Kiecolt-Glaser & Newton, 2001; Rohrbaugh, 2014).

Lastly, an analysis of demand-withdraw couple interaction in the early 1990s alcohol project illustrates how well-intentioned *therapeutic* efforts can have ironic consequences as well. The two treatments in that study (Rohrbaugh et al., 1995), cognitive-behavioral therapy (CBT) and family-systems therapy (FST—a preliminary prototype of FAMCON), differed substantially in the level of demand they placed on the drinker for abstinence and change. Although drinking was a primary target for change in both approaches, CBT took a firm stance about expected abstinence from alcohol (e.g., using adjunctive breathalyzer tests to ensure compliance), while FST employed more permissive, indirect strategies to work with clients' resistance. Before treatment began, we had obtained observational measures of how much each couple engaged in demand-withdraw interaction, focusing on the pattern of wife's demand and husband's withdrawal during a discussion of the husband's drinking. Association with later retention and abstinence were striking: When couples high in this particular demand-withdraw pattern received CBT, they attended fewer sessions and tended to have poorer drinking outcomes—whereas for FST, levels of this pattern made little difference. Thus, for high-demand couples, CBT may have ironically provided "more of the same" ineffective solution: The alcoholic husbands appeared to resist a demanding therapy in the same way they resisted their demanding wives (Shoham, Rohrbaugh, Stickle, & Jacob, 1998). Similar results emerged in a recent study of family therapy for adolescent drug abuse, where pretreatment parent-demand/adolescent-withdraw moderated the relationship between observed therapist demand and clinical outcome (Rynes, Rohrbaugh, Lebensohn-Chialvo, & Shoham, 2014).

ASSESSMENT AND SELECTION OF PATIENTS

The first phase of FAMCON, beginning with preliminary phone contacts and continuing until the opinion/feedback session, is primarily about assessment, but it includes some preliminary indirect intervention as well (see section on "Treatment"). This typically happens in two to five sessions, most more than an hour in duration. The format is mainly conjoint (seeing partners or family members together) but often includes individual meetings as well. With couples, for example, we routinely see clients separately (though briefly) to assess partner commitment, possible violence, or other concerns they may be reluctant to express in each other's presence. Similarly, when complaints occur in multigenerational configurations, we might meet with parents or caregivers alone and/or with children or the identified patient alone.

In general, the main goals of assessment are to (1) define a resolvable complaint; (2) identify ironic processes (problem-solution loops) and patterns of symptom-system fit that may help to maintain the complaint; and (3) understand clients' unique language and preferred views of the problem, themselves, and each other. The first two goals provide a template for *where* to intervene, while the third informs *how* to intervene.

The first assessment task is to obtain a very specific, behavioral picture of the complaint, including who sees it as a problem, and why it is a problem now. A useful guideline is having enough details to answer the question, "If we had a video of this, what would I see?" Later the consultant also solicits a clear behavioral picture of what the clients will accept as a minimum change goal. For example, "What would he (or she, or the two of you) be doing differently that will let you know this problem is taking a turn for the better?"

The next step requires an equally specific inquiry about the behaviors most closely related to the problem, especially what happens immediately *after* problem behavior occurs. Of particular interest is what the clients and other concerned people are doing to handle, prevent, or resolve the complaint, as well as what happens in response to these attempted solutions. From this begins to emerge a formulation of ironic problem maintenance—and perhaps of the specific solution behaviors that will be the focus of strategic intervention. Also of interest are shifts in relationship patterns that follow performance of the complaint (e.g., increased closeness or involvement, reduced conflict, more competent functioning by another family member), as this may provide clues about symptom-system fit and possible paths to neutralizing it.

The most relevant problem-maintaining patterns are current ones (how people organize around or attempt to manage the complaint *now*), but solutions tried and discarded in the past may also give hints about what has worked before—and may work again. In one of our alcohol treatment cases (Rohrbaugh et al., 1995), a wife, who in the past had taken a hard line with her husband about not drinking at the dinner table, later reversed this stance because she did not want to be controlling. As his drinking problem worsened, he further withdrew from the family, and she dealt with it less and less directly by busying herself in other activities or retreating to her study to meditate. Careful inquiry revealed that the former hardline approach, though distasteful, had actually worked: When the wife had set limits, the husband had controlled his drinking. By relabeling her former, more assertive stance as caring and reassuring to the husband, the therapist was later able to help the wife reverse her stance in a way that broke the problem cycle.

The final assessment goal—grasping clients' unique views or "position"—is crucial to the later task of framing suggestions in ways clients will accept. Assessing these views depends mainly on paying careful attention to what people say. For example, how do they see themselves and want to be seen by others? What do they hold near and dear? When are they at their best, and what do others notice at those times? We also find it helpful to understand how people view themselves as a couple or family, and typically ask questions, such as "If people who know you well were describing you two as a couple, what would they say?" or "What words or phrases capture the strength of your family (or relationship) – its values, flavor, and unique style?" And at some point, the consultant will usually also ask for their best guess as to *why* a particular problem is happening—and why they handle it the way they do.

Other important client views concern customership and readiness for change. Although much will be evident from how people initially present themselves, direct questions such as "Whose idea was it to come?" "Yours equally?" "Why now?" and

"Who is most optimistic that this consultation will help?" often make this crucial aspect of client position clearer. It is also useful to understand how clients sought help for the complaint in the past, what they found helpful or unhelpful, how the helper(s) viewed their problems, and how the therapy or consultation ended.

Finally, regarding patient selection and applicability, there are several circumstances in which we think the FAMCON approach is not ideal. First, in keeping with the social-cybernetic emphasis on interrupting patterns of problem maintenance, FAMCON is most suited to stable, persistent problems, where clients or clinicians in some way feel stuck; this approach is probably *least* applicable to crisis situations, health transitions (e.g., adapting to a cancer diagnosis), or prevention aims—although other forms of consultation or psychoeducation based on nonsystemic (e.g., social learning or biomedical) assumptions might well be useful in those contexts. Second, because communal coping is often a key change mechanism, FAMCON seems to work best when there are stable, committed relationships on which to build: Having to rebuild such commitment or repair relationship estrangements before addressing the central complaint can overload the clinical agenda. Third, we find FAMCON most helpful in the framework of stepped care, and not ideal as a first-line treatment: If other, more economical interventions work—even those focused on individuals—that should be sufficient.

TREATMENT

FAMCON typically proceeds through a series of distinct phases: preparation, assessment, feedback (the opinion session), and follow-up. In the *preparation phase*, the team uses preliminary phone contacts to decide whom to see in what format. Deciding whom to see initially depends on the team's preliminary assessment and hypotheses (based on phone contacts with more than one member of the client system) about likely patterns of problem maintenance and possibilities for productive communal coping. For adult problems this is usually (but not always) a couple, and who participates may change during the course of FAMCON. When stuck, we add people—both conceptually and in the consulting room—and this adds leverage for therapeutic change.

In the *assessment phase*, usually consisting of two to four sessions over several weeks, the consultants conduct a systemic assessment of problem-maintaining interactional patterns (e.g., ironic problem-solution loops, relationship-stabilizing consequences of symptoms, problem-maintaining coalitions) via interview, direct observation, and optional daily diary phone-ins. In addition to its overt aims, the assessment phase includes several forms of indirect intervention, including circular questions about possible implications of change; questions designed to stimulate and enhance communal coping, via inquiries about how partners or family members have managed difficulties together in the past; and a solution-focused homework assignment at the end of session 1, where the consultant asks clients to make notes on aspects of their relationship (and each other) they would like to preserve, or *not* change.

With some cases—usually involving couples—we also employ a daily-diary procedure in which clients independently leave messages in our voice mail every morning for at least 14 consecutive days to answer a series of questions about the preceding day. The questions concern specific problem and solution patterns relevant to the case, as well as mood, relationship quality, and communal coping (e.g., How many cigarettes did you smoke yesterday? How much did you try to discourage your partner from smoking? How close and connected did you feel?). Because clients answer each question on a quantitative (0- to 10-point) scale, it is possible to identify couple-specific trends over time, including the extent to which what one person does (e.g., frequency of smoking) correlates from day to day with what one's partner does (e.g., intensity of influence attempts) as well with other aspects of the respondent's own experience (e.g., mood-activity correlations). In addition to illuminating key dynamics, we find that presenting selected daily diary results in the feedback/opinion session enhances the credibility of the consultant's observations and therapeutic recommendations. In applications to smoking or substance use cessation, most couples also do a shortened version of the daily call-ins again later, for a week before and after their planned quit date, which provides a basis for regular contact with the team during the difficult transition.

For the pivotal *opinion/feedback* session, the team prepares and presents a carefully scripted message that (a) compliments couple/family strengths and acknowledges clients' noble intentions; (b) frames

change as difficult but possible, if family members work together; (c) presents selected data from the daily diary exercise (if applicable) to highlight relevant patterns; (d) offers direct or indirect suggestions for less-of-the-same solution behavior (beginning interruption of ironic processes); (e) directly or indirectly challenges couple or family patterns that the problem may help to maintain (beginning neutralization of symptom-system fit); (f) encourages communal problem solving and decision making by "you as a couple" or "you as a family"; and (g) invites couple- or family-level commitment to some specific behavior change. When the target complaint does not involve substance use, the invitation to consider a specific behavior change (offered at the end of the opinion session) is more likely to focus on interrupting some specific aspect of problem maintenance than on initiating change in the problem itself by setting a quit date. The presenter of the opinion is usually a relatively high-status member of the team, who follows prepared notes, and we sometimes give a written outline to family members as well.

In the *follow-up phase*, where intersession intervals are typically longer and depend on client response, the consultants amplify and build upon small changes, adjust treatment strategies to address reluctance, and prevent relapse. This phase comprises all contacts after the opinion/feedback session, employing techniques that are more strategic than educational. For example, we frame the meaning of changes to fit clients' preferred views, caution people against changing too fast, and sometimes respond to intractable reluctance with strategic reflection. As before, all sessions include multiple consultants, with at least one team member observing and phoning in suggestions from behind a one-way mirror. An exception is strategic reflection, where clients themselves go behind the mirror to observe team members empathically discussing the pros and cons of changing their situation.

In addition to direct and indirect suggestions, the follow-up phase sometimes incorporates *enactment modules* designed to bring problem-maintaining interaction sequences into the consulting room, where we try to interrupt them directly. For example, a consultant might first invite a couple to enact a sequence where the spouse exhorts the patient to change some health behavior and then encourages the patient to try a less-of-the-same approach (again via enactment) to the problem at hand. Similarly, for symptom-system fit, the consultant might promote enactment-based exposure to whatever the symptom helps clients approach or avoid (e.g., negotiating a conflict or talking intimately without smoking). For couples in which one partner has a disorder such as posttraumatic stress disorder (PTSD), an interesting variation of this strategy is to involve both partners—not just the patient—in graded real-life exposure to situations they have avoided *together* (e.g., noisy social gatherings), all within a communal coping frame. This of course entails extra-session homework rather than in-session enactment.

Most fundamentally, FAMCON pattern interruption turns on identifying problem-maintaining interaction sequences and formulating strategic objectives that specify what behavior by whom in which situation(s) would suffice to break the pattern. To optimize pattern interruption, the team frames suggestions for change in terms consistent with clients' preferred views of the problem, themselves, and each other. Importantly, these interventions do not depend on client understanding or awareness: The idea is simply to interrupt entrenched sequences of behavior, from which we assume cognitive change will follow as clients construct new meanings for their changed behavior. In addition, because change requires interrupting what people habitually do with each other, the path to new (less-of-the-same) behavior can appear bumpy and discontinuous, with starts and stops and even minor crises occurring before new interaction patterns replace old ones.

Compared to other approaches, FAMCON makes more use of indirect, strategic tactics such as tailored reframing, metaphor, restraint from change, strategic reflection, or even prescribing the very experiences clients aim to avoid. These methods tend not to be a first line of approach, but they are often helpful when problem-maintaining interaction patterns are highly entrenched. Another key guideline is "when stuck, add people"—both conceptually and in the consulting room.

A nontrivial semantic (and strategic) consideration is what to call this approach when presenting it to clients. In general, we find the term "consultation" preferable to "therapy" and especially "*family* therapy." This is particularly so with health complaints, where pushing people to acknowledge or address relationship problems in the context of coping with physical illness can easily have ironic consequences, even when those

problems may seem obvious to an observer. For example, implying that patients might benefit from couple or family therapy can arouse resistance when partners or family members avoid overt conflict with each other (a common relational correlate of chronic somatic complaints), or when one client system favors a "therapy" solution while others do not. On the other hand, offering in-depth "consultation" helps to frame the clinical encounter as an endeavor in which several "heads" are better than one and a communal orientation by the people involved will increase the likelihood of success.

Another semantic distinction, useful for clinicians (rather than clients) in understanding problem maintenance and planning interventions, involves investigating what people *do* rather than what they *have*. Thus, rather than attempting to identify or diagnose some particular psychological disorder (what people *have*), it is more useful to explicate how they *do* whatever symptoms may be involved. For example, asking how people show a problem like anxiety, pain, or depression leads naturally to questions about what other people do in response—and what happens next. From this, circular sequences of interaction begin to emerge, helping clinicians more easily shift the conceptual locus of problem maintenance from inside to outside the "skin" (see earlier).

Finally, we will briefly note some common criticisms of the FAMCON approach. One is that the social-cybernetic framework is superficial and oversimplified—that mere pattern interruption will not prevent people from getting stuck in the same old ways. While this makes good sense from psychodynamic and other perspectives, our view is that assumptions about underlying cause unnecessarily complicate the clinician's task and make change more difficult to achieve. A second criticism is that a purely systemic approach discounts individual determinants of behavior (e.g., personality traits, internal conflicts, enduring mental representations) and does not provide clients with generalizable skills or insights. Indeed, setting aside familiar psychological and dispositional constructs in favor of interpersonal feedback circuits goes against common intellectual wisdom. Although clients' individual views do play a key role in FAMCON, that role is secondary: We prefer to accept and use a client's idiosyncratic view to promote pattern interruption rather than taking the view itself (even if it appears dysfunctional) as a target for change. Third, because FAMCON consultants are not always explicit with clients about their rationale for specific interventions, the approach may seem unnecessarily manipulative. As noted earlier, we see the strategic stance as most indicated when problem-maintaining patterns appear highly entrenched or do not respond to more straightforward intervention. Last, because FAMCON requires multiple clinicians and time-intensive planning, its application in many real-world community settings may not be practical, even in the framework of stepped care. Indeed, most applications of FAMCON to date have occurred in university or medical school training clinics where cost was not an overriding factor. Thus, whether this approach can claim the status of a disseminable, cost-effective, evidence-based treatment remains to be seen.

DIVERSITY

FAMCON places great emphasis on understanding, validating, and working within client meaning systems related to all dimensions of diversity. The approach is fundamentally nonnormative, with no guiding assumptions about what constitutes health or pathology and no specific guidelines for addressing matters related to age, race, gender identity, sexual orientation, culture, socioeconomic status, and so on. On the other hand, we do often address such matters indirectly in selecting members of the clinical team. While an ideal team includes, at minimum, a skilled family systems consultant and a health professional (e.g., a medical doctor or a registered nurse) with both general and complaint-specific expertise, we also find it helpful to have a member whose life experience or background is relevant to members of the client system. One example of this—in addition to diversity consideration—is including a professional or paraprofessional fellow traveler with direct experience regarding the problem at hand (e.g., a cancer survivor, former smoker, combat veteran, or parent of a diabetic child).

CLINICAL ILLUSTRATION

The following case, described at greater length by Rohrbaugh, Kogan, and Shoham (2012), features

a depressed husband and bipolar wife complaining of severe communication difficulties related to the husband's kidney cancer and diabetes. Over six FAMCON sessions, strategic interventions focused mainly on interrupting ironic interpersonal processes helped to resolve the presenting complaint. Interventions addressing symptom-system fit and communal coping were present as well but played a secondary role in this case.

Mark (58 years old) and Emma (54 years old) sought help for "communication difficulties" related to Mark's deteriorating health. Mark faced an apparent recurrence of kidney cancer, for which he had surgery 8 years earlier; he was also diabetic and not fully adherent to a medical regimen. In fact, his erratic health behavior was a major focus of concern for Emma, a former nurse, and the couple had increasingly volatile arguments about this, marked by Emma's "rage" and Mark's withdrawal. Feeling "depressed" and considering separation, Mark had recently sought individual (cognitive-behavioral) therapy, but after eight sessions, the therapist recommended working on "communication problems" and referred him to our family consultation clinic for help with this.

Mark and Emma—White, Jewish, childless, and unemployed—had been married 15 years (his third marriage, her fourth). The couple met in a psychiatric hospital where Emma carried a diagnosis of bipolar disorder and Mark was seriously depressed following a suicide attempt. They experienced an intense emotional connection as fellow inpatients and married 2 months after discharge. Since then, both had received more or less continuous outpatient treatment (including multiple medications and supportive counseling), with no further hospitalizations. Both had also given up their jobs and qualified for Social Security Disability income (his medical, hers psychiatric) 3–4 years before their consultation with us.

Clinical observations during the FAMCON assessment phase revealed ironic interaction patterns centered mainly on matters of health. In a typical sequence, Emma responded to perceived signs of Mark's despondence, dietary indiscretion, or medical compliance with questions and exhortations about what he should do (or let Emma do) to take better care of himself. Mark's usual response was mild verbal reassurance that he would be OK and suggestions that Emma calm down, but this prompted more intense criticism, anger, and demands. As the cycle escalated, Mark would become more avoidant and withdrawn, eventually retreating to the bedroom or leaving the apartment. Nevertheless, both partners believed that talking about their difficulties was the best way to resolve them and, at Mark's suggestion, had initiated a ritual of taking brief "water breaks" every few hours when they were at home together (as they were most of each day) to discuss matters of concern, using *I*-statements and other active listening techniques they had learned from previous therapists and self-help books. Although both felt the water breaks were useful, Emma wanted more of them than Mark did, and both acknowledged a recent increase in out-of-control arguments, including one that immediately followed a water break.

Several couple strengths were also relevant to case formulation and treatment planning: One was that Mark and Emma's complementary ways of caring for each other sometimes worked. For example, Mark was able to redirect Emma from "perseverating" and "going faster and faster" by suggesting other things for her to do, and he appreciated Emma pushing him to take daily walks and "get away from the TV" (which she did because "Mark's having structure and space for exercise is good for his health"). Another was the couple's sense of humor, which they demonstrated when we asked what their arguments would look like if someone recorded them on videotape: Emma said, "I'll show you," then slammed a book on the table and marched toward the consulting room door. Mark first grimaced, then smiled and looked amused, saying only that he appreciates her sense of humor.

In session 3, when the team conducted a brief genogram interview, we learned that family members on both sides had discouraged them from marrying and some, like Mark's sister, had been openly critical of Emma pursuing psychiatric SSDI status. There were many other notable dynamics in each partner's family of origin, but these had little bearing on our central formulation and intervention. Finally, in response to inquiries about signs the communication difficulties were improving, both cited Emma's "rage" as especially distressing and were interested in finding better ways to regulate the intensity of her emotional expression. The team accepted, and later validated, their attribution of the rage to Emma's passionate advocacy for Mark's well-being, for them as a couple, and for worthy causes more generally.

In developing its case formulation, the team focused on a nexus of interwoven ironic processes, through which each partner's well-intentioned solutions fed back to keep the communication difficulties going or make them worse. One strand had familiar elements of a demand-withdraw pattern, where Emma's interrogation and exhortations about Mark's diet and diabetes regimen led to progressive withdrawal, more demands, and so on. Another ironic circuit involved Mark's attempts to calm Emma when she became upset, and yet another was the couple's attempts to resolve their communication difficulties by persistently talking about them. The team's strategic objectives included (a) Emma reversing or reducing her high-demand approach to influencing Mark's health behavior and encouraging autonomy instead; (b) Mark helping Emma regulate her rage by taking charge, rather than withdrawing, and by encouraging catharsis and expression, rather than telling her to relax and calm down; and (c) the couple finding ways to communicate and resolve their differences nonverbally, rather than pursuing verbal discussion. The challenge, of course, was how to persuade or arrange for the partners to make these small but potentially drastic changes when doing more of the same made such good sense to them.

Also relevant to the formulation were symptom-system fit and communal coping. The former appeared pervasive in the couple's relationship, owing to their shared identity as psychiatric patients who organized their lives around meeting medical and mental health challenges. Because this had evolved in the face of persistent skepticism and discouragement from family members, the team was careful to avoid replicating this apparent ironic pattern. At the same time, however, we thought more day-to-day activities and relationships not organized around their role(s) as psychiatric patients would signify positive change, and several indirect interventions aimed to open the possibility of their moving in this direction. A fortuitous flip side of this symptom-system fit was that communal coping came easily for Mark and Emma, and we reinforced this throughout the consultation process.

Intervention followed the usual FAMCON format, with six consultation sessions over 4 months, plus three telephone follow-up contacts over the next year. After three assessment meetings, the team presented a carefully prepared "opinion" that (a) reinforced couple strengths, using data from a daily diary exercise to supplement our observations and seed pattern interruption (e.g., on days when they talked more, communication and well-being appeared to deteriorate); (b) recommended Emma promote Mark's health by encouraging even more exercise autonomy; (c) prescribed a nonverbal "rage reduction" ritual, to be initiated and administered by Mark if/when Emma's anger exceeded a discomfort threshold; and (d) advised the couple to go slow in developing additional activities and relationships outside the mental health system because this could undermine their identity as psychiatric patients and upset the expectations of important others (e.g., Mark's sister) who have come to see them in this way. The most impactful component appeared to have been the rage reduction ritual, which required that Mark coach Emma on how to hit the floor, and subsequently a chair, with a foam encounter bat. After rehearsing this several times in the session—first seriously and then with some humor—both partners agreed they would use the bat at home if the need were to arise.

Two weeks later the couple reported doing much better. Emma had used the bat only once, but at her own initiative (after a frustrating support group meeting). The team gently chastised Mark for abandoning his managerial caretaking responsibilities, guided him through another rehearsal, and recommended he initiate at least one prophylactic rage management session in the coming weeks if there was no opportunity to do this remedially. At the final FAMCON session 6 weeks later, the couple reported much improved communication and no more bad fights, and the team implemented a relapse prevention intervention by asking if they would know how to make things worse again (thus highlighting each partner's specific behavioral contributions to problem-exacerbating patterns).

Follow-up phone contacts with Emma and Mark over the next year indicated that their situation remained stable, at least in regard to the presenting complaints: There had been no more bad fights or uncontrolled rage, Mark's health habits had improved (he was exercising more and had lost 10 pounds), and both partners expressed pride in their more nuanced approach to communication. Change in symptom-system fit was less clear: Although both had become involved in a synagogue group and related volunteer activities, they continued taking multiple psychiatric medications, and Emma continued

her intensive involvement with mental health advocacy groups. Sadly, in the 12-month follow-up call, the couple reported that Mark's kidney cancer had taken a turn for the worse and might require more aggressive treatments. They conveyed this news calmly, with Emma adding a communal coda: "No matter what happens, we're in this together."

CONCLUSIONS/KEY POINTS

- FAMCON embodies a systemic (social-cybernetic) view of health behavior problems and a team-based format for brief intervention based on that view.
- Case formulations take relationships rather than individuals as the primary unit of analysis and attach more importance to problem maintenance than to etiology.
- Interventions aim to interrupt two types of repeating interpersonal feedback circuits—*ironic processes* (when attempted solutions maintain problems) and *symptom-system fit* (when problems stabilize relationships)—as well as to mobilize *communal coping* by the people involved (when we-ness promotes change).
- The intervention format, usually spanning no more than 10 sessions over 2–5 months, consists of a semistructured preparation/assessment phase, a focused feedback (opinion) session, and follow-up sessions designed to initiate, amplify, and solidify interpersonal change.
- FAMCON pattern interruption turns on identifying problem-maintaining interaction sequences and formulating strategic objectives that specify what behavior by whom in which situation(s) would suffice to break the pattern.
- To interrupt entrenched sequences of behavior, consultants optimize pattern frame suggestions for change in terms consistent with clients' preferred views of the problem, themselves, and each other.
- Change does not depend on insight, awareness, skill development, or emotional processing.
- Although FAMCON has not yet received attention in randomized clinical trials, an open trial with health-compromised smokers showed promising results. Other research documents the likely importance of putative mechanisms—ironic processes, symptom-system fit, and communal coping.
- In addition to smoking, we have successfully applied FAMCON with complaints related to health conditions ranging from heart disease, cancer, chronic pain, and dementia to alcoholism, anxiety, and depression.
- Because the FAMCON approach requires multiple professional participants and labor-intensive treatment planning, cost-effectiveness is a key consideration. This approach is probably most applicable in the framework of stepped care, after first-line interventions have not been successful.

REVIEW QUESTIONS

1. What basic assumptions guide the FAMCON social-cybernetic approach?
2. What does it mean to think "systemically" and to intervene "strategically"?
3. What essential clinical procedures comprise the FAMCON approach?
4. What are the putative mechanisms of change in this approach?
5. What are some limitations and criticisms of the FAMCON social-cybernetic approach?

AUTHOR NOTE

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RESOURCES

American Association for Marriage and Family Therapy (AAMFT): http://www.aamft.org

American Family Therapy Academy (AFTA): http://www.afta.org

Family Process: The Journal: http://www.family-process.org/about-us/fpjournal [published by Wiley-Blackwell]

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13

Integrative Psychotherapies in Historical Perspective

John C. Norcross
Marvin R. Goldfried
Barrett E. Zimmerman

Abstract
Psychotherapy integration has a long and colorful history, with its beginnings tracing back at least eight decades. There was a dramatic increase in the literature starting in the 1980s as integration progressed from a latent theme to an actual movement. In addition to reviewing psychotherapy integration in historical perspective, this chapter discusses the reasons for its recent popularity and its multiple variations (technical eclecticism, theoretical integration, common factors, assimilative integration). A growing focus has been on the therapy change process, in which common factors operate across orientations as well as specific contributions from each orientation. The chapter also reviews the accumulating research on integrative therapies and the contributions of multicultural diversity. The authors conclude by discussing an exciting emphasis on integrating research and practice and the probable future of integrative treatments.

Keywords: psychotherapy integration, integrative therapy, eclecticism, research–practice gap, history of psychotherapy

Rivalry among theoretical orientations has a long and undistinguished history in psychotherapy, dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affections in a "dogma eat dogma" environment (Parloff, 1980). Clinicians traditionally operated from within their own particular theoretical framework, often to the point of being blind to alternative conceptualizations and potentially superior interventions (Goldfried, 1980). Mutual antipathy and exchange of puerile insults between adherents of rival orientations were very much the order of the day. Indeed, many students today are surprised and shocked at these "therapy wars" (Saltzman & Norcross, 1990) and the concurrent resistance to integration that characterized the earlier history of psychotherapy.

Psychotherapy integration is characterized by dissatisfaction with single-school approaches and by a concomitant desire to look across theoretical boundaries to see what can be learned from other ways of conducting psychotherapy. Although various labels are applied to this movement—*eclecticism*, *integration*, *convergence*, and *rapprochement*—the goals are similar indeed. The ultimate outcome of integration, not yet fully realized, is to enhance the efficacy, efficiency, and applicability of psychotherapy.

In this chapter, we will explicate the influential historical context, major theoretical variations, and outcome research in psychotherapy integration, thereby setting the stage for the subsequent chapter on integrative psychotherapies in practice. We begin by describing the historical development of

integrative therapies from their early stirrings in the 1930s to their full manifestation in the 1980s and 1990s.

HISTORICAL BACKGROUND

Integration as a point of view has probably existed as long as philosophy and psychotherapy. In philosophy, the third-century biographer, Diogenes Laertius, referred to an eclectic school that flourished in Alexandria in the second century AD (Lunde, 1974). In psychotherapy, Freud consciously struggled with the selection and integration of diverse methods (Frances, 1988).

More formal ideas on synthesizing the psychotherapies appeared in the literature as early as the 1930s. Although interest in integrative and eclectic approaches dates back to the 1930s, it consisted primarily of a latent theme rather than a more clearly delineated field of study. Consequently, it was not until the 1980s, when the field of psychotherapy integration became an actual movement, that historical reviews were published (Arkowitz & Messer, 1984). Given space limitations, we will only touch on some of the highlights of the historical trend toward psychotherapy integration. More thorough description and analysis may be found elsewhere (Goldfried, Glass, & Arnkoff, 2011; Goldfried, Pachankis, & Bell, 2005).

The Early Stirrings

One of the earliest attempts to integrate the psychotherapies was made by French, who delivered an address at the American Psychiatric Association meeting in 1932. In his talk, which was somewhat heretical at the time, he attempted to link psychoanalysis and Pavlovian conditioning. His presentation was published the following year (French, 1933), together with comments from members of the audience. The publication included not only his conceptual links between two orientations (e.g., repression and extinction) but also the very mixed reactions of members of the audience. While some applauded French's stance, others were outraged by his attempt to cross such diverse theoretical boundaries.

A few years later, Rosenzweig (1936) outlined what was to be the first commentary on common elements across the different theoretical schools of thought. Rosenzweig argued that the effectiveness of all forms of psychotherapy could be explained by (1) the ability of therapists to instill a sense of hope in their patients; (2) the ability of interpretations, regardless of their accuracy, to make the poorly understood nature of the problem more understandable; and (3) the synergistic nature of the change process, whereby a differential focus on a given aspect of human functioning (e.g., thoughts, feelings, and behavior) can have positive effects on other aspects of the patient's functioning.

Little more was written on the topic until 1950, when Dollard and Miller published their classic work *Personality and Psychotherapy*. In a book dedicated to "Freud and Pavlov and their students," Dollard and Miller, like French before them, described how various psychoanalytic concepts could best be understood in a framework of learning theory. Although this translation of one orientation into another did relatively little to create any innovative interventions, the book was a seminal contribution and remained continuously in print for some 30 years.

Beginning in the late 1950s, Frederick Thorne (1957, 1967) persuasively argued that any skilled professional should come prepared with more than one tool. He emphasized the need for clinicians to fill their toolboxes with methods drawn from different theoretical orientations. Thorne likened psychotherapy to a plumber who would use only a screwdriver in his work. Like such a plumber, inveterate psychotherapists applied the same treatment to all people, regardless of individual differences, and expected the patient to adapt to the therapist rather than vice versa.

In general, only a handful of writers addressed the issue of therapeutic rapprochement from the 1930s through the 1950s. During this period, there was relatively little diversity of orientations, a preoccupying economic depression, a devastating world war, and a period of social and political conservatism that no doubt discouraged psychotherapists from undertaking this process of self-examination. All this changed in the 1960s, when the field witnessed a marked shift in interest toward psychotherapy integration.

The 1960s

In his landmark book *Persuasion and Healing*, Jerome Frank (1961) picked up on the theme of common ingredients that seemed to be associated with psychological change and other forms of healing. He argued

that a variety of different healing methods—primitive shamanism, religious conversion, brainwashing, the placebo effect in medicine—all served to instill an expectation for change or improvement. According to Frank, this establishment of hope dealt directly with patients' demoralization and set in motion a process of change.

Three decades after French published his presentation that drew parallels between Freud and Pavlov, Alexander (1963) reaffirmed the notion that psychodynamic therapy might best be understood in learning theory terms. A respected psychoanalyst, Alexander observed that "we are witnessing the beginnings of a most promising integration of psychoanalytic theory with learning theory, which may lead to unpredictable advances in the theory and practice of the psychotherapies" (p. 48). In the same year, Carl Rogers (1963) observed that therapists were becoming increasingly less tied to their own particular theoretical orientations, and that the field was becoming better able to observe more directly what was actually going on during the change process.

In his influential book *The Modes and Morals of Psychotherapy*, London (1964) highlighted both the strengths and the limitations associated with psychodynamic and behavioral orientations. Challenging the constraints associated with each of these orientations, London stated: "There is a quiet blending of techniques by artful therapists of either school: A blending that takes account of the fact that people are considerably simpler than the Insight schools give them credit for, but that they are also more complicated than the Action therapists would like to believe" (p. 39). In England, Marks and Gelder (1966) similarly acknowledged that there was probably common ground as well as differences between psychodynamic and behavioral approaches. They suggested that the two approaches might best be viewed as complementary rather than antagonistic.

In 1967, Arnold Lazarus stepped out of the constraints of his behavioral roots by maintaining that clinicians could be fruitfully "technically eclectic" without necessarily subscribing to the theoretical superstructure associated with any given intervention procedure. Very much the pragmatic clinician, Lazarus urged others to use the criterion of clinical effectiveness, rather than of theoretical school, to determine how they intervene. Those early statements eventually blossomed into his multimodal therapy (Lazarus, 1989).

Acknowledging that behavioral procedures, such as systematic desensitization, were beginning to have demonstrated clinical effectiveness, Bergin (1968) suggested that such interventions could be more effective if employed within a therapeutic context involving warmth, empathy, and a certain amount of interpretation. Both specific technical methods and general relational qualities could be seamlessly incorporated into treatment. This comprehensive approach was seen as being particularly relevant in the most complex clinical cases.

Following the tradition of French and Alexander, Marmor (1969) argued that all forms of therapy, whether the theory acknowledges it or not, involve principles of learning. Such learning, however, probably went beyond a simple stimulus-response (S-R) model and involved cognitive factors as well. Marmor also concluded that neither the behavioral nor psychodynamic approaches were sufficient in themselves to implement change, and like others before him, Marmor concluded that the two forms of therapy might best be viewed as complementary.

The 1970s

Writing in the newly founded journal *Behavior Therapy*, Bergin (1970) noted that the introduction of cognitive methods (e.g., reappraisal of life events) into behavior therapy may well lead to the investigation of problems that traditional behavior therapy failed to consider. His prophecy turned out to be accurate, as many behavior therapists involved in the creation of cognitive interventions (e.g., Davison, Goldfried, Lazarus, Mahoney, and Meichenbaum) later developed an interest in psychotherapy integration.

The ways that therapies may be integrated, both clinically and conceptually, were considered in a series of papers by Feather and Rhoads (1972a, 1972b). Birk (1973) followed up on this point, noting that the behavioral approach helped to provide a focus on external stimuli (e.g., work deadlines), whereas the psychodynamic approach dealt more with internal phenomena (e.g., thoughts, feelings). Just how these two same orientations might be used to treat sexual disorders was outlined in Kaplan's (1974) *The New Sex Therapy*.

In 1975, a number of important books and articles on integration were published. In *Misunderstandings of the Self*, Raimy (1975) suggested that a common

factor across therapeutic orientations was their ability to alter the patients' misconceptions of themselves and others. In the first of a series of articles on psychotherapy integration written by the German psychologist Bastine (1975), common strategies together with specific procedures by which they might be implemented were similarly outlined. In the first of many contributions, Wachtel (1975) suggested how psychodynamic and behavioral approaches could complement each other, such as the former helping to identify problematic interpersonal themes and the latter supplying methods to encourage new behavior patterns. This thesis was expanded into what has since become a classic work, namely, *Psychoanalysis and Behavior Therapy* (Wachtel, 1977).

The humanistic traditions were also beginning to assimilate other approaches. Egan (1975), for example, expanded his experiential orientation to acknowledge the potential contributions of the behavioral approach. The editor of the *Journal of Humanistic Psychology* (Greening, 1978), for another, urged his experiential colleagues to remain open to efforts at rapprochement.

Numerous scientist-practitioners began to challenge the utility of approaching psychological problems through the lens of one theory. From the systemic tradition, Gurman (1978, p. 131), underscoring what we all too often forget, advocated that therapy is not "a reified set of procedures, but an evolving science." Strupp (1976) took his psychoanalytic colleagues to task for continuing its use of procedures based on faith and tradition rather than on data that deal with clinical effectiveness. In a textbook that reviewed leading systems of psychotherapy, Prochaska (1979) ended with the presentation of a transtheoretical model that encompassed various schools of thought and that considered the patient's stage of change.

At the same time, Goldfried and Davison (1976) published *Clinical Behavior Therapy*, in which they suggested that "It is time for behavior therapists to stop regarding themselves as an outgroup and instead to enter into serious and hopefully mutually fruitful dialogues with their nonbehavioral colleagues" (p. 15). The fact that clinicians of varying orientations were already doing so was reflected in a survey by Garfield and Kurtz (1977), in which they found half of the clinical psychologists in the United States considered themselves eclectic.

The 1980s

During the 1980s, psychotherapy integration moved from a latent theme to a clearly defined area of interest—indeed, a movement. In this decade, numerous books, journals, articles, chapters, and conferences appeared on the subject, and a professional society dedicated to the advancement of psychotherapy integration was formed.

In an *American Psychologist* article, Goldfried (1980) reviewed the movement toward psychotherapy integration and suggested that fruitful comparison across different orientations might be based on clinical strategies or principles. These strategies—for example, corrective experiences and feedback—occupy a level of abstraction somewhere between specific techniques and global theories.

Also at the beginning of this decade, the fact that psychotherapy integration was more international in scope became increasingly evident. In England, Dryden (1980) dealt with the difference in therapeutic style across theoretical orientations. In Germany, Bastine (1980) discussed the methods for accomplishing an integration of the psychotherapies, as well as its theoretical and practical benefits. From French-speaking Canada, Lacomte and Castonguay (1987) edited *Rapprochement et Integration en Psychotherapie.*

In the early 1980s there was a dramatic increase in the number of books written from an integrative perspective, including *Converging Themes in Psychotherapy* (Goldfried, 1982) and an integrative volume on marital therapy (Seagraves, 1982). This was but the beginning, as a continual stream of volumes appeared over the next few years (e.g., Arkowitz & Messer, 1984; Beutler, 1983; Prochaska & DiClemente, 1984). Moreover, journals began to feature special discussions on the topic of psychotherapy integration, such as a 1982 issue of *Behavior Therapy* and a 1983 issue of the *British Journal of Clinical Psychology.*

Recognizing the need for an organization to bring together these separate voices and foster the growing integration movement, the Society for the Exploration of Psychotherapy Integration (SEPI) was founded in 1983. SEPI is interdisciplinary in nature and has grown to be international in its scope. The purpose of SEPI was to provide a community in which dialogue across orientations, and also between researchers and clinicians, might take place.

As more authors became interested in the topic of psychotherapy integration, there developed a need for more outlets for their ideas. Consequently, several journals appeared, such as the *Journal of Integrative and Eclectic Psychotherapy*, *Integrative Psychiatry*, and the *Journal of Psychotherapy Integration*, the latter serving as the official publication of SEPI.

Toward the end of the 1980s, major books on psychotherapy integration were accompanied by handbooks devoted to the integration movement. Among these were a *Handbook of Eclectic Psychotherapy* and a follow-up *Casebook* (Norcross, 1986, 1987) asking clinicians of disparate orientations to comment on the same case.

With the growth of the integration movement, too, came a predictable focus on specific issues. Cases in point were special sections on the possibilities of common language in psychotherapy (Norcross, 1987) and recommendations on integrative training (Beutler et al., 1987). The integration of different therapeutic modalities, such as individual and family therapy, was also increasingly the focus of attention (e.g., Allen, 1988; Feldman, 1989; Wachtel & Wachtel, 1986). Toward the end of the 1980s, there were calls for controlled research on psychotherapy integration. Both the need and possible directions for future work in this area were crystallized by a National Institute of Mental Health research conference on psychotherapy integration (Wolfe & Goldfried, 1988).

As the decade came to a close, Norcross and Prochaska (1988) revisited and updated Garfield and Kurtz's (1977) study on eclectic views. The results demonstrated that the majority of psychologists now preferred the label of *integrative* over *eclectic* in describing their theoretical orientation. The authors observed that "integration by design is steadily replacing eclecticism by default" (p. 173). The transition from eclecticism to integration had begun and would stabilize in the next decade.

The 1990s

If the 1980s witnessed the establishment of integration as a movement, then the 1990s saw the ideas of this movement become generally recognized and adopted by a wide variety of researchers and clinicians alike. Indeed, integrative themes became part of the prevailing zeitgeist and were increasingly incorporated into mainstream writing.

A steady stream of influential books demonstrated how multiple schools could be integrated in practice. *Interpersonal Process in Cognitive Therapy* (Safran & Segal, 1990) outlined how the clinical effectiveness of cognitive therapy could be enhanced by incorporating principles and techniques associated with interpersonal theory. Bohart and Swildens (1990) brought an integrative approach to client-centered therapy, describing the common underlying factors in psychotherapy and how these are related to client-centered therapy. Expanding on work begun in the 1980s, Ryle (1990) discussed how his cognitive-analytic therapy integrated aspects of cognitive, psychodynamic, and behavior therapies.

The first edition of the *Handbook of Psychotherapy Integration*, edited by Norcross and Goldfried (1992), offered a comprehensive examination of the theory and practice of integrative psychotherapy. The editors concluded that it was unlikely that the psychotherapy integration movement would provide the field with a grand, overarching theoretical orientation. Instead, they proposed that integrative efforts would lead to increased consensus on the interventions that were indicated for certain clinical problems.

During the next year, Stricker and Gold (1993) published their *Comprehensive Handbook of Psychotherapy Integration*, which included contributions on a variety of topics such as individual approaches to integration, the integration of traditional and nontraditional approaches, and psychotherapy integration for specific disorders and specific populations.

Several observers (e.g., Arkowitz, 1989) called for the integration of psychotherapy into the science of psychology. They noted that behavior therapy was a fitting example of the successful integration of a psychotherapeutic approach into mainstream psychology. They went on to say that the successful integration of psychotherapy into the broader field of psychology would address the conceptual and scientific limits of psychotherapy.

In the later part of the decade, calls for more outcome research and more international perspectives on integrative therapies continued. Just a few years later, Schottenbauer, Glass, and Arnkoff (2005) noted that there had been a dramatic increase in outcome research on psychotherapy integration. Toward the end of the 1990s, integrative themes

continued to take root internationally, as evidenced by a bevy of integrative perspectives from an international perspective (e.g., Fernández-Álvarez, 1992/2001).

We noted at the outset of this chapter that our historical review ends with the 20th century. This is an arbitrary, but convenient point at which to stop; the history of psychotherapy integration certainly continues beyond that point.

WHY INTEGRATION?

Given the fact that psychotherapy integration can be traced to the early 1930s, the question has been raised as to why it has only been in more recent years that it has captured the interest of mental health professionals. In an attempt to answer this question, we have identified eight interacting and mutually reinforcing factors (Arkowitz, 1992; Norcross & Goldfried, 2005).

1. The first is the proliferation of different schools of psychotherapy over the years, causing fragmentation and confusion. Which of 400+ theories should be studied, taught, or bought? This might also be called the exhaustion theory of integration: peace among warring schools at last.
2. Related to this "hyperinflation of brand-name therapies" is the growing awareness that no one approach to therapy has been found to be applicable to all patients. Clinical reality has come to demand a more flexible, if not integrative, perspective.
3. The concurrent interest of the federal government and insurance companies in psychotherapeutic services has brought with it growing pressure for accountability, consensus, and pragmatism; there is something to be said for the differing schools "hanging together" rather than "hanging separately" under such intense scrutiny.
4. As psychotherapy has become short term in nature, and as it has begun to focus on specific clinical problems, therapists of disparate orientations have started to share a more common focus. Dealing with clinical realities within time constraints has promoted the tendency to use whatever works, regardless of orientation.
5. Therapists have had increased opportunities to observe and experiment with different therapeutic interventions. This has occurred with the advent of therapy manuals, availability of hundreds of psychotherapy videotapes, and the growth of problem-oriented specialty clinics that are staffed by professionals of various orientations and disciplines.
6. As a result of decades of psychotherapy outcome research, a frequent conclusion has been drawn that for most disorders, no one theoretical approach has been shown to be consistently more effective than any other. Meta-analytic research has shown charity for all treatments and malice toward none (London, 1988).
7. Partly as a consequence of this failure to find consistent differential effectiveness, there is a growing awareness and appreciation of the common factors that exist in all forms of therapy. A common factors approach, as we shall see shortly, is one of the major varieties of psychotherapy integration.
8. A final and critical impetus to psychotherapy integration has been the formation of a professional network—SEPI—that has provided an invaluable context within which integration-minded professionals can work.

It is difficult to determine which of these separate factors has proven most instrumental in engendering the enduring interest in psychotherapy integration. What is clear, however, is that forces operating both inside and outside the field of psychotherapy have contributed to this trend. Whatever the relative contributions of these factors, all have operated in forming a new zeitgeist, a hospitable atmosphere in which to pursue psychotherapy integration. And, as practitioners boldly experimented with, and as researchers rigorously evaluated such integrative treatments, they have generally found the clinical results most gratifying.

MAJOR DEVELOPMENTS AND VARIATIONS

Psychotherapy integration, as is now evident, comes in many guises and manifestations. It is clearly neither a monolithic entity nor a single operationalized

system. In this sense, referring to *the* integrative psychotherapy causes one to fall prey to the *uniformity myth*, a pervasive misconception that all psychological treatments sharing the same brand name are conceptualized and conducted identically (Kiesler, 1966).

This caution notwithstanding, the modal theoretical orientation of contemporary psychotherapists in North American and Western Europe is *integrative*. Approximately one third to one half of mental health professionals disavow any affiliation with a particular school of therapy and, instead, endorse a variation of psychotherapy integration (Norcross & Goldfried, 2005).

Survey research over the past 40 years demonstrates a definite preference for both the term *integration* and the practice of theoretical integration, as opposed to *eclecticism*. Clinicians now prefer the self-identification of *integrative* over *eclectic* by an almost 2 to 1 margin (Norcross, Karpiak, & Lister, 2005). This preference probably represents a historical shift analogous to social progression: one that proceeds from segregation to desegregation to integration. Eclecticism represented desegregation, in which ideas, methods, and people from diverse theoretical backgrounds intermingle. Integration, by small contrast, entails viable integrative principles for assimilating and accommodating the best that different systems have to offer.

That same line of research on North American psychologists (Norcross et al., 2005) reveals historical shifts in the practices of self-described integrationists and eclectics. In the 1970s, the most popular hybrids of theoretical orientations were psychoanalytic and learning, psychoanalytic and client centered, and learning and humanistic (Garfield & Kurtz, 1977). In the 2000s, the most popular combinations all involved cognitive therapy: cognitive and behavioral, cognitive and humanistic, cognitive and psychoanalytic, cognitive and interpersonal, and cognitive and systemic. As is true of the field in general, the cognitive orientation has permeated integrative practices.

Commensurate with its maturation, psychotherapy integration has differentiated more clearly into separate variations or subtypes. The four principal varieties are (1) technical eclecticism, (2) theoretical integration, (3) common factors, and (4) assimilative integration. All four share a desire to increase therapeutic effectiveness by looking beyond the confines of single-school perspectives, but they do so in rather different ways and at different levels.

Technical Eclecticism

Eclecticism is the least theoretical of the four varieties, but it should not be construed as either atheoretical or antitheoretical (Lazarus, Beutler, & Norcross, 1992). Technical eclectics seek to improve our ability to select the best treatment for the person and the problem. This search is guided primarily by data on what has worked best for other patients in the past with similar disorders and similar characteristics. In this sense, eclecticism predicts for whom interventions will work: The foundation is empirical rather than theoretical. The systematic treatment selection of Larry Beutler (Beutler & Clarkin, 1990; Beutler, Consoli, Lenore, & Sheltzer, Chapter 14, this volume) and the multimodal therapy of Arnold Lazarus (1989, 2005) exemplify eclecticism. Beutler's approach subsequently evolved to a variation of common factors where crosscutting principles rather than interventions were the bridging variables (Beutler, Clarkin, & Bongar, 2000; Castonguay & Beutler, 2006).

Proponents of technical eclecticism use procedures drawn from different sources without necessarily subscribing to the theories that spawn them. That is, no necessary connection exists between metabeliefs and techniques. In the words of Lazarus (1967, p. 416): "To attempt a theoretical rapprochement is as futile as trying to picture the edge of the universe. But to read through the vast array of literature on psychotherapy, *in search of techniques*, can be clinically enriching and therapeutically rewarding."

Theoretical Integration

In this form of synthesis, two or more therapies are integrated in the hope that the result will be better than that resulting from the constituent therapies alone. As the name implies, the emphasis is on combining the underlying theories of psychotherapies—what London (1986) eloquently labeled "theory smushing." This is done along with the blending of therapy techniques from each—what London called "technique melding." Various proposals to integrate psychoanalytic, behavioral, and relational theories illustrate this direction, most notably the work of Paul

Wachtel (1977, 1987), as well as grander schemes to meld all the major systems of psychotherapy, as in the transtheoretical model of Prochaska and DiClemente (1984, 2005).

Theoretical integration entails a commitment to a conceptual synthesis beyond the technical blend of methods. The goal is to create a conceptual framework that synthesizes the best elements of two or more approaches of therapy. However, it aspires to more than a simple combination; it seeks an emergent theory that is more than the sum of its parts and that leads to new directions for practice and research. The primary distinction between technical eclecticism and theoretical integration, then, is that between empirical pragmatism and theoretical flexibility. *Integration* refers to a more ambitious commitment to a conceptual creation beyond eclecticism's pragmatic blending of procedures. In the words of Wachtel (1991, p. 44): "The habits and boundaries associated with the various schools are hard to eclipse, and for most of us integration remains more a goal than a constant daily reality. Eclecticism in practice and integration in aspiration is an accurate description of what most of us in the integrative movement do much of the time."

Common Factors

In this variation of psychotherapy integration, practitioners value the core ingredients that different therapies share, toward the eventual goal of developing more parsimonious and efficacious treatments based on those commonalities. This search is predicated on the widespread belief and accumulating research that commonalities are more important in accounting for psychotherapy outcome than the unique factors that differentiate among them. In specifying what is common across disparate orientations, we may also be selecting what works best among them. The work of Jerome Frank (1973; Frank & Frank, 1993), Bruce Wampold (2001), and Scott Miller and Barry Duncan (Duncan, Miller, Wampold, & Hubble, 2010) have been among the most influential contributors to the common factors approach.

The energetic debate in the field between those emphasizing the power of therapeutic commonalities and those stressing the unique or specific factors attributed to different therapies has gradually given way to a consensus that is not a dichotomy. Indeed, the field of psychotherapy can gradually integrate by combining the fundamental similarities *and* the useful differences across the schools (Beitman, 1992). In this way, we can maximize effectiveness by employing those factors common across therapies highlighted in research while capitalizing on contributions of specific techniques found to be differentially effective for selected circumstances (Lambert, 1992).

Assimilative Integration

The fourth and most contentious pathway is *assimilative integration*, which entails a firm grounding in one system of psychotherapy but with a willingness to selectively incorporate (assimilate) practices and views from other systems (Messer, 2001). In doing so, assimilative integration combines the advantages of a single, coherent theoretical system with the flexibility of a broader range of technical interventions from multiple systems. A cognitive therapist, for instance, might use the gestalt two-chair dialogue or a systemic paradoxical directive in an otherwise cognitive course of treatment.

To its proponents, assimilative integration is a realistic way station on the path to a sophisticated integration; to its detractors, it is a waste station of people unwilling to commit themselves to integration. Both camps agree that assimilation is a tentative step toward full integration: Most therapists gradually incorporate parts and methods of other approaches once they discover the limitations of their original approach. Inevitably, therapists gradually integrate new methods into their home theory.

These four integrative pathways are not mutually exclusive, of course. No technical eclectic can disregard theory, and no theoretical integrationist can ignore technique. Without some commonalities among different schools of psychotherapy, theoretical integration would prove impossible. And even the most ardent proponents of common factors cannot practice "nonspecifically" or "commonly" on their own; specific methods must be applied.

Although psychotherapists have not settled on a single route to the integrative summit, it has firmly rejected *syncretism*—uncritical and unsystematic combinations. This haphazard approach is primarily an outgrowth of pet techniques and inadequate training. It is an arbitrary blend of methods without systematic rationale or empirical verification (Eysenck, 1970).

Psychotherapy integration, by contrast, is the product of years of painstaking training, research, and experience. It is integration by design, not default; that is, clinicians competent in several therapeutic systems who systematically select treatment methods and therapeutic relationships on the basis of outcome research and patient need.

THEORY OF CHANGE

In comparison to single-school psychotherapies, integrative models are distinctive in at least two respects. First, psychotherapy integration posits that a large number and wide range of mechanisms constitute the active ingredients of change. Psychoanalysts may believe that interpretations, analysis of resistance, and resolution of transference are the active mechanisms of change, while behaviorists may attribute change to skill training, desensitization, and contingency management. Integrative therapists believe that both the awareness-enhancing processes of psychoanalysis and the action-producing processes of behaviorism—plus many others—are the curative factors in psychotherapy. In sum, psychotherapy integration embraces an inclusive and broad epistemology of change, one that is bound together by its reliance on empirical rather than theoretical bases for knowledge.

Second, integrative therapies are comparatively unique in that they typically emphasize process over content. This distinction between process and content in psychotherapy is a critical one (Held, 1991). Psychotherapy systems without formal theories of personality, such as integrative approaches, are primarily process theories and have few predetermined concepts about the content of therapy. They attempt to capitalize on the unique aspect of each case by restricting the imposition of formal content. By contrast, most systems of psychotherapy focus on the content to be changed as a carryover from that system's theory of personality and psychopathology. Many books purportedly focusing on psychotherapy frequently confuse content and process and, as a consequence, examine the content of therapy, with little explanation about the processes (Prochaska & Norcross, 2014). Put differently, theories of personality and psychopathology tell us *what* needs to be changed, while theories of process tell us *how* change occurs (Arkowitz, 1989).

A comparative analysis reveals how much psychotherapy systems agree on the processes producing change (the how) while disagreeing on the content to be changed (the what). In other words, different theories do not dictate the specific interventions to use as much as they determine the therapeutic goals or content to pursue.

As an illustration, consider the psychological treatment of specific phobias. Freud (1919), the intrapsychic master, stressed that if the psychoanalyst actively induced patients to expose themselves to the feared stimuli, "a considerable moderation" of the phobia would be achieved. This observation predates the contemporary consensus on the importance of exposure methods in alleviating specific phobic behaviors. Freud, then, early and readily understood the process of reducing phobic behavior, but he decided that the desirable content or goal of psychoanalysis was to make the unconscious conscious. He opted to disregard the behavioral process of change in pursuit of other content to be changed (Norcross, 1991).

One means of conceptualizing the theory of change is to focus on a level of abstraction between specific technique and global theory (Goldfried, 1980). We will probably never reach common ground on the global theories (e.g., psychodynamic, experiential, behavioral, systemic), and searching for commonalities in terms of specific procedures (e.g., interpretation, two-chair technique, self-monitoring, genograms) will probably not reveal much more than minor points of similarity. By contrast, an intermediate level of abstraction, known as *principles of change* or *clinical strategies*, fits between global theories and specific techniques. Promising principles of change include feedback, corrective emotional experience, counterconditioning, and the therapeutic relationship.

Although there are reportedly over 400 different psychological therapies based on divergent theoretical assumptions, the transtheoretical model, developed by Prochaska, DiClemente, and colleagues, has been able to identify only 10 different *processes of change*. These processes or principles of change occur at that middle level of abstraction, and each process subsumes dozens of potential therapy techniques. The processes were initially identified in a comparative analysis of the leading psychotherapy systems (Prochaska, 1979) and were subsequently confirmed and refined in a series of research studies on self-initiated and treatment-facilitated change

(Prochaska, DiClemente, & Norcross, 1992). The transtheoretical model was designed to be complex enough to do justice to the complexities of behavior change, yet simple enough to reduce confusion on the field.

Table 13.1 presents these 10 change processes, along with their definitions and representative examples of specific techniques. As seen there, several processes of change are primarily used by the verbal or insight therapies, such as psychoanalytic and experiential approaches. Several other processes are used primarily, if not exclusively, by the directive or action therapies, notably behavior therapy and some forms of family systems therapy. Comparative studies of psychotherapy further indicate that certain therapies, principally gestalt and cognitive approaches, employ processes traditionally associated with both insight and action therapies. All therapies employ the therapeutic relationship and self-liberation in treatment, although they vary in the emphasis and label applied to them.

Examining the theory of change and organizing the change processes make more clinical sense within the stages of change. Individuals modifying problem behaviors progress through an invariant series of stages, from contemplation to maintenance. *Contemplation* is the stage in which individuals are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action. Gradually, individuals move into *preparation*, the stage that combines intention and behavioral criteria. Here they are committed to taking action in the near future and may have already taken a few small or tentative steps toward eliminating the problem. *Action* is the next stage in which individuals modify their behavior, experiences, or environments in order to overcome their problem. Action requires the most overt behavioral change and requires a considerable commitment of time and energy. And last, *maintenance* is the stage in which individuals work to prevent relapse and consolidate the gains obtained during action.

Competing systems of psychotherapy have promulgated apparently rival processes of change, but ostensibly contradictory processes of change become complementary when embedded in the stages of change.

TABLE 13.1 Definitions and Representative Interventions of the Processes of Change

Process	*Definitions: Representative Interventions*
Verbal/Insight Therapies	
Consciousness raising	Increasing information about self and problem: observations, confrontations, interpretations, bibliotherapy
Self-re-evaluation	Assessing how one feels and thinks about oneself with respect to a problem: value clarification, reflections, imagery, corrective emotional experience
Dramatic relief	Experiencing and expressing feelings about one's problems and solutions: catharsis/abreaction, psychodrama, grieving for losses, role-playing
Environmental reevaluation	Assessing how one's problem affects the social environment: perspective taking, empathy training, documentaries
Behavioral/Action Therapies	
Counterconditioning	Substituting alternatives for problem behaviors: relaxation, desensitization, assertion, cognitive disputation
Stimulus control	Avoiding or countering stimuli that elicit problem behaviors: restructuring one's environmnent (e.g., removing alcohol), avoiding high-risk cues, fading techniques
Contingency management	Rewarding or punishing oneself or others for making changes: contingency contracts, overt and covert reinforcement, self-reward, punishment
All Therapies	
Helping relationships	Being open and trusting about problems with someone who cares: therapeutic alliance, social support, nonpossessive warmth
Self-liberation	Choosing and committing to change: decision making, encouragement, logotherapy techniques, commitment-enhancing techniques
A Few Therapies	
Social liberation	Increasing alternatives for nonproblem behaviors available in society: advocating for rights of the repressed, empowering, policy interventions

Source: Adapted from Prochaska, DiClemente, & Norcross (1992).

Specifically, change processes traditionally associated with the experiential, humanistic, and psychoanalytic persuasions are most useful during the contemplation stage. Change processes traditionally associated with behavioral, exposure, and systemic tradition are most useful during the action and maintenance stages. Throughout the cycle of change, helping relationships prove invaluable. Scores of research studies indicate that the change processes are differentially employed and effective, depending on the stage of change (Norcross, Krebs, & Prochaska, 2011; Rosen, 2000).

A number of other organizing heuristics have been advanced to demonstrate the complementary, not contradictory, nature of change processes in psychotherapy. Different goals for the psychological treatment of the identical clinical problems, for example, will probably generate different change processes and psychotherapy systems. A goal of expanded awareness of a problem's origins would lead one to employ primarily verbal or insight processes, while patients desiring overt behavior change with little historical or intrapersonal awareness would lead to action and behavioral process. A person's personality style, to take another example, may also dictate preferential use of some change processes over others. As Beutler and colleagues discuss in Chapter 14 (this volume), highly resistant patients respond better to less directive therapies than to highly structured, directive interventions.

Theoretical complementarity is a key to synthesizing the major systems of psychotherapy. Each theoretical tradition has a place, often a differential place, in the "big picture" of behavior change. Depending on the client's stage of change, treatment goals, personality style, culture, and other key tailoring variables, different therapy systems will play more or less of a prominent role (Norcross, 2011).

In sum, the integrative theory of change is naturally pluralistic and inclusive. There are many ways to change, and research demonstrates that principles or processes of change can usefully guide clinical practice (Castonguay & Beutler, 2006). Psychotherapy should be tailored to the unique client and singular situation, instead of to the therapist's preferred theory. That's the sea change fostered by integrative therapies.

RESEARCH ON EFFICACY AND EFFECTIVENESS

Outcome research on integrative therapies has flourished in the past decade. In one guise, the entire body of psychotherapy research provides the foundation for integrative treatment: mix and match theories (theoretical integration), techniques (technical eclecticism), and change principles (common factors). Integration tries to incorporate state-of-the-art research findings into its open framework, in contrast to becoming yet another "system" of psychotherapy. In another guise, outcome research is building for treatment selection according to client transdiagnostic characteristics. A recent interdivisional American Psychological Association task force commissioned a series of meta-analyses and concluded that adapting therapy is demonstrably effective depending upon the client's reactance level, stages of change, preferences, culture, coping style, and religion (see Norcross, 2011, for details). The accumulating research evidence allows us to create a new integrative therapy for each patient.

In still another guise, research has demonstrated the efficacy and effectiveness of particular integrative therapies. The majority of randomized controlled trials (RCTs) on adult and child psychotherapy have been conducted on cognitive-behavioral therapy, an avowed hybrid or integration. Transtheoretical therapy, emotionally focused therapy, multisystemic therapy, cognitive analytic therapy (CAT), systematic treatment selection, integrative couples therapy, eye movement desensitization and reprocessing (EMDR), and others are all self-described integrative therapies that have each garnered support from four or more RCTs (Schottenbauer et al., 2005).

Multiple RCTs have been conducted on the efficacy of transtheoretical therapy and systematic treatment selection, which share an emphasis on change processes/principles and on tailoring psychotherapy to the individual's transdiagnostic features. Matching in-person therapy and online self-help to a patient's stage of change has been found superior to alternative treatments for depression, stress management, smoking, substance abuse, bullying, and multiple health behaviors (see Prochaska & Norcross, 2014, chapter 17, for a review). Likewise, tailoring treatment to a client's reactance level, coping style, and level of functional impairment increases success rates, as does systematic treatment selection in general (Beutler, Forrester, Gallagher-Thompson, Thompson, & Tomlins, 2012).

The evidence that integrative therapies work is plentiful and growing. That evidence suggests integrative therapies work as well as single-school therapies for particular mental disorders. The crucial test

will be whether integrative therapies, by virtue of their flexibility and responsiveness, will perform even better than single-school therapies across disorders and for complex comorbid patients. That research agenda has just begun.

DIVERSITY

Psychotherapy integration prizes diversity in clients, clinicians, and conceptualizations. Indeed, the twin integrative maxims of "no treatment works for everyone" and "different strokes for different folks" impel tailoring to diverse cultures. By culture, we do not refer solely to race, but more broadly to the wonderful diversity of humanity: age and generational influences, (dis)ability status, religion, ethnicity, socioeconomic status, sexual orientation and gender identity, indigenous heritage, national origin, and so on (Hays, 1996).

Single-school therapies, particularly those born of a dominant "parent" and rooted in a culture-bound theory of personality, tend to subtly maintain White, androcentric (male-centered), Western European, heterosexual norms. Many of the single-school "universal" principles are now correctly perceived as examples of clinical myopia or cultural imperialism. Integrative therapies, by contrast, rely on neither a particular founder nor a theory of personality. Our sole "universal" principle is that people and cultures differ and should be treated as such. Evidence-based pluralism reigns as integration infuses diversity and flexibility into psychotherapy. No wonder that virtually every multicultural and culturally responsive theory describes itself as "integrative" in practice.

When offered to clients, integrative psychotherapies manifest as culturally sensitive or culturally adapted—modified to improve client utilization, retention, and outcome. Such cultural adaptation materially improves the effectiveness of treatment, particularly orienting treatment to a specific cultural group (instead of a variety of cultural backgrounds) and conducting therapy in the client's native language (Smith, Domenech Rodríguez, & Bernal, 2011). Especially ineffective is the use of translators in sessions because their use is associated with weak alliances, more misdiagnoses (usually more severe than necessary), and higher dropout rates (Paniagua, 2005).

The upshot is for psychotherapists of all persuasions to mutually explore the singular needs and unique cultures of clients. One effective practice, especially for historically marginalized populations, is to acquaint beginning clients with the respective roles of patient and therapist. Many patients hold divergent expectations about the process of psychotherapy and may be uncomfortable with mental health treatment. Pretherapy orientation is designed to clarify these expectations and to collaboratively define a more comfortable role for the client (Ogrodniczuk, Joyce, & Piper, 2005). That role for patients of color typically entails plentiful overt therapist support and positive regard, which evidences an even stronger link to therapy outcome than for White patients (Farber & Doolin, 2011).

We enthusiastically embrace diversity in psychotherapy. It is called integration, diversity within unity. Integrative therapy posits that the context for every individual—African, Asian, Latina/o, or Anglo; straight, gay, bisexual, or transgender; Muslim, Christian, Jew, or atheist—is unique. And each psychotherapy intervention needs to be individually constructed and contextualized to match the needs of a particular person. In some cases, this involves helping individuals become free from social oppression. In other cases, it means helping them become free from mental obsessions. In yet other cases, it involves treatment of biological depression (Prochaska & Norcross, 2014).

CONCLUSIONS AND KEY POINTS

Integrative therapy has progressed from a latent interest to an informal movement to an accepted reality. Virtually all psychotherapy textbooks, such as this one, routinely include an integrative chapter. This transformation has begun to shift our attention from "*who* is correct" to "*what* is correct" in psychotherapy (Goldfried, 1980, p. 991). Probably for the first time since the birth of psychotherapy a mere 120 years ago, the majority of mental health professionals are overtly expressing dissatisfaction with any single-school approach and publicly acknowledging their commitment to learning from other ways of thinking about behavior change.

Whether we characterize it as a gradual evolution or an abrupt revolution, psychotherapy integration in its many forms will represent the therapeutic zeitgeist

of the future. Indeed, a recent Delphi poll of psychotherapy experts (Norcross, Pfund, & Prochaska, 2013) revealed that integrative therapies were among the top three therapies predicted to increase the most in use over the next decade (along with mindfulness and cognitive-behavioral therapies). That surge parallels the excitement more generally in integrative science—research that spans disciplinary boundaries and that combines different levels of analysis of the same phenomena.

As psychotherapy integration has matured, it is frequently characterized in a multitude of confusing ways. One routinely encounters references in the literature and in the classroom to integrating self-help and psychotherapy, medication and psychotherapy, Western and Eastern perspectives, social advocacy and individual treatment, and so on. All are indeed laudable pursuits, but we restricted ourselves in this chapter to the traditional meaning of integration as the blending of diverse theoretical orientations.

Another important form of psychotherapy integration involves attempts to close the gap between research and practice, and integrate these two approaches to understanding psychotherapy. As noted earlier, SEPI has played an instrumental role in encouraging therapists to be more open to integrating potentially helpful contributions from other orientations. We are particularly excited about SEPI's expanded mission to also work toward the integration of research and practice. The incessant demands from policymakers and insurance companies for empirical accountability of psychosocial treatments require a collaborative effort between practitioners and researchers. The goal is to enable clinicians to learn and utilize the findings of cutting-edge research, and for researchers to learn from the observations of practitioners working with the issues that arise in the actual practice of therapy. The development of practice–research networks is a case in point, wherein therapists are contributing research findings in conjunction with their clinical work (Castonguay, Barkham, Lutz, & McAleavy, 2013).

Another attempt to integrate research and practice is reflected in the collaborative initiative of the Society of Clinical Psychology (APA Division 12)and the Division of Psychotherapy (APA Division 29) to create a Two-Way Bridge between Research and Practice (Goldfried et al., 2014). The initiative is based on the assumption that any difficulties associated with applying empirically supported treatments in practice will provide vital information about those variables that are in need of future research. In essence, the Two-Way Bridge provides a feedback mechanism from practitioner to researcher, offering clinically relevant questions and concerns in need of further investigation—giving the practitioner a voice in the research process. The first three surveys of the initiative—on panic disorder, social anxiety, and general anxiety disorder—have been published, and at the time of this writing, two additional surveys have also been completed, providing feedback on the clinical use of empirically supported treatments for posttraumatic stress disorder and obsessive-compulsive disorder.

Psychotherapy integration, as presented in this and the next chapter, constitutes a vibrant movement and effective approach to treatment. Integration has been catalytic in the search for new ways of conceptualizing and conducting psychotherapy, ways that go beyond the confines of single schools. Integrative perspectives have encouraged practitioners and researchers to examine what other theories and therapies have to offer them and, more important, their clients. The ongoing attempts to integrate research and practice will strengthen integrative therapies, in particular, and mental health treatments, in general. Our abiding hope is that psychotherapy integration will persist in engendering an open system of informed pluralism, deepening rapprochement between theories, and promoting meaningful collaborations between researchers and practitioners that lead to more effective psychotherapies.

REVIEW QUESTIONS

1. Define "psychotherapy integration." Is it the lack of a theoretical orientation, a separate orientation, or both?
2. What are some of the major reasons that led to integration in psychotherapy?
3. Define the four major variations or subtypes of psychotherapy integration. Which one do you prefer and why?
4. The authors advance a multidimensional, transtheoretical perspective on behavior

change. With which of the 10 processes or principles of change are you most familiar? Least familiar?

5. What distinguished theoretical integration from technical eclecticism in early theories?
6. Would you characterize yourself as an integrationist? If so, what are your primary motivations for doing so? If not, why not?

RESOURCES

Readings

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Videos

Goldfried, M. R. (2007). *Cognitive–affective behavior therapy*. (DVD). Washington, DC: American Psychological Association.

Norcross, J. C. (2013). *Integrative psychotherapy*. (DVD). Washington, DC: American Psychological Association.

Norcross, J. C. (2016). *Integrative supervision*. (DVD). Washington, DC: American Psychological Association.

Websites

Inner Life: http://www.innerlife.com (An online treatment matching system, rooted in Systematic Treatment Selection, for use by patients and professionals)

Society for the Exploration of Psychotherapy Integration: http://www.sepiweb.org

Transtheoretical Model: http://www.uri.edu/research/cprc/

Two-Way Bridge Between Research and Practice: http://www.stonybrook.edu/twowaybridge

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14

Integrative and Eclectic Therapies in Practice

Larry E. Beutler
Andrés J. Consoli
Samarea Lenore
Joshua M. Sheltzer

Abstract
Technical eclecticism is one thrust of the psychotherapy integration movement and, by definition, emphasizes the fit of specific techniques to different classes of patients. Systematic treatment selection (STS) evolved from an eclectic approach (Beutler, 1983; Beutler & Consoli, 1992), but it has come to represent a broader approach in which therapeutic change is driven by the clinician's compliance with crosscutting principles and strategies that are associated with optimal change. Using principles to select interventions, rather than either supplying a menu of specific techniques or a list of brand-named interventions, characterizes the contemporary version of STS.

Keywords: empirically derived principles, psychotherapy strategies, human change, state and traits

Systematic treatment selection (STS) is an empirically based method for selecting and applying crosscutting principles of psychotherapy to behavioral health problems. The STS system is also a procedure for determining, selecting, and applying optimal treatment strategies to respond to the needs and characteristics of a broad range of patients (Beutler, Williams, & Norcross, 2008).

The development of the contemporary STS is the product of much research. This research began with an analysis and cross-validation of the principles of effective therapy (Beutler, Clarkin, & Bongar, 2000) and more recently by a task force that was charged with defining the basic principles that accounted for improvement in psychotherapy (Castonguay & Beutler, 2006). The latest distillation of the basic principles has been compiled by Constantino, Castonguay, and Beutler (in press). Collectively, the STS system has evolved through a two-pronged process of extracting and defining principles of change from extant literature and then testing their efficacy via confirmatory research. Concomitantly the process has been assisted by the development of measures that inform the clinician's actions and their supervisors through systematic and continuous feedback and feedforward loops. Specifically, the measures assess clients' characteristics relevant to treatment and beyond diagnosis as well as clients' circumstances. The measures also evaluate the therapeutic alliance. The scores from these measures are used, in turn, to choose the most empirically supported, clinically relevant intervention possible, ergo, systematic treatment selection.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION IN SYSTEMATIC TREATMENT SELECTION

Principles of Change

Principles of change are simply statements that express a reliably observed relationship between quality of interventions, participants, or context/relationship and improvement. These principles were founded in empirical research, by identifying as many variables as possible that correlated with positive patient change either directly or through a moderating/mediating process. The direct and indirect effects of these variables on outcome, as well as their relationships with other classes of variables, were catalogued. The subsequent list of correlates of positive outcomes was then subjected to a variety of cross-validation procedures in which the roles of mediators and moderators were identified.

Extracting constructs that reliably predict change required, first, an exhaustive review of empirical literature. Accordingly, Beutler and collaborators (Beutler & Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000; Beutler & Mitchell, 1981) undertook several substantial reviews of the psychotherapy literature. These reviews focused on identifying correlates of change within the general psychotherapy literature as well as within the literature on the treatment of depression, anxiety, and chemical abuse. From these reviews a list of patient and treatment variables that related to positive outcomes was extracted. The list was further reduced by finding common terms and categories, each one combining similar constructs under a single label (Beutler, Clarkin, & Bongar, 2000).

The constructs emerging from these reviews were of two general types. Some variables were observed to play the role of activators or mediators of change, while others exerted a differential or moderating effect on outcomes. For example, the therapeutic relationship was usually observed to be a mediator of change, while variables like client resistance emerged as having moderating effects on treatments, even to the point of serving as a differential determiner of what procedures were effective (Beutler & Clarkin, 1990). The varied ways in which the variables contributed to outcome were expressed in the articulation of the principles (Beutler et al., 2000).

Through the process of clustering and combining patient and intervention qualities, Beutler, Clarkin, and Bongar (2000) were able to reduce the variety of constructs that had been described in the literature to a manageable few. These observed relationships with outcomes constituted 13 of the 18 principles presented in Box 14.1. The remaining five principles in this initial system were derived from studies of clinician consensus in dealing with life-threatening self-harm. The principles derived focused on the interactive roles of three kinds of variables that contributed to change: (a) those associated with the states and traits of the patient, (b) those associated with the skill and use of interventions, and (c) those that constituted a fit between the previous two categories (patients and interventions).

As Beutler, Clarkin, and Bongar (2000) began consolidating lists of treatment-related constructs into principles, they grappled with ways to provide the clinician with meaningful guidance on how to apply those principles. They quickly saw the need for developing a measuring instrument to capture the expanding list of constructs that underlay the principles. Such an encompassing instrument would eliminate the need to use a large variety of separate instruments to capture the needed patient dimensions. The STS-Clinician Rating Form (STS-CRF) was developed (Fisher, Beutler, & Williams, 1999) as a research instrument and translated into a web-based assessment system (Beutler & Williams, 1999). The web-based program provided narrative and graphic data that were accompanied by an evidence-informed report that suggested an intentional program of treatment.

The STS-CRF assessed 17 patient symptom areas and eight patient and contextual qualities, now expressed in the 18 principles. These dimensions included level of impairment, level of social support, degree of complexity (comorbidity) of the problem, degree of chronicity presented, frequency of resistant-like behaviors, tendencies to use internalizing coping strategies when confronting change, tendencies to use externalizing coping strategies, and the level of subjective distress.

In 2008 the STS-CRF was revised and expanded in order to capitalize on what had been learned from the early application and to incorporate a variety of additional principles that had emerged from the literature (Castonguay & Beutler, 2006; Constantino, Castonguay, & Beutler, in press). The revised version, now renamed the STS/Innerlife (Beutler et al., 2008), evaluates and monitors change in 22 different symptom-focused areas. The evidence-based predictors were expanded to include seven quantitatively

BOX 14.1 18 Principles of Effective Psychotherapy

REASONABLE AND BASIC PRINCIPLES

Prognosis

1. The likelihood of improvement (prognosis) is a positive function of social support level and a negative function of functional impairment.
2. Prognosis is attenuated by patient complexity/chronicity and by an absence of patient distress. Facilitating social support enhances the likelihood of good outcome among patients with complex/chronic problems.

Level and Intensity of Care

3. Psychoactive medication exerts its best effects among those patients with high functional impairment and high complexity/chronicity.
4. Likelihood and magnitude of improvement are increased among patients with complex/chronic problems by the application of multiperson therapy.
5. Benefits correspond to treatment intensity among functionally impaired patients.

Risk Reduction

6. Risk is reduced by careful assessment of risk situations in the course of establishing a diagnosis and history.
7. Risk is reduced and patient compliance is increased when the treatment includes family intervention.
8. Risk and retention are optimized if the patient is realistically informed about the probable length and effectiveness of the treatment and has a clear understanding of the roles and activities that are expected of him or her during the course of the treatment.
9. Risk is reduced if the clinician routinely questions patients about suicidal feelings, intent, and plans.
10. Ethical and legal principles suggest that documentation and consultation are advisable.

OPTIMAL PRINCIPLES

Note: The original order of the principles has been rearranged to reflect some commonalities.

Relationship Principles

11. Therapeutic change is greatest when the therapist is skillful and provides trust, acceptance, acknowledgment, collaboration, and respect for the patient within an environment that both supports risk and provides maximal safety.
12. Therapeutic change is most likely when the therapeutic procedures do not evoke patient resistance.

Principle of Exposure and Extinction

13. Therapeutic change is most likely when the patient is exposed to objects or targets of behavioral and emotional avoidance.
14. Therapeutic change is greatest when a patient is stimulated to emotional arousal in a safe environment until problematic responses diminish or extinguish.

Principle of Treatment Sequencing

15. Therapeutic change is most likely if the initial focus of change efforts is to build new skills and alter disruptive symptoms.

Differential Treatment Principles

16. Therapeutic change is greatest when the relative balance of interventions either favors the use of skill-building and symptom-removal procedures among patients who externalize or favors the use of insight and relationship-focused procedures among patients who internalize.
17. Therapeutic change is greatest when the directiveness of the intervention is either inversely correspondent with the patient's current level of resistance or authoritatively prescribes a continuation of the symptomatic behavior.
18. The likelihood of therapeutic change is greatest when the patient's level of emotional stress is moderate, neither being excessively high nor excessively low.

defined treatment predictors (functional impairment, symptom severity, social support/isolation, chronicity, externalized coping style, internalized coping style, resistance traits), three nominal or ordinal predictors (readiness for change, preference for therapist, sexual minority stress), and other demographic status variables (e.g., age, education, ethnicity, culture, immigration status, etc.). Reliability and validity data have been supportive of the STS/Innerlife across cultures (Michelson, 2014; Regner, Kimpara, & Beutler, 2012; Song et al., 2015). The STS/Innerlife was introduced as a cloud-based, clinically sensitive instrument that presented an expanded list of options for the therapist, including self-help resources, and a self-help report for the patient, as well as expanded intake and progress reports both for the therapist and the patient.

It is relatively easy to define the principles that guide a system that is, in fact, built on principles. It is somewhat harder when the approach insists that those principles be based on sound scientific evidence. In a later section of this chapter we will describe research that the approach has generated and which provides an additional level of validity to the principles.

The 18 principles defined by Beutler, Clarkin, and Bongar (2000) were divided into Basic Principles and Optimal Principles. The former were comprised of principles that mediated change and that could be observed without direct access to the therapy process. In contrast, Optimal Principles were those that operated differentially—in other words, as moderators of change—and required a direct inspection of the therapist's interventions, which were then "fit" to the patient characteristics. These principles were the foundation for the construction and use of the first web-based version of the STS–CRF (Fisher et al., 1999).

The list of principles, which comprise the STS system, is not considered finite. New principles have been added to the algorithms predicting outcomes whenever it became apparent that these principles were empirically grounded and reliable. For example, a joint task force of Division 12 of the American Psychological Association (APA) and the North American Society for Psychotherapy Research (NASPR) expanded the list of principles across four diagnostic groups and separately identified mediating principles related to participant factors, intervention factors, contextual/relationship factors, and moderating variables related to the fit of therapy and patient factors (Castonguay & Beutler, 2006).

Observing that the resulting list of 61 principles was unwieldy and varied widely in the level of research support, a follow-up process of refining the principles and assessing their value by comparison to a stable standard of research support has been undertaken and its results are now available (Constantino et al., in press). This effort has reduced the number of well-established principles to fewer than 40 and has identified the level of research support for each.

As the STS/Innerlife conceptual system has been evolving, it has become clear that some of the evidence-based principles derived in these latter publications are particularly strong in predicting and enhancing therapy outcomes. With this awareness has come the concomitant awareness that the principles are relatively independent from one another and more or less additive in their effects (Beutler, 2009; Beutler, Moleiro, Malik, & Harwood, 2003). That is, even if one organizes the formulation around compliance with only a relatively small number of the most powerful principles, one can obtain very good predictions of outcomes (Beutler, 2009; Beutler, Moleiro, et al., 2003; Holt et al., 2015).

Case Conceptualization

In the STS system, case conceptualization and its concomitant case formulations are designed to be grounded on and informed by the existing scientific literature as distilled onto the therapeutic principles outlined in Box 14.1. Case conceptualization relies on extracting the patient qualities from the empirically derived principles and organizing these into a plan of operation. That is, the case formulation is simply a personalized description of the patient on the major variables that are inherent to predicting outcomes. Following the format of the STS/Innerlife, the formulation includes (a) a description of the dominant symptoms, (b) relevant demographic and preference background factors, (c) the level of impairment experienced in daily functioning, (d) patient coping style and expressed personality, and (e) level of anticipated resistance to expressions of help. An abbreviated list of principles that were extracted from a longer list of principles (Constantino et al., in press) is here used to illustrate the contents of the formulation. A list of eight principles (see Box 14.2) has been successfully used in the training of predoctoral psychology trainees and has achieved good benefits with their patients (Holt et al., 2015).

BOX 14.2 Eight Principles of Change in Innerlife

IMPAIRMENT-LEVEL PRINCIPLE

1. For all patients with moderate to severe impairment, the therapist should identify social service or medical care needs and arrange for attention to these needs. Those with low social support systems, in particular, need assistance from the therapist to develop social support and support services. This may mean the use of adjunctive group or multiperson interventions.

RELATIONSHIP PRINCIPLES (WORKING ALLIANCE)

2. Therapy is likely to be beneficial if a strong working alliance is established and maintained during the course of treatment.
3. The qualities of a good working alliance are likely to be facilitated if the therapist relates to clients in an empathic way; adopts an attitude of caring, warmth, and acceptance; and has an attitude of congruence or authenticity.
4. Therapists are likely to resolve alliance ruptures when addressing such ruptures in an empathic and flexible way.

RESISTANCE PRINCIPLES

5. In dealing with the resistant client, the therapist's use of directive therapeutic interventions should be planned to inversely correspond with the patient's manifest level of resistant traits and states. Nonconfrontational strategies are most helpful in working with such clients.

COPING STYLE PRINCIPLES

6. Clients whose personalities are characterized by relatively high "externalizing" styles (e.g., impulsivity, social gregariousness, emotional lability, and external blame for problems) benefit more from direct behavioral change and symptom reduction efforts, including building new skills and managing impulses, than they do from procedures that are designed to facilitate insight and self-awareness.
7. Clients whose personalities are characterized by relatively high "internalizing" styles (e.g., low levels of impulsivity, indecisiveness, self-inspection, and overcontrol) tend to benefit more from procedures that foster self-inspection, self-understanding, insight, interpersonal attachments, and self-esteem than they do from procedures that aim at directly altering symptoms and building new social skills.

READINESS PRINCIPLE

8. Clients who are in more advanced stages of readiness for change (e.g., preparation, action, maintenance) are more likely to improve in psychotherapy than those at lower stages of readiness (precontemplation, contemplation).

The principles listed in Box 14.2 were written in common language in order to be easily understood. This common language structure focuses the clinician on patient factors that activate and moderate treatment, rather than on superfluous factors that have more limited treatment value. To be responsive to the principles and to retain a focus on treatment rather than exclusively on diagnosis, the formulation calls for an assessment, first, of the patient's level of functional impairment (FI). FI level is comprised of four basic constructs: symptom severity, chronicity, comorbidity, and lack of social support (Someah, Stein, Edwards, & Beutler, 2015). In this process, it is helpful to explicate the way in which the impairment is manifested. Thus, diagnostic information is also relevant and especially important for clarifying the level of chronicity and the presence of comorbid problems.

Beyond FI, the principles guide the clinician to integrate into the formulation information about the patient's ability to form relationships and what form these relationships have taken in the past. Drawing both from the patient's history of making and breaking relationships and capacity for insight, this assessment also incorporates information about the patient's social support systems. Relatedly, information

is procured about how easily the patient is able to accept influence from others, and how that impacts both FI and patients' abilities to form relationships. In this instance, the information addresses how well the patient can accept the therapist's role as helper and dictates to the therapist, in turn, how to respond to the patient in developing a therapeutic relationship.

Personality factors are also addressed and are drawn from all of the foregoing areas of functioning to speak directly to how the patient copes and how effective such coping is. Patients vary in coping, both in style (internalizing and externalizing) but also in rigidity of coping and the inverse, how inconsistently they cope. That is, what combination of internalizing and externalizing strategies is used? What styles are dominant? How easily can a patient adapt his or her coping to the pressures of the environment? Are the patient's coping strategies sufficiently consistent as to make them predictable and stable?

STS case conceptualization and formulation are progressive, with each factor building on the last, and this is especially true of the individual's readiness for change. This variable permeates all other factors, being important to understand how impaired the patient is, influencing how readily the patient can form a working relationship, influencing the patient's ability to accept influence from others, and affecting how the patient will respond and cope if and when expectations are not met. The formulation, thus conceived, is helpful to the clinician, in part because each piece of the puzzle is focused on the most important question facing the clinician: How can this patient best be helped?

RESEARCH ON EFFICACY AND EFFECTIVENESS OF SYSTEMATIC TREATMENT SELECTION

Research on STS has focused specifically on validating the various principles informing the STS-CRF and STS/Innerlife assessments. The research itself has been of two types: (a) post hoc literature reviews and meta-analyses of the STS concepts as studied by other researchers and (b) ad hoc or "predictive," data-based research on different patient groups in order to confirm causal connections and to refine the principles to optimize time and outcomes.

Post Hoc Research Reviews

More than 15 reviews have been devoted to identifying predictors and correlates of therapeutic change (e.g., Beutler, 1979, 1983; Beutler & Clarkin, 1990; Beutler et al., 2000; Beutler & Mitchell, 1981). While these reviews all focused on ways to identify procedures that would be effective with different patients, the most important and inclusive of them was that by Beutler, Clarkin, and Bongar (2000). By the time this review was completed, it became clear that the original pursuit of a menu of techniques which would fit each patient type was futile. The basis of the treatment selection that we sought to develop shifted from an eclectic form, which focused on techniques, to an integrative, strategic, and principle-driven approach that focused on crosscutting principles that could be applied across patient groups and therapeutic models.

Nonetheless, defining principles proved to have its own problems, not the least of which was that the number of principles that can be identified can be almost infinite in length. The more principles, the more complex and difficult it may be for the therapist to incorporate them into an integrated program of treatment. As noted, the 18 principles defined by Beutler, Clarkin, and Bongar soon became 61 (Castonguay & Beutler, 2006) as more investigators were involved in the process. Thus, it became necessary to attend to the overlap and to redefine the list to ensure that all the principles were supported by a relevant and meaningful number of empirical studies (Constantino et al., in press). It also led to identifying the relative importance of the different principles (i.e., their level of empirical support and their power to predict) in order to make a meaningful curriculum for training and applying the STS model (Holt et al., 2015). Finally, it underlined the importance of using technology to help the clinician integrate the principles and to incorporate them into coherent treatment plans.

Some of these developments necessitated that we conduct meta-analyses on several of the principles in order to establish their predictive power (Beutler, Harwood, Kimpara, Verderame, & Blau, 2011; Beutler, Harwood, Michelson, Song, & Holman, 2011; Beutler, Malik, et al., 2003; Someah et al., 2015). By supplementing the studies conducted in our own laboratory with meta-analyses reported by others (e.g., Budd & Hughes, 2009; Norcross,

2011; Wampold, 2001; Wampold & Imel, 2015), Constantino, Castonguay, and Beutler (in press) were able to reduce the number of meaningful principles to a more workable number. Thus, the eight principles used in the study of psychotherapy training (Holt et al., 2015) and computations of the expected impact of using just four principles in clinical practice (Beutler, 2009) provided direction in how to reduce and integrate the list of principles. In all of these analyses, the effect sizes (*d*) for individual principles have ranged from .13 (Relationship principle[s]) to .83 (Resistance principle). Finally, the advent of the cloud-based assessment and treatment-planning tool (www.innerlife.com) provided a way to integrate the principles into a workable treatment plan.

Predictive Studies

Following the extraction of the 18 principles that formed the basis for STS, Beutler, Clarkin, and Bongar (2000) instituted a cross-validation study on a sample of 289 patients/participants drawn from seven independent studies conducted by four different research groups. The studies were included because they assessed various qualities and characteristics, including many of those extracted from the earlier research review. These qualities ranged from personality traits (e.g., coping style, resistant traits, impairment) to living contexts (e.g., social support, culture). For the cross-validation study each principle extracted from the archival research articulated the empirically observed relationship between outcomes and two or more variables representing patient qualities, interventions, or contextual/relationship factors. Because the original studies methodologies were similar, the seven data sets were subjected to a common procedure. Attempting to parallel the structure of a clinical practice, we trained five experienced clinical psychologists to serve as proxy clinicians in a clinical setting who could reliably rate the clinical processes using especially constructed rating forms. Proxy therapists received information sequentially, making decisions at each point that paralleled what would be required of an actual therapist on site. Intake data were followed by judgments about intake status and predicted change, in-treatment data were used to assess the role of process variables, and end-of-treatment data were assessed against the earlier predictions.

Drawing from the raw data in each study, the clinicians were randomly assigned to the 289 patients. The clinicians were first provided with videotapes of the initial interviews along with the results of at least one personality test given at intake (MMPI-2 or MCMI), a variety of symptom checklists, demographic rating sheets, and a pretest measure of outcome that would serve as an outcome measure (BDI, SCL-90, etc.), each of which had been administered in the various studies. The STS target predictor and outcome variables were extracted from these instruments. Videotapes were used to familiarize the proxy clinicians and raters with data on which to assess therapist compliance with the principles that matched intervention to STS dimensions over time. The categories of therapist behavior within the sessions at various time points were selected to correspond with those identifying desired therapist behaviors articulated in the principles as well (see Box 14.1). These intervention classes included methods of intensifying treatment (medication, multiple therapies, increased frequency and length of treatment, etc.), directive and nondirective interventions, insight-focused and symptom-focused interventions, arousal induction procedures, and emotional tempering procedures.

The constructs that constituted the first STS research assessment system proved to be well supported by extant research in the independent cross-validation and were found to be good predictors of outcome, earning an estimated effect size of 1.33. The STS system ushered in the initiation and publication of a series of studies, primarily using randomized controlled trials methodologies to further assess the predictive validity of the STS principles. Most of these studies focused on testing only one or two of the principles related to intervention–patient fit, yet the findings proved to be consistently supportive (e.g., Beutler, Moleiro, et al., 2003; Karno, Beutler, & Harwood, 2002; Harwood, Beutler, Castillo, & Karno, 2006).

Patient functional impairment (Beutler et al., 2000), resistance traits (Beutler, Harwood, Michelson, et al, 2011), and coping style preferences (Beutler, Harwood, Kimpara, et al, 2011) proved to have distinguishing and differential effects on outcomes, depending on their fit with different classes of intervention. Collectively, these treatment variables, along with the mediating influence of relationship quality, provided an additive influence in psychotherapy outcome (Beutler, 2009; Beutler, Forrester, Gallagher-Thompson, Thompson, & Tomlins, 2012).

Indeed, the more principles with which one complied, the greater the outcomes, across disorders and studies, even when the patients had comorbid and complex problems (Beutler, Moleiro, et al., 2003).

ASSESSMENT AND SELECTION OF PATIENTS

The STS conceptual system relies heavily on the assessment of the patient's traits, states, and problem areas as well as the qualities that comprise the interventions. The STS/Innerlife was developed to ensure an economical way to match treatment-relevant characteristics of the patient to the pattern and type of intervention that would optimize gains.

The intake evaluation consists of a clinical interview and an assessment of treatment-related factors described in the section of formulation and embedded within the principles presented in Box 14.2. The assessment may consist of a variety of different instruments or an instrument like the STS/Innerlife. The latter has the advantage of keeping the therapist focused on how the patient may be helped. It also has an advantage because the symptom elevations obtained from it can be tracked over time to mark change.

There are several indicators and a few contraindicators for treatment. If patients are willing to make changes, have some minimal skill to both focus on problems without excessive avoidance, and relate to people in a socially adaptive manner, they may be good candidates for psychotherapy. The STS system, however, does not restrict itself to planning psychotherapy, nor is the treatment restricted to a particular diagnostic group. The principles also relate to the use of medication, self-help and tertiary care facilities, and programmatic factors that are employed by an institution's staff (see Box 14.1). Thus, even if the patient is unable to relate to others in a socialized and nondangerous way, there are still strategies that can be applied to warding off danger and to overcoming resistance to change. Nonetheless, if a patient is actively psychotic, unable to develop relationships, and unwilling to enter treatment, the likelihood of any coherent and accepted treatment program being implemented is low.

Thus, the clinical assessment typically begins with a clinical interview that evaluates patient mental status, preferences, and both treatment and family history. The patient is then administered one of the forms of the STS, usually the STS/Innerlife via computer or, alternatively, a battery of tests that yields information on the major treatment-planning factors. If one is using the STS/Innerlife, graphic results are presented to identify the most problematic symptoms and their elevations, across 22 problem areas, and also to identify patient readiness for change, relative internalizing and externalizing characteristics, resistance potential, subjective distress, and level of risk for self or other harm, as well as other treatment-relevant characteristics. The narrative report provides some suggestions about selecting a manualized treatment that is compatible with these patient qualities and some recommendations for establishing the treatment environment and program in a compatible way.

The STS/Innerlife usually takes under 20 minutes to administer, depending on how many problem areas are found to be significant. The use of case-based logic allows the process to adjust itself to the patient's own responses, selecting or omitting certain questions to shorten the process as much as possible. Most literate patients above the age of 17 can respond appropriately to the items, although thought disorder and dishonesty may limit the accuracy of the results. The STS can also be used to monitor change over time, and the cloud-based narrative includes self-help materials for patients and a narrative report that is designed to help them understand their problems and the possible help available.

TREATMENT

To illustrate treatment decisions and their application, we will draw upon and explain in some detail the application of the eight principles presented in Box 14.2.

Principle 1: Impairment Level

This first principle pertains to the relationship between patient impairment and the intensity of treatment provided, suggesting that the more impaired the patient, the more intensive the needed treatment (Someah et al., 2015). Intensity, in turn, can be defined in many ways by the clinician (e.g., use of adjunctive therapies, increasing frequency or length, use of supplementary medications, increasing restrictiveness of the setting, etc.), depending in part on the therapist's clinical skills and theoretical leanings.

The STS/Innerlife provides objective evidence of several dimensions that collectively comprise a measure of functional impairment (Someah et al., 2015). These dimensions include symptom severity, chronicity/comorbidity, and (inversely) social support. Risk level is also measured by the STS/Innerlife and may provide some additional information about how impaired the patient may be.

Symptom intensity and chronicity/comorbidity as aspects of the impairment level of the patient can also be accessed through the patient's diagnosis. Functional impairment, and by implication, diagnoses have their greatest value for directing the clinician to consider altering treatment in two areas: (1) treatment setting and (2) assignment of medical and other adjunctive treatment modalities. Diagnostic conditions may also serve as indicators for the use of specific medications. Antipsychotics (neuroleptics), antianxiety drugs (anxiolytics), stimulants, antidepressants, antimanics, and various combinations of these drugs have specific effects on the nature of the symptoms that are reflected in these diagnostic groupings. Conditions that are serious, debilitating, or life-threatening (i.e., those indicating high risk or functional impairment) lead to the recommendation of treatment settings that are restrictive and protective (inpatient or partial-care settings). Serious conditions such as these also give rise to the suggested need for more intensive or long-term treatment or multimodal treatments. Among the diagnoses for which restrictive treatments must be given consideration are psychotic conditions, bipolar mood disorders, major depression with suicidal intentions, some organic disorders in which serious decompensation is observed, and acute substance abuse in which detoxification is required.

There is a third area of treatment that is also considered when assigning an appropriate intensity of treatment, one that is not easily identified through the patient's diagnosis but is described in the STS/Innerlife output—namely, the management of the treatment length, frequency, and type. Treatment intensity can be applied in many different ways, and there is little to indicate that one way is better than another (Beutler et al., 2000). Thus, adjunctive treatments, including family or group therapy, medication, and self-help groups, can often provide the needed intensity. Likewise, increasing the frequency and length of treatment, interspersing sessions with follow-up calls or e-mails, and other creative solutions can increase frequency.

Although diagnosis is a primary variable in determining the treatment context, the patient's access to a supportive social environment is also considered. Indeed, lack of social support triggers specific efforts to encourage social involvement, including the use of multiperson therapy. The role of social support plays an important role in the patient's successful outcome. For example, the patient's access to consistent social/familial support is a principal variable in determining whether improvement will persist after treatment (e.g., relapse) and is implicated in decisions to use family and group therapies. In using social support to make discriminating treatment decisions, it is often helpful to know how many (and what) individuals are geographically available to the patient, as well as the degree to which the patient feels supported by these people.

In problems characterized by low or moderate impairment levels, psychotherapy often becomes a more prominent part of the treatment than in very serious cases, and concomitantly, STS becomes an increasingly valuable way to effect change as the impairment becomes less severe (Beutler, Forrester, et al., 2012). Individuals whose impairment level allows them to be self-evaluative and to logically evaluate the choices that face them are potential candidates. If, in addition, they have a history of having supportive and caring relationships, with some degree of both giving and receiving nurturance, then the likelihood that they will be able to participate fruitfully in an outpatient treatment program is increased. These latter decisions are made through a review of the prospective patient's history, current support levels, and current functioning, and they are addressed in the STS report narrative.

Principles 2–4: Working Alliance

The patient–therapist relationship comprises a crucial set of principles that establish the efficacy of systematic treatment. The working alliance is the foundation of psychotherapy; it is only through a strong relationship that the therapist can induce and maintain receptivity to the treatment while seeking to meet the patient's preferences. Hence, it is important that the evaluating clinician take steps to counter any factors that might impede forging a working unit of patient and therapist.

In accordance with the three relationship principles (see Box 14.2), and after making decisions about setting and intensity of treatment, the therapist strives to present himself/herself in an empathic and caring way. This means that the primary task of this early phase of treatment is *listening*. The therapist must listen and the patient must experience and believe that he or she is being listened to for the relationship to develop. Howard and colleagues (Howard, Kopta, Krause, & Orlinsky, 1986; Kopta, Howard, Lowry, & Beutler, 1994) have identified three phases of treatment, the first being the restoration of hope. They observe that this initial phase is founded in the quality of the relationship and sets the stage for the success of all phases to follow: symptom change and character change.

When the relationship becomes strained or even ruptured, thereafter, the therapist must be able to recognize it and heal it again through listening and supporting. STS sets forth three steps that foster this healing (Beutler & Harwood, 2000). They consist of listening and affirming, questioning without defensiveness, and renegotiating the therapeutic contract. This three-step process is a distillation of the formulation by Safran, Muran, and Eubanks-Carter (2011).

Several methods are proposed as ways to help ensure that the treatment relationship develops in a helpful manner. One of the most frequently researched is based on assigning therapists to patients based on similarity of culture, gender, age, religion, preferences, and expectations, and still others are built on assigning similar and different values (see Castonguay & Beutler, 2006; Norcross, 2011). While all have been successful in at least some studies, a persistent problem with using strategies that assign specific therapists to patients is they require having available a large cadre of clinicians who fit all the available parameters of a potential match. Such a large number of potential therapists is usually outside of the realm of possibility in most clinics and outpatient practices.

Thus, while the STS system plans for the fit of patient–therapist preferences, beliefs, and cultural dimensions, the additional treatment plan calls for therapists to accommodate these factors and understand their significance so they can develop an appropriate response. The effective relationship depends primarily on the therapist's ability to listen and understand the patient as a cultural being, to jointly ponder about the role of family and cultural values, norms, and beliefs on presenting complaints and attempted solutions, and then to provide support without judgment.

Principle 5: Resistance

Principle 5 (see Box 14.2) indicates that the effective interventions suggested may vary in level of directiveness, with nondirective and evocative questioning being recommended for highly resistant patients and more directive interventions for nonresistant patients. Directive interventions require the patient to provide information, undertake certain behaviors, or attend to a particular stimulus. In other words, it requires a reciprocal response from the patient. In contrast, nondirective interventions place the therapist rather than the patient in the role of respondent. The patient expresses or acts in some fashion and the therapist simply tries to facilitate a continuation in the patient-selected direction of movement. Thus, reflections, clarifications, and restatements are the most used procedures.

Although the latter interventions may be used by a variety of therapists using a variety of therapy models, it is often with the assumption that the patient is being defensive or difficult. In contrast to the usual formulation of resistance, in STS, resistance is construed as self-preserving. Moreover, when resistance occurs, it is not embodied in the patient as much as in the therapeutic context. The context is often perceived by the patient as "dangerous" and to be resisted. If the therapist is sufficiently creative and nonconfrontative as to change or restructure the context in compliance with the associated STS principles, the environment may come to be perceived as less dangerous than before. It is likely, then, that the patient will respond with less resistance.

In contrast, patients who are assessed as being relatively cooperative are likely to benefit from therapist direction, instruction, guidance, interpretation, and structuring. In a review of a meta-analysis of resistant/reactive patients, researchers observed high effect sizes confirming that a patient's high-level resistance may be founded in a treatment that is poorly matched to the patient's manifest resistance (Beutler, Harwood, Michelson et al., 2011). Although further exploration of this phenomenon is needed, Beutler, Harwood, Michelson, et al. (2011) propose an interesting direction of research: the advantages of a direct

measure of the patient's resistance and, reciprocally, the therapist's level of directiveness.

Principles 6 and 7: Coping Style

Two STS principles that guide treatment formulations relate to addressing patient coping style (see Box 14.2). Together they indicate that the ways patients cope with personal and interpersonal threats bear a relatively strong relationship to how well they respond to the focus of different psychotherapy strategies. Moreover, the principles suggest that coping styles can be conceptualized as a pattern between two independent dimensions, *internalization* and *externalization*. In evoking change, the clinician addresses both the elevation of the two coping style dimensions and their relative balance. The principles, likewise, guide the therapist to respond with a corresponding balance of insight-focused and symptom-focused interventions (Beutler, Brookman, Harwood, Alimohamed, & Malik, 2001; Beutler, Harwood, Kimpara, et al., 2011).

Patients who cope with problems by externalization tend to blame others or objects when things go wrong, they fail to take responsibility, act out impulsively or rebel, become argumentative or vent out loudly, and engage in direct avoidance of problems. That is, they may leave treatment prematurely, seek to change therapists, or simply deny the problem. Such patients have been shown to become more responsive to treatment if it focuses on behavioral change and symptom reduction efforts, including building new skills and managing impulses, rather than to treatments that foster indirect change through insight and self-awareness (see, for example, Beutler, Harwood, Kimpara, et al., 2011). An externalizing coping style is considered to be an enduring trait and has been most widely measured by various combinations of MMPI scales, by the coping style scales of the STS/Innerlife, and by clinical impressions from the patient's history.

Alternatively, patients who cope with stress by internalizing responsibility, self-blame, heightened self-consciousness, and withdrawal tend to respond better to insight-oriented treatments than to behavioral change ones. In fact, in a meta-analysis of 12 studies, Beutler, Harwood, et al. (2011) found that patients whose treatment procedure was appropriately matched with their identifiable coping style had a 58% better outcome than patients who were randomly matched.

The method of addressing an internalizing coping style requires that the therapist have a personal map of what type of conflict and inner struggle is present if insight or awareness is to be achieved. The particular formulation or map to be used is not specified by the STS system. Instead, the map that guides the therapist to activate one or the other (or a mix) of these coping styles is determined by the therapist's own theoretical perspectives. Producing insight can happen in numerous ways, allowing for some flexibility in how the internal struggle is understood. Thus, by whatever means, there is a need for a therapist to have a theoretical system by which to understand internalizing problems and to complete the formulation for working with internalizing individuals.

Principle 8: Readiness

Finally, a patient's readiness for change is used in Principle 8 (see Box 14.2) both as a point of focus early in treatment and at the time of termination. Stages of readiness range from precontemplation, through contemplation, preparation for change, action, and maintenance (including slips, lapses, and relapses). Patients' stages of readiness for change are correlated with outcomes, are key to setting up follow-up procedures, and for building the initial relationship (Norcross, Krebs, & Prochaska, 2011).

The concept of readiness is similar in many ways to the concept of one's coping style. There is, however, a very important difference that has significant treatment implications. Namely, coping style implies the presence of a relatively stable trait, indicating that it is difficult to change, whereas readiness is more state-like and situational in nature. The distinction has obvious long-standing implications for treatment. A state implies that it is a fluid condition in which the patient can progress to more advanced stages of readiness and can regress to less advanced stages in relatively short periods of time.

Patients' stages of change are associated with the kind of objectives underlying the interventions most likely to be used to transition them to a higher point of readiness, and it is done in accordance with their coping style. For example, externalizing patients with little awareness of the impact of their behavior and with little motivation or thought about change may

benefit from a therapist that starts treatment with relatively confrontative interventions that raise and confront the patient with the problem. Obviously, however, the confrontation must not be so strong as to push the patient out of treatment. As the prospect of change and then a commitment to make a change become more prominent, the therapist can settle into the more reasoned objective of making direct impacts on symptoms, as dictated by the patient's coping style.

In concert, the STS system suggests that internalizing patients, who are at the action stage of readiness, can be encouraged to action through achieving knowledge about why they are avoiding action and the fears that may provoke regression of the readiness stage. Combining the recommendations for addressing the traits of internalizing and externalizing processes can be adjusted to fit the means to move one from one stage of readiness to another.

DIVERSITY

Diversity is central to STS. It is present in the very definition of therapy as well as in the recognition of the unique contributions made to treatment by a given therapist. It is also present in STS's regard of the patient as a cultural being and in the appreciation of the role of the therapeutic relationship and the interventions proposed. Specifically, in STS, diversity is involved in the definition of therapy as a sociocultural practice where trained professionals welcome and seek to understand patients' own take on therapy and on their presenting concerns, rather than relying on preconceived notions framed by diagnostic categories. Similarly, diversity in STS is present in the appreciation of therapists as practitioners engaged in a lifelong journey of developing themselves as culturally competent and humble human service providers who strive to become aware of their privileges and overcome possible prejudicial attitudes associated with their upbringing and current circumstances.

STS recognizes the crucial role that the person of the therapist plays in the provision of services. Therefore, STS emphasizes the cultivation of a broad latitude of acceptance and flexibility in the therapist as the fertile ground where a therapeutic relationship can grow. Moreover, diversity in STS involves the regard not only of therapists but also of patients as racial, ethnic, cultural, able, sexual, gendered beings who bring to the therapeutic encounter values, beliefs, and attitudes born out of their own histories and contexts. In STS, patients' stories are listened to, regarded, and appreciated in their own right and for the purpose of facilitating the establishment of a therapeutic relationship, an empathic human bond with potential healing features that are culturally sanctioned. Finally, in STS, diversity is present in the proper appreciation of the power differential involved in the relationship and in the variety of interventions utilized to develop and maintain the therapeutic contract. In other words, in STS, one size does not fit all; the intentional personalization of the treatment according to a range of patients' variables and systematically selected interventions is yet another way in which diversity is honored by STS.

It should be noted that several aspects of STS have been used and researched in many countries such as Argentina, China, Japan, Portugal, Spain, Switzerland, and the United States, tested with diverse samples in those countries, and developed in many languages, including Chinese, English, Japanese, Spanish, and Portuguese (see, for example, Beutler, Mohr, Grawe, Engle, & MacDonald, 1991; Corbella et al., 2003; Song et al., 2015; Wong, Beutler, & Zane, 2007). The overall findings indicate some robust cross-cultural similarities among some of the most important concepts informing STS, such as resistance, coping style, and internal and external distress. The studies also highlight some possible cross-cultural dissimilarities, depending on the nations involved, such as interpersonal differences in social distress, including isolation, withdrawal, and the involvement of others between US samples compared and contrasted to Chinese samples. Nonetheless, much remains to be studied, particularly with respect to other diversity dimensions, such as gender identity, religion and spirituality, socioeconomic status, among others.

CLINICAL ILLUSTRATION

Esperanza was a 45-year-old, married Latina female and mother of three children who presented to treatment due to a history of depression and domestic violence perpetrated primarily by her husband. She denied child abuse taking place in the home other than the witnessing of the domestic violence incidents. She had been married for over two decades and had experience mood difficulties since her

adolescent years. The reported domestic violence had been going on since early in their marriage and had exacerbated over the years. Esperanza, who achieved a fifth-grade education in Guatemala, her country of origin, worked as an independent house cleaner approximately 5 days a week. Her husband, Hans, an immigrant from Germany, worked in a machine shop; according to Esperanza, Hans had struggled with an intense relationship with alcohol that was ongoing at the time they met. Their three children were all in their early 20s and lived at home. The oldest had been physically abusive toward Esperanza on a few occasions, while the middle child had sought to protect his mother from the abuse and convinced her to seek services. She denied alcohol or drug use by her children.

Therapy started with an assessment of Esperanza's impairment level that showed a sizable concern with safety due to escalating violence in her home. Suicidality was limited to general ideas about being "better off dead," but she indicated no specific plan and shared a sense of duty to her children ("be there for them"). While initially reluctant, Esperanza agreed to consult with a local women's shelter, where she found safety for the time being. Meanwhile, a temporary restraining order was placed on Hans, and he eventually agreed to attend a batterer intervention program and drug abuse treatment.

Esperanza participated in outpatient psychotherapy with a bilingual therapist; the therapy was conducted in Spanish to honor Esperanza's preference. The therapist asked Esperanza about her views of psychotherapy, to which she responded with some familiarity since the owner of one of the houses she cleaned was a therapist. She was initially reluctant to disclose much yet felt that the fact that the therapist spoke Spanish made it easier to self-disclose over time. She agreed to complete the standard assessments in Spanish, though these were read to her due to limited reading proficiency on her part. Interestingly enough, this arrangement helped the therapist gain a better understanding not only of Esperanza's difficulties but also of her own elaborations on the questions being asked.

The results indicated a low resistance level and an internalizing coping style, which in accordance to the STS principles are best addressed with structuring interventions and exploratory strategies that emphasize self-understanding and insight, explore patterns of interpersonal attachments, and build self-esteem. As such, Esperanza experienced the initial recommendation by the therapist to seek help from a shelter as being "taken seriously for the first time," which in turn made her more trusting of the therapist. The therapist asked Esperanza about her views on her mood difficulties, which she indicated to be "character flaws." The exploration of her take on her own difficulties led to an appreciation of a strict, harsh upbringing that involved frequent corporal punishment.

Esperanza and her therapist worked together on expanding her views of self to include that of a devoted mother, a reliable worker, and a courageous woman who honored her son's pleas to seek help. As the working alliance grew stronger, Esperanza developed a kinder way to relate to herself, giving herself permission to express and accept appreciation of her strengths. Esperanza's abilities to engage and contribute to the therapeutic alliance were used to emphasize the importance of rebuilding her social support network in an effort to scaffold her incipient determination to redress her family circumstances. This proved to be a crucial matter in her path from victim to survivor of domestic violence as her social support network helped her stay the course when clinical and legal matters involved proved to be quite demanding and challenging of her time, attention, and stamina. Hans dropped out of his own treatment and engaged in actions that violated the restraining order. Esperanza's social support network and her therapist helped her remain committed to redressing her circumstances. A year into treatment Esperanza decided to relocate closer to one of her sisters in another state in the United States, and she did so together with two of her children.

CONCLUSIONS/KEY POINTS

STS is an empirically based, integrative psychotherapy approach in which practitioners are guided to attend closely to a set of clients' characteristics beyond diagnosis in order to decide on an optimal context in which to deliver the necessary treatment and to then structure the particulars of that treatment for a specific individual. Therapists' actions are informed by cross-cutting principles and strategies that research studies have shown to be most likely to bring about the desired change and guide the optimal process to arrive at such change. Furthermore, STS recognizes the importance of not only patients'

characteristics and treatment contexts but also of therapists' individualities, as all these dimensions together are likely to influence markedly the establishment of a therapeutic relationship and working alliance. For most patients, the therapeutic alliance is a means to bringing about the sought-after treatment gains, yet for some patients the vicissitudes of forming such an alliance may be the treatment itself.

In short, some key points that characterize the actions of STS therapists include the following:

- Evaluate patients along treatment-relevant dimensions such as their functional impairment, their ability to establish a therapeutic relationship, and/or possible obstacles that may prevent that, for instance, their level of resistance, coping style, and readiness to change.
- Concern yourself with patients' cultural norms, values, and beliefs that may influence presenting complaints, the perception of psychotherapy services, the course of treatment, and the preferred intervention modality.
- Engage in active reflection about yourself as a cultural being and mind the ways in which you can best facilitate patients' access to care and treatment adherence.
- Emphasize the importance of the treatment relationship and working alliance, stay attuned to alliance strains, and use empirically derived procedures to heal alliance ruptures.
- Match patients' characteristics (such as resistance and coping style) to the strategies to be implemented in order to maximize treatment gains.
- Attend consistently to patients' readiness for change as well as the evolution of such readiness throughout treatment.

REVIEW QUESTIONS

1. How does the STS define principles of change?
2. What does the STS identify as the three steps that stimulate healing within the relationship between a patient and therapist?
3. What did Howard and colleagues identify as the three phases of treatment?
4. Highly resistant patients benefit more from what type of questioning/intervention?
5. What do the authors of this chapter mean when it is posited that "one size does not fit all"?

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PART II

Psychotherapy by Modalities and Populations

15

Group Therapy: Theory and Practice

J. Scott Rutan
Joseph J. Shay

Abstract
This chapter spells out the uniquely healing forces present in group psychotherapy. We begin by looking at the social isolation in our society, which is manifest in the hungering for personal connection through internet groups. We discuss briefly the history of group therapy and note the various types of groups that are available and their particular benefits. We offer techniques for group formation and leadership, including how to screen members for groups and how to negotiate group agreements. Using clinical examples, we highlight the therapeutic forces at work in group therapy throughout the chapter. Finally, we summarize current research that documents the effectiveness of group psychotherapy.

Keywords: group therapy, power of relationships, change factors, group therapy research, group therapist roles

Why group therapy? Given the variety of psychotherapeutic interventions available to the clinician, is there any special benefit to group therapy as a treatment?

Human beings are social animals, meant to be in relationships. The extent of our ability to engage in intimate relationships can be said to determine our psychological health. Yet, as Shankar Vedantam (2006) wrote in *The Washington Post*, "Americans are far more socially isolated today than they were two decades ago, and a sharply growing number of people say they have no one in whom they can confide, according to a comprehensive new evaluation of the decline of social ties in the United States."

Although striving for relationships is universal, the path to gaining relationships is often more challenging now than in previous generations. One primary cause for these changes is the dramatic increase in mobility of individuals in society. Another is the way that technological advances have impacted modern communication and, as a consequence, relationships. No one can doubt that the Internet has become a central—and often beneficial—aspect of modern life. We search for data, we find pictures and videos, *and* we often seek relationships. Sites like Facebook, Linked-In, Twitter, Meet-Up, online dating services, forums, and blogs all provide opportunities to have "virtual" friendships, relationships with people never met "in person." But as Goleman (2013) notes:

> [S]ocial media … expose us to a large number of interactions with people we don't actually know and may never know, who are kind of secondary relationships.… But they have nothing like the emotional importance of the people we care about and love who are in our primary circle of friends and family. So what happens is that the relationships online often become very diluted.… The emotional brain and the social brain are designed for face-to-face interaction. You want to

> be able to hug the person, to hear their tone of voice, see their facial expression, understand their posture. This is what the social brain does in an instant: it creates a sense of simpatico, of rapport, that is almost impossible to duplicate in social media. (p. 109)

In recent years, we have learned that when the need for genuine connection is not fulfilled, it can lead not only to discomfort but to even more catastrophic outcomes. Luo and collaborators (Luo, Hawkley, Waite, & Cacioppo, 2012) studied 2,100 adults and found a significant connection between feelings of loneliness and mortality. Vaillant (2012), in his classic longitudinal study of 268 men, concluded that healthy attachments were not only desirable but "a matter of life or death" (p. 179).

Group therapy is a powerful way to address the interpersonal issues that lead to disconnection, disaffiliation, and distress. Moreover, group therapy is well suited to help people who suffer from self-esteem issues, anxiety, depression, and a host of other complaints that bring people to the clinician's doorstep. When people sit in a room together and share their experiences, whether those that occurred outside the room or those within the group itself, a process unfolds by which group members not only learn more about their thoughts, feelings, and actions but also are given the immediate opportunity to act differently based on this self-understanding.

There is more than one model of group therapy, just as there are multiple theories trying to explain it. Rather than enumerate the many theories that attempt to harness the power of groups, we will focus on what can happen in therapy groups that either cannot happen in individual therapy or will happen in diluted or different ways in individual therapy.

Let us first place group therapy in context by offering a brief history.

HISTORY

Most credit Joseph Pratt, an internist working at the Massachusetts General Hospital in Boston, with leading the first "therapy group" (Rutan, Stone, & Shay, 2007, p. 12). In July 1905, Pratt put together a group of 15 patients suffering from tuberculosis. This group would not look at all like the modern therapy group. The format was more that of a classroom lecture, with Dr. Pratt providing information about the disease to the group of his patients. Pratt's work is usually cited as the beginning of group therapy for two reasons: (1) this is the first known situation in which groups of patients could talk and learn about their common problem, and (2) it was the first known group in which patients had to agree to a common set of group rules before being admitted into the group. (The reader may wish to return to the first edition of this book in which Rosenbaum and Patterson [1995] provide a more extensive presentation of the beginning of group therapy in the United States.)

World War II provides a more practical beginning point for group psychotherapy as we know it. That war created far more patients with psychological distress than could be treated by available caregivers. The result was an attempt to reach more patients by collecting them in groups.

What happened, even in hastily constructed groups typically led by individuals with no training in group therapy or group process, surprised everyone. Just by being in groups, the patients seemed to do better. A focus of this chapter will be to elaborate on how and why this occurs. What happens when groups of individuals are put together that can lead to growth? Conversely, it is important to know what harm can occur in groups, as we see in such modern events as large-scale partisan scapegoating and small-scale school bullying.

Group therapy began as a pragmatic, rather atheoretical approach. Soon, however, various theories were articulated to explain what was happening in the process. For example, in the 1940s, when group therapy began, more or less as we know it today, psychoanalytic theory was dominant. Consequently, many tried to explain what happens in therapy groups in classic analytic terms. It was quickly realized, however, that the individualistic and dyadic bases of analytic theory do not fit well in the interpersonal world of groups. With the advent of the more interpersonal modifications of classic dynamic theory, such as object relations theory (Klein, 1946), self psychology (Kohut, 1971), Lacanian theory (Lacan, 1968), interpersonal theory (Sullivan, 1953), relational theory (Mitchell, 1988), intersubjective theory (Stolorow, Atwood, & Brandchaft, 1994), attachment theory (Bowlby, 1988), and the like, a more viable and accessible theoretical understanding of what happens in therapy groups emerged. Each of these modifications to classic psychoanalytic theory appreciates the

interpersonal nature of both the shaping and healing of personality.

In addition, cognitive-behavioral therapists (CBT) began employing groups to help members learn more about distorted cognitions that lead to dysfunctional lives, and dialectical behavior therapists (DBT) found that groups were especially good ways to impart their skill training.

Like the fable of the blind men trying to determine how an elephant looks, each of these theories illuminates part of the "truth." We are still seeking a comprehensive theory of personality that can persuasively illuminate the DNA of group therapy.

In the following sections, we will describe the factors that lead to growth and healing in groups, that is, the mechanisms of change, after which we discuss how to construct and lead groups in ways that will harness those factors most effectively.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS WITHIN GROUP THERAPY

Types of Groups

Therapy groups can be configured in many different ways, depending upon the goals of the group. The two major types of groups are time limited and open ended.

Time-Limited Groups

Many groups in clinical practice, including those in hospitals and agencies, are time limited in nature. The majority of time-limited groups are structured to meet from 10 to 20 weeks, but others can run for a year or two. The key is that they are contracted to meet for a specific number of sessions over a defined period of time, and this usually means that new members are not added once the group begins. When members cannot be added after an initial period, such groups are referred to as "closed groups." Time-limited groups are also focused on specific goals and/or populations and are typically formed homogeneously. For example, they can be formed demographically, such as women's groups, men's groups, lesbian and gay groups, veterans groups, and so on. They can also be formed according to life issues (divorce groups, crisis groups, grief groups, and the like). Finally, these groups can be formed according to diagnostic issues, such as groups for those experiencing eating disorders, social anxiety, breast cancer, or borderline personality.

Open-Ended Groups

Open-ended (or "long-term") groups provide a more extensive exploration of interpersonal styles and defenses. Whereas time-limited groups are typically formed homogeneously, the usual open-ended group is more a miniature facsimile of society, a heterogeneous group of individuals. Mature open-ended groups do best when the membership represents the diversity of the society at large. Furthermore, open-ended groups provide members the experience of comings and goings, as members terminate and new members join. Hope is a particularly important curative factor in these groups because nowhere else in psychotherapy can individuals observe the process working in others before they experience change in themselves.

Composing a Group

Beginning a group can be a daunting task. The first decision a group leader has to make is: What kind of group will this be? Is this to be a time-limited, homogeneous group, a CBT group, a psychoeducational group, or an open-ended psychodynamic group? Then the leader must decide how to compose the group vis-à-vis age, gender, and cultural diversity. Generally speaking, one can make the case that there is a group for everyone. Therapists run groups for children, for adolescents, and for adults of every age. In addition, although most groups are heterosexual in composition, there are groups formed by gender and by sexual identity. There are also therapy groups composed by cultural, ethnic, or religious affiliation, for example, groups for Latinas/os, African Americans, Asian Americans, indigenous people, Jews, Catholics, and so on. As suggested earlier, groups can also be composed along thematic lines, for example, groups for the bereaved or for survivors of trauma or cancer.

For the typical open-ended heterogeneous psychotherapy group, two overarching principles may help the leader in composing a group. The first is the "Noah's Ark" principle. The leader should try to

ensure that every member of the group has at least one other member with whom he or she can identify along some meaningful dimension, for example, having another member in the group who has never been married, or another who is also on medication, or another who has been psychiatrically hospitalized. The second is that every member of the group has at least some capacity for self-exploration, insight, and mentalization. This is less important in support groups, where members come to share a sense of having gone through a common painful experience or issue.

Screening Group Members

Having decided on the nature of the group, including its goals and composition, the leader then selects group members by screening potential candidates in individual screening meetings. Some therapists prefer to meet only once before having the individual join the group, while others will hold two or three preliminary sessions.

Although most groups are heterogeneous, the question in either a homogenous or heterogeneous group situation is the same: Who is best suited for a group therapy modality and who is not? As described earlier, certain characteristics make it more likely that one can profit from a group experience, and even with only a few of these characteristics, a group can be useful. Besides no preexisting relationships with other group members, Rutan, Stone, and Shay (2007, p. 114) list the following desirable attributes to be considered when evaluating individuals for group therapy:

- Ability to acknowledge need for others
- Self-reflective capacity
- Role flexibility
- Ability to give and receive feedback
- Empathic capacity
- Frustration tolerance

If someone has a high degree of each of those attributes, he or she would likely not need therapy. Potential group members are assessed on those variables to see if they have extreme impairments regarding these factors, and if so, they may not yet be ready for a group. Of course, this varies by the *type* of group one is forming. If one is forming a homogeneous, time-limited group, these considerations are less important than in a heterogeneous, open-ended group because the group roles and goals are more circumscribed and because all the members will share a common denominator that will help them achieve cohesion.

There are, of course, particular individuals for whom group is not generally considered a good choice. Often these individuals can successfully join a group after a period of individual psychotherapy. According to Rutan, Stone, and Shay (2014), poor candidates for group include the following:

- Individuals who refuse to enter a group
- Individuals unable or unwilling to keep the group agreements
- Individuals with whom the therapist is too uncomfortable to work
- Individuals in acute crisis
- Individuals with poor impulse control
- Individuals with certain character defenses (e.g., externalizing responsibility exclusively)

To summarize, when evaluating a potential group member, the question is not only "Is this a good candidate for group therapy?" but also "Are there any reasons why this person should *not* be in a group?" As suggested throughout this chapter, we hold that a majority of people who come to therapy come for help in their interpersonal relationships and therefore group is likely an excellent therapeutic disposition.

Preparing Group Members

During the process of screening a member for the group, the therapist is also preparing the member for the group experience. Though early dropouts are a fact of life in group therapy, good pregroup preparation increases the likelihood that members will remain in the group because they have an idea of what to expect. What, then, are the elements of good pregroup preparation?

First and foremost is the formation of the therapeutic alliance. Nothing is more central to a patient's successful experience in the group than to experience a solid alliance with the therapist. In the screening meeting(s), the therapist builds a preliminary alliance through expressing a thoughtful understanding of the patient's issues and communicating

an empathic appreciation of the struggles that the patient has undergone. At the same time, it is essential that the member also experiences a sense of cohesion with the entire group, which comes to serve as the group equivalent of the individual alliance.

Together, the patient and leader negotiate and collaborate on developing particular goals for the patient to work on in the group. Of importance here is that group leaders not impose their goals on the patient but listen carefully to elicit what the patient reasonably and realistically wants to improve in life. Notably, the goals that patients highlight in these early meetings often yield to other and at times even deeper goals as the group experience progresses. For example, the goal of improving one's social relationships, once accomplished, might be superseded by the goal of achieving a deeply intimate relationship with a life mate.

It is also important to impart information about how the group runs. Because most candidates for group therapy have little or no experience in an actual therapy group, the leader needs to describe the general structure and rationale of the group, and to help the candidate anticipate scenarios likely to occur. It is important for the leader to make clear that group therapy can involve tense and conflictual interactions that are both expected and ultimately helpful because they can lead to deeper self-awareness and personal growth. Leaders also make clear that they will be less active, as a rule, than the activity level one may have experienced from an individual therapist.

As a potential group member hears more about how the group works, she or he might become more anxious. This provides an ideal opportunity to explore the expectable anxiety for any member entering a group. By normalizing this anxiety and helping prepare for it, the therapist mitigates the group member's experience in the initial sessions when it is typical to wonder, "What am I doing here? Did I make a mistake? Why did the therapist put me in *this* group?" Not only are candidates typically reluctant to join a group, but once present they are often even more reluctant to be there. If fitting, the group therapist can point out how this very reluctance is precisely related to the reasons the individual is seeking therapy.

Another central task in the preparation phase is to present the group agreements and to receive the member's acceptance of these agreements. Such agreements (sometimes called the "group contract") vary depending on the type of group. Presenting the agreements to the member also provides information about how the group will operate.

We believe the single biggest error group therapists can make in leading open-ended therapy groups is *not* having a clear set of group agreements that members accept before entering the group. Even in homogenously composed, time-limited groups, it is very important to have an overt set of group agreements.

Typical agreements in an open-ended psychodynamic group are as follows:

- To be present each week, to be on time, and to remain throughout the meeting
- To work actively on the problems that brought them to the group
- To put feelings into words, not actions
- To use the relationships made in the group therapeutically, not socially
- To remain in the group until the problems that brought them to the group have been resolved
- To be responsible for paying the therapy fees
- To protect the names and identities of fellow group members
- To terminate appropriately

It is important to note that these are group "agreements," not group "laws." It is expected that at times members will honor other agreements, such as to family or work. However, having to bear responsibility for the group agreements not only increases the likely benefits to the group and the individual but also leads to useful clinical data in helping members understand how they deal with interpersonal responsibilities in other areas.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION IN GROUP THERAPY

There are several attempts in the literature to distill what might be called "therapeutic factors" in group therapy (Bloch & Crouch, 1985; Macaskill, 1982; MacKenzie, 1987; Yalom & Leszcz, 2005) irrespective of which particular theory is espoused. The most thorough-going model, offered by Yalom and Leszcz (2005), lists 11 therapeutic factors in group therapy. These are (1) instillation of hope, (2) universality, (3) imparting of information, (4) altruism, (5) the

corrective recapitulation of the primary family group, (6) development of socializing techniques, (7) imitative behavior, (8) interpersonal learning, (9) group cohesion, (10) catharsis, and (11) existential factors. As we examine each of these factors, we can see how they are uniquely present in group therapy.

1. *Instillation of hope.* Most patients enter therapy with some modicum of *hope* even if mitigated by the anxiety of exposing their issues in public or the reluctance to share the therapist. We can presume that most patients enter all forms of psychotherapy with some vestige of hope, or why would they arrive at all? But, in therapy groups, especially long-term groups, this hope is uniquely supported because individual patients can observe other group members improve even before experiencing their own improvement.

Example: Adele had been chronically depressed for many years. She felt hopeless that she could ever feel good, that she could ever find true love, that she could ever find a productive career. As Barbara was terminating her work with the group, Adele let her know that she had been a beacon of hope for her. "You were in the same hopeless place I was in. But you *did* get out of it, and it helped me realize that I could, too." From that point on, Adele was much more active and positive in both the group and her out-of-group life.

2. *Universality.* Many patients enter therapy feeling a profound aloneness, especially about the aspects of self that they consider shameful and have kept private. The feeling that "no one else is like me" is countered in powerful ways in therapy groups as individuals learn that their experience is typically more universal than singular. As Yalom and Leszcz (2005) state, "There is no human deed or thought that lies fully outside the experience of other people" (p. 6). The realization that one's private and often shameful experience is shared by others is itself quite healing. Groups are an obvious venue for helping patients experience universality.

Example: Carl was referred to a therapy group as part of his impaired physician status. He had been relieved of his hospital duties and stripped of his medical license due to alcohol and heroin addiction. In addition, his wife was divorcing him and his two adolescent children refused to speak with him. Carl was filled with shame. When he entered the group, he courageously reported to the group the full extent of his dilemma, and he waited to be chastised and criticized for being such a monumental failure. Instead, members began sharing *their* experiences of shame—the man whose affair cost him his marriage, the coach who inappropriately touched one of his players and was banned from all teaching and coaching, the priest who had engaged in sexual relations, and so on.

3. *Imparting of information.* Many types of groups rely on imparting of information. These "psychoeducational groups" include symptom-focused groups such as cancer support groups, eating disorder groups, cognitive-behavioral groups for social anxiety, and dialectical behavior therapy groups for patients with borderline personality disorder. While information is certainly imparted in all therapy groups, psychoeducational or theme-centered groups rely predominantly on this factor. In other theoretical approaches to group therapy, direct advice or coaching is not encouraged. In psychoeducational groups, however, members often give useful information to one another.

Example: Denise had come a long way in her therapy. A history of serious sexual abuse in childhood had left her far too wary to date or risk an intimate relationship. Now she was ready to try dating, but she had no clue how to go about it. While the group dealt primarily with her fears and anxieties about dating, they also managed to convey the safest and most successful online dating sites and the best singles' mixers as well as offering useful suggestions about writing her profile.

4. *Altruism.* Altruism, or selflessly helping others with no thought of return, can be a healing experience. In Judaism the word *mitzvah* captures this thought—the "doing of a good deed" can be self-enriching, though not at all the rationale for the act. Groups, in marked contrast to individual therapy, offer opportunities for members to be altruistic and to glean the results of such behavior.

Example: Earl had enormous self-loathing. In the group, Earl was open, candid, and risk taking; thus, he was beloved by the members, yet his self-loathing was so profound, he could barely accept or understand that the others in the group actually liked him and cared for him. However, when another member said one evening, "Earl, I think of you so often. When I was at rock bottom, you were the kindest person in my life. I cannot tell you how much that meant to me … how much *you* meant to me … how much you *mean* to me." Earl responded, with tears in his eyes, "I've never felt that I did anything positive for anyone in my life."

5. *The corrective recapitulation of the primary family group.* One powerful therapeutic phenomenon in psychodynamic psychotherapy is the occurrence of transference. In long-term groups, members often unconsciously react to various group members in ways that they react (or have reacted) to family members. Indeed, so powerful is this process that at times such reactions will begin on the group member's first day in the group!

In individual therapy, the therapist is the target of transference, while therapy groups provide many targets for transference. The multiple opportunities for distortions, projections, and misperceptions provide a rich source of data about the interpersonal interactions of the group that, in turn, provide the therapist and the members a clear window into the forces that have shaped the perceptions and interactions of the group members—and the ways these can land the member in trouble in life.*Example:* Frances typically presented a grumpy façade. She rarely smiled, was quick to anger, and uniformly critical of both the group leader and her group colleagues. She was difficult to like and often received that feedback from others. Not surprisingly, she had come to group out of a profound sense of loneliness and lack of friends. Typically she "heard" others as critical of her, even when they were not. And when she spoke, she would talk over anyone who tried to dialogue with her. One evening, many months into her group membership, she exploded, "This group is not helping. It is like my family. No one likes me. No one has anything positive to say about me. I feel here just like I did growing up." Fortunately, Frances was able to stick with the group, and from that moment things began to change. The group pointed out that her behavior invited them to respond to her in ways that she *expected*, not ways that she *wanted*. And Frances was able to let them know how painful her early years had been and how her expectation that people would not like her and would criticize her led her to keep people at a distance. It was not long after that when Frances related in the group that she had been making a few friends at work.

6. *Development of socializing techniques.* In individual therapy patients can talk about their difficulties in making friends and getting along with others, and they might even role-play with the therapist some new ways to interact. Therapy groups have the advantage of offering a more immediate opportunity to observe how others behave in similar circumstances. Furthermore, groups offer a safe environment for group members to try different behaviors for themselves in the here and now of the session.

Example: George was a man with schizophrenia who lived predominantly on the street. Nonetheless, more often than not he would remember to attend his hospital-based therapy group. George was a sweet and caring man who was well liked by his group colleagues. However, his personal hygiene was so poor that he arrived with a distinct and unpleasant odor each week. In one meeting the members began discussing washing clothes. In this seemingly random conversation, they covered how to use washing machines, how to separate colors from whites, and how much soap and softener to use. When the leader finally observed, "George, I think perhaps your friends here are suggesting you need to wash your clothes more often," George responded with surprise, "Really?" It soon became apparent that he had never thought of washing clothes and had never noticed his own unpleasant odor. He was pleased to receive this information and from that day forward arrived in clean clothes and without the distinctive odor. He also reported, with pleasure, that people now sat next to him on the subway.

7. *Imitative behavior.* Patients in individual therapy often model behavior after their therapists. The group environment, in which patients

can learn from watching and imitating many others, is a far richer venue. Individuals learn behavioral responses from the family groups in which they are reared, and often these responses are accepted as "givens." In groups, members observe other behavioral responses and, as a result, can decide to diversify their behavioral repertoire to more suitably serve their current life.

Example: Helen was raised in a very conservative, religious family in the Midwest. Sexuality was a taboo subject in the house, and she recalls hearing her father tell her mother to "dress Helen as dowdy as possible." She had come to group therapy to learn why she had such difficulty finding a life partner. In the course of her group she was fascinated by Peggy, a wonderfully playful and flirtatious woman. Months later, when Helen indeed fell in love and became engaged, she told the group, "If I had not learned to flirt from Peggy... and learned that it is okay to flirt from all of you ... I would never have met John."

8. *Interpersonal learning*. More than any other treatment modality, group therapy offers the best medium for interpersonal learning because it is, as suggested earlier, a social microcosm. This is perhaps its most powerful feature. Group members bring into the group their personality, their relational styles, their patterned defenses, and their unexamined assumptions about life into the group. A careful exploration of how members perceive and engage in relationships in the room can provide a wealth of important experiences and observations that help members understand and change themselves. Indeed, in one research study in which group members were invited to rate what actually helped them in group therapy, three of the five items rated most highly were as follows: Discovering and accepting previously unknown or unacceptable parts of myself (rated highest); Other members honestly telling me what they think of me (rated third); and The group's teaching me about the type of impression I make on others (rated fifth) (Yalom & Leszcz, 2005, pp. 82–86). In each of the earlier examples, one can see how membership in a group can bring change through the interactions that occur each session.
9. *Cohesion*. For many group therapists and researchers (Budman et al., 1989; Burlingame, Fuhriman, & Johnson, 2002; Joyce, Piper, & Ogrodniczuk, 2007; Kipnes, Piper, & Joyce, 2002), group cohesion is akin to the therapeutic alliance in individual therapy. For any group to be maximally effective, there must be a sense of cohesion, a feeling that "we are in this together." This is confirmed by several research findings (Carless & DePaola, 2000; Yalom, 1975; Yalom, Houts, Zimerberg, & Rand, 1967). Often in groups, difficult or painful exchanges occur. In a cohesive group there is always the underlying conviction that the members are fundamentally trying to help, not hurt, one another. It is doubtful that the positive gains illustrated in the earlier examples could have occurred if those individuals did not feel a sense of cohesiveness in their groups.
10. *Catharsis*. Catharsis is the free expression of deep feeling. For many years this was held to be the primary healing factor in psychotherapy. In classic psychoanalytic theory, the goal of therapy was making the unconscious conscious, and a major vehicle for achieving this was the unleashing of previously repressed emotion. Josef Breuer (1842–1925) even developed a technique called "the cathartic treatment." Yalom noted that two of the top four items rated most helpful by group members were in the category of catharsis: Being able to say what was bothering me instead of holding it in (rated second), and Learning how to express my feelings (rated fourth) (Yalom & Leszcz, 2005, p. 84). In the heyday of experience groups (see Lieberman, Yalom, & Miles, 1973), the more raw the feeling evoked by the group, the better. In the current era, the expression of emotion is still considered useful and necessary, but it is not considered by most clinicians to be the primary healing factor. Nonetheless, groups tend to facilitate the experiencing and expressing of deep emotion.
11. *Existential factors*. Yalom grouped many things into this category. Coming from a theoretical basis in existential philosophy and theory, he pointed out that groups are excellent places for members to accept responsibility for their lives and to contemplate and consider the consequences of their decisions. In fact, tied for the

fifth most highly rated item by group members was: "Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others" (Yalom & Leszcz, 2005, p. 87).

RESEARCH ON EFFICACY AND EFFECTIVENESS IN GROUP THERAPY

Few clinicians doubt the benefits of group therapy, and the research bears out this conviction. There is ample evidence that group therapy of all types is an effective and valuable intervention modality. Burlingame, Strauss, and Joyce (2013) review the efficacy and effectiveness literature examining several hundred studies, which they divide into five categories: group interventions in which group treatment was primary (e.g., for mood disorders, social phobia, panic, obsessive-compulsive disorder [OCD], and eating disorders); adjunctive (e.g., for substance-related disorders and trauma-related disorders); occurred within medical settings (e.g., for breast cancer, and pain and somatoform disorders); treated severe mental illness (e.g., schizophrenia or personality disorders); or was compared for effectiveness to individual treatment. Their conclusion that group therapy is a powerfully effective modality of treatment is clear: "Taken together, the last decade of research … continued to provide clear support for group treatment with good or excellent evidence for most disorders reviewed (panic, social phobia, OCD, eating disorders, substance abuse, trauma-related disorders, breast cancer, schizophrenia, and personality disorders) and promising for others (mood, pain/somatoform, inpatient)" (Burlingame, Strauss, & Joyce, 2013, p. 664).

Although their focus is guided by the emphasis of the recent decade on rigorous empirical research, they make clear that they could also have criticized much of the randomized control research for "not explicitly incorporating group properties" (Burlingame et al., 2013, p. 640) such as the structure of a group (e.g., preparation, composition, selection, norming), group processes (e.g., role functioning, cohesion, group climate), and stages of group development.

How important is it to take note of such properties? In the case of group composition, for example, Piper and collaborators (Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007) found that "the higher the percentage of patients in a therapy group who had a history of relatively mature relationships, the better the outcome for all patients in the group, regardless of the form of therapy or the individual patient's quality of object relations score" (p. 116). Or, if we consider the important person-group (P-G) fit, in a study of incarcerated women who were members of a trauma recovery group, "change in P-G fit in terms of avoidance and conflict was found to be a significant predictor of change in PTSD and session attendance, respectively" (Piper et al., 2007, p. 107). Also, we know that arriving with better interpersonal skills and/or positive expectations about the benefit of group are "promising predictors of group process, outcome and retention" (Baker, Burlingame, Cox, Beecher, & Gleave, 2013, p. 299).

Of significant note is that the research literature is becoming increasingly sophisticated not only with respect to research design but also with regard to challenging the assumptions of prior research and theory. For example, there is a vast literature on the concept of group cohesion with respect to its relationship to outcome, typically concluding that there is a positive correlation with outcome (Burlingame, McClendon, & Alonso, 2011). However, when examined closely, as Bednar and Kaul (1978) put it, "there is little cohesion in the cohesion research" (p. 800). More recently, several researcher/clinicians have also questioned "the intuitive notion that cohesiveness necessarily leads to positive outcomes. To the extent that the need for harmony is prioritized over the need for personal expression, dissent, and challenge, then it could be that cohesiveness might have negative as well as positive implications for members of group therapy" (Hornsey, Dwyer, Oei, & Dingle, 2009, p. 267).

The clinical literature, partly guided by research results, has also become more nuanced. For many decades, for example, the stages of group development have been repeated as gospel to students of group therapy: forming, storming, norming, performing, and adjourning (Forsyth, 1999). Recently, however, Johnson (2013) points to research that storming does not always occur in successful groups or in particular kinds of groups, and when it does occur, it may not actually be helpful to the success of a group. Greene (2012), addressing the critique that outcome studies have "limited relevance or practical utility" (p. 325) for the clinician, is pleased that more recent research "is showing signs of redressing this limitation as it begins to reveal a growing appreciation for the

importance of studying mediating variables as part of the overall experimental design" (p. 326).

In this spirit, Rivera and Darke (2012) report on a group treatment program adopting an integrative focus, which appeals to the everyday clinician in that it addresses some of the concerns of an overly narrow approach being offered to a widely varying patient population. As they put it, "The scientific literature almost always focuses on the examination of distinctive packages of therapy, pitting one modality against another in the treatment of clients diagnosed with specific disorders, exhibiting a relatively narrow range of designated symptoms. However, in the day-to-day life of the group room, where therapists and participants struggle to ameliorate entrenched, complex, and multi-level symptoms, a range of interventions and modalities is required to ensure that the group program is as effective as possible for individuals with a wide variety of difficulties and capacities, and at differing stages of treatment" (p. 522). In their treatment model, they amalgamate three empirically supported therapies, namely, transference-focused psychotherapy (Kernberg, Yeomans, Clarkin, & Levy 2008), mentalization-based therapy (Allen, Fonagy, & Bateman, 2008), and dialectical behavior therapy (Linehan, 1993).

Finally, in recent years, growing attention has been given to the role of attachment difficulties in many forms of psychopathology, including the effects of attachment on the brain (Cortina & Marrone, 2003; Cozolino, 2006; Schore, 2003). In the past decade, group therapists have attended to this matter (cf. Flores, 2008, 2010; Markin & Marmarosh, 2010) as have researchers (Lawson, Barnes, Madkins, & Francois-Lamonte, 2006; Marmarosh et al., 2009; Shechtman & Dvir, 2006). In general, the research literature points to how one's entering attachment style affects group participation and progress and also how group therapy can improve the ability to attach.

The results about the benefits of group therapy are quite favorable. As Motherwell and Shay (2014) concluded, the research "confirms what for many therapists has always been evident, namely that group therapy is inimitably suited to help those with interpersonal issues which result in an ungratifying life" (p. 226).

DIVERSITY IN GROUP THERAPY

As suggested earlier, perhaps the greatest advantage of group therapy is that it can effectively serve virtually anyone who enters it because of its underlying support of diversity. What we mean here is that all groups will, in their nature, include people who are different from one another, whether markedly different in heterogeneous groups in which members vary in age, class, gender, gender identity, and so on, or even in homogenous groups in which members are selected because they share, for example, an identity (females), a gender identity (lesbians), a problem concern (cancer), an attribute (aged), a culture (Latinas/os), and so on.

In either instance, people can be very different from one another. Group therapy, unlike other forms of therapy, capitalizes on such differences. A goal of heterogeneous groups is to help members see how they are actually alike on many dimensions, and a goal of homogenous groups is to help members see how they are also different. In both instances, group members are encouraged to tolerate, appreciate, and value both the similarities and differences.

A surface understanding of what takes place in a group of gay men, for example, might have one think that the men share common and predictable experiences as gay men in society. As group therapy unfolds, it may expose the many differences in the histories of these men; in the nature of their relationships to others, men and women alike; and in their connections to the society at large. This can be enlightening to the group members in that they can simultaneously enjoy a bond of shared connection while appreciating the differences among them, resulting in knowledge and experiences that can be informative and even liberating.

This is similarly true with respect to groups that are composed heterogeneously or homogenously for age, race, ethnicity, culture, national origin, socioeconomic status, and (dis)ability. How critical it is for all of us to develop respect for how we are alike and how we are different—and group therapy is uniquely positioned to offer a context for this.

As a way to deepen empathic understanding in individual therapy, it can be very useful for the therapist to share important characteristics with the patient. "We are both in our 60s so, as your therapist, I may have a better window into your experience than a 35-year-old therapist." In group therapy, however, the young group therapist can count on the shared similarities of members in the group making less relevant what the therapist shares with the particular patient.

Having said this, is the therapist wiser to focus on similarities or on differences? Or, if both, what factors help in this determination? This leads to the basic question: How is the group most effectively used in the therapeutic process, bearing in mind the earlier therapeutic factors and also the diversity present in all groups. Depending on the focus of the group and its goals and format, different therapeutic factors will be emphasized.

Focus on the Individual

Sometimes the group serves as an audience to the work of the individual. Groups in this category can include psychoeducational groups, Alchoholics Anonymous and other 12-step groups, transactional analysis groups (Berne, 1964), or Gestalt groups (Perls, 1969). These groups discourage "crosstalk" and minimize the focus on interpersonal interactions, with either the leader providing information or individual members "doing their work" while the audience observes. These groups can be small or large, since many members can observe an individual at work.

Focus on the Group as a Whole

In other instances, the therapeutic focus is on the group as a whole rather than on individual members or on subsets of members. Following the tradition of Wilfred Bion (1960), S. H. Foulkes (1964), and the Tavistock Clinic in London, these groups study themselves. Very little individual, personal data are considered. Rather, the focus is on the working of the group itself. The theoretical premise is grounded in classic Gestalt psychology and holds that no individual can be understood in isolation because individuals exist only in social networks. By studying the group as a whole (the "ground"), the individuals who comprise it (the "figures") will automatically be influenced. Such groups can also be small or large, at times including several hundred members.

Focus on Group Member Interactions

The most common focus of therapeutic groups is on the interaction that develops among group members. These groups are typically composed of 10 members or fewer. Here, too, there are multiple approaches that focus on the way people relate in their therapy groups. For example, some practitioners focus only on here-and-now interactions occurring in the group, considering material brought from outside events and relationships to be a distraction and/or an avoidance. The underlying theory here is that people will always be themselves, and that whatever is most salient for the therapeutic process will reveal itself in the relationships that occur in the group. (Many therapists weave back and forth between the here and now and the there and then.)

Particularly in open-ended groups (see later discussion), relationships develop among members, and in these relationships members cannot help but demonstrate their characteristic interpersonal styles. To the degree that members honor the group agreement to be as honest as possible, these groups provide a unique opportunity to gain feedback on how one's interpersonal understanding is faulty or how one's interactional style impacts others. As Robert Burns wrote in *To a Louse*, "O wad some Power the giftie gie us, to see oursels as ithers see us!" (Oh would some Power with vision teach us, To see ourselves as others see us![1]

TREATMENT AND CLINICAL ILLUSTRATIONS

So what does a group therapist actually *do* to facilitate the curative factors in therapy groups? Many therapists in training or early-career professionals express a fear of leading a group. There are not only more people in the room to understand and contend with, but they know from having observed some groups during training that the interactions can frequently get heated and intense. Sometimes the interactions include criticisms of the therapist that, unlike the individual therapy office, are made in front of a number of people, thereby exposing the therapist to anxiety or shame. In addition, therapists are not immune to the tendency to experience groups according to their own early family experiences.

Group therapy is considered by many to be more complicated than individual or couples therapy (Motherwell & Shay, 2014). There is so much to keep in mind. Rutan, Stone, and Shay (2014) list various *roles* and areas of *focus* that the group therapists must maintain. And these roles and foci will change

depending on the theoretical orientation of the group therapist and the goals of the group.

Roles

Group therapists must negotiate their roles along three axes. These are activity/nonactivity, transparency/opaqueness, and gratification/frustration.

Activity/Nonactivity

In many psychoeducational groups or other time-limited groups, the group therapist is typically more active than the leader in an open-ended psychodynamic group. All group therapists are always "active" in terms of listening, assessing, and understanding. But, depending on the therapeutic factors they rely on and the goals of their groups, some will be less verbally active. For example, in the first meeting of a time-limited or psychoeducational group, the leader might be quite active in assisting the members to get to know one another. In a psychodynamic group, on the other hand, the leader would be far less active in order to observe the greeting style that each member brings to the group.

Transparency/Opaqueness

Psychodynamic therapists are usually on the opaque side of this axis because they want to follow the natural group process without unduly influencing it. In many homogeneously formed groups, such as groups for substance abusers or trauma survivors, the leader may have disclosed having had the same problem in his or her life. In such instances, the leader is much more transparent. For example, if the therapist has to cancel an appointment due to a "family illness," those therapists relying less on transference would probably be quite transparent in letting the group know who was ill and how ill they were. A psychodynamic therapist would not be opposed to sharing that information but would typically be opaque for a while in order to learn what fantasies the members might have.

Gratification/Frustration

Groups that focus on support rather than insight typically have leaders who are more gratifying, for example, overtly encouraging and complimentary to group members. Groups that focus on helping members gain insight into unconscious processes or motives can be more frustrating because leaders will allow more anxiety to develop as members act out their interpersonal issues. Leaders will vary on this axis according to how much affect they feel is needed for effective therapy or can be tolerated by the group to continue its work. In the earlier example of family illness for the therapist, those patients who were not immediately given information about the illness that resulted in a meeting being cancelled will likely feel frustrated, but for the dynamic therapist that is a small price to pay to gain access to fantasies and projections. So long as the patients understand that the therapist is acting on their behalf, and not sadistically, they are characteristically willing to pay that price.

Foci

Depending on their theoretical orientation or goals for the group, group therapists will focus on different areas. Rutan, Stone, and Shay (2014) describe the following areas of focus: past versus present, group as a whole versus individual focus, affect versus cognition, process versus content, and insight versus relationship. Although these are posed as either/or, in practice, most clinicians vary their interventions across the spectrum of these foci, depending on the particular nature of the group on any given day, the developmental stage of the group, and the needs of specific group members in a specific session.

Past/Present/Future

Janus is the Roman god who continually looks both forward and backward. This represents a useful metaphor as therapists consider how much to focus on the past, the present, and the future. Classic psychoanalysts focused on historic etiology of current psychopathology, and thus they would continually look to history to help understand the present. These therapists hold to the George Santayana's (1905) dictum, "Those who cannot remember the past are condemned to repeat it" (p. 284).

Other therapists assume that group members will bring all their personality traits and patterns into the group, and they will focus almost exclusively on the

here-and-now interactions between group members. Existential therapists focus on the future, both the predictable results of current decisions and grappling with the dilemma of finding meaning in a life clearly limited by time.

Group as a Whole/Individual

There are times when it is useful to use the power of the whole group. One example of this is when scapegoating occurs. Scapegoating is a common experience in groups and one that group therapists must always be attentive to. Historically, the scapegoat refers to the story in Leviticus (16:8,10,26) where the sins of the tribe are placed on a goat, which is then led off into the woods, symbolically freeing the individuals of their sins.

In groups, an individual is often singled out as the "cause" of the group's unrest or dissatisfaction. There is a sense the group would be far better if this person were removed, sent to the woods. Indeed, often individuals unconsciously volunteer for this role because it is an historically familiar role, where the individual has learned the "lightning rod" role to take on the negative feelings for the whole family.

In examples cited previously, both Frances and Judy were prime candidates to be scapegoated. Their prickly behavior did not endear them to their fellow members. Indeed, Kevin told Frances she was "driving me nuts," and Judy took on the role of the scapegoat and fled the group, leaving the group relieved that she was gone, though in this cohesive group she was able to return and learn from the experience.

It can be assumed that members like Frances and Judy often say things that others in the group feel but are reluctant to say. A classic group-as-a-whole therapist response on those occasions would be, "Perhaps Frances (or Judy) is speaking for the group." Indeed, one of the best ways to deal with scapegoating is to consider it from a group-as-a-whole perspective.

Affect/Cognition

Therapists of all persuasions face the dilemma of deciding how best to balance feelings with cognitions. Cognitive-behavioral therapists tend to work primarily in the cognitive realm, while dynamic therapists focus on affective issues, but there comes a time in even the most affectively focused therapy when some cognitive closure is important, and vice-versa.

In the earlier example of altruism, Earl is filled with feeling when another member tells him he has been important to her. The feeling itself is healing, but it is also important that Earl understand *why* he was so filled with feeling (namely, to understand that he has rarely experienced himself as an important and helpful person).

Process/Content

To the degree that therapists use unconscious processes as an important therapeutic factor, they will pay special attention to the process of the communications. In psychodynamic group therapy, it is assumed that at some level groups never change the subject. In the example of Bob, the content was about how to wash clothes effectively, but the deeper process had to do with the group's reaction to the odor resulting from Bob's personal uncleanliness.

Insight/Relationship

Freud posited that therapy worked by making the unconscious conscious. Kohut posited that therapy worked by the corrective emotional experience it offered. Those positions represent the poles of this insight/relationship axis. For those leaning on Freudian concepts, the group is used as a medium for providing insight. For those leaning on the more interpersonal theories, therapy groups are a network of relationships.

Groups are especially potent sources for interpersonal learning. Indeed, one could say the main therapeutic factor at work in groups is the corrective *relational* experience. In each of the earlier examples, the interpersonal element is present. Adele's experience of hope arose in the context of her relationship with Barbara. Carl experienced universality as his co-group members shared with him their shames. Denise was able to hear information about dating because she felt safe in the relationships she had developed. It was the familial relationships in her group that allowed Frances to recall and re-experience feelings from her childhood. Helen was able to gain new interpersonal skills by adopting behaviors learned from fellow group members. It was directly due to the relationships he had forged in his group that

Isaac could see and accept responsibility for how he "trained" women to disappoint him.

CONCLUSIONS/KEY POINTS

As this volume demonstrates, there are many successful paths to therapeutic intervention. We have indicated in this chapter that group therapy offers a unique path in that it addresses interpersonal problems which are possibly even more pervasive today than in the past. Many factors can be said to contribute to this increase in relational difficulties. For one thing, we live in an era of remarkable social mobility, which has fragmented the institutions of family and community (cf. Putnam, 2000). Another factor is the sizable increase of interpersonal communication through social media which, although having wonderful benefits, also has striking and yet to be completely understood drawbacks. As clinicians, we are witness to the fact that many individuals seek therapy for help with interpersonal issues of one kind or another. In such instances, there is arguably no more powerful modality than group therapy.

In this chapter we have (1) presented a history of group therapy, noting that it began as a powerful response at a time of need; (2) described different types of groups; (3) presented guidelines for composing a group and for screening group members; (4) suggested guidelines for preparing individuals for group membership; (5) underscored the therapeutic factors by which group therapy operates; (6) cited research that documents the effectiveness of group psychotherapy; and (7) underlined leadership roles and foci that vary depending on the model held by the group therapist. From its earliest inception as a therapeutic modality, group therapy has provided a unique arena for the expression and healing of interpersonal issues. Given the trend of society toward fewer social structures that offer group experiences in everyday life, we believe group therapy will provide an increasingly valued and singular therapeutic modality for interpersonal health and growth.

REVIEW QUESTIONS

1. Do all groups work in the same way?
2. What do therapy groups offer that individual therapy does not?
3. Which therapeutic factors are more relevant for which type of group?
4. What are the advantages and disadvantages of time-limited or open-ended groups?
5. Are time-limited and open-ended groups composed differently?

NOTE

1. Translated by Michael Burch. Available at http://www.thehypertexts.com/Robert%20Burns%20Best%20Poems.htm

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16

Family Therapy: Theory and Practice

Guillermo Bernal
Keishalee Gómez-Arroyo

Abstract
In this chapter we present an overview of the theories and practices of family therapy. First, we offer a brief discussion on the context that led to the development of the family therapy movement and the evolution of key theoretical approaches (i.e., systemic, behavioral, psychoanalytic, intergenerational, constructionist, and integrated). Next, the major theoretical constructs of family therapy and the theory of change of the model are presented. We summarize the available research on systemic therapies as well as how diversity is integrated in family therapies. The treatment procedures employed are discussed, and a case presentation is used to illustrate key aspects of both the case conceptualization and the interventions made with a Latina/o family struggling with the drug abuse of a family member.

Keywords: family therapy, contextual therapy, couple therapy, treatment strategies, diversity in therapy

The standard explanation for why family therapy arose is the frustration with individual approaches, particularly, psychoanalysis that did not seem to work well with behavior problems, schizophrenia, and children. Here we offer an alternative and more contextual explanation for the rise of family therapy. We hypothesize that social, cultural, and historical processes such as technological, economic, and political changes stress the so-called traditional family and that the system itself offers a response to these stressors with the emergence of the family movement to "treat" the stress or disruption. In other words, at the societal level, the family disruption is the "symptom" for which the broader system itself provides a remedy in the form of the family therapy movement.

The changes experienced by the family during the past 200 years, particularly in the industrialized world, have no historical precedent. Prior to the industrial revolution, the family engaged in tasks and functions that included the socialization and education of its members, care of the ill and elderly, economic support, food, shelter, and work. Other functions of the family included reproduction and satisfaction of emotional and affective needs.

With industrialization, social institutions replaced these tasks that served as the adhesive element for members of the family. The family changed from an organization based on multiple connections and activities to an organization almost entirely connected by emotional and affective expression. Thus, in contexts of advanced economic development, the contemporary family has become a social system almost entirely held together by the bonds of love and affection. A serious threat to the loss of love is likely to disrupt the family unit, if there are no other connections to sustain the system. Emerging problems within the

family required a new treatment. The inclusion of family members as a group in therapy sessions began in the 1950s and grew remarkably over the ensuing decades. Could the emergence of family therapy in the 1950 be a random occurrence? Based on events such as women having to leave the workforce and return "home" to make way for the men shortly after World War II, and the idealization of the "nuclear family," it seems reasonable to assume that it was not coincidental (Bernal, Morales-Cruz, & Gómez-Arroyo, 2015).

Other movements such as family life education, child guidance, parent education, and a number of new psychotherapy modalities such as group dynamics, brief and couples therapy, and behavioral approaches impacted and intersected with family therapy approaches (Guerin, 1976). The development of family therapy began in different parts of the United States (e.g., Palo Alto, Philadelphia, New York, and Topeka) and then the movement went international. Some of the figures who helped advance a systemic approach were Gregory Bateson, Ivan Boszormenyi-Nagy, Jay Haley, Don Jackson, Christian Midelfort, Salvador Minuchin, Virginia Satir, Carl Whitaker, and Lyman Wynne (Goldenberg & Goldenberg, 2000; Gurman & Kniskern, 1991; Nichols & Schwartz, 2006). Also, the contribution of social workers such as Virginia Satir, Peggy Papp, Froma Walsh, Harry Aponte, Michael White, Doug Breunlin, Olga Silverstein, Louise Braveman, Steve de Shazer, Peggy Penn, Betty Carter, Braulio Montalvo, and Monica McGoldrick in the late 20th century are remarkable (Nichols & Schwartz, 2006). They had been working with the family as a social unit as well as the focus of intervention (Ackerman, 1961; Gurman & Kniskern, 1991). While these ideas were taking prominence, in the 1970s the marital counseling field was later merged with the family therapy movement (Olson, 1970).

The major family therapy schools in the United States differed in terms of their focus of intervention, techniques, and especially in the reformulation of individual problems as a family problem and the mechanism for maintaining the problem or symptom (Gurman & Kniskern, 1991). Embedded in systemic thinking is the interconnectivity of events and that the dominant forces in our lives are not external to the family. Thus, therapy was oriented toward the transformation of interaction patterns that were hypothesized to maintain the dysfunction. A broader historical vision of the family was proposed by several key figures, expanding the nuclear notion of the family to include intergenerational (Boszormenyi-Nagy & Spark, 1973; Boszormenyi-Nagy & Ulrich, 1981), multigenerational (Bowen, 1972, 1978), family of origin (Framo, 1992), and contextual (Boszormenyi-Nagy & Krasner, 1980) approaches.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS IN FAMILY THERAPY

In the last 50 years, a wide range of family approaches has emerged. Prior to working with families, most of the family therapy pioneers were trained in general psychiatry and worked with children and families. Some of these pioneers were Gregory Bateson (1904–1980), Jay Haley (1923–2007), Donald Jackson (1920–1968), and John Weakland (1919–1995) in California; Murray Bowen (1913–1990) in Topeka and later Washington; Theodore Lidz (1910–2001) in Baltimore and then in New Haven; Carl Whitaker (1912–1995) and Malone in Atlanta; Nathan Ackerman (1908–1971) in New York; and Rosen, Scheflen, Birdwhistlein, Zuky, Boszormenyi-Nagy, and Salvador Minuchin (1921–) in Philadelphia (Guerin, 1976; Nichols & Schwartz, 2006).

The Mental Research Institute (MRI) developed the brief therapy approach (Gregory Bateson, Don Jackson, John Weakland, Paul Watzlawick, Lynn Segal, Arthur Bodin, Robert Fish, and Wendel Ray). The MRI as a project began with a research grant to study levels of communication. Several articles were published on the use of general systems theory, cybernetics, and multilevel human communication as a framework for understanding the family organization. One of the contributions was the article on the double bind theory titled "Toward a Theory of Schizophrenia." Bateson's work was central to the systems thinking and therapy in relation to family patterns of interactions that are connecting with communication levels theory (Bateson, Jackson, Haley, & Weakland, 1956).

Jay Haley was a distinguished member of Bateson's group; later in the mid-1970s he developed the strategic therapy based on much of the work of the master clinician and hypnotherapist Milton Erickson. The strategic family therapy hypothesized that most of the problems consist in hierarchy imbalance. A key focus is the identification of processes that maintain the problem or symptom that is assumed to have a protective function. The therapist's role is to design

interventions aimed at destabilizing and challenging the resistance to change, and helping family members to resolve the present problem. The assessment in the strategic therapy entailed (1) identifying specific problem in family life cycle and their external stressors, as well as communication patterns and hierarchical roles; and (2) managing power and emotional issues.

Jay Haley and Salvador Minuchin developed key concepts on family communication and structure. Both worked to expand the strategic and structural family approach, respectively. Their models assume that healthy families have demarcated hierarchies between parents and filial units. These units can change through different family life cycle stages (i.e., modifying rules and roles from child to preadolescent stress). In structural family therapy, as advanced by authors such as Salvador Minuchin, Braulio Montalvo, Charles Fishman, Bernice Rosman, and others, the central hypothesis is concerned with the family capacity to manage the internal stress of life cycle changes in balance with the external stressors (Minuchin & Fishman, 1981).

Another approach that included family interaction is behavioral parent training, where cognition and behavior are sustained by repetitive patterns. The emphasis here is to identify the problem patterns and to teach skills to modified negative behaviors in family members. Initially systemic behavioral approaches were used to train parents to modify children's behavior (Patterson, 1970, 1975), and to work with couples (Stuart, 1969). Also, functional variations of family therapy focused their attention on the repetitive behavioral and communication patterns. Moreover, in Milan, the constructivist-oriented systemic family therapy group emerged that worked with the underlying beliefs and narratives that sustain the dysfunctional family patterns of interactions (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). Thus, therapy was directed at transforming the organization or interactional processes between family members (Goldenberg & Goldenberg, 2000; Gurman & Kniskern, 1991).

Other family therapy models such as psychoanalytic, contextual, and transgenerational therapy hypothesized that historical, contextual, and intergenerational processes shape the belief system and the family interaction (de Shazer et al., 2007). Interestingly, some psychoanalysts began treating couples by concurrent and conjoint sessions with husbands and wives. The psychoanalytic family therapy model is reflected in Bela Mittleman's words, as she points out the fact that in some cases relationship issues are more important than the individual intrapsychic representation: "Because of the continuous and intimate nature of marriage, every neurosis in a married person is strongly anchored in the marital relationship. It is [a] useful and at times indispensable therapeutic measure to concentrate the analytic discussions on the complementary patterns and, if necessary, to have both mates treated" (Mittleman, 1944, p. 291). Systemic thinking was expanded with the notion that historical and broader contextual forces influenced the family. Within systems thinking the idea was to move beyond the language of internal individual psychological constructs as well as beyond the power dynamics implicit in interactional and communication approaches. The search was for a language of relationships that would offer a broader vision of intergenerational processes and contexts (Boszormenyi-Nagy & Ulrich, 1981). Contextual family therapy was developed by Ivan Boszormenyi-Nagy (1920–2007) and collaborators (e.g., Boszormenyi- Nagy & Krasner, 1980; Boszormenyi-Nagy & Spark, 1973; Boszormenyi-Nagy & Ulrich, 1981). This approach was also complemented by the work of Murray Bowen with a multigenerational focus on the family system (Bowen, 1978) and by James Framo's (1922–2001) family of origin approach (1992). Multigenerational concepts generally entail at least three generations of the family as a means of understanding processes learned and repeated from one generation to the next.

The term "contextual" refers to the emphasis given to the context of intergenerational relationships and the balance of fairness in human relations. This context is characterized by the consideration of the welfare of all family members in current and previous generations (Boszormenyi-Nagy & Spark, 1973; Boszormenyi-Nagy & Ulrich, 1981). Boszormenyi-Nagy and Spark (1973) distinguish each individual in the family as a subsystem by studying the boundaries of those subsystems. The concept of boundaries refers to those characteristics that define the limits of the subsystem in terms of proximity and hierarchy (e.g., distinguish parents from children on the basis of authority). Boundaries are often manifested by rules that may be expressed overtly or covertly and from very concrete to abstract levels. The examination of boundaries usually provides information on relationships and the

distribution of power in the family. In addition to these generic subsystems, there are other subsystems originated on the basis of particular characteristics presented in the family relationships and referred to as coalitions or alliances from which, for example, dyads and triangulations may result. In coalitions and alliances, for example, boundaries may be represented by secrets that delimit a triangulated system. In this kind of system, for instance, two family members may exert some power over a third member by mutually sharing some information they conceal from the third party (Boszormenyi-Nagy & Ulrich, 1981; Bowen, 1972).

As the family system develops, boundaries in either subsystem are subject to change. Imagine the family system as a circle, when boundaries are established by who enters, comes out, who is related to whom, and what we allow inside the systems, and what not. Dysfunctional family systems may be characterized by either diffuse or unclear boundaries between subsystems, which are conceptualized as enmeshed and disengaged (Minuchin, 1974; Minuchin & Fishman, 1981). Enmeshed families have the circle closed and rigid for the exterior, but it is highly permeable and open in the internal area, where the family roles are not clear and change constantly. Meanwhile, in disengaged systems the circle is open to the exterior (e.g., permeable boundaries to extended family or relatives) but has rigid and close internal limits. Undifferentiated family ego mass or fused (Bowen, 1978), merged (Boszormenyi-Nagy & Spark, 1973), symbiotic (Searles, 1965), and those with rigid boundaries are disengaged or overly rigid relationships (Minuchin, 1974). A balance between firm and flexible boundaries seems to be the key element in healthy family relations. It should be noted that these concepts describing dysfunctional families are extensions of individual notions of pathology that value independence (e.g., individuation-separation) over dependence and are probably specific to Western industrialized societies. What is missing are constructs that value "interdependence," which is how the authors of this chapter choose to interpret these concepts in the family therapy literature.

The role structure is one significant aspect in the family system, because it is through roles that family members acquire a sense of identity and belongingness to the system. The term "role" describes a "function" given to a member by the family system and assumed by that member. Development of roles in the family is a complex process. It begins by one or more family members experiencing the need for someone to fulfill a particular function in the family system. Roles assigned to members in the family tend to be permanent, inflexible, discontinuous, and complementary. In complementary, for someone to assume a role in the family, someone else has to assume a corresponding position (Boszormenyi-Nagy & Krasner, 1980). Examples of complementary dysfunctional roles in the family may be as follows: the strong and the weak, the distant and the pursuer, the one who gives and the one who receives, and so on.

Communication is one of the major channels that regulate the system, the role structures, and its boundaries (Boszormenyi-Nagy & Ulrich, 1981). We are always communicating through verbal or nonverbal messages. Two elements can be distinguished in the message: (a) the "content" or overt information transmitted to the sender and (b) a covert element of the message, that is, a "statement" about the relationship between the people who are communicating. The content of the message is often expressed verbally, while the statement is expressed nonverbally. Agreement between the overt (content) and covert (statement) elements of the message results in an open and straightforward type of communication (Watzlawick, Beavin, & Jackson, 1967). Disagreements between the overt content of a message (e.g., "I love you") and the covert statement of a message (e.g., the person pulls away) are considered pathological.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION IN FAMILY THERAPY

"Change becomes necessary to re-establish the norm, both for comfort and survival" (Watzlawick, Weakland, & Fisch, 1974, p. 31). MRI brief therapy proponents argued that family problems are maintained by the wrong efforts to solve problems. Watzlawick et al. (1974) described this process as problem formation. Problems are considered as more than life difficulties, given that when a family comes to therapy, they are stuck or deadlocked. The view is that such deadlocks are created and maintained through the mismanagement of difficulties. This problem formation issue occurs when family members (1) do not recognize the problem as a problem

(by denying) (in other words, the family knows that actions or changes are indispensable, but no one takes action); (2) take action but at an inappropriate time (in other words, the family doesn't have the resources to handle the situation); and (3) take action at the wrong level or focus (Watzlawick et. al. 1974). In attempting to support changes, the therapist needs to answer two questions: How has the problem been maintained? And what is necessary to change it?

Theory of change in family therapy transcends individual psychology. Individual psychology, whether behavioral or psychodynamic, hinges on a need satisfaction as a goal of success in therapy (Boszormenyi-Nagy & Spark, 1973). The contract is individual and success is defined in terms of needs and satisfactions of the person seeking help. Change is viewed as either learning new patterns of behavior or personality change. Systems theory expanded the notion of change to the family context. Notions of structure, power, boundaries, hierarchy, and communications entered the language of change.

Principles of change in transgenerational family therapies examine the degree of emotional and intellectual differentiation in family members. A differentiated person can be engaged in a family system without participating in fused relationships. This is important for the development of a mature relationship with others. The Bowen therapy approach describes the emotional patterns of close family by the concept "nuclear family emotional system." The goal of therapy is to improve the emotional differentiation among family members. An undifferentiated family may transmit the relationship structures from one generation to the next. Thus, taking an "I" position is a way of detriangulating by stepping out of alliances or coalitions in the family system. Often it is difficult to separate oneself from emotionally charged family experiences. Emotions are neither good nor bad; they are inherent to the human experience. The important issue here is to distinguish between emotions that belong to oneself versus those that correspond to other family members.

Strategic family therapy frames the problems as a communication issue and focuses on reestablishing the hierarchy in the family. The therapist takes action to help the family change present family problems. Originally the MRI group conceptualized family problems as a process with the issue of power as secondary to the interactional patterns. Watzlawick, Weakland, and Fish (1974) proposed that the presenting problem was in fact maintained by repetitive behavior within the family. The focus of therapy is to identify such patterns by asking questions and prescribing tasks or homework to disrupt such patterns.

The structural family approach (Minuchin, 1974; Minuchin & Fishman, 1981) focuses on reorganizing the family structure so that there are clear boundaries between parental, marital, and filial subsystems. The hypotheses are that family enmeshment (diffused boundaries) or disengagement (overly rigid boundaries) undergirds the problem or symptom. The therapist focuses on the present interactions and restoring healthy (i.e., permeable) boundaries between subsystems. When balance in the structure is restored, the therapy may possibly conclude.

Most family theories of change hold an "interventionist" approach to change. The therapist observes the system and intervenes in one way or another to move it along. However, in a contextual approach the central question becomes who benefits the most from change, what change, and in whose interest? The implicit value is a participatory one in which all family members are involved in contributing to a change that is desirable and beneficial to everyone. Rather than incorporating notions of cures into the model with its emphasis on pathology, the preference is to consider the notion of "liberation" (p. 166)—a political rather than a medical concept (Boszormenyi-Nagy & Spark, 1973).

Change is an ongoing multilateral process that is part of dialogue and relatedness. The principle of change is viewed as a dialectical progression between conflicts of interest on the one hand and reflection linked to action on the other. By directly addressing conflicts of interest within the family, examining the burden and merits of various family members and their limitations, a context for dialogue is woven. The greatest liberating possibility for posterity lies within a dialogue of trust and mutual consideration. The dialogue supported in the contextual model of family therapy has a dialectical structure of reflection in the service of action and action in the service of reflection (Bernal & Flores-Ortiz, 1991). Action without a reflection of social, family, political, and economic context hinges on activism. Similarly, reflection without a commitment to action and reciprocity is an empty sort of analysis. The dialectic between action and reflection is an essential element of relational change.

Next, we review briefly the contextual family therapy (CTF) approach because it represents an integrated family therapy model and it is used later in this chapter to conceptualize a case. The case formulations in CFT takes into consideration (1) the definition of the problem in operational terms, (2) the exploration of previous solutions attempted, (3) the definition of a concrete and realistic change, and (4) the establishment of a plan that is then implemented to arrive at the expected changes. Contextual conceptualization considers four dimensions: (a) material or facts that include the biological predispositions and the events the family has experienced as a whole; (b) the psychological elements of particular family members; (c) the interactional patterns and role functioning of the system; and (d) the ethical-relational dimension that provides information regarding motivational elements underlying the structure and functioning of the family system.

Each dimension serves to clarify the relational foundation upon which the family system rests. The concepts of legacy and loyalty are central to understanding the historical context of the family, which may be influencing current relationships. The relational foundation of the family hinges on processes passed down from one generation to the next and is transmitted to younger generations. Legacies refer to imperatives based on earned entitlements from prior generations and denote a configuration of expectations originated in rootedness. These expectations can be described as an invisible set of rules or inherited obligations that stem from the universal implication of being raised by parents. Legacies are often inflexible and place the person in the role of a passive recipient of family history (Boszormenyi-Nagy & Spark, 1973). A common legacy is the expectation that children will continue family traditions. More specific kinds of legacies result from a variety of factors such as idiosyncratic facts and family pattern traditions (i.e., legacy of achievement, legacy of shame, loss, etc.) (Boszormenyi-Nagy & Spark, 1973). Legacies must be balanced against a variety of other claims in the life of the individual. Furthermore, while legacies are shaped by the actions of individuals in one generation, these actions become part of the legacy for the next generation (Boszormenyi-Nagy, 1972).

Loyalty is understood in terms of family relations, and it refers to a sense of adherence or bonding among family members based on earned merits. Thus, the concept of loyalty implies the existence of a structured group of expectations to which all members are committed. In this sense, loyalty can be described as an internalized obligation or commitment to a structured group of expectations in the family (Boszormenyi-Nagy, 1972). Loyalty may be expressed in two different directions: horizontal (toward the nuclear family) and vertical (toward the family of origin). A loyalty conflict occurs when these two horizontal and vertical loyalties clash. The conflicts become particularly critical at times in which there are imminent changes in the stages of the life cycle of the family. For example, loyalty may become a conflict at a time when the family is close to some kind of separation. Thus, on the one hand, there is an expectation for the young adult to leave the household, to become autonomous, and perhaps to marry or establish his or her own family. On the other hand, there may be the need for an equally competing expectation to remain attached to the family and fulfill loyalty obligations (Bernal & Ysern, 1986). Indeed, the capacity for family members to negotiate and through "individuation." Negative loyalties underline often invisible destructive forces that connect family members; these covert forces are identified as "invisible loyalties" and are considered a source of resistance to change. Contributing to the legacy through destructive actions in the present (such as drug abuse) is a form of invisible loyalty.

CTF promotes change in problem areas by helping the family to identify invisible loyalties and destructive entitlements and to develop a plan for more constructive ways to express loyalty. The therapist is concerned with examining the legacies in the family and supporting the demonstrations of loyalties that are nondestructive. The therapist supports initiatives from family members in personalizing their family history and owing their family legacy in efforts to find positive manifestations of loyalty. A second way the therapist promotes change is by facilitating trust building by focusing on a balance of fairness in family relations, examining the consequences of actions or inactions, and on improving dialogue between family members. Through the building of trust, therapy serves as a resource for problem solving and as a means of reducing symptoms in the family.

RESEARCH ON EFFICACY AND EFFECTIVENESS OF FAMILY THERAPY

There is evidence that supports the effectiveness of different systemic family therapies for a range of conditions and problems. A number of meta-analyses and systematic reviews have been published documenting the positive outcomes of family therapy. One of the early comprehensive meta-analysis was conducted on 163 randomized clinical trials (RCTs). Most clients in family therapy showed improved outcomes over those in the comparison conditions after treatment. More recently, two systematic reviews have shown that family therapy is effective for internalizing (Retzlaff, von Sydow, Beher, Haun, & Schweitzer, 2013a) and externalizing (von Sydow, Retzlaff, Beher, Haun, & Schweitzer, 2013b), conditions in children and adolescents. More specifically, brief strategic family therapy (BSFT) appears to be an effective treatment for conduct disorder and delinquency in adolescents (Henggeler & Sheidow, 2012; Robbins, Michael, Horigian, & Szapocznik, 2008), and for behavior problem and drug abuse (e.g., Szapocznik & Williams, 2000; Santisteban et al., 2003). Moreover, there is evidence in favor of strategic and behavioral family therapies for depression and for child behavior and problems (Steinberg, Sayger, & Szykula, 1997).

Several couple or marital therapy modalities such as behavioral, cognitive-behavioral, and insight oriented have empirical support (Shadish & Baldwin, 2005). Also, a meta-analysis of systemic couple and family therapy was performed on systemic and systems therapy with family, couple, group, and multifamily group therapy for the treatment of mental conditions. Family systems therapy was found to show positive results for a variety of conditions (von Sydow, Beher, Schweitzer, & Retzlaff, 2010).

Furthermore, there is strong support for the positive effects of family therapy treatments on drug and alcohol abuse, behavioral problems, child and adolescent disorders, conflict in couples, affective disorders, intimate partner violence, and health conditions (Retzlaff et al., 2013; Stanton & Shadish, 1997; Sexton & Datchi, 2014; Stratton et al., 2015; Tanner-Smith, Jo-Wilson, & Lipsey, 2013; von Sydow et al., 2010). With regard to drug-abusing adolescents, there is evidence favoring family therapy based on comparative effectiveness studies. Yet other types of interventions were found helpful in reducing drug abuse (Tanner-Smith et al., 2013). With BFST for adolescent drug abuse, the effects on family functioning were more or less equal to the control condition or other treatments. Adolescents in family therapy stayed in therapy longer than the comparison group, which is a positive outcome for treatment (Lindstrom, Filges, & Jorgensen, 2015). Another meta-analysis compared different models of family therapy (BSFT, multidimensional family therapy, and functional family therapy) for adolescent delinquency and drug abuse (Baldwin, Christian, Berkeljon, Shadish, & Bean, 2012). The findings showed that all the family therapy conditions were significantly better than treatment as usual and alternative therapies. Taken as a whole, there is evidence on the effectiveness of family therapy with adolescent drug abuse.

In terms of adult drug abuse one meta-analysis found support in favor of family therapy over counseling or individual therapy, peer group, and psychoeducational interventions (Stanton & Shadish, 1997). This meta-analysis entailed a total of 3,500 patients and family members. One unpublished randomized clinical trial reviewed in the meta-analysis was on intergenerational therapy based on CFT for the treatment of methadone maintenance patients in comparison to a psychoeducational condition (Bernal, Flores-Ortiz, Sorensen, Diamond, & Bonilla, 1990).

DIVERSITY IN FAMILY THERAPY

At the level of theory, most systemic approaches embrace culture, context, and diversity. However, as McGoldrick and Hardy (2008) have noted, multicultural aspects of contemporary society are often overlooked, with family therapy models assuming generalizability to all populations without regard to their cultural limitations. These authors called upon the field of family therapy to "re-vision" their theories, models, practices, and concepts, noting that many families either never make it into therapy or find other methods useful.

Cultural competence is a notion that has evolved over the years as part of the multicultural movement (Bernal & Domenech-Rodríguez, 2012). Cultural competence includes both process and skill components in connection with the earlier notion of the knowledge and awareness of the client's culture (Sue, 1998; Sue, Zane, Hall, & Lauren, 2009).

There is a wealth of literature on working with diverse populations and ethnocultural groups

(ECGs) with a variety of approaches. Some argue for the development of culturally sensitive treatments that are designed for particular groups (Hall, 2001), while others propose cultural adaptations of evidence-based treatments that infuse already established treatments with culture, language, and context (Bernal & Domenech-Rodríguez, 2012). Some professional organizations, such as the American Psychological Association (2003), have approved guidelines on multicultural education, training, research, practice, and organizational change. Recently, a two-volume handbook on multicultural psychology (Leong, 2014) appeared, and the *Journal of Cross-Cultural Psychology* published a special issue on cultural competence (Chiu, Lonner, Matsumoto, & Ward, 2013).

Family therapy scholars have written extensively on ways to step outside of the interior of the family and consider, as well, other processes such as culture and context. One early volume dealt with ethnicity and family therapy (McGoldrick, Giordano, & García-Preto, 2005) and was first published in 1982. Subsequently, a number of other important publications advanced the family therapy with African American families (Boyd-Franklin, 1989), Asian American families (Lee, 2000), Latina/o families (Falicov, 2000), and other ethnic minority families (Ho, Rasheed, & Rasheed, 2003).

Many articles have been written on engagement and recruitment of families into therapy (e.g., Bukstein, 2000; Curtis, Ronan, & Borduin, 2004; Retzlaff et al., 2013; Stratton, 2011; von Sydow et al., 2013). Sensitivity to culture, language, race, ethnicity, gender, and class is critical to building a context of trust. Also, basic clinical skills that deemphasize blaming and emphasize supporting all members of the family are essential. Thus, a combination of good clinical skills together with cultural competence is likely to go a long way toward facilitating engagement and retention of diverse families in treatment.

TREATMENT IN FAMILY THERAPY

Family therapy includes the identification of factors that maintain symptoms in the family system and the promotion of trust in family relationships.[1] In the contextual approach these goals are accomplished by examining the four dimensions with the family. The treatment described is a brief therapy of 10–12 sessions developed as part of a research project (Bernal et al., 1990). The treatment includes initial, middle, and closing stages. The main goals of the initial stage are (1) to engage the family in treatment, (2) to establish a treatment contract that includes the identification of specific areas of conflict to work on during therapy, and (3) to define the problem. The middle stage focuses on building trust, identifying factors that maintain the symptoms, and examining the consequences of maintaining a "status quo." Framo's (1992) intergenerational approach where family of origin sessions are used to diagnose how past family problems are relived in the present is also employed here. The latter aspect is examined simultaneously, as factors that are maintaining the symptoms are identified. The identification of such factors is achieved by examining the family system from multiple perspectives: (1) facts and events that affect the life of the family and impose limitations; (2) structure and functioning of the system, composition of subsystems from the family system, losses in the family and ways in which they have been coping; (3) ethical-relational aspects of the relationship among family members (i.e., entitlements, obligations, merits, debts, and, in general, the degree of fairness in the relationships among family members); and (4) legacies, invisible loyalties, and destructive entitlements.

The closing stage deals with two main issues. The first is designing a plan of action to make changes in areas of conflict. A key strategy is finding ways in which fairness in the relationships can be rebalanced, by building trust and/or rebuilding a support system for the family by supporting the reconnection among members of the system. The second issue is discussing termination (i.e., analysis of the process of therapy, evaluation of therapy goals) and conducting an examination of action plans to work on once the therapy terminates.

All the sessions include an update of events, and in most of the sessions a task (directive) is assigned. This task deals with specific issues discussed during the session. Tasks are evaluated in ensuing sessions. One of the tasks given to all the families is the construction of a family tree or genogram. Genograms serve as a resource to map family relations that contain the family's history, clinical information, stage in family lifecycle, contexts, and help to understand interactional patterns (McGoldrick, 2011). The genogram also serves as an intervention to focus on

individual and collective strengths and to explore unresolved conflicts; it also serves as an activity for all family members to learn about their history.

Basic Strategies of the Family Therapies

A number of principles and concepts govern the behavior of therapists conducting family therapy. These principles guide therapists' conceptualizations and interventions throughout the treatment process. The therapist works with the family from a position of fairness and concern for all family members, whether or not they are present in the treatment room or involved directly in the therapy. While there is an interest on the side of all family members, the therapist makes explicit imbalances of fairness, exploitation, or injustices in the family, and holds family members accountable for the consequences of their actions.

The multilateral partiality is necessarily multiperson oriented. The contract between the therapist and client includes the network of family relationships. Because the contract is multilateral or collective in nature, the goals of therapy are oriented toward maximizing the benefit for all family members (Boszormenyi-Nagy & Ulrich, 1981).

Treatment Strategies

Therapeutic strategies and interventions are based on challenging cutoffs, pushing for integrity in relationships, and pressing for the possibility of reconnections that build trust in family relationships. In other words, treatment strategies need to be oriented toward mobilizing human resources that exist in the family's context. Bowen (1978) defines emotional cutoffs as representing the unresolved emotional attachments to the family of origin. The way in which people separate or disconnect from the prior generation in order to start their lives in the present generation often reflects the severity of the emotional cutoff. Such cutoff or disconnection may occur through physical distance, infrequent contacts with family, or through denial or withdrawal; this notion is similar to the concepts of "rejunction" and "disjunction." Rejunction is a basic goal of CFT and signifies a process of reconnection based on multilateral fairness and the building of trust in relationships.

The treatment strategies are based on building trust with a priority of positive outcomes for future generations. The therapist's challenges of cutoffs and support for rejunctive efforts are central aspects of treatment strategies. Another element of treatment strategies is based on an understanding of the ethical-relational conflicts characterizing any one particular family. A "conflict of interest" may be defined as a condition in which the welfare interests among family members are in opposition.

The therapist works with the family and examines the ethical-relational issues; this notion refers to "the long-term preservation of an oscillating balance among family members, whereby the basic interests of each are taken into account" (Boszormenyi-Nagy & Ulrich, 1981, p. 160). The assessment of such conflicts of interests is critical, since interventions to follow are based on such conflicts. The therapist may help the family resolve such conflict of interests with interventions that range from arranging tasks, to comments, interpretations, paradoxes, and promoting dialogue.

One useful CFT strategies is parentification, defined as the "subjective distortion of a relationship as if one's partner or even children were one's own parent" (Boszormenyi-Nagy & Spark, 1973). Parentification represents a reconstruction of one's past relationship with one's parent in a current adult relationship or in a relationship with one's children. This process is important because, in a sense, parentified relationships comprise one of the essences of family therapy, not unlike how transference relationships comprise the essence of individual psychodynamic therapy (Bernal, 1982). Parentification is the process element that keeps families enmeshed (Minuchin, 1974), undifferentiated (Bowen, 1978), or fused (Boszormenyi-Nagy & Spark, 1973).

The parentification process becomes dysfunctional when it impairs the growth of one or several family members at any of the stages of the life cycle. For instance, in the case of a young adult with extreme difficulties in separating from his or her parents, the overriding sense of indebtedness for having abandoned or rejected his or her parents may be expressed by extreme devotion to his or her child, as if the child were the parent. Both of them attempt to remain loyal and to reduce the indebtedness to his or her own parents through extreme devotion to the child. The child is placed in an ethical-relational dilemma, where he or she is expected to behave both

as an obedient child and as a nurturing or protective parent.

Moreover deparentification is the ongoing work of the family therapist to reverse the dysfunctional family situation through a series of steps to rebalance the ethical-relational structure of family relationships. Because parentification has its roots in the previous generation, often to work effectively at deparentifying a family, several generations must be involved in the treatment.

Boszormenyi-Nagy and Ulrich (1981) proposed a few basic elements of the deparentification process: (1) acknowledgment of the parentified member's positive contribution to the family (legacy); (2) a period of examination and reflection with the parents on how they may have been parentified in their own families of origin; (3) an action component that connects the acknowledgment of the parentified family member(s) with the experience of the parent's parentification; and (4) an emphasis on how each family member can work toward rebalancing relationships and specifically underscoring how all family members can act decisively in improving the family situation. This last step holds accountable all individuals, including the parents or the parental surrogates, to make the needed changes in the family.

CLINICAL ILLUSTRATION

The Colón Family

In this section a case history is presented to integrate the theoretical material with the basic strategies of family therapy using a CFT approach for a family treated in 12 sessions. The family was recruited for treatment from a methadone clinic that was the site for a research project. This family was not charged for the therapy, and all sessions were video recorded. The names and some facts have been changed to ensure anonymity.

Three aspects are examined in this case: (1) relevant issues regarding family history, for example diversity differences and drug addiction issues; (2) therapeutic process addressing diversity and drugs problems; (3) conceptualization of the case based on the four dimensions proposed in CFT; and (4) conclusions are drawn regarding the therapy.

Family History

The Colón family is a couple: Esteban, 35 years old, and Claudia, 28 years old. Esteban has two younger brothers and a sister. His mother is from El Salvador (Central America) and migrated to the United States when she was young. The research team approached Esteban and Claudia, and they agreed to participate in the study. He said that he wanted to improve his relationship with Claudia, who was also motivated to undertake therapy for the same reason.

Esteban is a musician who abuses drugs and was enrolled in a methadone treatment program. He has been in and out of methadone treatment for 7 years. He started using drugs (heroin and cocaine) when he was a teenager. Out of the 7 years of treatment, Esteban stated that he had been drug-free for 2 consecutive years. During these 2 years he met Claudia. They dated for 6 months, after which they decided to live together. When Esteban and Claudia met, he was working with a musical group heavily involved in drugs. However, he managed to stay "clean." Esteban said that during a party with this group while Claudia was away, somehow he got drugs in his system and was dismissed from the program from which he was about to graduate. Esteban holds his friends accountable for this incident and expressed resentment with the methadone program for not believing him and not giving him a second chance. As a result, Esteban went back to using drugs. During this time he found support in Claudia and decided to give serious thought to getting "clean" again.

Esteban is the oldest of three children. His father is 72, and his mother is 60 years old.

His younger brother also abused heroin, and his sister is depressed. Father and mother are divorced. He described his father as abusive and as having many conflicts with his mother, who at times supported his addiction.

Claudia is from Nicaragua. Her half-sister died at age 17 in a car accident when Claudia was 8 years old. The accident occurred after a high school party and she had been drinking. Claudia's father also died under tragic circumstances. Both deaths were surrounded by mystery and perhaps "shame." The family suspects that he committed suicide. Claudia describes her father as a cold and detached person who came from a family with a history of numerous separations and losses.

Treatment Process

The treatment consisted of 12 interviews over 6 months. The therapeutic process can be divided into four stages: (1) honeymoon stage, (2) definition of the problem, (3) reaching a compromise, and (4) termination. The first stage lasted for the first and second sessions. In the first session, the couple identified goals for therapy. These goals were to work on problems such as (a) lack of trust, (b) difficulties communicating with each other, (c) difficult relationships with their respective families of origin, (d) Esteban's irresponsibility, and (e) Claudia's stubbornness. The first session also dealt with plans and expectations regarding the wedding. The goals from the point of view of the CFT were to help the couple (a) reach an ethical balance in their relationship based on fairness and recognition of obligations and entitlements, (b) build or restore trust, (c) reduce or eliminate symptoms, and (d) find more constructive ways the couple could use to express loyalty to their families of origin. The therapy was conducted in the preferred language of the couple, which was a mix of Spanish and English. Also, attention was given to the migration background of their respective families of origin and the legacy of loss in their respective families of origin.

The second session focused on events around the wedding. There was a sense of accomplishment expressed by the couple, particularly by Esteban. Manifestations of recent success on Esteban's part were, first, the wedding itself represented a statement of commitment and revindication to his fiancé, family, and friends. This statement was well accepted and recognized by the presence of family and friends at the wedding. Second, other signs of Esteban's success were the two jobs that he was holding.

The second stage (sessions 3–5) focused on the definition of the problem. This stage was characterized by intense and continuous arguments between the couple. Esteban manifested resentment and anger by what he described as Claudia's controlling attitudes and demanded recognition and acknowledgment from her for his efforts of revindication. Claudia, in turn, complained that Esteban was irresponsible and dishonest with her and had not changed enough. She expressed resentment, felt exploited by Esteban, and feared that he could betray and abandon her at any time, or worse, would continue exploiting her.

This stage dealt with the similarities between the couples' patterns of communication and the patterns used in their respective families of origin. Efforts were concentrated on examining Esteban and Claudia's roles in their families of origin. Recognition was given to both for the contribution they made to their parents in accepting these roles. The importance of settling old family accounts was stressed to help the couple free themselves from destructive roles and enabling them to work on the relationship they had with each other.

During the third stage (sessions 6–8) the couple was able to reach a compromise in their relationship. Discussions in this stage were less charged with resentment, were less intense, and the feelings of anger and frustration seemed to have diminished. The couple was better disposed emotionally and more ready to examine issues of trust in their relationship.

The last stage dealt with termination. Here the couple made conclusive statements about the commitments each made and the plans to improve the relationship in the future. Esteban reported that he had noticed some changes in his relationship with his parents, particularly with his mother.

There were some facts in the lives of the Colón couple that imposed conditions essentially unchangeable and to which they both had to adjust. The most immediate fact was the life stage the Colón family was going through as newlyweds. While the couple had been living together for a year prior to their marriage, they consolidated their relationship by making a commitment to marry. This commitment implied moving away from their families of origin and toward each other. Such movement required changes on different levels. First, both partners had to look less toward their family of origin for emotional needs and more toward each other. Moreover, the respective parents had to deal with the loss. This loss may have been significant in the case of the Colón couple because Claudia was an only child of parents who were approaching old age.

Other facts that the Colóns had to face were (a) Esteban's drug addiction, especially now that he was in the process of recovery; and (b) two tragic losses in Claudia's family, the death of her half-sister and her father. All of the aforementioned facts impinge directly or indirectly on the terms on which Esteban and Claudia based their relationship.

Esteban and Claudia seemed to be looking to the other for satisfaction of personal needs, and

Esteban has a history of being extremely dependent, irresponsible, and in need of someone to take care of him. Apparently, he found in Claudia the person that would, at least in part, respond to those needs. However, he also seemed to feel guilty for "taking" from Claudia and not being able to give as much in return. Paradoxically, Esteban felt that either relating to her on those terms (i.e., showing dependency and irresponsibility) or taking more charge of his life would result in losing his wife. She had made threats to abandon him if he didn't change; however, Esteban's efforts at independence were not well received or acknowledged by her.

Claudia also seemed to be in a difficult situation. She related to others taking charge of the situation, and in doing so, she felt exploited by Esteban. Giving acknowledgment and supporting Esteban's efforts to be more independent would result in her giving up her controlling attitudes, which was something she could not afford to do given her difficulties with other ways of relating. She appeared to experience much difficulty in giving acknowledgment, in part, because she did not receive much recognition from her father.

The relationship patterns used by Esteban and Claudia stem from their families of origin. Esteban's role in his family was the "scapegoat" and the "failure." Esteban's acceptance of this role seemed to serve several purposes: (a) it provided a focus of blame and accusation, thus preventing his parents from facing the problems in their marriage. As (Boszormenyi-Nagy & Spark, 1973) suggests, parents have a problem child instead of a difficult marriage. In this sense, accepting the role of the problem child (b) serves to give parents the opportunity to remain parents by continuing to care for their child, and (c) contribute to the stability of the family as a whole (an overprotective mother needs a dependent child and vice versa).

Moreover, the role assigned to and assumed by Claudia in her family was to be the strong one, the caretaker. This legacy seemed to have been transmitted, first, by her grandfather to her father and, finally, to her. Second, her maternal grandmother with whom Claudia, in part, identified transmitted it as well. This role of being the "strong one" in the family was given to her along with a sense of emotional detachment.

Both Esteban and Claudia shared a violation of trust in their relationship, as well as inequity and exploitation. Esteban acknowledged that he had received a great deal from Claudia during a time when he needed support the most. However, he feared that now, when he was trying to pay her back, she was getting even and sabotaging his efforts. Claudia, in turn, had the fear that Esteban was going to continue exploiting her or would betray and abandon her.

Not until the couple was able to recognize and acknowledge mutual entitlements and obligations were they able to define what was fair in their relationship. Claudia felt that she was entitled to expect Esteban to be responsible, stay away from drugs, and be honest with her. Esteban agreed that she deserved that and even more. He pointed out that he was attempting to pay her back by complying with her request that he be responsible and honest, and also by contributing to the financial support of the family, thus giving her an opportunity to attend school.

Several steps taken in the treatment of the family presented earlier were crucial. One can ask, How was drug abuse addressed in this therapy? The fact that Esteban was in a methadone maintenance program provided a context for the couple to address issues of trust in their relationship and with their family of origin. With Esteban's drug use essentially more or less under control, the couple could focus on working on their relationship. A first step is to ensure that the drug problem is being addressed, and in this case the methadone maintenance program was an important resource. Second, it was necessary to help the couple define the nature of the problem. In doing so, it was essential for the therapist to side with each member of the couple, enabling them to present their frustration and resentment in more constructive ways. This "multidirected partiality" is the basic method and a contextual principle that guides the therapist's action aimed at promoting an atmosphere of trust. As opposite sides of the conflict emerged, the couple was better able to decide on what was fair in their relationship. One important intervention in transcending the emotionally charged conflict in the therapy was to first review possible sources of the conflict stemming from the seemingly invisible loyalties from the families of origin, and second to elicit from the couple recognition and acknowledgment each deserved for the contributions made to their families through the marital conflict and drug abuse.

CONCLUSIONS/KEY POINTS

In this chapter we offered a brief historical overview of the evolution of family therapy, highlighting its social and historical context. A contextual thesis is proposed in which socio-cultural-historical processes stress the family on the one hand, while on the other, the broader context responds to the stressors with the emergence of the family therapy movement to treat or repair the family. The early developments in the family movement are presented, highlighting basic theories and practices of various family therapies as introduced by the early pioneers in the field that contributed to different family therapy systems approaches (e.g., behavioral, communications, intergenerational, psychodynamic, strategic, structural, narrative, etc.). How cases are conceptualized within a family systems perspective was presented with special attention to the principles of change used by different family system models. The available evidence on the various models of family therapy shows that there is a wealth of research pointing to the effectiveness of various family therapy approaches for a variety of conditions and populations. At the level of theory, most family therapy approaches embrace diversity; however, some scholars have noted that family therapy may need to "re-vision" its theory and practice to focus more adequately on multicultural processes. The basics steps in the family therapy of a couple were presented based on an integrative family systems approach. The systems therapies are an integrative, strength-based, and resource-oriented approach that can be applied to families and couples with multiple clinical problems.

REVIEW QUESTIONS

1. What are some of the conventional and less conventional explanations of the development of family therapy? Discuss the inclusion of the concept of "contextual" in family therapy.
2. Discuss the principles of change in family therapy and how these notions of change inform your case conceptualization and treatment.
3. What is the fundamental goal of family therapy, and what is the key methodological resource?
4. Describe the difference between a focus on interactions and communications and one on relational ethics.
5. What cultural competencies would help you in the delivery of family therapy?

NOTE

1. This section is based on a session-by-session *Manual for Intergenerational Family Therapy of Drug Abuse* developed by Guillermo Bernal, Yvette Flores-Ortiz, Carmenza Rodríguez-Dragin, and Guy Diamond as part of a clinical trial of contextual family therapy.

RESOURCES

Websites

Ackerman Institute for the Family: http://www.ackerman.org Video Gallery: https://www.ackerman.org/about-us/video-gallery

The Ackerman Podcast: http://ackerman.podbean.com

American Association of Marriage and Family Therapy: http://www.aamft.org/izmid15/AAMFT/Content/Resources.aspx

American Family Therapy Academy: http://www.afta.org/web-resources

The Bowen Center: http://www.bowencenter.org

Family Process Institute: http://www.familyprocess.org

Institute for Contextual Approach: http://www.acceptic bnederland.nl/en

Mental Research Institute: http://www.mri.org

Minuchin Center for the Family: http://www.minuchincenter.org

The Multicultural Family Institute (MFI): http://multiculturalfamily.org

An in-depth interview with Monica McGoldrick of the Multicultural Family Institute: http://www.psychotherapy.net

Psychotherapy videos https://www.psychotherapy.net/videos/approach/family-therapy

The Virginia Satir Global Network: http://satirglobal.org

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17

Electronic-Based Therapies: Theory and Practice

Alinne Z. Barrera
Meagan L. Stanley
Alex R. Kelman

Abstract
The use of personal and health-related electronic-based tools has grown rapidly over the past few decades. This chapter is an introduction to the use of electronic-based interventions for psychological issues, with a focus on Internet-based interventions. The Internet can be a valuable tool, providing up-to-date and reliable health information as well as effectively assisting in preventing and treating a wide range of mental and health-related illnesses. Whether used as a stand-alone intervention or as adjuncts to more traditional formats of psychological treatments, electronic-based tools and interventions may provide users with more anonymity and flexibility, thus allowing for a broader group of individuals to partake in affordable psychological resources. Individuals who have been chronically underserved are now better able to access psychological tools to reduce symptomology and augment functioning. As a result, electronic-based tools and interventions have been looked to as a means of coping with mental illness worldwide, thus having the potential to substantially reduce the global burden of disease.

Keywords: eHealth, mHealth, information technologies, communication technologies, Internet interventions, Web-based

The utilization, integration, and reliance on technology for personal, professional, and recreational purposes have increased significantly in the past 10–15 years (PEW Research Center, 2014). Mental health providers, systems, and professional organizations have embraced this innovative method of communication and service delivery (Kazdin & Blase, 2011). In recognition of this growing trend, this chapter presents an overview of the use of technologies to deliver psychological interventions with a focus on Internet-based interventions.

BACKGROUND AND EVOLUTION OF ONLINE INTERVENTIONS

Lifetime prevalence estimates of anxiety, mood, externalizing, and substance use disorders range from 18% to 36% (Kessler et al., 2009). Untreated psychiatric issues can impact an individual's overall health, productivity, and interpersonal relationships (Kazdin & Blase, 2011; Kessler et al., 2009). Unfortunately, however, individuals suffering from mental health issues generally do not have access to,

or seek psychological treatment from, health providers (Kohn, Saxena, Levav, & Saraceno, 2004). The limited number of trained professionals and budget shortages for mental health services in many regions of the world create barriers to accessing affordable and effective care (World Health Organization [WHO], 2009). Even when providers are available, psychological barriers to treatment exist, hindering those who need help from obtaining it. Individuals with limited experience or knowledge of the process of psychotherapy may find sitting face to face with a therapist to be highly unfamiliar or uncomfortable. Additionally, stigma associated with psychiatric conditions or psychotherapy may greatly impact an individual's decision to seek or stay in treatment once connected to a provider (Alvidrez & Azocar, 1999). Time constraints, transportation, lack of providers speaking the individual's preferred language, and inability to find child care are often cited as personal barriers to care for individuals from diverse ethnic and cultural backgrounds (Alvidrez & Azocar, 1999).

It is clear that psychological disorders contribute significantly to the global burden of disease (Kessler et al., 2009; Kohn et al., 2004). Fortunately, leveraging the appropriate treatment tools can combat this burden. There is growing evidence for innovative treatment modalities that take advantage of the latest technologies (Kazdin & Blase, 2011). Today, approximately 34% of the world population uses the Internet, with nearly all of those users accessing the web at least once per day (Internet World Stats, 2012). Internet usage between 2000 and 2012 increased significantly worldwide, with the greatest growth occurring in African, Middle Eastern, and Latin American/Caribbean countries. In the United States, 72% of Internet users look for health information online, with 35% looking for specific information about their own diagnosis and treatment needs (Fox & Duggan, 2013). More than half of those searching for online personal health information later seek follow-up care from an in-person health provider. This trend exemplifies the ongoing need to integrate electronic-based resources into face-to-face treatment practices so that the broadest group of individuals can be served.

With the reach of technology expanding among diverse populations across the world, psychological interventions targeting health issues can be disseminated at a much larger scale. Tools and interventions that utilize technology as a means of service delivery can potentially be accessible at any time or location, can provide anonymity, and may provide much-needed services to those who are unable to use or secure local resources. Traditional face-to-face psychological interventions continue to be the most common format for delivering treatment. However, given the barriers to care indicated, nontraditional interventions should be considered to help individuals who are unable or unwilling to seek in-person psychotherapy.

TECHNOLOGY-BASED PSYCHOLOGICAL INTERVENTIONS

As technology has progressed over the past several decades, the methods of delivering psychological interventions have also evolved. Telephone- and computer-based interventions delivered on desktop computers (e.g., CD-ROM) led the way to more advanced intervention methods using the Internet, text messaging, and mobile devices. Each mode of delivery has aimed to extend the reach of psychological tools, with the goal of reducing distress and improving overall well-being.

Telephone-Assisted Interventions

Evidenced-based treatments delivered over the telephone provide some of the first examples of psychological treatment not bound to a therapy room. In the 1990s, telephone-administered cognitive-behavioral therapy (T-CBT) emerged, with insurance and private medical groups providing 1-900 numbers, which offered counseling resources over the phone (Mohr et al., 2005). These services were among the first nontraditional, technology-based psychotherapy resources available to individuals who were unable to attend in-person treatment. Results of studies comparing T-CBT to in-person cognitive-behavioral therapy (CBT) found that both formats offered similar benefits (Mohr et al., 2005) and provided support for the advancement of remote psychotherapy.

E-Therapy

Although definitions vary, e-therapy (or online counseling) can be described as the delivery of psychotherapy via an active and ongoing interaction between a

mental health provider and a client through purely online communication (Richards & Viganó, 2013). E-therapy interventions can be a stand-alone service or used as an adjunct to other interventions. Regardless, e-therapy is therapist directed, thus involving a licensed or trained mental health provider leading treatment and providing the client support and guidance (Manhal-Baugus, 2001). For example, an e-therapist may communicate and interact with clients through the use of video conferencing, online messaging, or chat rooms.

Online Peer-to-Peer Support Groups

With the rise of Internet access across the world, people have greater opportunities for connecting online. Peer-to-peer support groups allow individuals to share experiences as well as provide and receive emotional support. Although these groups existed prior to the Internet, they have become increasingly more widespread during the Internet age. However, sufficient evidence is limited to suggest health benefits (Eysenbach, Powell, Englesakis, Rizo, & Stern, 2004). While some studies show desirable outcomes when the online peer-to-peer support groups were coupled with CBT interventions, the extent to which these groups contributed to the effects of these interventions is indistinguishable (Eysenbach et al., 2004). Further research is necessary before these types of support groups can be recommended with confidence (Eysenbach et al., 2004).

Internet Interventions

Internet interventions differ from e-therapy, such that the content of the intervention is in the form of a predetermined format that is often automated but can be enhanced with interactive features (Andersson & Cuijpers, 2009). Internet interventions are more likely to be synchronous, which allows users to receive immediate input, feedback, and suggestions based on how they are engaging with the intervention. Internet interventions have the ability to normalize and personalize mental health treatment by providing up-to-date and reliable information that can easily be tailored to the specific needs or characteristics of the consumer. Although tailored interventions require more sophisticated technologies, they may be more attractive to consumers who are seeking a greater level of personalization. Internet-based interventions can also be used as transdiagnostic interventions to target co-occurring issues within a single program.

Internet interventions can be further divided by the level of guidance or interaction provided by those delivering the intervention. Availability by phone or email to provide feedback, support, and encouragement is a typical means of interaction. In contrast, fully automated or unguided Internet interventions do not include the ongoing monitoring of the site or user input. Users may receive feedback or email messages, but the information provided is based on algorithms that are predetermined rather than responsive to real-time input by the user (Andersson & Titov, 2014).

In some instances, Internet interventions are considered to be nonconsumable. Nonconsumable interventions, which are often unguided and/or fully automated, can be reused without adding significant extra cost or need for resources such as time, trained professionals, financial support, and so on (Muñoz, 2010). In contrast, consumable interventions, such as an individual or a group psychotherapy session, cannot be administered more than once for the same cost and rely on the time of licensed mental health care providers (Muñoz, 2010). In this way, Internet interventions have the potential to reach individuals around the world for very little additional cost per individual.

Special Considerations for Online Interventions

There are ethical and practical concerns that need to be addressed in the delivery of technology-based psychological interventions. Competency and informed consent to engage in the intervention, understanding of the intervention content, and addressing issues related to adverse effects are a few of the major issues to consider when using technology to deliver psychological interventions. Data security and privacy are also of concern for both site organizers and users. Without the use of sophisticated encryption software, firewalls, and extreme caution by researchers and clinicians, the risk of exposing private and confidential information is a major concern (Manhal-Baugus, 2001).

Engagement in the intervention, adherence to the protocol, and the development of therapeutic alliances are clinical concerns that weigh heavily on

the impending impact of technology-based interventions. Adherence and engagement in Internet interventions is a factor that should be examined closely and is of particular importance given the high rate of attrition in online interventions (Christensen, Griffiths, & Farrer, 2009). Meta-analytic reports of Internet interventions for depression suggest that greater interaction and human support by the intervention organizers result in more positive outcomes (Andersson & Cuijpers, 2009; Cowpertwait & Clarke, 2013). Depression interventions that include personalized telephone or email reminders have been associated with lower rates of depression and attrition, and greater overall well-being (Cowpertwait & Clarke, 2013). Similar findings have been documented in behavior change health interventions where procedures aimed at increasing communication with users (e.g., messaging) produced greater effectiveness of the intervention (Webb, Joseph, Yardley, & Michie, 2010).

Online therapeutic interventions, like e-therapy, cannot rely on the benefits of the therapeutic alliance, which is a hallmark characteristic of successful psychotherapy outcomes (Norcross & Wampold, 2011). Not only is it more difficult to establish rapport via online communication, high-risk individuals may not receive the immediate attention and support that is found with face-to-face treatment (Manhal-Baugus, 2001). The loss of interpersonal cues, such as nonverbal behaviors or voice intonation, and the limited training available on how to be an e-therapist are factors that need to be examined further (Barak, Hen, Boniel-Nissim, & Shapira, 2008). Recent reports, however, provide evidence demonstrating the possibility of developing therapeutic alliances that are comparable to face-to-face psychotherapy (Richards & Viganó, 2013). Continued communication with users through telephone monitoring or electronic booster sessions, predetermined and personalized messages (e.g., text, email), or the integration of message boards, for example, may play a role in improving and maintaining the therapeutic alliance. Online resources to manage increased severity of symptoms, crisis, and ongoing support are available and should be made available to all participants of technology-based interventions. Ongoing monitoring of automated systems is definitely warranted with risk management procedures clearly delineated to participants who choose to engage with the sites.

THEORETICAL APPROACHES AND VARIATIONS OF ELECTRONIC-BASED THERAPIES

Currently, CBT is the leading theoretical orientation guiding online interventions for psychological issues, such as depression and anxiety (Cuijpers, van Straten, & Andersson, 2008; Griffiths & Christensen, 2006). CBT is a highly structured approach, in which the format and constructs are easily adaptable to text, audio, video, and other technology tools (e.g., text messaging). It is argued that users receive all the benefits of in-person CBT as through Internet-delivered CBT, but in a more easily accessible format (Postel, De Haan, & De Jung, 2008) with potentially greater breadth of material (Andersson, Carlbring, Ljótsson, & Hedman, 2013). As such, earlier electronic versions of CBT were initially text heavy or PDF versions of protocols that required downloading or reading materials on a computer screen. Consistent with the proliferation of technological advances, more recent intervention designs include enhanced delivery of content using interactive features such as text messaging and social media (Morris & Aguilera, 2012).

For CBT-based Internet interventions, online content can be easily divided into modules or lessons that include psychoeducational information and the teaching of specific skills, homework assignments, and self-guided exercises to complete during or between each lesson. There is significant variability in the format or preferred mode of delivery (e.g., self-guided, concurrent with another treatment), the level of engagement with the user (e.g., email, phone support, online forums), and how the input of new information is used (e.g., tailor intervention content or provide feedback). Contemporary behaviorally based interventions, such as acceptance and commitment therapy (ACT), have recently been adapted to electronic format. A series of prerecorded audio files of meditations have been incorporated into a mindfulness-based Internet protocol to treat anxiety disorders (Boettcher et al., 2014). A guided ACT Internet intervention was also developed to teach chronic pain coping strategies (Buhrman et al., 2013).

Problem-solving therapy (PST), interpersonal psychotherapy (IPT), and psychodynamic approaches are also available in electronic format. Warmerdam and colleagues (2008) examined a brief PST Internet intervention, which required users to engage in problem-solving steps through the use

of exercises, forms, and built-in feedback, over the course of 5 weeks. The intervention did not include audiovisual components, but support was provided via email contact with a practitioner (Warmerdam, van Straten, Twisk, Riper, & Cuijpers, 2008). In addition, Buhrman and colleagues (2013) found a self-guided IPT Internet intervention to be effective in reducing depressive symptoms; however, higher dropout rates were found for this intervention than with a CBT-based equivalent. Finally, a self-guided psychodynamic psychotherapy Internet-based intervention was created by Johansson and colleagues that included nine modules focused on psychodynamic principles and constructs related to depression (see Johansson, Frederick, & Andersson, 2013, for a detailed description). Each module encourages users to implement the strategies presented and to document their experiences in written format, which can then be shared with their therapist for feedback (Johansson et al., 2013).

RESEARCH ON EFFICACY AND EFFECTIVENESS OF ELECTRONIC-BASED THERAPIES

Regardless of theoretical approach, there is growing evidence that psychological interventions are effective when adapted and delivered over the Internet (Johansson & Andersson, 2012). We review their use with clients presenting with a variety of difficulties.

Depression

Depression has received significant attention in Internet-delivered intervention research with a large proportion evaluating the application of CBT principles. Researchers in Sweden have identified 20 controlled studies on guided Internet-CBT alone (Andersson et al., 2013). Current research on Internet interventions for depression demonstrates reductions in depressive symptomatology relative to controls, with comparable outcomes as face-to-face CBT (see Andersson & Cuijpers, 2009; Cowpertwait & Clarke, 2013; Spek et al., 2007). Across all of the reviewed nonpsychoeducational Internet interventions for depression, the effect was moderate for individuals experiencing depression, both at the subthreshold and diagnosable level of severity; Internet interventions that were adjuncts to treatment as usual, however, did not result in improved outcomes (Cowpertwait & Clarke, 2013). Finally, Internet interventions that integrated some level of contact with the research team resulted in better outcomes, particularly when guidance provided was practical and supportive (Andersson & Titov, 2014).

MoodGYM is an example of an Internet intervention that was developed to prevent depression in a community sample. Participants were randomized to the MoodGYM program, a psychoeducational website, or a control condition (Christensen, Griffiths, & Jorm, 2004). MoodGYM applies CBT principles of cognitive restructuring, positive activity scheduling, relaxation, and assertiveness training delivered in five weekly modules. Both active interventions resulted in greater reductions in depressive symptoms at posttest when compared to the control condition; however, only the MoodGYM condition demonstrated improved dysfunctional thinking when compared to the control condition. Based on results from a follow-up study, reductions in depression were maintained at 6 months only by those assigned to MoodGYM; by 12 months, individuals assigned to both active conditions reported greater reductions in depressive symptoms relative to individuals in the control condition (Mackinnon, Griffiths, & Christensen, 2008).

Postpartum Depression

The accuracy and quality of the resources available online about affective changes throughout pregnancy are variable, with a number of websites providing incomplete and possibly incorrect information (Moore & Ayers, 2011). Web-based PPD screening tools and educational resources have been received favorably by providers and postpartum women (Wisner et al., 2008). Internet treatment interventions for depressed postpartum women have successfully been implemented (Danaher et al., 2013; O'Mahen et al., 2014). Although limited to a few studies, Internet interventions to prevent PPD are in development and are currently being tested (e.g., Haga, Drozd, Brendryen, & Slinning, 2013; Jones et al., 2013).

The Mothers and Babies/*Mamás y Bebés* Internet Project was a fully automated, Internet-based, two-condition pilot randomized controlled trial designed to examine the efficacy of a web-adapted mood management prevention intervention (Barrera, Wickham, &

Muñoz, 2014). The study website recruited, screened, and randomized pregnant women to a mood management Internet intervention or to an information-only control condition. The self-help mood management intervention (*Mamás y Bebés*/Mothers and Babies Course, Muñoz et al., 2007) is guided by a CBT framework that incorporates social-learning and attachment theories to teach pregnant women how to foster meaningful relationships with their unborn and newborn baby. The intervention is delivered in eight separate lessons grouped by thematic module (thoughts, activities, interactions with others) and integrates cultural considerations relevant to low-income, diverse women. Preliminary analyses are currently underway. Given the global reach of this trial, additional cultural considerations related to pregnancy and motherhood, for example, are currently being identified and integrated into the next iteration of the Internet intervention.

Anxiety and Related Disorders

Internet-delivered interventions have been developed for panic, social anxiety, generalized anxiety, obsessive-compulsive, and posttraumatic stress disorder; stress and concern over health issues have also been examined and are grouped in this category. Based on a review of 18 Internet interventions targeting anxiety, all studies except for one social phobia program demonstrated significant results regardless of the type of control group employed (Griffiths, Farrer, & Christensen, 2010). For individuals with diagnosable anxiety disorders (panic disorder, social phobia, posttraumatic stress disorder, unspecified anxiety disorders, and studies that targeted both depression and anxiety), the effects of the interventions ranged from small to large (.29 to 1.74).

Internet-based CBT (iCBT) was as effective as face-to-face CBT for panic disorder, with and without agoraphobia, and resulted in a reduction of long-term social anxiety symptoms (Andersson et al., 2013). Additionally, iCBT demonstrated promising initial positive outcomes for generalized anxiety disorder (Andersson et al., 2013). A review of trauma recovery websites suggests that stand-alone self-help Internet interventions, as well as clinician-driven therapy with web-enhanced intervention tools, were associated with positive reductions in posttraumatic stress symptoms (Benight, Ruzek, & Waldrep, 2008). Stand-alone interventions applied mostly CBT principles, whereas therapist-driven interventions incorporated motivational feedback messages tailored to the participant's stage of change with the goal of encouraging engagement with the site. Limited data currently exist for severe health anxiety, obsessive-compulsive disorder, and specific phobia (Andersson et al., 2013).

The Online Anxiety Prevention (OAP) program is an intervention for participants who endorsed symptoms, but it did not meet diagnosis for a particular disorder. It was examined in a sample of university students with anxiety sensitivity (Griffiths & Christensen, 2006). The 6-week OAP intervention was based on a CBT framework comprised of six modules that discussed psychoeducation, relaxation training, interoceptive exposure, cognitive restructuring, and relapse prevention. When compared to a waitlist control, the OAP intervention was more effective at reducing cognitions related to anxiety; however, it was ineffective in decreasing anxiety symptoms (Griffiths & Christensen, 2006).

Alcohol Use and Abuse

Early Internet interventions for alcohol use were primarily focused on psychoeducational information, and assessing and providing feedback on reported alcohol use behaviors (Hester & Delaney, 1997). In a systematic review, Bewick et al. (2008) found that participants rated Internet interventions favorably: 80% found it helpful, 61% rated the feedback as accurate, 57% thought the material was interesting, and 20%–56% perceived the interventions to be useful in helping them modify their consumption, regardless of actual changes seen in behaviors.

Riper and colleagues reported on the positive effect of unguided and guided Internet interventions for problematic drinking (Riper et al., 2011), as well as for alcohol consumers who did not meet diagnostic criteria for an alcohol use disorder (Riper et al., 2014). Meta-analysis results indicate that relative to a control condition, Internet interventions were effective at reducing total alcohol consumption and increasing adherence to low-risk drinking guidelines (Riper et al., 2011). The authors highlight that these findings are better than or comparable to traditional interventions (i.e., face-to-face treatment in primary care settings, community-based bibliotherapy).

Tobacco Use

There are over 1 billion smokers worldwide with 6 million deaths each year caused by the consumption of tobacco products (WHO, 2014). Technology-based smoking cessation interventions that are computer or Internet based have the potential to make a significant impact on this worldwide epidemic (e.g., Myung, McDonnell, Kazinets, Seo, & Moskowitz, 2009). Automated, tailored Internet-based smoking cessation interventions appear to be effective for highly motivated adults (Shahab & McEwen, 2009). A follow-up systematic review (Hutton et al., 2011) was conducted to expand the data presented by Shahab and McEwen (2009) to examine (a) the efficacy of randomized controlled trials that included college age and adolescent populations and to (b) examine website use and factors that may contribute to the efficacy of smoking cessation Internet interventions. Over half of the studies (n = 21) reviewed were based on CBT principles; transtheoretical, motivational, problem-solving, and self-efficacy approaches were also used. The content and delivery of the interventions varied across the studies reviewed and included the use of mail, email, telephone, and web-based features. Findings for the adult studies suggested that Internet interventions that incorporated other components (e.g., email reminders) were more effective than static (e.g., self-help booklet) or delayed comparisons (Hutton et al., 2011). Tailored interventions and greater exposure to the study website resulted in higher rates of abstinence. Data for college and adolescent populations were limited or provided mixed findings, therefore rendering them inconclusive.

The *Tomando Control*/Taking Control smoking cessation website is an Internet intervention that has tested different online methods to facilitate smoking cessation (Muñoz et al., 2014). Interventions tested included the following: a web-adapted smoking cessation guide (*Guia para dejar de fumar*/Stop smoking guide); email messages that were individually timed to participants' quit date; a mood management intervention; and an online forum. A recent report summarizing the findings of trials conducted by this team since 1998 emphasized that smoking rates can be reduced with fully automated Internet interventions (Muñoz et al., 2014). Specifically, 12-month quit rates obtained in a four-condition trial among Spanish and English speakers (20% and 21%, respectively) were comparable to traditional quit methods (e.g., nicotine patch) even when participants were counted as smoking in the absence of follow-up data (missing = smoking).

Health-Related Issues

As previously stated, 72% of Internet users search for health information online for themselves or for someone else (Fox & Duggan, 2013). In the United States, 60% of adults polled stated that they use the Internet to track their weight, diet, and exercise routine, and 33% have tracked their blood pressure, blood sugar, headaches, or sleep patterns (PEW Research Center, 2013). Difficulties with physical health are often treated with Internet interventions that are based on in-person behavioral treatments that have been adapted for online delivery (Ritterband et al., 2003). A full review of the growing evidence for Internet interventions for health-related issues is beyond the scope of this chapter yet available from other sources (see Hou, Charley, & Roberson, 2014).

Summary of Research on Efficacy and Effectiveness of Electronic-Based Therapies

A large proportion of psychological and health-focused Internet interventions use a CBT framework given the extensive literature supporting the use of these intervention approaches in traditional face-to-face prevention and treatment trials. Although the aforementioned studies provide efficacy data for Internet-based interventions, Internet-based psychological treatments are still quite new. As a result, additional well-controlled randomized studies are needed to elucidate which types of Internet interventions are best for different clinical and nonclinical populations. For example, some researchers have found that Internet interventions are more effective when therapists are actively involved in supporting participants (Gellatly et al., 2007). Additionally, although a guided approach may be a beneficial component of Internet interventions, requiring clinician involvement creates difficulties in widespread implementation. Although this could possibly augment the effect of these interventions, therapist aid becomes a logistically and financially difficult issue when trying to employ Internet interventions on a global scale.

Research still needs to be conducted that can further assess the efficacy of fully automated trials relative to trials that have significant human support. It is feasible that some disorders may be amenable to remission with fully automated programs, whereas other disorders may require more clinician support in order to decrease symptoms.

ELECTRONIC-BASED THERAPIES AND DIVERSE POPULATIONS

The limited diversity in the samples that comprise effective Internet-based interventions adds some concern about the generalizability of the findings for other demographic groups. For example, a majority of the studies cited were limited to users who were recruited in medical centers or university settings, included users who had higher educational attainment and annual incomes, who were experienced technology users, and who were seeking online resources. As such, more research needs to be conducted on Internet interventions with individuals who are underserved or who underutilize online mental health interventions and resources.

Access to technology is a major barrier when it comes to electronic-based interventions. The "digital divide" refers to the gap in technology use among marginalized populations such as older adults and those residing in rural communities, as well as individuals from lower socioeconomic status and among certain ethnic or racial backgrounds. Individuals with greater economic and educational attainment and younger age have traditionally been at the forefront of the technology industry. Recently, however, rates of Internet use have increased more rapidly among US Latino-a/Hispanic, African American, and older adult populations. Similarly, although countries in Asia, Europe, and North America continue to have the highest number of Internet users, 10-year growth in access to and utilization of the Internet was largest in African, Middle Eastern, and Latin America/Caribbean regions of the world (Internet World Stats, 2012). Thus, although the level of utilization remains lower among some individuals in the United States and in developing nations around the world, this is rapidly changing given reductions in cost and improved quality, both of which may be contributing to increased access and use.

The Institute for International Internet Interventions (i4Health) at Palo Alto University and the Internet World Health Research Center at the University of California, San Francisco/San Francisco General Hospital is a collaborative team of psychologists, researchers, and trainees focused on expanding the reach of self-help, automated technology-driven interventions that are rooted in evidence-based psychological treatments and that integrate cultural and linguistic considerations. As such, technology-based tools are developed and tested among Spanish- and English-speaking individuals who otherwise may not receive or have access to interventions for preventable and treatable emotional and behavioral issues (e.g., Muñoz et al., 2014). The Mothers and Babies/*Mamás y Bebés* Internet Project, for example, recruited and enrolled Spanish- and English-speaking pregnant women from 92 countries and independent territories (Barrera, Kelman, & Muñoz, 2014). In an effort to acknowledge the diversity of the women who participated in the original trial, a follow-up study was conducted inviting all enrolled participants to provide feedback on the intervention's content (e.g., clarity) and to indicate how the materials could be adapted to reflect women from their region of the world. Qualitative analyses are currently underway to examine thematic patterns in the content and structural presentation of the intervention that may be influenced by cultural and linguistic differences.

CLINICAL ILLUSTRATION OF AN ELECTRONIC-BASED THERAPY

The following case illustration of an Internet intervention is based on characteristics of a typical participant in the Mothers and Babies/*Mamás y Bebés* Internet Project, a prevention of PPD Internet intervention trial. All names and references are fictitious.

Lourdes is a married, college-educated, 28-year-old female living in an urban area in Latin America. She is 20 weeks pregnant with her first baby. Lourdes accesses the Internet from work and mostly for using social media sites, checking email, and conducting online searches. She has never accessed mental health services in her community, but she would consider talking to someone if she noticed changes in how she was feeling emotionally. Recently, she has used the Internet to look up information about her pregnancy and how to

care for a newborn baby. It was during one of these searches that she came across the ad for the Mothers and Babies/*Mamás y Bebés* Internet Project and decided to join the study because she was interested in learning skills to build a healthy relationship with her newborn baby.

After consenting to participate in the program, Lourdes completed questionnaires that indicated she did not meet diagnostic criteria for a current or past major depressive episode; she did, however, endorse experiencing symptoms that were characteristic of depression. She was tired, irritable, and felt less energetic. Furthermore, Lourdes noticed that she was having difficulty getting around due to her weight gain and, therefore, often opted to stay at home rather than socialize with family and friends. Lourdes completed this initial questionnaire, which at the end provided her with feedback on how her symptom scores compared to other women and offered suggestions on how to maintain a healthy mood during pregnancy. The final page of this online questionnaire provided her with the link to the study website, where she could access the Internet intervention materials. She was also informed that the link (along with her unique login and password) would be included in a welcome email sent to the account she provided when she agreed to participate. The website system automatically randomized Lourdes to the Internet intervention using a stratified randomization algorithm encoded into the website structure.

Within days of joining the study, Lourdes accessed the first module of the Internet intervention. In this module, she read text pages and charts, watched a few 1- to 3-minute videos that explained theoretical constructs, and responded to online worksheets by typing how the material she learned applied to her specific situation. Once she completed this module she had the option to continue to the next module or return at another time. Lourdes found this introductory module useful and simple to understand. She had heard about women staying in bed after giving birth, but she did not know there was a name for it.

As part of the initial questionnaires, Lourdes provided information about her place of origin (e.g., type of neighborhood, country of residence) that was then used to adapt and personalize the intervention content. For example, recommendations for activities to engage in while pregnant were reflective of what pregnant women from urban areas in previous studies had indicated were activities they engaged in with their newborn babies. Similarly, sample expectations about being a new mother or ideas about how to manage this new role were based on what other women in her region of Latin America had indicated. Examples used to teach the theoretical principles of the intervention included cultural values and behaviors related to pregnancy and motherhood experiences of women from all regions of the world, including Latin American countries. Lourdes appreciated this more personalized content as it was consistent with her own experiences, demonstrated alternate approaches, and provided her a sense of community and support given that the intervention site stated that this information was based on women with a similar background as herself.

One month after Lourdes joined the study, she received the first monthly automated email inviting her to tell the research team how she was doing. Each monthly email invitation (up to 6 months postpartum) linked participants to follow-up questions about their pregnancy status and symptoms of depression during the past month. Participants who indicated elevated depression symptoms or thoughts of death received a special message instructing them to obtain immediate support from a trusted family member or friend, to contact their provider, or to visit the nearest hospital. Participants were also reminded to continue to use the intervention site at their own pace and encouraged to finish all eight modules of the intervention in order to maximize the benefits of the program.

All procedures were fully automated; the study protocol did not include additional personalized communication with Lourdes or any of the participants. In addition, there was no tailoring of the intervention to respond to participant interactions with the intervention site. These features would have likely improved participant experiences and depression outcomes. For example, personalized email messages that reminded participants of where and how to access the intervention or when they last accessed the site may have improved engagement with the intervention materials or served as a reminder to return. Using more interactive technologies, such as text messaging or mobile device compatibility, would have been responsive to changes in how individuals are accessing technology. Future iterations of this Internet intervention will integrate these features.

CONCLUSIONS/KEY POINTS

This chapter serves as an introduction to the use of the Internet to deliver psychological interventions. Electronic-based interventions for psychological and health issues have proliferated in the past 15 years. Given the shortage of psychological resources worldwide, providers are encouraged to consider interventions other than clinician-delivered, face-to-face psychotherapy, such as integrating methods of delivery that include the use of technology, nonprofessionals, self-help resources, and other media outlets (Kazdin & Blase, 2011). The aim is not to replace clinicians with computers or hardware systems; rather, the different modalities share a common goal, which is to reduce the suffering caused by untreated psychological symptoms. As clinicians and researchers, we hold a responsibility to take advantage of the benefits of using these technologies, which have the potential to reduce the burden of mental health disease.

- Technology-based tools can be an important resource to reduce global burden of disease.
- The technology-based movement started with the use of telephone support and static electronic-based materials, and current tools function more automatically.
- CBT is the most common theoretical approach utilized for Internet interventions because it is easily adaptable to an automated, web-based format.
- Although Internet interventions have come a long way, there is still substantial room for growth. These interventions are still being adapted to reach the broadest groups of individuals.
- As accessibility to technology increases across the world, electronic-based interventions will become more viable options for populations who may not have access to face-to-face care.

REVIEW QUESTIONS

1. What technologies can be helpful in decreasing the burden of psychological disorders?
2. How can therapeutic alliance improve as technology becomes more advanced?
3. What are ethical and legal implications of an automated electronic-based therapeutic format?
4. How might you integrate the knowledge from this chapter into clinical practice?
5. Are there psychological disorders that are not appropriate for an Internet intervention?

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RESOURCES

Websites

Institute for International Internet Interventions for Health: http://www.i4Health-pau.org

International Society for Mental Health Online: http://www.ismho.org

International Society for Research on Internet Interventions: http://www.isrii.org

Internet World Health Research Center: http://health.ucsf.edu/

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18

Psychological Therapy With Children and Adolescents: Theory and Practice

Alexandra L. Hoff
Anna J. Swan
Rogelio J. Mercado
Elana R. Kagan
Erika A. Crawford
Philip C. Kendall

Abstract
Interventions have been developed to address psychological problems in children and adolescents, typically based in diverse theoretical models. Depending on the theory guiding the intervention and the problem(s)/disorder(s) it targets, these psychological therapies may be focused on the individual youth, the parents, the parent–child dyad, or the family as a whole. Psychological therapy with children and adolescents begins with a case conceptualization derived from a comprehensive assessment using multiple methods and informants. The conceptualization considers the child, parent, and therapist factors that may influence the day-to-day features of therapy as well as the outcome. This chapter describes the theoretical developments informing treatment for youth, the factors to consider in case conceptualization, the empirical support for psychosocial interventions for youth, and the importance of "flexibility within fidelity" when considering diversity.

Keywords: developmental models, empirically supported treatments, mechanisms of change, parents, family

As did psychological therapy[1] for adults, the use of therapy to address psychological and developmental problems in children and adolescents began about a century ago in the tradition of Freud, a tradition continued by his daughter into the 20th century (Weisz, 2004). At about the same time, Watson was studying the acquisition of behavior in humans and demonstrated how children can acquire fears through conditioning. This early work on conditioning informed approaches to addressing fears through learning. Although an interest in applying psychological therapy to address problems in youth continued, a mid-century attempt to examine the effectiveness of the practices in use at the time revealed that, speaking

generally, these practices were not associated with improvements more than the passage of time (Levitt, 1957). Recent decades, however, have witnessed a marked increase in the rigor of study regarding psychological therapy for youth: The former reliance on generic practices has shifted to the development and evaluation of developmentally sensitive treatment procedures specifically for children and adolescents (e.g., Kendall, 2012a), and these interventions are often detailed in treatment manuals that guide practice. In addition, treatment outcome research has evaluated the degree to which specific programs have beneficial effects on target problems, and the results provide empirical support for the efficacy of various psychological therapies for youth. To the field's credit, various youth-focused and family-focused treatment approaches endorsed today to treat many problems in youth have undergone evaluation via randomized controlled trials (RCTs) and have shown promise as efficacious interventions. As a result of the recent shift toward the evaluation of treatment outcomes via RCTs in the tradition of the medical field, certain psychotherapeutic treatments have fallen out of favor. Some psychologists who continue to hold strongly to certain traditions believe that there is an unnecessary bias toward cognitive- and behavioral-based therapies because they conform more readily to current research standards. Nevertheless, general guidelines support treatments for youth that have undergone empirical study and found to be effective, and our coverage will describe and refer to these works.

MAJOR THEORETICAL DEVELOPMENTS IN THERAPY WITH YOUTH

To address the various problems that youth and their families may face, several treatments have been developed that may focus on one or more of these problems. These therapies emerged from different psychological theories, including cognitive and behavioral theories, interpersonal theories, learning theories, and family systems theories. They may focus on the youth as an individual, the youth's parents as influences on the youth's behavior, or the family system as a whole.

Individual-Focused Treatments

Cognitive-behavioral therapy (CBT) is a treatment approach that has received empirical support, particularly for the treatment of anxiety disorders, obsessive-compulsive disorders, and depressive disorders in youth (Ollendick & King, 2012). Stemming from both behavioral and cognitive traditions, CBT is fundamentally based on the reciprocal influence among thoughts, feelings, and behaviors. Accordingly, treatment focuses on identifying and challenging maladaptive thoughts, or "self-talk," and providing behavioral evidence (e.g., gradual exposure to feared/avoided situations for anxiety; activation and experiments for depressed mood). For example, theory and research suggest that behavioral exposures are a key component in the effective treatment of anxiety—they provide the opportunity for youth to experience reductions in physiological anxiety (i.e., habituation), as well as shifts in cognition and enhanced self-efficacy (Peterman, Read, Wei, & Kendall, 2015). These topics have been studied in CBT, but may not be unique to CBT. That said, it seems that such shifts allow a situation that was previously associated with fear and avoidance to become associated with lessened anxiety and increased coping. Early sessions of CBT for anxiety typically involve education about anxiety, including the identification of somatic markers and anxious self-talk, as well as teaching skills to challenge anxiety-provoking thoughts so that youth feel prepared to cope with anxiety in exposure tasks. When treating depression in youth, as another illustration, addressing the youth's depressogenic thoughts and teaching coping skills are aimed at behavioral activation. Similar to exposures in CBT for anxiety, behavioral activation for depressed mood is achieved through youth trying potentially positive activities to have them experience and notice positive shifts in cognition and emotion (e.g., Stark, Streusand, Krumholz, & Patel, 2010). Although CBT for youth is often youth focused and conducted individually, parents and/or families may be involved in treatment to varying degrees. CBT may also be conducted in a group format. In general, some overarching goals of CBT are to provide needed tools and skills to youth, to coach the youth in the use of these skills in real-world practice settings, and to build self-efficacy for using the tools and skills on their own when treatment ends.

Another individual-focused treatment for adolescents with depression is interpersonal therapy (IPT; Mufson, Weissman, Moreau, & Garfinkle, 1999). IPT focuses on fostering positive relationships as a mechanism of improving depressive symptoms. Because adolescence is typically a transitional period

regarding interpersonal relationships with family members and with peers, IPT for adolescent depression focuses on navigating these relationships effectively (Jacobson & Mufson, 2010). IPT consists of psychoeducation, identification of emotions, and building interpersonal skills. The goal is to teach adolescents to identify more readily the connections between their emotions and their relationships and to navigate both their emotional and interpersonal experiences more positively and effectively. The therapist and adolescent typically identify a problematic relationship that seems to be most associated with the adolescent's depression, as well as an interpersonal problem area (e.g., grief, role transition, role dispute, or interpersonal deficits), and these become the focus of treatment. IPT has also been used as a model for treating bulimia nervosa (Robin, Gilroy, & Dennis, 1998).

Behavioral Treatments

Therapies that focus on shaping children's and adolescents' behavior directly have been developed to address externalizing problems and other behavioral difficulties. Behavior-focused treatments for youth are typically based in learning theory (e.g., operant conditioning) and involve increasing prosocial and adaptive behaviors while decreasing problematic behaviors through the use of contingencies of reinforcement. For example, applied behavioral analysis (ABA) and similar intensive interventions for youth on the autism spectrum involve several weekly hours of individual work with the child, reinforcing first very simple requested and imitated behaviors and working up to more complex language and social behaviors through shaping (Smith, 2010). Both prompted and spontaneous desired behaviors are consistently rewarded, with prompts fading as the child learns. Parents are involved in ABA interventions, although the therapist may work primarily with the child (e.g., Wood & Drahota, 2005).

Other behavioral interventions for youth have considerable parent involvement. Indeed, parent management training involves therapists working directly with parents to help them effectively intervene to increase desirable behaviors (and decrease undesirable behaviors) in their children. The goals of parent management training interventions are to decrease parents' inadvertent modeling and reinforcement of children's antisocial behavior (e.g., via coercion and punishment of undesirable behavior, as well as negative reinforcement such as "giving in" when a child's oppositional behavior escalates to a certain level) and to increase the modeling and reinforcement of prosocial behavior through positive reinforcement of desirable behavior, breaking desirable behaviors down into easily achievable steps, and consistent limit setting (e.g., Forgatch & Patterson, 2010). For the most part in behavioral interventions for youth, an emphasis is placed on the reinforcement of prosocial and desirable behaviors over the punishment of undesirable ones.

Family-Based Treatments

In addition to learning-based behavioral interventions, other family-based interventions have been developed. Structural family therapy (SFT), for instance, is based in the theory that the context of the family and the interactions that exist between family members influence the individual youth. SFT thus seeks to address problems through analysis and adjustment of family structure and interpersonal interactions (Minuchin, 1974). In SFT and more recent variations on this type of intervention, social interactions are increasingly viewed as important contexts in which symptoms of emotional and behavioral problems occur, with all behavior considered as a form of communication. These social interactions can be observed, and patterns of communication can be recognized that may be maintaining emotional or behavior difficulties in any one individual. Alternative patterns of behavior and communication can then be proposed as an attempt to improve these difficulties (Lindblad-Goldberg & Northey, 2013).

Parent–child interaction therapy (PCIT) is another family-based intervention that focuses on the communications between family members, in this case specifically a child and his or her parent(s). Developed to address disruptive behavior problems in children, the goal of PCIT is to promote prosocial behavior in children (Zisser & Eyberg, 2010). The PCIT therapist teaches and role-plays interaction skills with parents and then coaches them through parent–child interactions. Parents are first taught child-directed interactions to promote parental responsiveness and nurturing behavior, followed by parent-directed interactions to effectively and consistently direct and control their child when necessary to reduce undesirable behaviors. PCIT is generally targeted toward

young children with disruptive behavior problems, but it is also useful with other problems.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION IN THERAPY WITH YOUTH

Child Factors

The role of cognition, emotion, behavior, and social functioning in maintaining psychopathology is central, and change in each of these domains is implicated in positive treatment outcomes.

Cognitive Change

Research studies support cognitive change as an important component of treatment for internalizing disorders (e.g., Hogendoorn et al., 2014). For example, decreases in anxious and negative self-talk have been found to mediate treatment outcome for anxious youth receiving CBT. Change in coping self-efficacy—that is, youth's perception of their ability to cope with previously provoking situations—has also been found to mediate outcomes (Kendall et al., 2014). For youth with depression, perfectionistic beliefs have been associated with greater symptom severity and with suicidality, and change in perfectionistic beliefs mediates improvement over the course of treatment (Jacobs et al., 2009). Although cognitive change has been less studied in youth with externalizing disorders, changes in negative automatic thoughts mediated treatment outcome in youth with comorbid depression and conduct disorder (Kaufman, Rohde, Seeley, Clarke, & Stice, 2005).

Behavioral Change

Maladaptive behaviors represent a key feature of most psychological disorders, and many interventions target disorder-maintaining behavior. For example, CBT for anxiety targets behavioral avoidance, a definitive symptom of anxiety, through exposure tasks, and CBT for depression targets withdrawal from pleasurable activities through behavioral activation. Research supports exposure tasks as a key component of CBT for youth anxiety (e.g., Bouchard, Mendlowitz, Coles, & Franklin, 2004), and there is evidence supporting the efficacy of behavioral activation in the treatment of adolescent depression (e.g., Ritschel, Ramirez, Jones, & Craighead, 2011). Behavioral problems are key features of externalizing disorders like oppositional defiant disorder and conduct disorder, and research supports the efficacy of parent management training as a way to reduce child aggression and noncompliance. According to those who study and treat such issues (e.g., Kazdin, 1997), targeting the antecedents and consequences of problem behaviors in youth with aggression and antisocial behavior is considered an important feature of effective intervention.

Emotional Change

Heightened experience of negative emotions and emotion regulation difficulties, including increased emotion reactivity, decreased emotion understanding, and poor emotion management, are implicated in both internalizing and externalizing disorders (e.g., Benjamin & Hinshaw, 2007). Some research supports emotional and affective change as an important therapy process variable. Changes in emotion regulation difficulties have been found to mediate changes in self-harm behaviors in youth receiving CBT for deliberate self-harm (Slee, Spinhoven, Garnefski, & Arensman, 2008). Affective changes (e.g., feelings of perceived loneliness) have been found to partially mediate treatment outcome in adolescents with social anxiety receiving social effectiveness therapy (Alfano et al., 2009). In adults, productive in-session emotional processing has been linked to treatment outcome (Greenberg, Auszra, & Herrman, 2007), but more research is needed to evaluate emotional processing as a mechanism of change in child and adolescent treatments (Lipsitz & Markowitz, 2013).

Social Change

Changes in social support, social skills, and interpersonal relationships are potential mechanisms of therapeutic change that warrant further research. Increasing social effectiveness (e.g., social skills) has been found to predict positive treatment outcome in youth with social anxiety (Alfano et al., 2009). IPT for depression hypothesizes that enhancing social support, decreasing interpersonal stress, and improving interpersonal skills mediate outcome (Lipsitz

& Markowitz, 2013); however, further research is needed to test these hypotheses.

Therapy Factors

The relationship between the client and the therapist (e.g., alliance) can be viewed as their bond, their mutual agreement on goals, and their collaborative effort through treatment. When working with youth, an alliance can refer to the youth–therapist alliance and/or the parent–therapist alliance. Both the youth–therapist and parent–therapist alliance are implicated in treatment outcomes, parenting practices, and rates of therapy attendance and dropout across disorders (e.g., Shirk, Karver, & Brown, 2011). Of interest, the use of challenges (exposure tasks) within therapy for anxiety does not negatively affect alliance: Across treatment sessions, the alliance rises and stays stable through the introduction of exposure tasks (Kendall et al., 2009).

Parent Factors

Research has identified a number of parenting practices and styles that are associated with youth psychopathology. To name a few, lack of parental warmth, parental overprotection or low involvement, and harsh and inconsistent parenting practices have been linked to youth depression, anxiety, and aggressive and antisocial behavior in youth (e.g., Wei & Kendall, 2014). For all disorders, parental modeling of behavior, such as fearful and avoidant or aggressive and antisocial behavior, may play a role in the development and maintenance of psychopathology in youth.

Given the importance of parental factors, many treatments involve parents to address problematic parenting behaviors; however, research supporting the efficacy of parental involvement differs based on the disorder and the level of development/age of the youth. Most treatments for anxious youth involve parents to ensure homework compliance and to assist with the generalization of skills to home and school environments. That said, meta-analyses and reviews indicate that although both child-focused and family CBT for youth anxiety are comparably effective, there is not a significant advantage of one format over the other (e.g., Manassis et al., 2014). However, there is some support for the notion that greater parental involvement is more beneficial for young children (e.g., Rapee, Schniering, & Hudson, 2009). Additionally, addressing family accommodation of avoidant anxiety behavior, an important part of treatment (e.g., Storch et al., 2010), is addressed in either format. In some interventions, family interactions are seen as the source of distress and focus of change.

Compared to treatments for internalizing disorders, treatments for externalizing disorders often rely upon parental involvement. Research on parent management training interventions suggests that when parents become less coercive and more effective in their parenting practices, child behavioral outcomes improve, and changes in critical, harsh, and inconsistent parenting mediate this favorable treatment outcome (e.g., Beauchaine, Webster-Stratton, & Reid, 2005). Similarly, in PCIT, parental differential attention to positive versus negative child behaviors has been found to predict changes in child behavior (Pemberton, Borrego, & Sherman, 2013), and therapists' in vivo coaching of parenting behaviors has been found to increase positive parenting practices. Increases in positive parenting may be a key principle of change in the treatment of aggressive and antisocial behavior in youth.

Case Conceptualization

To inform case conceptualization and guide treatment, a thorough assessment of the individual, interpersonal, and parenting/family factors is warranted. Case conceptualization is an ongoing process: It is recommended that these factors be assessed prior to beginning therapy and throughout treatment in order to monitor progress and to incorporate new or changing information.

A diagnostic case conceptualization involves assessing the youth's presenting problems and accompanying symptoms. Gathering information from multiple informants, especially when working with youth, is valuable to assemble the "big picture." Sometimes children are unable or unwilling to report their concerns, highlighting the value of parental input; conversely, parents may be unaware of concerns their child has at school or with friends, emphasizing the need for youth and teacher reports. Semistructured interviews are considered the gold standard for diagnosing psychological disorders. The

Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present and Lifetime Version (K-SADS-PL; Kaufman et al., 1997) is one such assessment. The Kiddie-Disruptive Behavior Disorder Schedule (K-DBDS; Keenan, Wakschlag, & Danis, 2001) is a semistructured interview for the assessment of oppositional defiant disorder, conduct disorder, and attention-deficit/hyperactivity disorder in preschool children.

Individual factors important to case conceptualization include maladaptive thought processes, behaviors, and emotion management strategies. For example, a child with a specific phobia may experience a heightened fear response, have thoughts like, "Something bad will happen," and avoid contact with phobic stimuli, yielding a short-term reduction in anxiety. The short-term reduction, however, does not help reduce anxiety in the long term. Helping youth to see their symptoms in terms of the relationship between thoughts, feelings, and behavior can facilitate treatment progress.

Interpersonal factors contributing to case conceptualizations with youth include social support/isolation, role transitions, and role disputes. Parent/family factors include parental control, parental modeling of maladaptive behaviors, ineffective parenting strategies, and the quality of attachment between child and parent. Parent psychopathology and family stress can also be important to case conceptualization, and research suggests that family factors can influence outcomes. For example, a parental anxiety disorder has been linked to limited maintenance of treatment gains: When a parent has an anxiety disorder, youth gains made at the end of treatment are less likely to be maintained 1 year later (Kendall et al., 2008). Other work suggests that the influence of parental psychopathology varies across development: Parental anxiety adversely affects treatment outcome in young children (when parents play a more active role), but not adolescents (e.g., Berman, Weems, Silverman, & Kurtines, 2000). The presence of parental attention-deficit/hyperactivity disorder (ADHD) symptoms has also been found to be adversely related to treatment outcomes in parent-training programs for youth with ADHD (e.g., Sonuga-Barke, Daley, & Thompson, 2002).

Assessing family stressors that may interfere with therapy attendance, engagement, and the transfer of skills learned in therapy to the home environment is an important component of case conceptualization. In youth with anxiety disorders, lower family dysfunction, parental frustration, parental stress (Crawford & Manassis, 2001), and caregiver strain (Compton et al., 2014) predict more favorable treatment response. Perceived family stress has been linked with worse outcomes for youth receiving therapy for aggressive and antisocial behavior, and treating parental stress may enhance treatment outcomes for youth.

EFFICACY AND EFFECTIVENESS OF THERAPY WITH YOUTH

Many therapeutic psychosocial interventions have been implemented, evaluated, and found to have support for use in addressing child and adolescent disorders. Examples of these empirically supported treatments are briefly described.

Depression

Numerous treatments have been developed for youth with depression. Among these, CBT and IPT are considered empirically supported. CBT is considered well established for both children and adolescents (David-Ferdon & Kaslow, 2008), and it typically involves psychoeducation, cognitive restructuring, attribution retraining, problem-solving training, and behavioral activation. For children, several CBT interventions have been classified as probably efficacious when compared to waitlist or usual care, including a school-based intervention that incorporates self-monitoring, self-evaluations, and self-reinforcement (Stark, Streusand, Arora, & Patel, 2012). For adolescents, individual CBT has emerged as probably efficacious, demonstrating improvement in depressive symptoms with or without parental involvement (David-Ferdon & Kaslow, 2008).

Some research suggests equal efficacy of behavioral therapy and CBT for both children and adolescents with depression (Hetrick et al., 2015). Some have posited that youth may struggle to understand the cognitive components of CBT, while still engaging in and mastering the behavioral components, but further research is needed to demonstrate this conclusively.

IPT is also an empirically supported treatment for adolescents with depression. IPT focuses on

interpersonal difficulties experienced by adolescents (e.g., changing parent–child relationships) and assists in the development of strategies, such as improved communication and social support, to facilitate improved interpersonal interactions, as described earlier. IPT-A has shown greater improvements over clinical monitoring conditions as well as individual supportive therapy conditions.

Anxiety Disorders

For anxiety disorders in youth, research has focused on CBT as the primary psychological intervention. CBT for anxiety in youth typically involves psychoeducation, cognitive restructuring, relaxation, problem solving, and graduated exposures to situations specific to the child's anxiety. CBT has been classified as probably efficacious for treating generalized anxiety disorder, social phobia, and separation anxiety disorder in youth and as well established for treating phobias (reviewed in Silverman, Pina, & Viswesvaran, 2008). Recent research suggests that CBT for anxiety in youth merits consideration as an established treatment (Kendall, 2012b). Meta-analyses of CBT in children and adolescents show that it consistently outperforms waitlist control conditions with recovery rates of primary anxiety diagnosis at approximately 60%. Variations in the format of treatment have not typically demonstrated differential effects on outcomes, with individual, group, and family CBT all showing similar response rates. Additional research has found maintenance of treatment gains several years after treatment.

In studies that examined CBT in comparison to other active treatments, outcomes are comparable and favorable. CBT alone (60%) and selective serotonin reuptake inhibitors (SSRIs) alone (55%) have demonstrated similar improvements in youths' anxiety symptoms, whereas their combination has shown an 80% positive response rate (Walkup et al., 2008). There has been a paucity of research comparing CBT to other psychological treatments, with mixed results among those that have (James, James, Cowdrey, Soler, & Choke, 2013). For youth with social phobia, social effectiveness training for children and adolescents, which includes social skills training in addition to typical CBT elements, has also been classified as probably efficacious (Spence, Donovan, & Brechman-Toussaint, 2000).

Obsessive-Compulsive Disorder

CBT for obsessive-compulsive disorder (OCD) has been classified as probably efficacious (Kircanski, Peris, & Piacentini, 2011). CBT for OCD is similar to that for anxiety, although there is additional targeting of compulsions through both exposure and response prevention (ERP). ERP requires clients to resist performing their compulsions during exposure tasks to demonstrate natural stress reduction and is the primary focus of treatment (Kircanski et al., 2011). Treatment evaluations of CBT for youth with OCD have found individual CBT, family-focused CBT, and group CBT to be comparably efficacious in reducing obsessive-compulsive symptoms. CBT has demonstrated equal response rates to SSRIs, with the combination of CBT and medication evidencing the greatest improvement (Pediatric OCD Treatment Study Team, 2004). In pediatric samples with OCD, family accommodation of the child's symptoms (e.g., assisting child with compulsions, taking on child's responsibilities, giving reassurance) has been identified as a mediator between the child's symptom severity and functional impairment (Kircanski et al., 2011), such that directly addressing (reducing) family accommodation is a valued part of the treatment.

Trauma

For youth who have experienced traumatic events, trauma-focused CBT (TF-CBT) has been classified as well established (Cohen, Mannarino, & Deblinger, 2010), and school-based group CBT has been classified as probably efficacious (reviewed in Silverman, Ortiz et al., 2008). TF-CBT uses cognitive and behavioral components, including psychoeducation, problem solving, anxiety management, trauma narration and organization of the traumatic event, and exposure tasks (Cohen et al., 2010). Overall, TF-CBT has demonstrated greater reductions in posttraumatic stress symptoms than waitlist and other psychosocial treatments, including supportive therapy, child-centered therapy, family therapy, and usual community care (Silverman, Ortiz et al., 2008). Furthermore, individual child CBT and family CBT have shown similar efficacy in symptom reduction. Additionally, both 8 and 16 sessions of TF-CBT with and without a trauma narrative have demonstrated similar symptom improvements (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). CBT has been linked to

significant reductions not only in posttraumatic stress symptoms but also depressive, anxious, and externalizing symptoms (Cohen et al., 2010; Silverman, Ortiz et al., 2008).

Eating Disorders

Few well-controlled studies have examined treatments for youth with anorexia nervosa (AN) or bulimia nervosa (BN). Nonetheless, family-based therapy is considered a first-line treatment for adolescents with AN (Lock, 2010). In family therapy for AN, parents are actively involved in their child's treatment and recovery through parent training, and control is then gradually transferred back to the adolescent (Fisher, Hetrick, & Rushford, 2010). Family-based therapy has been associated with greater improvement and maintenance of gains than a nonspecific individual therapy and a psychoanalytic individual therapy (Keel & Haedt, 2008). Findings have been mixed as to whether family-based therapy is associated with greater improvement than individual therapy; however, family-based therapy appears to maintain greater gains over follow-up periods of 6 to 12 months than individual therapy (reviewed in Couturier, Kimber, & Szatmari, 2013). Within family therapy, conjoint family therapy (in which parents and youth participate in joint sessions) has demonstrated a slight advantage over separate parent and child sessions. No differences have been observed between short-term and long-term family-based therapy for adolescents with AN (Keel & Haedt, 2008).

There is a paucity of investigations of treatments for adolescents with BN, as onset is typically in late adolescence or early adulthood. Those studies that have examined interventions for BN in adolescents have found that both family therapy and CBT demonstrate similar symptom improvement (e.g., Loeb & le Grange, 2009). It is unclear if one is more efficacious than the other, though for older adolescents (18–21 years), CBT may have a slight advantage (Keel & Haedt, 2008).

Disruptive Behavior

Among the variety of psychosocial treatments that have been developed for disruptive behavior in children and adolescents, behavioral approaches have demonstrated the greatest effects (Comer, Chow, Chan, Cooper-Vince, & Wilson, 2013). Behavioral interventions typically target the interaction between parent and child through family and parent sessions. Parents are taught to praise appropriate behavior, ignore negative behavior, and to implement effective discipline within a structured and consistent reward system. Some interventions include problem-solving skills training, which has been found to produce greater reductions in disruptive behaviors than relationship therapy (e.g., Webster-Stratton, Reid, & Hammond, 2004). Parent management training has demonstrated significantly greater symptom reduction than client-centered treatment and bibliotherapy, and it is considered a well-established intervention for children and adolescents (Chorpita et al., 2011). Parent management training has also demonstrated effectiveness over waitlist conditions in "real-world" clinics (Michelson, Davenport, Dretzke, Barlow, & Day, 2013).

There is some evidence that CBT can be efficacious in treating disruptive behavior. In group CBT for disruptive behavior, children attend weekly sessions to learn problem-solving skills and anger control strategies, and then they practice these skills in situations designed to arouse anger. This approach has led to reductions in disruptive symptoms and has been said to meet the criteria for a probably efficacious treatment (Lochman, Barry, & Pardini, 2003). However, disruptiveness is not an "easy target" for treatment, and other modalities and strategies merit evaluation. Some research suggests that CBT is efficacious in treating disruptive behaviors in adolescence, perhaps linked to their more developed cognitive functioning (McCart, Priester, Davies, & Azen, 2006).

Attention-Deficit/Hyperactivity Disorder

Behavioral treatments are the only psychological interventions found to be helpful in the treatment of children with ADHD. Although ADHD is most frequently treated with medication, both behavioral parent training and behavioral classroom management can be considered effective for ADHD (Pelham & Fabiano, 2008). Such interventions typically involve parent- or teacher-implemented reward systems, including daily report cards, awarding points, and assigning time-outs. In comparison to other interventions (e.g., nondirective parent counseling; support),

behavioral interventions have been found to result in greater reductions in disruptive behavior. Though the results have not been uniform, in some instances behavioral therapy and medication are associated with comparable rates of symptom reduction (Sibley, Kuriyan, Evans, Waxmonsky, & Smith, 2014).

Autism Spectrum Disorders

Applied behavioral analysis (ABA), consisting of 40 hours a week of intensive behavioral intervention and training, is the most researched treatment for children with autism spectrum disorders (ASD) (Rogers & Vismara, 2008). Approximately 50% of children with ASD make significant gains, achieving normal IQ, being placed in mainstream education, and evidencing increases in adaptive behavior (e.g., Reichow, 2012). Modest gains have also been found with fewer hours of treatment per week. Several studies have supplemented ABA with additional aspects of treatment, such as speech therapy for the child and social communication training for parents, and have demonstrated significant improvement in language development and vocabulary. The findings suggest that gains made with ABA are limited to children with a less severe diagnosis, and IQ and social variables have been identified as influencing forces (Rogers & Vismara, 2008).

Research indicates that there is a high comorbidity between ASD and anxiety disorders, with approximately 45% of youth meeting diagnostic criteria for an anxiety disorder and up to 85% experiencing clinically meaningful anxiety symptoms (reviewed in Lin, Wood, Storch, & Sze, 2013). In addition to traditional anxiety symptoms, youth with ASD also appear to experience atypical anxiety symptoms surrounding ASD-specific characteristics, such as fear of change and atypical specific phobias (Kerns et al., 2014). Similar to typically developing youth with anxiety disorders, modified CBT has demonstrated efficacy in treating anxiety in youth with ASD (see Lin et al., 2013, for review).

DIVERSITY CONSIDERATIONS IN THERAPY WITH YOUTH

There has been an increased recognition of the need for cultural competency within the mental health field. Although not a problem unique to clinicians who work with children and adolescents, research has begun to address issues related to providing evidence-based practices for diverse youth.

Although diversity can be defined in many ways, much research has focused on ethnic and cultural factors. For a variety of mental health problems, there is a strong foundation of evidence-based treatments (EBTs) that are generally efficacious (Kazdin, 2000) across ethnic and cultural variations. In a review of EBTs with ethnic minority youth populations, Huey and Polo (2008) reported that many EBTs were effective in treating their respective problems when used with a sample of ethnic minority youth. Although these treatments have not yet met criteria for being *well established*, several are *probably or possibly efficacious*, a distinction indicating efficacy versus an active placebo and verification by independent researchers. *Probably and possibly efficacious* treatments were found for a variety of disorders (e.g., conduct problems, anxiety, depression, etc.), primarily for African American or Hispanic/Latino/a youth (Huey & Polo, 2008). Researchers have also examined *adapting* EBTs for use with ethnic minority youth. These approaches entail making modifications that allow treatment to align with the values, beliefs, and traditions of a given group (e.g., Gallardo, Yeh, Trimble, & Parham, 2012). Only a handful of these approaches have been undertaken (Huey & Polo identified 10), primarily with African American and Hispanic/Latino/a populations, but they were deemed probably or possibly efficacious as well.

Regardless of the treatment or the target problem, clinicians working with youth are wise to be cognizant of the manner in which cultural factors can influence both the development of the problem and progress in treatment. The lens of multiculturalism and cultural competency provides a framework in which case conceptualization and treatment can be viewed. Culture can be defined as a series of beliefs, values, codes of behavior, and attitudes that are passed down among social groups (Kashima & Gelfand, 2012). Cultural competency goes beyond simply being aware of broad generalizations of typical expectations of a cultural group (Sue, Zane, & Nagayama Hall, 2009) and requires consideration of the child's own experience of what is it like for him or her to be a part of that culture. Working with youth almost always necessitates interaction with parents and other systems. Even if there is not direct contact with these entities, having

an awareness of how cultural factors can impact the youth at the family, organizational (i.e., school), and larger community levels will facilitate treatment (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010).

A therapist's cultural competency is aided by understanding the ways in which cultural factors can influence development. Cultural differences, for example, are seen with respect to theory of mind (e.g., focusing on contextual or situational attributions to explain behavior), and these can be tied to the individual versus collectivist orientation of cultures. More broadly, differences have been found for average age of attainment of developmental milestones, the amount of independence and autonomy expected of children, and conceptualization of what types of attachment styles are considered normative (for review, see Pumariega & Joshi, 2010). These factors merit consideration when making evaluations about material discussed during therapy or results from assessment measures, especially considering that these measures themselves may need added attention to achieve validity with diverse cultures/groups.

An important developmental period concerns the building of one's individual identity. Erikson (1950) postulated that one's identity was a product of the interplay between the individual and one's larger group spheres, and he believed that identity formation was the principal task of adolescent development. Research suggests that identity formation in adolescence is remarkably similar across genders and different ethnicities; however, both acculturation and gender do influence the manner in which youth use particular processes and, therefore, the outcomes of identity development (Schwartz & Montgomery, 2002). Issues regarding identity formation can be particularly relevant for those youth who come from a multicultural household or immigrant families. Indeed, second-generation youth have been found to be at a much higher risk for the development of psychological problems (Pumariega, Rothe, & Pumariega, 2005), though issues besides conflicting identities are also influential, such as racism, discrimination, and microagressions. These may be issues that are particularly salient for youth. For example, there is some suggestion that the effects of perceived racism on psychological distress are larger for children than for adults (Schmitt, Brnascombe, Postmes, & Garcia, 2014). For clinicians, this presents a unique challenge to help youth form their own identity and to foster resilience and healthy ways of coping with these negative contextual factors.

To work effectively with diverse clients, it is helpful for clinicians to examine their assumptions and beliefs about the world. Concerning youth, clinicians should consider how the presenting problem and the treatment program are viewed not only by the client but also by the client's parents, community, and other settings (e.g., school). They should also take into account how cultural and contextual factors may influence attitudes toward treatment, conceptions of mental illness, and assumptions about the role of the clinician. Indeed, "flexibility within fidelity" (Kendall et al., 2008) is part of the process of delivering mental health care to diverse youth.

CLINICAL ILLUSTRATION

Eli was a 10-year-old Caucasian boy referred by his school counselor for difficulties associated with anxiety. He lived with his parents and 8-year-old sister in a small, middle-class suburban community. Eli was in the fifth grade and had always done very well in school, but his anxiety about going to school had increasingly interfered with his ability to focus in class in the year leading up to his referral for treatment, resulting in a slight decline in his grades. Although Eli's shyness made it difficult for him to make new friends, he was a courteous, kind, and well-liked boy. Eli's family was close-knit, and he got along well with his parents and sister.

Prior to beginning treatment and to guide conceptualization, Eli and his parents were interviewed separately using the Anxiety Disorders Interview Schedule, child and parent versions. During the interview, Eli's parents reported that Eli was experiencing symptoms consistent with social anxiety disorder. Eli had reportedly always been a shy child, but his desire to please others had led him to become increasingly anxious in social situations in recent years. Eli's parents reported that Eli feared negative evaluation in a number of social and performance situations, including working in groups, soliciting help from his teacher, joining in on conversations, giving oral reports in class, and performing during track meets. Eli's parents also reported that Eli avoided social situations: He would ask his teacher if he could write a paper rather than give an oral report; he often felt nauseous before track meets and avoided

competing; and he avoided talking to new people and consequently had few friends. Per Eli's own report, his symptoms were consistent with social anxiety disorder, and both Eli and his parents reported that his fear and avoidance of social situations was causing serious interference in his social and academic life.

In addition to social anxiety, Eli and his parents reported symptoms consistent with separation anxiety disorder. Per his parents' report, Eli had difficulty separating from his parents to go to school and to go to sleep at night. Eli and his mother had a bedtime routine during which they would read together and talk about his day, and Eli's mother would lie down with him until he fell asleep. They had had this routine since Eli was very young, and Eli was afraid to go to sleep without his mother in the room. Eli's mother reported enjoying their time together in the evenings, but that Eli's fear of going to sleep without her in the room caused difficulties when she went out with friends at night or on short business trips. Eli reported feeling nauseous in the mornings before school and would often try to stay home. Once in school, Eli reported worrying about harm befalling his parents. Similarly, Eli's parents reported that Eli experienced anticipatory worry prior to being separated and that he would call his parents multiple times when they were not together. Eli's parents reported that Eli's separation anxiety was interfering with his social life (e.g., he was unable to go on sleepovers) as well as with his academic life (e.g., his grades were suffering in school because of his difficulty concentrating when away from his parents). Eli had always been close with his parents, particularly his mother, and had had difficulty separating from them since he was very young, but his fear and avoidance of being away from his parents had worsened in the past year.

Treatment

Based on the assessment, Eli met criteria for social anxiety disorder and separation anxiety disorder, conditions that can be treated with CBT. Eli's age, good performance in school, and compliant nature suggested that he would be able to understand CBT concepts (e.g., anxious and coping thoughts) and would be motivated to participate actively in treatment. *The Coping Cat* program (Kendall & Hedtke, 2006a, 2006b) is a manual-based program that guides treatment for children with anxiety—guiding the therapist on how to address simultaneously Eli's symptoms of separation and social anxiety. The first half of treatment focused on rapport and skill building. The therapist helped Eli to identify and understand his emotions, with an emphasis on helping Eli to recognize his personal signs of anxiety (e.g., racing heart, sweaty palms). To target physical symptoms of anxiety, Eli practiced relaxation (e.g., deep, diaphragmatic breathing; progressive muscle relaxation). To target negative self-talk associated with anxiety, the therapist worked with Eli to identify his anxious thoughts or "thinking traps." For example, Eli reported that when he was at a track meet, he would think, "I am going to make a mistake, and everyone will laugh at me." The therapist guided Eli in challenging his anxious thoughts (cognitive restructuring). Eli was encouraged to consider the evidence for and against his anxious thoughts using questions like "What has happened in the past?" and "What is the most likely outcome?" Answering these questions helped Eli to form his own "coping thoughts," such as "I'm going to try my best" and "Nobody's perfect," thoughts that he would then say to himself when faced with an anxiety-provoking situation. Later in the skill-building portion of treatment, the therapist taught Eli problem-solving skills and introduced the concept of rewards for brave behavior. Throughout treatment, the therapist worked with Eli to establish a collaborative working relationship (e.g., "You are an expert on you; I'm an expert on anxiety, and we can work together to see what's best for you"). Skills such as relaxation and challenging anxious thoughts were presented in a developmentally appropriate way. For example, the image of squeezing and dropping lemons was used to practice tensing and relaxing muscles, and Eli was encouraged to imagine a "thought bubble" over his head to help identify his anxious thoughts. Skills were practiced multiple times in session, as well as in short at-home assignments, to develop mastery and self-efficacy.

During the second stage of treatment, the therapist worked with Eli to put his newly learned coping skills into practice in exposure tasks. The therapist collaborated with Eli to construct a fear hierarchy that listed Eli's feared situations from 0 (no anxiety) to 8 (maximum anxiety). For example, Eli rated being in his bedroom while his mother was in the kitchen as a 2. Going over to a friend's house for a sleepover was rated as an 8. Over the course of the second half of treatment, Eli was encouraged to approach feared

situations, starting with situations at the bottom of his fear hierarchy and working his way up. Eli practiced facing his fears by completing challenges (i.e., exposure tasks) in session and outside of therapy. For example, in one session, Eli completed a challenge during which he talked with several new people (e.g., administering a survey to four strangers). Eli and the therapist formulated a homework challenge: asking a classmate at school three questions. Eli was encouraged to monitor his anxiety before, during, and after the challenge task, and to reward himself for his effort. In the following session, Eli and his therapist reviewed the experience of doing the homework challenge.

As is typical given Eli's age, the therapist met with Eli's parents at several points throughout treatment. Two of the treatment sessions were parent-only sessions: one at the beginning of treatment to get parent input to identify/hone treatment goals and provide parents with an overview of the treatment program and one parent-only session prior to beginning the exposure tasks. Eli's parents were encouraged to model brave behavior, to reward Eli for approaching feared situations (and related efforts), and to minimize/eliminate any accommodation of anxious behavior. Eli's parents were invited to meet with Eli and the therapist at the end of each session to review the in-session exposure tasks and to plan at-home exposures for the coming week. In working with Eli's parents and family, the therapist remained sensitive and aware of family culture and dynamics. For example, when planning exposures that involved Eli going to bed by himself, the therapist worked with the family to plan a nighttime routine in which he would spend some time reading and talking with his mother outside his bedroom before going to bed, so that their cherished close time together was preserved while Eli worked toward being able to go to bed independently.

After 20 sessions (approximately 8 psychoeducation sessions and 12 exposure sessions), both Eli and his parents reported meaningful improvements. Eli was able to manage his anxiety when separated from his parents, and he had gone to a peer's home for his first sleepover. Eli was competing regularly in track meets and even invited a new friend on a play-date. In the final session, as part of the *Coping Cat* program, Eli made a "commercial" in which he celebrated his progress and his ability to manage anxiety. During this final session, the therapist also spoke with Eli and his parents about the importance of adopting a "challenge lifestyle" by continuing to approach (rather than avoid) feared situations.

CONCLUSIONS/KEY POINTS

Psychosocial interventions for children and adolescents, based in different theoretical models, are available to address mental and behavioral health problems affecting youth. Psychosocial treatments may be focused on the individual youth, their parents, or the family as a whole and may target problematic behaviors, cognitions, and/or interpersonal relationships. These interventions are built on thorough and ongoing case conceptualization, which considers contextual factors within the family, school and community environment, and social relationships. Changes in cognitive, emotional, behavioral, and social functioning, along with therapy and family factors, may all influence treatment progress and outcomes.

Several specific interventions have received scientific support for addressing psychological and behavioral problems in youth (see Kendall, 2012a). CBT has been shown to be an effective psychosocial intervention for youth anxiety and obsessive-compulsive disorders and is also supported in the treatment of depression. Behavior-focused interventions are empirically supported for externalizing problems, such as ADHD and disruptive behavior disorders, as well as autism spectrum disorders. Within an empirically based framework, it is recognized that therapists working with youth employ "flexibility within fidelity" (Kendall et al., 2008) and remain adaptive to developmental and cultural influences. Treatments that have received empirical support receive endorsement, but other approaches also merit research attention.

Key Points

- Contemporary psychosocial interventions for youth may be youth focused, parent/family focused, or environmentally focused and are based in various theoretical frameworks (e.g., cognitive-behavioral theory, learning theories, and family systems).
- Comprehensive assessment, using information from youth, parents, teachers, and family

members, informs the case conceptualization and intervention.

- Mechanisms of change across therapy with youth include changes in youth's cognition (e.g., self-talk; sense of coping efficacy) and behavior (e.g., approach instead of avoidance; activation instead of isolation) and parent behaviors (what to ignore, what to reward).
- Although there are areas where further research is warranted, several interventions for various psychosocial problems in youth have been applied, evaluated, and found to be effective (empirically supported treatments).
- When working with children and adolescents and their parents, it is important to consider developmental level and cultural influences.

REVIEW QUESTIONS

1. What are the major theoretical bases for therapy with children and adolescents today?
2. What types of assessment tools may be used to aid case conceptualization?
3. What child, family, and therapist factors may be influential in treatment progress with youth?
4. What therapy interventions have received empirical support for addressing depression, anxiety, obsessive-compulsive disorder, trauma, eating disorders, disruptive behavior, attention-deficit/hyperactivity disorder, and autism spectrum disorders in children and adolescents?
5. How are cultural influences on development important in early childhood and in adolescence?

NOTE

1. We steered away from the word "psychotherapy" when referring to treatments for youth because of the connotation (to many people) to the more historic features. Instead, we use "psychological therapy" because it is more accurate in the generic sense.

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19

Psychotherapy With Older Adults: Theory and Practice

Adriana Hyams
Forrest Scogin

Abstract
This chapter provides a brief history of psychotherapy with older adults and an overview of six evidence-based psychotherapies commonly used with this population (i.e., life review, psychodynamic, interpersonal, cognitive-behavioral, behavioral activation, and problem-solving psychotherapy), including research evidence to support their efficacy. It discusses issues to consider when conceptualizing and adapting psychotherapies for older adults, such as diagnoses common to late-life and typical biopsychosocial themes that arise in psychotherapy. Various aspects of diversity may also play an important role in treatment planning. Finally, a case study illustrates that many of these approaches may be, and in fact often are, used eclectically with clients.

Keywords: older adult, psychotherapy, evidence-based, diversity, conceptualization

In the early 1900s, it was believed that psychotherapy with older adults was contraindicated because they were incapable of change or slow to learn new things (Hepple, 2004). Psychodynamically oriented psychotherapy, the dominant modality for much of the 20th century, tended to focus on childhood through young adult life. Development beyond young adulthood was deemphasized and thought to be determined by early experience (Hepple, 2004). Older adulthood was a period of decline, not a time of potentially positive psychological experiences. Existential concerns (e.g., death, achieving a meaningful life) were not emphasized. It was not until the second half of the 20th century that Erik Erikson (1902–1994), himself trained in psychodynamic theory, recognized older adulthood in the cycle of development, with its tasks of generativity versus stagnation and integrity versus despair (Erikson, 1950). In evaluating their lives, he postulated older adults are motivated to feel they have passed knowledge or skills on to younger generations as part of their legacy (i.e., generativity). If they do not believe they have achieved this goal, their lives may seem meaningless and self-absorbed; nothing will remain of them after they pass. The task of integrity versus despair engages older adults to evaluate their lives for both positives and negatives. If they are satisfied with their lives, they have integrity. If not, they despair because their lives are almost over, and they experience a lack of fulfillment.

Another theorist who had a more developed view of aging was Carl Jung (1875–1961). He saw late life as a time to expand oneself and grow as death draws near. Older adults have the freedom to shed their concerns about society's judgments and do what they always wanted. For example, if the person was discouraged from making art as a child because of a lack of ability, late life is the time to experience it. Living life as though each day might be the last would be an appropriate motto (Patton, 2006).

One theory of aging consistent with both of these theorists' ideas is the socioemotional selectivity theory. It posits that when people feel their time left on Earth is limited, they are more likely to seek positive, meaningful social experiences to gain emotional sustenance than people with many more years to live. Thus, older adults will concentrate their declining physical and cognitive energies on interactions with people with whom they have the strongest relationships (e.g., family and long-time friends). Emotionally, they focus on the positive aspects of these relationships and downplay the negative. They live in the moment instead of planning for the future. These ideas become significant in psychotherapy with older adults because when clients begin to have psychological problems due to fears about the end of life, for example, they can be encouraged to focus on the present in therapy and to form goals for what they want now (Carstensen, Isaacowitz, & Charles, 1999).

Around 1980, late life received more attention with the substantial growth of the field of geropsychology (i.e., the specialized field of psychology concerned with the psychological, behavioral, biological, and social aspects of aging) and its research (Krampen & Wall, 2003). The work of Larry Thompson and Dolores Gallagher-Thompson primarily led the way in establishing the efficacy of psychotherapy with older adults. As this population rapidly increases, it is becoming more and more important for psychotherapists to be well versed in how to treat the complicated biopsychosocial pictures that older adults bring.

MAJOR THEORETICAL APPROACHES AND VARIATIONS FOR OLDER ADULTS

The following six approaches to psychotherapy with older adults are presented in no particular order. They were chosen because they are the most frequently used with older adults, and some have a long history. All of them have an evidentiary base, but some have been tested more than others. Aspects of these treatments are often used eclectically, so they are invaluable in constructing a toolbox for work with older adults.

Life Review Psychotherapy

One type of psychotherapy developed specifically for older adults and influenced by Erikson's task of integrity versus despair is life review. From this perspective, older adults are compelled to recall their life experiences, good and bad, and reintegrate them into a meaningful whole. The process helps older adults gain a greater understanding of their lives and themselves and may allow them to come to terms with losses. Photographs, music, memorabilia, field trips, and genealogies may cue memories, and sometimes tape recordings, written documents, or scrapbooks can make memories permanent for future generations to learn from, facilitating the task of generativity versus stagnation (Haber, 2006). Life review is believed to improve socialization, mental health, and life satisfaction while providing cognitive stimulation.

Psychodynamic Psychotherapy

Psychodynamic theory assumes all developmental stages may influence older adults' present states, and the symptoms they are experiencing may have unconscious meaning (Gallagher-Thompson et al., 2000). In particular, if issues from these developmental stages linger, it may be more difficult for older adults to cope with current related stressors or losses (Karel & Hinrichsen, 2000).

Understanding current and past relationships is integral to psychodynamic psychotherapy, and transference and countertransference in the therapeutic relationship are thought to illustrate everyday interpersonal patterns (Garner, 2002). Transference refers to the reactions clients have toward psychotherapists, and countertransference is the reaction psychotherapists have toward clients. These may influence work with older adults. If their physical health is in decline, for example, psychotherapists may pity them, which can affect psychotherapists' abilities to be objective. Alternatively, psychotherapists may glorify older adults, wishing they could be the grandparents they wanted to have. For older adults, sexual attraction to psychotherapists may arise. Sometimes, however, younger psychotherapists have been influenced by a society that believes older adults have no sexual feelings (Garner, 2002). They may inadvertently discount these feelings or discourage older adults from exploring sexual concerns in psychotherapy. Older adults may also see psychotherapists as sons or daughters because of the age difference, or they may treat psychotherapists as parents because of the attention

and care shown to them. Psychotherapists' responses may be influenced by their own issues with their parents and important relationships (Morgan, 2003).

Interpersonal Psychotherapy

The focus on relationships in psychodynamic psychotherapy played a role in the development of interpersonal psychotherapy (IPT) in the 1970s. IPT began to be used extensively with older adults in the 1990s (Hinrichsen, 2008). The theory proposes depression is instigated, perpetuated, and exacerbated by problems in relationships, which may include role changes, interpersonal conflicts, complicated grief, and interpersonal skill deficits. This rationale is explained to clients to get their "buy-in," and psychoeducation about depression is also provided (e.g., comparing it to any other physical illness that should and can be treated). To understand how relationships are operating in depression, psychotherapists and clients explore current, and sometimes past, relationships, communication patterns, expressions of feelings, and/or role transitions (Hinrichsen, 2008; Miller & Reynolds, 2007).

Clients may be helped to cope with new roles by exploring their feelings surrounding the transitions, including mourning the loss of old roles. Comparing the pros and cons of the old and new roles, encouraging them to contemplate positive changes that have developed because of the new roles, and focusing on abilities they still have may bring acceptance. Adapting to new roles increases self-esteem. Because role transitions are often difficult, motivating clients to contemplate ways to seek out support from significant others or to develop new relationships is important (Hinrichsen, 2008; Miller & Reynolds, 2007).

When interpersonal conflicts occur, the reasons for disagreement and the values of all parties can be explored in psychotherapy. Communication between parties is relevant, as misunderstandings can ensue when people are not clear about their feelings or desires. Similarly, sometimes parties say things in ways that inadvertently offend others. Thus, exploring parties' communication patterns, both negative and positive, is useful. It may be accomplished through role-plays, modeling for the client how a positive interaction might occur, or consideration of the therapeutic relationship (e.g., reviewing positive and negative interactions the therapist and client have and determining whether similar patterns occur in other relationships the client has).

Discussing how their interactions contribute to their feelings is important and can give older adults insight into more productive interactions. When there is an understanding of the points of view and the communication patterns of all sides, then a plan can be developed to move forward. With older adults, sometimes directly offering suggestions for developing healthier relationships is appropriate, if clients are having difficulty realizing their options. They may need to change their expectations of others or implement new communication strategies.

When the goals of psychotherapy have been accomplished, it is time to consider termination. Termination is crucial because the end of the therapeutic relationship may be perceived as another loss. Thus, discussion of clients' competence and self-efficacy should be reinforced to encourage them that they can manage challenges (Gallagher-Thompson et al., 2000; Hinrichsen, 2008).

Finally, IPT can be difficult if clients are cognitively impaired. Poor memory can prompt role disputes because events are remembered differently by older adults and their caregivers. Fortunately, successful modifications to IPT have been created. Caregivers are invited into the psychotherapy process, either in joint or individual sessions. In individual sessions, caregivers may express concerns about the older adults that they do not want to express in front of them, or they may have worries regarding the future that they need to discuss with someone.

Joint sessions facilitate successful problem solving from both points of view, or they engender understanding of caregivers' feelings/situation, which care recipients may not have realized before. Joint sessions are a strategy for reinforcing gains made in psychotherapy, as caregivers can remind care recipients of these over the course of the week. They can be educational for caregivers, too, as they may not fully understand what care recipients are capable of or not.

Sometimes caregivers may take away care recipients' decision-making opportunities completely, thinking they can no longer be independent in any sense. However, to maintain care recipients' dignity, caregivers can provide them with multiple-choice options, which will give them some semblance of agency. Showing the dyads how to break down problem solving into smaller, more manageable steps may further encourage care recipients' ownership of their decisions.

Furthermore, praising care recipients for completed tasks is motivating (Miller & Reynolds, 2007).

Cognitive-Behavioral Psychotherapy

Whereas the preceding therapeutic approaches consider maladaptive emotions and interpersonal relations, cognitive-behavioral psychotherapy (CBT) emphasizes maladaptive thoughts and behaviors as central to problems in living. The central premise in Beckian CBT, the prototype model used with older adults, is that information processing (e.g., about the self, experiences, or the future) leads to negative emotions, and emotions trigger maladaptive behavioral responses (e.g., avoidance). Thoughts are often identified as extremes (e.g., sometimes is construed as "always" or "never"), or clients may catastrophize, thinking the worst will happen. In CBT, clients are guided to find evidence for and against their own thoughts to make them more adaptive.

Most CBT protocols tend to work from a 16- to 20-session model and are more directive and structured than, for example, IPT. It may include relaxation training, assertiveness training, problem solving, or pleasant events scheduling. CBT is skill oriented and uses homework as a tool to reach and practice desired outcomes. Psychotherapists may ask clients to keep thought records, where they track their maladaptive thoughts, what triggered them (e.g., the situation), how they felt when they thought them, what made them worse or better, how long they lasted, and how they behaved because of them. These records are used to devise intervention plans (Evans, 2007; Karel & Hinrichsen, 2000). One commonly used assignment is the three-column technique, where clients describe events, identify maladaptive thoughts, and observe the emotions and the resulting behaviors.

An important consideration for older adults is their cognitive capacity because CBT requires the use of working memory and attention. Cognitive screeners such as the St. Louis University Memory Screening (SLUMS; Morley & Tumosa, 2002) may be used during the initial sessions to get a sense of their abilities. CBT may be adapted for older adults by repeating and summarizing information discussed in sessions, discussing ideas in different ways, and using folders and/or notebooks to keep all session materials in one place where older adults can refer back to them as needed (Evans, 2007).

Behavioral Activation

Behavioral activation (BA) represents an approach stemming from traditional operant learning theories in which depression is associated with a lean schedule of reinforcement (Ferster, 1973). BA may be especially useful for older adults who do not have the desire or cognitive capacity to delve into their thoughts. Contemporary models of BA suggest that older adults with comorbid depression and anxiety may avoid their typical activities and ruminate about negative consequences of doing them (Hopko, Lejuez, Ruggiero, & Eifert, 2003). BA aims to increase pleasurable activities to improve mood and mental health. After explaining the rationale behind BA, the approach begins with a functional analysis of the older adult that focuses on the environment and significant life events related to the episode of depression (e.g., death of a loved one, chronic illness, etc.). Psychotherapists and clients also discuss avoidance patterns, changes in routine, and decreased activity to understand how best to implement BA. Then clients can talk about the kinds of activities that would be pleasurable to them and that they are willing to do. Making pleasant events schedules can be an important part of BA because it is thought that clients' avoidance disrupts social rhythms, which contributes to the depression. Thus, re-establishing old routines or making new ones can stabilize mood. Additionally, clients should fill out activity logs and record how they feel while doing the activities so they can observe the effect of activity on mood. The logs also prod clients and psychotherapists to discuss what worked and to troubleshoot problems and modify schedules. Another way to optimize treatment outcomes is by starting with activities that are easier to achieve, giving clients a sense of mastery, and then progressing to more difficult activities. Alternatively, breaking down challenging tasks into smaller, manageable chunks can be helpful (Jacobson, Martell, & Dimidjian, 2001). Combining difficult tasks with pleasurable ones may assuage any discomfort challenging tasks bring (Holland & Diliberto, 2012).

Problem-Solving Psychotherapy

Another active, solution-focused psychotherapy for older adults is problem-solving psychotherapy (PST). Similar to the rationale for BA, older adults with depression suffer from avolition and inertia,

which makes it unlikely they will take the reins and consider how to resolve the problems that instigated and perpetuate their depression. Or they may feel poor problem-solving skills led them to the situations that triggered their depression. Additionally, executive functioning, that is, the cognitive ability that makes it possible to anticipate the consequences of a decision, consider the pros and cons of different solutions, and make changes as necessary, declines with age and is impaired further with depression. PST teaches these older adults how to solve their own problems. It is thought that when they see they are capable of making good decisions, they will feel a sense of self-efficacy that empowers them and that will have a positive effect on their mental health (Areán, 2009).

In the first session, the rationale for the psychotherapy is explained. A list of problems ordered from easiest to hardest is created. It may be that the easiest problems can be solved without therapist assistance, which is encouraged. The psychotherapy will likely begin with a moderately difficult problem so that older adults can grasp the steps of problem solving and observe their utility, hopefully before the next psychotherapy session. A moderately difficult problem also decreases the possibility older adults will become emotionally consumed by the issue. The problem should be delineated in a detailed, concrete manner that facilitates the creation of concrete, achievable goals. Then potential solutions to the problem should be listed without allowing clients to judge them. This dissuades them from perseverating on one solution without giving the others a fair chance, or from insisting that none will work. The pros and cons of each solution are considered before clients choose the one they like best. These might include a consideration of the amount of time or effort required to carry out a particular solution, how affordable it is, or whether it will create other problems. When a decision is made, clients work with the therapist to devise a plan to carry it out. If it seems like it will be an arduous task, the therapist can integrate BA into the treatment, planning enjoyable activities during the week to break up the work. Motivation to follow through with the plan may be increased if it can be connected to another pleasant event. At the next session, clients discuss their plans' successes and setbacks. They take what they learned from their experiences and generate new solutions to remaining problems (Areán, 2009).

PST can last about eight sessions, with some psychotherapists preferring weekly sessions and others biweekly sessions (Areán, 2009). If older adults have cognitive impairments, psychotherapists become more directive and focus on easier problems to ensure clients learn the steps of good problem solving before they move on to harder problems.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION IN PSYCHOTHERAPY WITH OLDER ADULTS

The choice of therapeutic approach takes into consideration the nature of the problem, the severity of the psychological symptoms, and the conceptualization of the older adults' biopsychosocial history (Francis & Kumar, 2013). Depression and anxiety are thought to be the most common mental disorders among older adults, but personality disorders are also common (Hooyman & Kiyak, 2011). They are often co-occurring, which may warrant combining psychotherapy techniques to target multiple facets of the emotional distress. Personality disorders may be hard to diagnose and difficult to treat. They require a lifelong pattern of maladaptive behaviors that the significant others who are currently in clients' lives may not be privy to (e.g., adult children) and that clients do not see as problematic. Personality disorders, such as borderline personality disorder, tend to diminish in intensity with age (Mordekar & Spence, 2008). Older adults may become less impulsive, more interpersonally appropriate, and less emotionally labile. Nonetheless, these are lifelong patterns of behaviors and they are well ingrained. Thus, older adults with personality disorders will likely have low motivation to change, and psychotherapy can be difficult. Research suggests it is important for psychotherapists to maintain boundaries with clients, and it can be helpful to work on improving existing relationships with significant others (Mordekar & Spence, 2008).

No matter which approach psychotherapists use, there are common themes that recur in work with older adults, often of loss. These may include deaths of family or friends, loss of independence that leads to placement in a nursing home, or retirement and the loss of professional identity. Processing clients' lives and using their life experiences and relationship patterns as tools for learning and growth helps them cope with their current problems and become

more adaptive. Conceptualizing older adults must include consideration of standard changes that emerge with advanced age. Medical conditions become more prevalent and numerous. Likewise, cognitive decline and sensory difficulties (i.e., hearing and vision) create obstacles to optimal functioning. These changes may lead to mental health problems, disability, decreased activity, role changes, loss of independence that requires caregiving, and feelings of becoming a burden to others. These consequences may convince older adults to seek psychotherapy. Furthermore, these conditions may require modifications to psychotherapy. Work with older adults may involve assisting them to become active again. However, ultimately, psychotherapists may not be assisting clients in changing but in accepting their losses (Evans, 2007; Garner, 2002). Considering all of these factors when conceptualizing older adults will enable psychotherapists to formulate effective treatment plans.

Psychotherapists may find a combination of approaches to be more effective than just one when conceptualizing older adults and their problems. Such eclectic approaches should focus on evidence-based therapies (EBTs) when possible. Scogin and Shah (2012) edited a text that identified EBTs for common disorders and problems presented by older adults: anxiety, depression, insomnia, memory complaints, dementia associated behavior problems, and caregiver distress. If the presenting problem deals with relationships, for example, IPT may be more appropriate than CBT. Those older adults who do a lot of thinking and reasoning may do better with CBT (Hepple, 2004). On the other hand, some older adults have too many cognitive decrements to engage with their thoughts, so BA may be more accessible to them. Nevertheless, the use of one therapeutic approach does not preclude the use of another; sometimes one theoretical orientation is most effective for targeting one problem while another approach will be used for another problem. For example, Greenlee et al. (2010) found older adults with comorbid depression and anxiety were less responsive to IPT than older adults with depression alone. They suggested combining CBT with IPT as a potentially more effective approach with such cases.

Whichever approaches are selected, there are common factors that make any psychotherapy effective: empathy, the therapeutic alliance, unconditional positive regard, goal consensus and collaboration, and client feedback (Laska, Gurman, & Wampold, 2014; Norcross & Wampold, 2011). Clients must play an active role in forming their own goals because if they are not on board with the process, progress will be unlikely. After choosing appropriate therapeutic approaches for clients based on their presenting problems and biopsychosocial history, it is important to explain the rationale for treatment with clients to secure their agreement and motivation. To achieve the goals, aspects of the therapeutic relationship assure clients feel safe about being open and honest so that exploration, insight, and change commence. Psychotherapists should strive to understand clients' emotions, thoughts, behaviors, and experience through empathy and offer appropriate support. The therapeutic alliance and unconditional positive regard are essential tools to achieve empathy because it is only through therapists' warmth, caring, and acceptance that clients can share their experiences, positive or negative, truthfully. Clients will also feel safe trying new things, potentially making mistakes, and growing. Finally, it is important to ask clients for feedback so that therapists know what is working for clients. If something is not working, therapists should not act defensively but try something different; approaches do not work with all clients. In fact, accepting negative feedback and overcoming it by trying a new strategy models adaptive behavior for clients.

RESEARCH ON EFFICACY AND EFFECTIVENESS OF PSYCHOTHERAPY WITH OLDER ADULTS

The preceding six psychotherapies have received varying attention in the literature, but all are supported as effective treatments for older adults. They all have shown they are capable of significantly decreasing depression (Francis & Kumar, 2013; Scogin et al., 2005; Snarski et al., 2011; Yon & Scogin, 2009). Some studies have found they diminish anxiety (Barrowclough et al., 2001; Cuijpers et al., 2014; Gorenstein et al., 2005; Korte, Bohlmeijer, Cappeliez, Smit, & Westerhof, 2012; Stanley et al., 2003). Often, psychological gains have been maintained at multiple-month follow-ups (Areán, Hegel, Vannoy, Fan, & Unuzter, 2008; Bruce et al., 2004; Gorenstein et al. 2005; Hinrichsen, 2008; Korte et al., 2012; Stanley et al., 2003). Importantly, the approaches have been found to be comparable in their outcomes

(Areán et al., 2008; Cuijpers et al., 2013; Francis & Kumar, 2013; Karel & Hinrichsen, 2000; Scogin et al., 2005). When compared to usual treatment, they tend to perform better (Areán et al., 2010; Francis & Kumar, 2013; Snarski et al., 2011).

Some approaches have achieved more unique research outcomes. IPT, in combination with medications or alone, has decreased depressive symptoms and suicidal ideation. IPT may be comparable to antidepressants (Bruce et al., 2004; Hinrichsen, 2008).

BA has been shown to be an effective stand-alone treatment. It has demonstrated it is equally effective at decreasing depression as medications with middle-aged adults (Dimidjian et al., 2006). It has been beneficial for bereaved older adults because it distances them from their losses by doing social activities or recalling positive memories about the deceased (Holland & Diliberto, 2012). In comparison to treatment as usual, older adult inpatients with mild to moderate cognitive impairment at a state geriatric psychiatry facility experienced decreased depression, regardless of degree of cognitive impairment (Snarski et al., 2011). In another study completed in the same facility with similar subjects, quality of life was rated significantly better after BA, though there was no effect on behavioral or psychological symptoms (DiNapoli, Scogin, Bryant, Sabastian, & Mundy, 2016). More research on BA with older adults is warranted.

Research on PST suggests its success does not seem limited to certain types of issues. Modifying PST for cognitively impaired older adults improved depression ratings so that 46% of the sample no longer met criteria for depression after 12 weeks, compared to 26% of a supportive psychotherapy comparison group (Areán et al., 2010).

CBT has received the most attention in the literature and therefore has received some of the most rigorous testing. The pooled effect size from 28 studies of CBT versus waitlist control was found to be 0.84 in a meta-analysis, though there were suggestions of publication biases (Cuijpers et al., 2014). Likewise, a meta-analysis of 75 randomized controlled trials demonstrated CBT achieved a mean effect size of 0.71, though there was pronounced evidence of publication biases (i.e., studies that were not published because they were not significant) (Cuijpers et al., 2013). Scogin et al. (2005) also found CBT had better outcomes than control conditions. Some studies have shown it reduced symptoms of depression and anxiety significantly more than other treatments, and it has achieved large effect sizes compared to other psychotherapies' small to moderate effect sizes (Barrowclough et al., 2001; Gorenstein et al., 2005). Furthermore, CBT outcomes are often maintained or improved upon at follow-up (Gorenstein et al. 2005; Stanley et al., 2003).

DIVERSITY

One important consideration when providing care to older adults is diversity. Psychotherapists will likely serve older adults of various races, ethnicities, cultures, sexual orientations, religions, socioeconomic statuses (SES), health conditions, sensory impairments, and cognitive abilities. These factors can make treatment complex and demand individualized intervention plans. Although there is sometimes evidence for a certain psychotherapy working significantly better for one racial/ethnic group than another (Scogin et al., 2007), there is also research showing psychotherapies are comparably successful across racial/ethnic groups. In particular, interdisciplinary approaches that combine education, medications, and psychotherapy are preferred (Areán et al., 2005; Lichtenberg, 1997; Quijano et al., 2007). Yet psychotherapists must consider whether diversity issues apply to clients when tailoring psychotherapy to individuals and providing nuanced, effective psychotherapy. There is no set formula or step-by-step guide to conducting psychotherapy. The process is guided by each unique client.

Diversity of Cultural Values

Of the approximately 40 million adults 65 years and older in the United States, about 8.5 million are racial and ethnic minorities, and their numbers are expected to grow 160% by 2030 (Administration on Aging [AOA], 2012). Members of the same ethnic minority can have different language and cultural backgrounds (e.g., Ecuadorian Latinos/as are different from Brazilian Latinos/as). Furthermore, there are differences between clients who have acculturated to the dominant culture, those who are bicultural, and those who are recent immigrants. Psychotherapists should be aware of their own cultural values as well as the values of their ethnic minority clients so

they can adapt psychotherapy to clients' needs and preferences.

Psychotherapists are also encouraged to be aware of possible cultural mistrust, a phenomenon where some racial or ethnic minorities may struggle to trust their Caucasian therapists. This may lead some minority clients to have low expectations for Caucasian psychotherapists and terminate early. Therapists are advised to keep in mind that that attitude may be in response to previous experiences of racism or discrimination encountered by ethnic minority clients and pose a challenge to the development of the therapeutic alliance. To overcome this barrier, psychotherapists must be open to exploring clients' beliefs that they have experienced racism or discrimination from psychotherapists, learning about clients' cultural beliefs and accepting them and their cultural mistrust without passing judgment. However, psychotherapists should not assume negative interactions in psychotherapy are due to cultural mistrust. As with any interaction, there may be many possible causes, and these should be explored before making an attribution (Crowther & Hyams, in press). Moreover, psychotherapists must hone in on their cultural competence and humility, particularly in relation to work with older adults.

Familism is a common cultural value shared across many ethnic minorities. It can be described as loyalty, reciprocity, and solidarity within one family (Crowther & Hyams, in press). It encourages some clients to rely on their families to make treatment decisions for them. Thus, family members of older adult clients may have an important role to play in clients' acceptance of an intervention plan. Alternatively, familism may lead older adults to expect and depend on their family members (e.g., spouses) for caregiving. That may generate guilt if caregivers do not fulfill familial obligations. Some research has suggested caregivers with cultural values of familism have poorer mental health than caregivers without these values, whereas other research has suggested familism may buffer and prevent emotional problems (Losada et al., 2006; Youn et al., 1999).

Diversity of Sexual Orientation

In addition to the growing number of racial and ethnic minorities, 1 to 3 million older adults are lesbian/gay/bisexual/transgender (LGBT). This number is expected to increase to 4 million by 2030. Discrimination often leads them to receive poorer health care and social services, such as reasonable housing and caregiving services (National Gay and Lesbian Task Force, 2006). As such, they may hide their orientation in the hope of receiving standard care. If they reside in certain states, they may have no legal authority to make medical, financial, or burial decisions for their partners who are in nursing homes or hospitals. These issues may surface in psychotherapy.

Diversity of Religion/Spirituality

Religion is highly valued in many older adults' lives, and they are more religiously active than younger adults. Importantly, religion acts as a buffer and coping mechanism for emotional distress. It tends to be even more valued in the lives of racial and ethnic minorities (Crowther & Hyams, in press). Different cultures and religions may have distinct views about death (e.g., the spiritual self may be more important than the physical self) that become relevant in psychotherapy (Garner, 2002). Religion may impact clients' conceptualizations of their problems and their reception of potential interventions, and psychotherapists may enhance psychotherapy by familiarizing themselves with these beliefs.

Medical Diversity

As previously discussed, medical comorbidity may influence psychotherapy as well. Some health conditions can lead to disability (e.g., Parkinson's disease), and some medications' side effects trigger emotional distress. Fears of physical decline, pain, dependency, and death may emerge. Psychotherapists can help by focusing attention on what older adults can do and how they can still help others, rather than ruminating about things they can no longer do (Karel & Hinrichsen, 2000). Disability may make it hard for clients to comply with some interventions (e.g., leaving the house for social opportunities). Psychotherapists should keep in mind that some distressed older adults have an exaggerated sense of their difficulties that dissuades them from activities they truly could do (Evans, 2007; Garner, 2002). This is sometimes termed "excess disability."

Relatedly, physical illnesses are seen as more acceptable than mental infirmities to some older adults. They tend to identify physical problems instead of emotional problems when they feel something is wrong with them (i.e., somaticize), so primary care physicians are often the first line of identification for mental health problems among older adults. However, health care providers may consider symptoms of depression and anxiety (e.g., fatigue, poor memory, sleep problems, pain, and gastrointestinal upset) as normal aspects of aging (Gallagher-Thompson et al., 2000). Psychotherapists can provide psychoeducation to clients to better inform their health care (Karel & Hinrichsen, 2000).

Diversity in Socioeconomic Status

Socioeconomic status (SES) may affect overall health and surface in psychotherapy. Those of lower SES may have lower health literacy, and they may not have the resources to engage in optimal health behaviors (Bowen, 2009; Shankar, McMunn, & Steptoe, 2010). Mental health is associated with physical health; thus, psychoeducation on health behaviors may be a focus of psychotherapy. Furthermore, SES may relate to overall low literacy that may impact one's understanding and engagement in psychotherapy. Psychotherapists may need to speak more concretely to make themselves and their interventions understood.

Cognitive Diversity

A decrease in some cognitive functions is common with aging. Specific changes in aging are slowed information processing speeds, decreased attention, poorer working memory and recall memory, and impaired executive functioning. These can interfere with psychotherapy processes. Conducting psychotherapy in a setting quiet and free of distractions is advised. Psychotherapists should speak at a slower rate; avoid long, complicated sentences; and present information in small, manageable chunks. Writing down key concepts from psychotherapy can jog older adults' memories from week to week and help in recall. Psychotherapists can also repeat and summarize concepts throughout a session (Knight & Lee, 2008). Using a cognitive screening instrument during the first session can inform psychotherapists of older adults' strengths and weaknesses and guide them toward an appropriate therapeutic approach (Gallagher-Thompson et al., 2000).

Diversity in Sensory Function

Some tactics that assist older adults with cognitive impairment can help those with hearing impairment as well. Hearing commonly deteriorates with age; 80% of older adults experience it. Together with slowed information processing of old age, it takes longer to process sounds (Gates & Mills, 2005). Furthermore, higher frequency sounds (e.g., female voices) are even more difficult to understand. Thus, it is important psychotherapists speak slowly and deeply, enunciating their words and facing older adults so they can see their lips moving, which may help them comprehend the sounds. When hearing loss is moderate or greater in severity, communication becomes difficult. Older adults mishear others and respond inappropriately. They may become uncomfortable socializing with others and may withdraw. Isolation often triggers depression, which affects older adults' desire to care for their physical health and promotes disability, which affects their desire and ability to socialize, so the cycle is exacerbated (Monzani, Galeazzi, Genovese, Marrara, & Martini, 2008). The psychosocial effects of hearing loss may be a reason older adults attend psychotherapy. Psychotherapists can target those negative effects and should be aware they may be lessened with hearing aids (Gates & Mills, 2005). Psychotherapists may do older adults a great service by discussing the pros and cons of hearing aids with them and determining if it makes sense to try them after seeing an audiologist.

Likewise, vision is affected with advanced age. Older adults often use reading glasses to attenuate presbyopia, which may be necessary in session if written material is used. Likewise, large, bold font may be helpful. Older adults may have more severe visual impairments due to cataracts, glaucoma, or macular degeneration. If vision is extremely poor, it may be worthwhile to use an audio recorder in sessions instead of written materials (Evans, 2007).

Cohort Differences

Psychotherapists should also consider cohort differences. The sociohistorical context in which older

adults grew up and lived their adult lives influences the way they perceive the world. It will likely influence their values, educational background, personalities, and what they will or will not do or discuss in psychotherapy. Baby boomers tend to be less involved with their communities, more liberal, and more extraverted than earlier cohorts. Earlier cohorts are more likely to be less educated and may use racist language and/or espouse such beliefs. They may be uncomfortable using certain words to describe their feelings (e.g., angry, anxious) and prefer to use others (e.g., irritated, frustrated, concerned) (Knight & Lee, 2008).

Relatedly, as psychotherapy is a relatively recent widely available treatment option, it may be quite important to explain what psychotherapy is to older adult clients. They may have the notion psychotherapists will give them advice or tell them what to do to solve their problems. Psychotherapists should explain that they will guide, but older adults will solve their own problems. Additionally, addressing fears of stigma is important, because they should know that psychological distress is not a personal flaw. Information on the efficacy of psychological treatments is also useful, as many persons underestimate the potential benefits of such intervention. Both psychotherapists and clients should explore their views about aging so that negative attitudes can be overcome and adaptive attitudes can reinforce change (Evans, 2007; Gallagher-Thompson et al., 2000).

Barriers to Treatment

Therapists may have to deal with barriers to treatment, as older adults may have disabilities, limited financial means, caregiving responsibilities that make it difficult for them to leave the house, or transportation issues that make it hard to attend sessions. Accommodations may include modifying the length of sessions or changing the therapy setting from a private practice or clinic to in-home or nursing home. If older adults have a lot of trouble getting the services they need, a social worker may be useful (Gallagher-Thompson et al., 2000; Karel & Hinrichsen, 2008).

CLINICAL ILLUSTRATION

Mr. S was an 80-year-old, widowed, Caucasian man. He had moved into town to be closer to his daughter, grandchildren, and great grandchildren but had left his old friends behind and was experiencing chronic low mood. He wanted his daughter to come with him on the many doctor's appointments he scheduled for himself. However, he was always upset that the doctors never found out what was really wrong with him and diagnosed him with anxiety issues. Although his daughter went with him to some appointments, she soon became annoyed with their repeated outcome and would not respond to her father's calls. Mr. S became more depressed and anxious. His primary care doctor referred him to a psychologist for in-home psychotherapy.

During the first session, the psychotherapist administered the SLUMS, Patient Health Questionnaire (PHQ-9), and Geriatric Anxiety Inventory (GAI). Mr. S scored a 24 on the SLUMS, indicating mild cognitive impairment, a 14 on the PHQ-9, indicating moderate depression, and a 13 on the GAI, indicating significant anxiety. The psychotherapist also noticed Mr. S had some difficulty hearing her. She proceeded to speak clearly, deeply, and more slowly in a raised conversational voice for that and all future sessions. When asked what his problems were, he clearly pinpointed the loss of his friends after his move. He also complained of his constant fatigue, poor sleep, and low mood but informed the psychotherapist that his primary care physician had told him these symptoms were part of normal aging. Although the psychotherapist educated him that these were symptoms consistent with depression, he had difficulty accepting that he had any emotional distress and preferred to blame the symptoms on an unknown physical problem his doctors had yet to discover. She clarified her role and their work together because Mr. S wanted to treat the sessions like social visits. When asked what he wanted to achieve in psychotherapy, he wanted to improve his socialization and sleep. The psychotherapist planned BA and sleep hygiene techniques to achieve these goals.

At the next session, the psychotherapist explained that engaging in pleasant activities improve one's mood. They proceeded to complete a functional analysis of his life prior to and following his move. In his new town, Mr. S decided he could go to church, engage in social pleasantries with other regular patrons at the diner he frequented, and walk around the local grocery store. These were all activities he used to enjoy. He believed he could either socialize

or be content surrounded by people, rather than be home alone. However, at subsequent sessions, Mr. S would inevitably provide some excuse (e.g., it was too hot/cold outside) for why he had not enacted his plans. Similarly, he would continually complain he could not sleep, but when the psychotherapist tried to work on sleep hygiene, he was unwilling to change his routine. He finally made it clear he did not want any interventions; he just wanted to talk about his problems.

Soon after they began psychotherapy, the psychotherapist realized there seemed to be a catastrophe occurring every time she arrived. She would gather more information about the situation and learn it was being blown out of proportion. She was able to talk Mr. S down from his anxiety by using CBT. She would ask him to pause and take some deep breaths, consider the situation, the various consequences of it, how likely each of the consequences was to occur, and how each of the consequences would likely affect him. He would slowly realize the situation was not as serious as he first thought, and he was capable of handling the consequences of the situation. With time, he began to challenge some of his exaggerated fears by himself so that he was not catastrophizing as much.

Another problem occurred when it was time for the psychotherapist to leave; Mr. S would frantically continue talking, trying to keep her longer. Also, when he cancelled a session because he had a doctor's appointment or had to go out of town, he would admit at the next session he had worried she would not come back. She always had to reassure him she would return. His fear of abandonment was probably due to his tenuous relationship with his daughter. Mr. S was worried he would lose his psychotherapist just as he felt he was losing his daughter. His disinterest in making any changes in his life, difficulty with emotion regulation and relationships, and fear of abandonment would make psychotherapy challenging.

The psychotherapist turned to life review because it would seem more like socializing, would hopefully generate positive memories that might improve his mood, and would allow her to learn about his relationships. Mr. S took to this very well and was soon providing details about his childhood, marriage, employment history, and finally his daughter. It became clear that although he wanted to be close to her, he did not know how to do so. He did not ask his daughter about her life and was satisfied just to be in the same room with her. He was a man of few words who was not comfortable revealing he was proud of her. She, on the other hand, was a warm, open, vocal person. Their communication styles were not meshing and were probably generating hard feelings.

The psychotherapist learned there was another reason for his daughter's distance; his great grandchildren were of mixed race, and Mr. S had made unkind comments about them to his daughter. Consistent with his age cohort, he had grown up with negative ideas about African Americans. However, he believed his daughter held the same beliefs. He lamented what he perceived as his grandchildren's disrespectful treatment of his daughter and her tendency to accept whatever they did. Like his daughter, Mr. S wanted the attention of his child, whether she respected him or not, but he could not see the similarity between her behavior and his.

Life review psychotherapy had taught and encouraged Mr. S to share more of himself with the psychotherapist. He trusted her more, and she felt he might be ready to do the necessary work to rebuild his relationship with his daughter. IPT seemed like the most appropriate choice for psychotherapy because Mr. S's depression was triggered by his move and loss of social support, worsened by his estranged relationship with his daughter, and maintained by his markedly limited interpersonal skills in communication.

Now that the therapeutic relationship was stronger and Mr. S was ready for change, the psychotherapist had a much easier time presenting her professional impressions of him. She readministered the PHQ-9 to him; his score indicated moderate to severe depression. The psychotherapist likened this test to a blood test his primary care physician might use to diagnose a health condition. Just as the physician would prescribe a medicine to treat whatever illness a lab test showed, a psychologist would offer psychotherapy (i.e., IPT) known to treat the emotional problems effectively. Mr. S was on board with this plan. They began to explore his communication patterns through his memories of positive and negative interactions with his daughter as well as through role-plays. Mr. S learned to see how what he said and did could be misinterpreted if he was not clear and straightforward about what he thought. Assuming his daughter knew what he

meant often led to misunderstandings because she actually did not understand what he meant when he did not give her the full story. He learned that even though he had raised his daughter with beliefs common to his time, it did not mean she still held those same beliefs. Her own life experiences molded her outlook so that she believed African Americans and Caucasians are equals. Furthermore, she loved her mixed-race grandchildren because they were her grandchildren, despite any faults they might display in their treatment of her. Similarly, Mr. S loved his daughter and still wanted to have a relationship with her despite the fact that she stopped communicating with him and did not treat him as he felt a daughter should.

When Mr. S and the therapist had a better grasp on the dysfunction, they brainstormed a plan to try a fresh start. He called his daughter with an apology for all the things he had come to realize he had done wrong and asked her for another chance to develop the relationship they should have had. His daughter accepted his proposal, and they began the work of getting to know each other again. They formed a stronger relationship, and he planned solutions to troublesome interactions in psychotherapy. Eventually, he came to psychotherapy with reports about how the relationship was going and what he had done to manage problems. The psychotherapist believed he was functioning well without her and suggested termination was warranted. At first, Mr. S was concerned to lose her, but she reminded him he was successfully navigating relationships without her. Mr. S acknowledged this was true and agreed to manage by himself, with the understanding he could always return, if he encountered obstacles with which he needed help.

CONCLUSIONS/KEY POINTS

- Older adults can make changes in their lives, as development continues until death.
- Life review psychotherapy helps older adults make meaning.
- Psychodynamic psychotherapy explores emotions, transference, and countertransference to understand relationships.
- IPT works on improving relationships to overcome depression.
- CBT challenges maladaptive thoughts, which is believed to lead to more adaptive moods and behaviors. It requires good working memory.
- BA emphasizes engaging in pleasant activities to improve mood and does not require older adults to process their thoughts.
- PST teaches older adults how to solve their problems by considering the pros and cons of solutions they generate, carrying them out, observing the outcomes, and modifying any kinks by tweaking the solutions and trying again. By resolving their own problems, older adults increase their self-esteem.
- To tailor psychotherapy to the individual, conceptualization of older adults should consider presenting problems, diagnoses, racial/ethnic background, sexual orientation, values, beliefs, SES, medical conditions, sensory impairments, and cognitive ability.

REVIEW QUESTIONS

1. What type of psychotherapy might be considered when working with an older adult who was recently diagnosed with a disabling medical condition and is having problems getting along with a caregiver?
2. An older adult requesting a therapist help him create a scrapbook with photos and stories from his life to leave to his family might be served with what type of psychotherapy?
3. A therapist is concerned she is getting too upset by her client, whose caustic behavior reminds her of a grandparent. She is vigilant of the transference and countertransference in their relationship. Her approach to psychotherapy is likely guided by which theory?
4. An older adult is disturbed by what she perceives as negative, judgmental looks she receives from various people in her life. Because she cannot generate solid evidence for her assumptions, her therapist asks her to consider alternative explanations for their facial expressions (e.g., they had a bad day and are worried about something else). What type of psychotherapy is being used?
5. An older male is uncomfortable discussing his feelings and thoughts. He wants to do

something that will distract him and help him feel better. What type of psychotherapy might be appropriate for him?

RESOURCES

Readings

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20

Psychotherapy With Women: Theory and Practice of Feminist Therapy

Melba J. T. Vasquez
Elisa Vasquez

Abstract
This chapter provides a brief historical background of psychology's attention to its understanding of the social construction of gender, and the evolution of feminist psychology and psychotherapy with women, in particular. We address major theoretical developments and variations when working with women. Included in that discussion is a review of the challenges from traditional therapies, societal challenges for women, and how feminist therapy has influenced professional ethics, especially in regard to traditional boundaries. We also describe how the basic principles of feminist therapy have had significant influence on other psychotherapy theories, and how feminist therapy has evolved to a stand-alone model of psychotherapy for both women and men. A brief review of the effectiveness of feminist therapy with women is included, as is a description of treatment factors and psychological issues affecting women, including identity factors such as race, ethnicity, sexual orientation and socioeconomic status.

Keywords: psychotherapy with women, feminist therapy, feminist ethics, diversity among women, efficacy of therapy

In recent years, the field of psychology has made great strides in its acceptance and understanding of the social construction of gender, and the resulting impact on the female psyche. In a time when the intersectionality of multiple identities, including gender, is gaining attention both in the therapy room and through psychological research, it is important to remember the struggles that helped bring about the current shift.

Inequities in the treatment of women in psychology were evident in the 1950s and 1960s. Bias was evident in published research and psychological treatment. Women were underrepresented both in the field and in psychological associations, especially in leadership roles. The lack of female psychologists meant that women seeking treatment were often treated by male therapists utilizing the leading psychological orientation of the time: psychoanalysis. Critiques of this theory suggest that restrictive gender roles were perpetuated in treatment, with many women being pathologized for not adhering to what a "normal" woman was thought to be (Rutherford & Granek, 2010).

By the late 1960s and the 1970s, leading female psychologists such as Phyllis Chesler (1940–), and Rhoda Unger (1939–), and psychiatrist Jean Baker Miller (1927–2006) discussed the difficulties they faced when pursuing higher education with stories riddled with blatant sexism from their male advisors, colleagues, and institutions. The battle

for establishing equal rights for women within psychology (and also out of it) was largely influenced by prolific and outspoken females. Naomi Weisstein (1939–2015), who was frustrated with the unfair treatment she experienced in graduate school, articulated the lack of psychological knowledge about women and women's issues in a groundbreaking article originally published in 1968. These sentiments echoed those delineated in the work that sparked the second wave of feminism (the first being the women's suffrage movement in the 1920s). *The Feminine Mystique* written by the National Organization for Women founder Betty Friedan (1921–2006) in 1963 portrayed what the lives of women were really like—a far cry from the docile housewife society would suggest.

Psychological research and mental health treatment during the time of the second wave focused primarily on the inner, personal traits of an individual to explain the behaviors, thoughts, and feelings of women. Feminist psychologists and supporters pointed out the omission of contextual and societal factors such as gender socialization and gender stereotypes, which inarguably influenced women's experiences and could not be denied when conceptualizing and treating women.

Women and Madness (1972), the revolutionary book by Phyllis Chesler, exposed the existence of sexism and perpetuation of gender stereotypes within the therapeutic relationship. Chesler argued that while women sought therapy to get help, they were frequently hurt by the reinforcement of an oppressive system playing out in the therapy room with their mostly male therapists. Conceptualization and treatment was often focused on exploring a woman's deviation from the social roles of mother and wife she was made to fill. Women's desires outside of motherhood such as receiving an education and having a profession were not being honored in psychotherapy. In fact, psychotherapy with women was plagued with what would today be considered unethical sexual interactions between therapist and client, largely disregarded as a result of the woman's sexual prowess, unmet sexual desires, or even for their own "therapeutic benefit" (Brown, 2010). Chesler's work sparked many female psychologists to want to take action against a patriarchal discipline, as women understood the importance of establishing their own voices in psychology and the potential danger of not doing so.

Theories of psychological development arose from the push to acknowledge and include women and their unique and individual life experiences in the field. It is important to note that at this time, definitions of sex and gender were becoming clearer. Rhoda Unger (1979) established the distinction between sex and gender, asserting that while sex was biological, gender was a set of characteristics and traits that are socially constructed and are attributed to males and females. This distinction gave room for the idea that gender was no longer an unchangeable feature of people, which in turn presented the need for process theories to emerge to understand how women develop psychologically, all the while paying particular attention to the sociocultural influences.

One such theory stemmed from the earlier works of Jean Baker Miller's *Toward a New Psychology of Women* (1976), which attempted to redefine previously negatively valued attributes of femininity (e.g., emotional weakness, vulnerability, etc.) as strengths. Relational-cultural theory relies on the idea that inherent power differences result in one person in a relationship acting inauthentically, often hiding or diminishing one's emotional experience for fear of being invalidated by the more powerful member of the relationship. Relational-cultural therapy aims to help the female client understand this paradigm and resolve to re-establish healthy, balanced relationships (Sharf, 2011).

Near the same time Miller was exploring her ideas, Carol Gilligan (1936–) was curious about the moral development of women and their decision-making processes. Women, she found, valued connectedness and the use of both thinking and feeling when making decisions, which, when viewed through a male-centered lens, was often considered to be characteristic of a lower stage of moral development (Pickren & Rutherford, 2010).

These pioneers, along with many of their colleagues, have undoubtedly shaped gender-based psychological theory and practice. Though each theory has its own unique aspects and beliefs, the fundamental and ubiquitous principles of these feminist ideologies have defined the term "feminist therapy." Many early feminist theories (including relational-cultural theory and Gilligan's moral development theory) and the therapies stemming from them were critiqued for focusing primarily on a middle-class, White idea of the female experience and purporting their essential generalizability to all women, despite

the influence of other factors such as race/ethnicity and socioeconomic status. The feminist therapies of today have been broadened to include the impact of many of these intersecting identities. Many of the ideas and values of feminist therapy have been integrated into other theoretical orientations and with clients of many different cultural backgrounds.

The term "feminist therapy" has been used for over four decades. We use here the definition of feminist therapy by Laura Brown, who described it in part as therapy based on a theory that has developed into a sophisticated postmodern, technically integrative model of practice that utilizes the analysis of gender, social location, and power as a primary strategy for comprehending human difficulties (Brown, 2010).

Central to feminist therapy are the principles that (a) relationships between people should strive to be equal (including the therapeutic relationship), (b) respect be given to all forms of diversity and experiences, (c) there are inherent social systems in place which can be oppressive and discriminatory toward women, and (d) there needs to be a commitment by the therapist to social justice. Ultimately, feminist therapy seeks the empowerment, validation, and growth of its clients.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS WHEN WORKING WITH WOMEN

When attention to counseling and psychotherapy with women became a focus in the 1970s, it was determined that the existing theory, research, and practice addressing the lives of women were inadequate (Worell & Remer, 2003). Stemming from these inadequacies was the development of alternative approaches to conceptualization and intervention with women.

The Problems With Traditional Therapies

There was concern that traditional therapies were sexist and gender biased in a variety of ways, including gender-biased stereotyping and diagnostic labeling, androcentric interpretations (based on male norms), and intrapsychic assumptions. For example, a male's progress in therapy at that time would have been measured by how independent, unemotional, competitive, and economically successful he becomes, while a woman's progress would have been measured by an increase in the quality of her nurturing and caretaking abilities and "appropriate" (e.g., nonintensive, nonangry) emotional expressiveness. Women, especially mothers, were blamed for dysfunctions in the family (Brown, 2010).

Feminist therapy has its roots in the humanistic psychotherapies, the "third force" of psychotherapy movements, because of the focus on the client as a valuable fellow person, rather than as a diagnosis, and because of the focus on the quality of the relationship (Rogers, 1957). However, aspects of sexism and misogyny were reflected in some of those experiences. Too many practitioners not only reinforced oppressive social norms about gender for women but also lacked boundaries regarding sexual contact between therapist and client (Brown, 2010).

Feminist theory has challenged these role restrictions and inappropriate behaviors and increased the importance of understanding the influence that clients' social, political, economic, and cultural environment played in clients' problems. Challenging, oppressive, and confusing experiences in the lives of women can lead to behaviors, thoughts, and feelings that women develop to cope. Those resulting ways of coping, not always functional, can lead society and sometimes even psychotherapists to blame the victim. Feminist theory and therapy promote an understanding of the oppressive aspects of the social construction of gender. This awareness leads the feminist therapist to be able to deconstruct and understand the role of oppression, whether in a movie, novel, news event, in families and other interpersonal interactions, and especially in the life of the client.

Societal Challenges for Women

Many if not most women are "survivors" of incest, rape, domestic violence, sexual harassment, career and employment discrimination, dual-career marriages, motherhood, divorce, single parenting, and/or the professional superwoman syndrome (a woman who works hard to perform well in her multiple, time-intensive roles; White & Frabutt, 2006). Women cope with body issues largely prompted by an endless societal obsession with how women should look (Worell & Remer, 2003). Consequently, women develop depression, anxiety, posttraumatic stress disorder, and

numerous other variations of mental difficulties and health challenges.

The feminist therapy belief system asserts that men and women are socialized toward different value systems, with male values holding more prestige. For example, more men than women value analytical thinking, independence, competition, and assertiveness; more women than men value nurturance, cooperation, intuition, empathy, and relationship interdependence. The relative prestige afforded to values that are associated with masculinity results in an often subconscious privileging of men and relegates women to feeling "less than" based on their gender identity, which is socially constructed to have less privilege. In addition, women have problems partly because of living in a society that devalues them, discriminates against them, and relegates them to an inferior status with less political and economic power than men. Feminist therapy conceptualizes psychopathology as primarily environmentally induced; that is, psychopathology is at least partly, if not largely, culturally determined. Thus, "the personal is political" in that the primary source of a client's psychopathology is not intrapsychic or personal, but rather is social and political (Gilbert, 1980). Both overt and covert discrimination of people based on gender oppress and limit the potential of all individuals.

Although opportunities for women have improved over the decades, many inequities remain for women. Women continue to deal with institutional discrimination and insidious, covert biases from those who may not even be aware of their subconscious behaviors. For example, although women's participation in higher education and the labor market has increased significantly, there are still challenging gender differences in career success, including promotions and salary (Eagly & Carli, 2007).

Feminist Therapy and Ethics

Feminist therapy has influenced professional ethics. A feminist code of ethics was developed by the Feminist Therapy Institute (2000), to address the inevitable fact that the therapist has more power in the therapeutic relationship by virtue of his or her role. This feminist code asserted that the therapist has responsibility for the maintenance of boundaries and for the empowerment of the client in all aspects of the psychotherapeutic experience.

Feminist multicultural therapists are those who incorporate an analysis of gender, race, and ethnicity as well as other aspects of identity in their understanding of human difficulties. Practitioners are encouraged to recognize the importance of feminist multicultural sensitivity, responsiveness, knowledge, and understanding about clients whose social location may result in behaviors that challenge professional boundaries. For example, giving gifts, making requests that the therapist attend clients' transitional life events, asking questions, requesting the therapist's self-disclosure, and engaging in nonsexual touch, such as hugs, may be influenced by a client's culture. Sometimes maintaining strict boundaries does more harm than engaging in a humane, genuine, authentic manner that is gender and/or culturally congruent. Many, if not most, feminist multicultural ethicists construe boundary issue maintenance in therapy as a continuous rather than a dichotomous issue. That is, issues of upholding boundaries are addressed throughout the therapy relationship with various situations and are not a singular occurrence. Decisions about boundary maintenance may vary according to situations and events, as well as client and therapist values and characteristics. Because boundary concerns are common in therapy, those who face dilemmas are encouraged to seek consultation with knowledgeable colleagues and to document the exception in treatment process notes (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007).

Feminist therapists were among those who influenced the evolution of the APA Ethical Principles of Psychologists and Code of Conduct (APA, 2002) and its revision that indicated that not all multiple relationships are unethical. Not all multiple or dual relationships are problematic, or avoidable, such as in small community populations. It is important, however, to distinguish when boundaries are helpful or potentially harmful, differentiating between *boundary crossings* and *boundary violations*. Boundary crossings refer to any activity that moves therapists away from a strictly neutral position with their patients. This activity may be helpful or harmful. An example of a boundary crossing that may be helpful to clients could include, for example, attending the wedding of a client, partly because the foci of therapy included clarification that marriage was indeed what the client wished to do. A boundary violation is a harmful boundary crossing. The notion of boundaries has evolved as

an important strategy to "do no harm" because the needs of the psychologist could potentially obstruct therapy. It is the therapist's responsibility to know which behaviors harm or help clients. Feminists were among the first to encourage conceptualizing motivations of integrity, respectfulness, compassion, and trustworthiness in order to be clear about assessing psychologists' responsibility to benefit the client and to take care to do no harm (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Feminist Therapy Relevant for Everyone

In the past 40 years, feminist therapy has evolved from an outside critique of mainstream psychotherapy to a stand-alone model of psychotherapy for both women and men. Feminist therapy is a sophisticated integrative model that combines the analysis of gender and power as well as social location of one's various identities such as race, culture, social class, sexual orientation, age, and ability/disability status in order to understand the problems and concerns of women as well as men (Brown, 2010). Feminist therapy has thus evolved to be more multicultural and global in its analyses. Although there are various permutations of feminist therapy, the central foci continue to be on dynamics of interpersonal and personal power within the psychotherapeutic process and in the client's life. The importance of promoting understanding of the political contexts that influence constructions of gender and related power, privilege, and powerlessness also continues to be central.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION WHEN WORKING WITH WOMEN

Many therapists who work with women consider their theoretical orientation to be that of a "feminist therapist" with influences from liberation psychology, multicultural psychology, and/or narrative psychotherapy (Brown, 2010). Other therapists may embrace a wide range of psychotherapy theoretical orientations, such as cognitive-behavioral, family systems, gestalt, and psychoanalytic, but they modify or replace elements of the orientations, goals, and concepts that violate the feminist belief system. Worell and Remer (2003) provide strategies for feminist principles to be applied to modify traditional orientations. Feminist therapy is an immensely diverse field, with its different variations reflecting the multiplicity of trajectories by which each feminist therapist has arrived at her or his version of the theory (Brown, 2010).

The Role of Biology

More recent models consider a biopsychosocial perspective of feminist conceptualization. Most models of feminist therapy focus on both risks and strengths as vital components of girls' and women's development and experiences. The interactions of physical, psychological, and sociocultural factors are considered in each period of development for women. Identity variables such as gender, race/ethnicity, socioeconomic status, age, ability, and sexual orientation contribute to the health continuum and interact with the biological capacities and vulnerabilities of the client; distress may thus be manifested in ways that are most consistent with those capacities and vulnerabilities (Goodheart, 2006). A person with depression or severe anxiety, for example, may more consistently be unable to challenge internalized oppressive social norms. Even when there is a strong biological etiology for a particular pattern of distress or dysfunction, research supports the idea that exposures to both overt and covert oppression, disempowerment, and violation are implicated in the expression of biological vulnerability to psychosis, depression, or anxiety (Brown, 2010).

The "biopsychosocial" perspective of psychological health is built upon the biological systems foundation that explains sickness and health to incorporate psychosocial dimensions, including family, community, culture, society, and the environment. In the biological realm, for example, a feminist therapist would formulate a goal of experiencing the body as a safe place, and accepting it rather than forcing it to be larger or smaller, assuming that it is adequately nourished, as opposed to trying to change one's body according to oppressive societal messages. If its size or shape was unsafe, change would happen in the service of safety, which could be empowering. Other paths to safety are also considered. Power in the body also implies connection with bodily desires for food, comfort, sexual pleasure, and rest. A stance of compassion toward one's body and its embodied experiences is a goal of feminist therapy (Brown, 2010).

The Tools of Psychotherapy

The tools of psychotherapy are used to promote awareness of the internal and external patriarchal realities that interfere with growth and personal power. They are used to challenge and change those that serve as a source of distress for women and men. A goal is to work collaboratively with the client and to avoid promoting oppression in the psychotherapy process itself.

Feminist therapists believe that relationships should be as egalitarian as possible; this is a cornerstone of feminist therapy. The expression of care is critical in the feminist relational-cultural model that promotes caring relationships in the psychotherapeutic process (Miller, 1976). Although the role of therapist always involves a power differential to some degree, elements of care, including respect, genuineness, and authenticity, are involved in attempts to empower the client. For example, feminist therapists were among the first to suggest that it would be ethical and empowering to provide self-disclosure when it is in the best interest of the client. Failing to answer clients' questions can be shaming for those who are chronically oppressed and humiliated in their own lives already. Additional principles include revaluating women to trust their experiences, to appreciate female-related values, to focus on strengths and resilience, to encourage women to nurture themselves as well as they do others, and to accept and like their own bodies (Worell & Remer, 2003).

Persistent gender disparities lead to a profound and differential impact on psychological and physical health and well-being (Goodheart, 2006). Techniques of feminist therapy strive to celebrate and illuminate women's strengths and capacities for resilience, and underline the disparities that prevent women's strengths from being fully actualized. Goals for feminist therapists include promotion of equal opportunities and egalitarianism for women and men, as well as for those whose identities result in oppression, that is, on the basis of race, socioeconomic status, disability, sexual orientation, and age. In psychotherapy, and especially with survivors of abuse, violence, and trauma, a feminist therapist would engage in empowerment strategies, including a sex-role analysis (Worell & Remer, 2003), helping clients become aware of how sex-role-related expectations and related power differences adversely affect them. Helping clients understand how gender and other social identities are sources of power, powerlessness, privilege, or lack of privilege and how those contribute to the development of distress and dysfunction is a key concept and goal of feminist therapy.

A key intervention, especially for victims/survivors of abuse, involves attending to safety issues. The client must first experience safety within the therapeutic relationship. A related intervention is to help clients acquire safety in the various aspects of their lives, including physical, emotional, financial, and other areas of safety. Sometimes effective treatment with battered or abused women necessitates some form of advocacy, consultation, or collaboration of the clinician with professionals in other agencies or institutions outside of the mental health field (e.g., domestic violence service providers, medical personnel, human relations personnel at clients' workplace, police agencies, attorneys; DePorto, 2003).

Assessment by feminist therapists includes the recognition that *The Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) has many problems of reliability and validity, and in many ways contributes to the oppression of women and others (Rice, Enns, & Nutt, 2014). When the *DSM* diagnosis is necessary for insurance or other purposes, most feminist therapists would engage in determining a diagnosis in collaboration with the client. A comprehensive assessment is informed by the many contextual factors that contribute to distress. Externalizing the basis of a client's problem shifts blame from shaming the client to powerful social forces. This can be empowering for clients. Assessment for sexual and other trauma, removing victim blame, reinterpreting family power dynamics, and reinterpreting "symptoms" are also key strategies. Symptoms are often individuals' attempts to cope in dysfunctional situations; it is often the case that those strategies, once adaptive, are no longer effective, and more effective skills can be taught. In addition, specific symptoms of distress and dysfunction may be defined as evidence of resistance to experiences of oppression (Brown, 2010).

Feminist therapists also engage in advocacy to change norms, policies, and influences in society. Feminist consciousness includes the awareness that one's maltreatment is not due to individual deficits, but to membership in a group that has been unfairly oppressed, and that society can and should be changed to give equal power and value to all members of society (Brown, 2010; Rice et al., 2014). Feminist therapists consider it their responsibility to work to

change society on an ongoing basis. The *Guidelines for Psychological Practice With Girls and Women* (APA, 2007) were developed to enhance awareness, knowledge, and skills of gender- and culture-sensitive psychological practice with women and girls from a variety of social classes, ethnic and racial groups, sexual orientations, and ability/disability statuses in the United States. This document serves as an excellent resource to implement the principles described in this section and chapter.

EFFICACY AND EFFECTIVENESS OF THERAPY WITH WOMEN

A Feminist Review

Early research on the effectiveness of feminist therapy in contrast to traditional therapies suggests that women who chose to engage in feminist-based therapy viewed therapy as more helpful than those who engaged in traditional therapy. It is important to note that feminist clients indicated a higher adherence to radical political beliefs and identified themselves as members of the women's movement more often than those being seen in traditional therapy, which might explain the relationship between therapy and perceived helpfulness (Marecek, Kravetz, & Finn, 1979).

Though previous outcome research on feminist principles exists, the increasingly ubiquitous nature of feminist therapy foundations in recent years has posed a challenge in the ability to isolate specific techniques and factors for evaluative purposes. Israeili and Santor (2000) identified core components of feminist work that are unique to feminist therapy, while acknowledging that many techniques central to feminist therapy are no longer exclusive but have been integrated and are established components of various therapeutic frameworks.

Attention to gender and social-role expectations is a key component of feminist therapy. Support for the use of social and gender-role analysis has been mixed, with some outcomes indicating increased positive effects on assertiveness (Gulanick, Howard, & Moreland, 1979) and others showing increased difficulty in maintaining relationships with the new information they received during therapy (Cassell, 1977).

Brown (2010) summarized findings indicating that the feminist empowerment model did result in increases in empowerment on cognitive, affective, and interpersonal aspects of the psychosocial axis of empowerment, with both brief (four or fewer sessions) or slightly longer (seven or more sessions). The technique of resocialization in feminist therapy reframes cognitions to produce a shift in self-esteem and self-image beliefs from those that perpetuate the largely patriarchal society that has often led them to adopt a sense of inferiority to one which reflects increased self-worth and adequacy. Research indicates that using this technique with women who are single mothers and have been abused helped to decrease their self-blame (Gottlieb, Burden, McCormick, & Nicarthy, 1983).

Though outcome research for feminist therapy is limited, therapeutic strategies, including establishing an egalitarian client–therapist relationship, collaboration on goals, and the support and acknowledgment of the client's subjective experience, are linked to positive therapeutic outcomes (Norcross, 2002). Furthermore, common factors research suggests that empowerment of the client, especially within the context of the therapy process, is associated with improved outcome. One of the most important common factors includes the therapeutic alliance between therapist and client (Lambert, 2004). Methods to promote the alliance include conveying respect, genuineness, and authenticity to the client, which are basic feminist psychotherapeutic values.

Treatment Factors

The literature consistently shows that women are more likely to seek mental health treatment than men (e.g., Wang et al., 2005). Certain factors exist that might influence the effectiveness of treatment with women, including the personal and societal values of what is considered "normal." The effectiveness of treatment for women may also be affected by therapist gender, with female clients possibly feeling as though gender-specific issues (such as fertility) are better empathized with a therapist of the same gender (Nadelson, Notman, & McCarthy, 2005). Kirshner, Genack, and Hauser (1978) found that female clients had better treatment responses, including improvement on their main problem and self-acceptance, and were generally more satisfied with treatment when they were paired with a same-gender therapist rather than an opposite-gender paring. Additionally, the gender makeup of group therapy is an important

aspect of treatment outcome, as women can end up feeling intimidated and discomforted about being vocal in a group with mixed gender (Nadelson et al., 2005).

Psychological Issues Affecting Women

Though men and women experience similar rates of mental illness overall, certain psychological issues are more prevalent in women, including depression, eating disorders, and anxiety disorders, with many issues presenting differently in women and men (National Institute of Mental Health, 2014). Beginning in adolescence and continuing into adulthood, females are twice as likely as males to experience symptoms of depression for reasons possibly influenced by both biological (e.g., hormones and genetics) and psychosocial factors (e.g., gender-role expectations). Women were also found to experience more somatic symptoms of depression, including appetite change and sleep disturbances (Wenzel, Steer, & Beck, 2005). There is evidence to suggest that the risk factors for developing depression in adulthood are different for women and include divorce, absence of social supports, and neuroticism, while the risk factors for men include financial stress, drug abuse, and conduct disorder (Kendler & Gardner, 2014).

Treatment for depression in women is varied, with some women choosing pharmacological treatment, psychotherapy, alternative methods, or a combination of treatments. Research on treatment outcomes based on gender is also varied. Cuijpers, Van Straten, Warmerdam, and Smits (2008) conducted a meta-analysis on the effectiveness of treatments for depression and concluded that there was no significant effect on outcome based on gender. The most common form of treatment was cognitive-behavioral therapy (CBT), which has wide support as an effective treatment for depression. Ogrodniczuk, Piper, Joyce, and McCallum (2001) found that women had lower depression rates when treated with a supportive therapy (i.e., focusing on immediate adaptation and external circumstances) rather than an interpretive therapy (i.e., focusing on enhancing insight with identification of patterns); however, alleviation of depression was not the goal of treatment. Though definitive outcomes for the treatment of depression in women are not established, most evidence suggests that men and women respond equally well to psychotherapeutic interventions.

Anxiety often co-occurs with depression and is consistently diagnosed more often in women than men; this trend is constant throughout the life span (Kessler et al., 2005). Differences exist for most recognized anxiety disorders, including panic disorder, generalized anxiety disorder (GAD), and posttraumatic stress disorder (PTSD) (Kessler et al., 1994). Recent research suggests that the existence of an anxiety disorder is more disabling and burdensome for women, as evidenced by frequency of medical facility visits, especially for women of European American descent (McLean, Asnaani, Litz, & Hofmann, 2011). Additionally, women tend to endorse more fear- and panic-related symptoms of anxiety than men (Pigott, 1999).

Recent reviews of pertinent research suggest that there was no effect of gender on treatment outcomes, though it is acknowledged that studies tend to underemphasize the potential differences and often omit gender as a contributing factor to the effectiveness of treatment (Silverman & Carter, 2006). Anxiety disorders are largely treated with CBT and/or anxiety medications, with effect sizes in the medium to large range (Olatunji, Cisler, & Deacon, 2010). One consideration in the treatment of anxiety in women is the prevalence of comorbidity with other anxiety and mood disorders, which is considerably higher for women and can potentially affect treatment outcomes (Bekker & van Mens-Verhulst, 2007).

Eating disorders affect both men and women, though women have much higher prevalence rates of all types of eating disorders, including anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED). A recent study showed that women were more likely than men to exhibit symptoms of fasting, vomiting, binge-eating, and feeling a loss of control over eating (Striegel-Moore et al., 2009). Factors affecting disordered eating include depression, a history of hearing negative comments about weight and eating habits (Jacobi et al., 2011), hereditary factors (Bulik, 2004), and unrealistically thin media portrayals of women (Stice, Spangler, & Agras, 2001). The leading and most supported therapies for treating AN, BN, and BED are CBT and interpersonal psychotherapy (IPT), which show comparable results in reducing symptoms of BN. Additionally, antidepressant medication has been shown to be effective in the treatment of BN, even at long-term

follow-up, though it was less effective for treating BED. Behavioral weight loss programs were shown to be effective in weight management in clients with BED, but the effects were not replicated in clients with BN (Wilson & Fairburn, 2002). AN has a mortality rate of 4% (Crow et al., 2009), but treatment outcome research of the disorder is lacking, largely due to the issues with treatment adherence. Attia and Walsh (2007) studied behavioral intervention treatment in intensive settings, including day hospital and inpatient facilities, and found positive results of restored weight and disordered eating behaviors. However, a longitudinal study by Treat, McCabe, Gaskill, and Marcus (2008) reported that over 50% of patients in intensive treatment were referred to a higher level of treatment within 6 months.

Although only a few of the most predominant mental health issues were explored in this section, it is important to note that the disorders affecting women often overlap and are influenced by a multitude of other biological, genetic, and psychosocial factors, one of which deserves considerable mention. Women are disproportionately victimized by sexual and interpersonal violence, including rape and domestic violence, the effects of which predict the emergence of many psychological disturbances, including the three aforementioned difficulties: anxiety (specifically PTSD), depression (Golding, 1999), and eating disorders (Fischer, Stojek, & Hartzell, 2011). When working with women in a clinical setting, all factors should be thoroughly considered and evaluated during assessment, diagnoses, and treatment planning for each client. In addition, clinicians should make appropriate efforts to remain knowledgeable about gender-related issues and their effect on the psychological health of women.

DIVERSITY AMONG WOMEN

As mentioned previously, intersectionality has gained considerable attention in recent years for providing a unique look into how one's different social identities interact to produce distinctive sets of strengths and challenges. From a gender perspective, intersectionality is the examination of how other identities, including, for example, racial/ethnic background, socioeconomic status (SES), and sexual orientation, influence the way a woman experiences womanhood. Additionally, some women experience multiple forms of oppression due to their many minority identities, while others might experience privilege in our society as a result of their identities (e.g., being heterosexual) (Ngan-Ling Chow, Segal, & Tan, 2011). Early counseling frameworks have been critiqued in the field for disregarding the existence of multiple identities and instead focusing on only one minority status (e.g., a woman of color is likely either seen as a woman or a person of color). Navigating multiple identities in multiple contexts has an undeniable effect on the psychological and emotional well-being of women, and therefore it has real implications for therapeutic work. These implications are especially important because research has shown that psychotherapy treatment is enhanced when clinicians tailor it to the individual and her unique situation, including attending to identity variables (Frank & Frank, 1991).

Race/Ethnicity

Though race and ethnicity are defined as different constructs in research (e.g., Hall, 1996), they will be referred to interchangeably in this section, given the scope of the chapter. Much of the work done examining the interaction of gender and race/ethnicity has addressed the discrimination, victimization, and harassment of racial/ethnic minority women in the workplace (e.g., Berdahl & Moore, 2006). Minority women experience more harassment than Caucasian men, Caucasian women, and racial/ethnic minority men (Berdahl & Moore, 2006). Latina and African American women are also paid the lowest wages (Browne, 1999) and occupy positions with the least amount of authority (Browne, Hewitt, Tigges, & Green, 2001). They are underrepresented in various settings associated with prestige. For example, ethnic minority women make up only about 12% of women faculty, significantly below the demographic representation in society (Chronicle of Higher Education, 2010). On a broader scale, the interactional, combined experience of racial and gender discrimination has been shown to lead to decreased well-being and increased likelihood of experiencing individual stressors, including financial, employment, and loss of social network (Perry, Harp, & Oser, 2013) as well as increased posttraumatic stress symptoms, lower life satisfaction, and increased depressive symptomology (Buchanan, Bergman, Bruce, Woods, & Lichty, 2009).

Sexual Orientation

Members of the lesbian/gay/bisexual/transgendered (LGBT) community are often reported to experience increased levels of mental health issues compared to their heterosexually identified counterparts (e.g., Cochran, Sullivan, & Mays, 2003). Deleterious effects have been linked to the fact that homosexuality was classified as a mental disorder until relatively recently. Research suggests that the elevated prevalence of mental health problems is influenced by the ever-present social stigma around LGBT-identified individuals (Herek & Garnets, 2007). A minority stress model has been proposed to conceptualize the types of stress associated with identifying as a sexual minority, including experiencing discrimination and victimization, hiding one's sexual orientation, and internalized negative thoughts toward those identifying as LGBT (Meyer, 2007).

Empirical support regarding specific disorders and populations of LGBT individuals has been mixed, though research suggests that the psychological impact of minority stress may not be the same for sexual minority men and women (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). Research on sexual minority women indicates increased rates of depression, suicide attempts, and anxiety disorders among homosexual women compared to heterosexual women (Gilman et al., 2001). Bisexual individuals also report higher levels of homonegativity when compared to homosexually identified females (Cox, Vanden Berghe, Dewaele, & Vincke, 2009), which might have clinical implications when working with bisexually identified females.

Herek and Garnets (2007) indicate that establishing a sense of safety with clients is imperative to meaningful and successful work—especially if they have experienced victimization about their sexual orientation. The coming-out process is also a particularly difficult time and can bring up an array of both positive and negative emotions for a variety of reasons—all of which should be assessed and integrated into therapeutic work if relevant.

Socioeconomic Status

SES involves a multitude of variables such as education, household income, occupational and social class, and past and current economic difficulties. In addition to the negative effects on physical health, low SES has been associated with increased levels of depression (Lorant et al., 2003) and greater prevalence of other common mental disorders, including anxiety (Lahelma, Laaksonen, Martikainen, Rahkonen, & Sarlio-Lähteenkorva, 2006). Environmental life stressors such as severe familial conflict, housing problems, and chronic illness have been suggested as a mediating factor in the relationship between SES and mental health problems (Amone-P'Olak et al., 2009).

There has been limited empirical research exploring the interaction of SES and gender in regard to mental health factors, and those studies that do focus primarily on depression. Women who fall into the low-SES category have been shown to be at higher risk for depressive symptoms (Cujipers & Smit, 2004) and are more likely to have depression as a result of increased experience of life stressors (Denton, Prus, & Walters, 2004). A recent meta-analysis of interventions aimed at reducing depressive symptoms of low-SES women found that these interventions overall were effective in reducing depression. The most common form of intervention was based in psychoeducation and was administered in a group format (van der Waerden, Hoefnagels, & Hosman, 2011).

It is important to note that though the intersections of these identities were discussed individually, there are an infinite number of ways all forms of identity interact and influence the way one exists in the world. As a therapist, it is crucial to acknowledge and accept a client's unique way of experiencing her multiple identities and provide an environment in which the nuanced and complex impact of these identities can be explored. The ability to assess which of these issues is at the forefront of the therapeutic process at any given time is an important part of the treatment. In the therapeutic hour, how the feminist therapist decides to intervene moment by moment depends on what she has come to understand about the client. The feminist therapist chooses between a corrective experience, an interactive engagement in the relationship, or enhancement of knowledge, based on whether and how the client's problems are related to environmental factors (Stark, 1999).

CLINICAL ILLUSTRATION: TRAUMA AND ABUSE

Feminist therapists view identities as being in continuous evolution, rather than fixed and rigid. This is

partly the basis of intervention, since a goal of therapy is to support the fact that a person's social location can evolve into those related to choice and empowerment on the part of the individual. There is enormous variability in the ways that identity development evolves. Because of feminist therapy's integrative approach to psychotherapy, there are no specific psychosocial interventions prescribed; rather, the feminist therapist tailors interventions to focus on the client's strengths, and thereby to promote skills, capacities, personal effectiveness, and power. Feminist therapists utilize tools from a variety of psychotherapies in collaboration with their clients. Keeping these principles in mind, a case illustration is provided; it is disguised to ensure confidentiality.

Dorothy is a 49-year-old Euro American woman who came to therapy when her husband of 30 years stated a wish for divorce. They had had marital problems 7 years previously, due to an affair that he had, but he had recommitted to the relationship. This time, he reported that he wanted a divorce because she kept the house messy, was overweight, had developed diabetes, and he no longer loved her, which resulted in Dorothy experiencing feelings of depression. He implied that if those problems were resolved, he may return to her. Dorothy was devastated, but not entirely surprised. She decided that she wanted to work to obtain the goals he wanted her to achieve.

In assessing the situation, it turned out that Dorothy's husband had been physically abusive on three occasions while drinking. He was chronically emotionally abusive and critical of her. Both of her adult children encouraged her to seek a divorce, because they did not think that their father was good enough to their mother. Psychotherapy involved helping Dorothy examine her husband's behaviors and how they affected her low self-worth. Part of her wanted to try to convince her husband to stay with her. Thus, it was important to acknowledge the positive benefits from her husband and the marriage in order for her to understand what elements kept her in the relationship and influenced her to want her husband to stay with her. She also had fears about being employed outside of the home because she had not done so for many years. It was helpful for Dorothy to assess the costs to her if she remained in the abusive, hurtful relationship. She acknowledged that she believed that her depression was at least partly due to the marital stresses.

Interestingly, a very public domestic violence incident by an NFL sports figure actually helped her evoke feelings of anger for other women and for herself. Although she understood and identified with the wife who chose to support her sports figure husband, she also was able to see how that could be self-destructive in the long run, especially if there was no true growth on the part of the perpetrator. Dorothy realized that she had been doing the majority of the work in the relationship, while her husband stood by to see how well she cleaned the house or checked to see how much weight she had lost. His disdain was evident when he searched out corners that had not been cleaned, for example.

Psychotherapy involved helping the client understand how the expectations of her role as wife were belittling and oppressive to her. She was depressed, and as such she had not maintained the home and body she actually loved. She began to take better care of her body and her environment primarily so that she could feel better physically and emotionally. She acknowledged that her low feelings of self-worth were due largely to the negative, hurtful, and unkind messages from her spouse.

Dorothy enrolled in courses to update her credentials as a nurse; she was trained as a nurse, but she had worked at home for almost 25 years. She began to engage in "anticipatory grief" of her marriage even as she began to look forward to a new chapter in her life. She was hurt, angry, guilty, and sad. She felt rejected and "thrown away," especially when she found out that her husband was having another affair.

Although all feelings were validated, it was important for Dorothy to understand some of the oppressive expectations of how she was supposed to be as a wife and previously as a mother, before her children left home. It took Dorothy a long time to realize that her husband was not going to come back to her. Although she had fears about looking for work at the age of 49, she was also excited and looking forward to a new chapter in her life. She became proactive in negotiating a fair settlement in the divorce, bought a place for herself to live as a single person, and joined various support groups. It was important for Dorothy to feel supported and to experience conditions created by the therapist where she felt safe and able to become aware of her own needs and goals, as opposed to those imposed by the therapist. Especially when discussing painful, shameful, and embarrassing information, it is helpful if therapists can normalize the experiences,

share information about the common experiences of others, and at times, self-disclose as well, if comfortable to the therapist, and as long as it is for the benefit of the client.

CONCLUSIONS AND KEY POINTS

Feminist psychotherapy was inspired by the battle to establish equal rights for women in society, as well as in psychology. Feminist psychologists critiqued psychotherapy theories that promoted restrictive gender roles, and that pathologized women for not adhering to what a normal woman was thought to be. Alternative approaches to conceptualization and intervention with women included the importance of understanding the influence that clients' social, political, economic, and cultural environments play in the problems of clients. Institutional sexism and the systematic disenfranchisement of women have been important in understanding the social conditions that give rise to problems for women.

The awareness and understanding of the oppressive aspects of the social construction of gender lead the feminist therapist to be able to deconstruct and to help the client understand the role of oppression in the life of the client. "The personal is political" in that, even when biology plays a role in a client's problems (as with psychosis, some forms of mood and anxiety disorders), the oppressive elements of the external environment are still considered to play significant roles.

Today, feminist therapy is a sophisticated integrative model that combines the analysis of gender and power as well as the social location of one's various identities, such as race, culture, social class, sexual orientation, age, and ability/disability status in order to understand problems and concerns of women and men. A biopsychosocial perspective of feminist conceptualization includes a focus on both risks and strengths as vital components of one's development and experiences. It considers the interactions of physical, psychological, and sociocultural factors in each period of development for women and men. Even when biology plays a role for a particular pattern of distress or dysfunction, exposures to both overt and covert oppression, disempowerment, and violation are implicated in the expression of vulnerability to psychosis, mood, and/or anxiety disorders.

Feminist therapists may embrace a wide range of theoretical orientations, but they often apply feminist principles to modify traditional orientations. Feminist therapy has had significant impact on some of those traditional orientations, and it has made them more relational in nature. Feminist therapy has also had impact on professional ethics, in promoting the importance of maintaining sexual boundaries with clients, as well as in improving clarity in distinguishing when boundaries are helpful or potentially limiting if not harmful. Clients from diverse identity groups may engage in a variety of behaviors that may challenge the area of traditional boundaries.

Feminist therapy has evolved to be more multicultural and global in its analyses and to become a stand-alone model of psychotherapy for both women and men. Feminist therapists work collaboratively with clients and promote egalitarian relationships as a cornerstone of their work. The expression of care, respect, authenticity, and genuineness is involved in empowerment for the client. Diagnoses are deemphasized; externalizing the basis of a client's problem shifts blame from shaming the client to powerful social forces. The reinterpretation and reframing of family power dynamics and symptoms are also important. Feminist therapists assist clients to be more effective, to apply the same standard of care that they provide to others to themselves, to set boundaries, and to promote leadership and related skill development. Feminist therapists also engage in advocacy to change norms, policies, and influences in society to promote equity and value for all members of society.

REVIEW QUESTIONS

1. Describe the forces that influenced the evolution of feminist therapy and name two theoretical developments of feminist therapy.
2. Describe the meaning of the phrase "the personal is political."
3. Describe the evolution of feminist therapy to one that provides the analysis of the intersections and "social location" of one's various identities.
4. What psychological issues have been identified as primarily affecting women? Describe the development of these issues from a biopsychosocial perspective of feminist conceptualization.

5. List three key tools and strategies of feminist therapy linked to positive therapeutic outcomes.

RESOURCES

Readings

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21

Psychotherapy With Men: Theory and Practice

Christopher T. H. Liang
Carin Molenaar

Abstract
This chapter presents a gender-aware perspective to psychotherapy with boys and men through an overview of theoretical frameworks, a presentation of evidenced-based approaches and emergent literature, and a case illustration. In light of current scholarship, we argue that practitioners seeking to best understand the needs of boys and men may approach their work from a social constructionist perspective that honors the myriad of ways men can influence and demonstrate gender. Drawing from this culturally aware perspective helps practitioners recognize that masculinity is not a static, rigid set of attitudes, behaviors, or traits. More accurately, masculinity is constantly enacted, adapted, or performed depending on contextual factors. This, in turn, can help practitioners gain awareness of their own biases and expectations for working with boys and men.

Keywords: masculinity ideology, psychotherapy, gender role socialization, social constructionist, intersectionality

Scholars have argued that the use of men as the reference group from which to judge women is a major limitation of the psychotherapy literature (Kilmartin, 2010). From this perspective, there is little need to study psychotherapy practice with boys and men because all literature has, by virtue of centering them in theory and research, historically privileged males and their experiences. Thus, theories of psychological development and psychotherapy are designed by men (e.g., Freud) for men, and there may be no need to examine critically whether and how psychotherapeutic practices may be benefitting men.

As a counterargument, scholars have argued that though men are privileged, a gender-aware perspective to psychotherapy with men is necessary to meet the needs of boys and men (e.g., Englar-Carlson, 2014). Proponents of this perspective argue that psychotherapy with men requires a deep understanding of how male gender role socialization shapes and influences the experiences of men in their everyday lives as well as in mental health services. To support the use of a gender-aware perspective, scholars point to data which suggest that boys and men are more likely to be diagnosed, referred for counseling, or disciplined because of behavioral problems (Snyder, Dillow, & Hoffman, 2008). Boys and men also experience higher rates of violence (US Department of Justice, 2007); psychological problems such as suicide, substance abuse problems, and attention-deficit disorder; and chronic physical health problems (Courtenay, 2011). Unfortunately, men also have been found to underutilize mental health services and hold more negative attitudes toward counseling and psychological services (Hammer, Vogel, &

Heimerdinger-Edwards, 2012). Underutilization of mental health services among men has been linked to mental health stigma, which is associated with masculine gender role socialization (Berger, Addis, Green, Mackowiak, & Goldberg, 2013). These data, which indicate that men are more at risk for psychological and physical health problems, suggest that men are not served well by the psychotherapy services that were purportedly designed with their experiences as the reference group. Scholars argue that in order to meet the needs of boys and men, practitioners must understand how boys and men *do* gender and how those scripts shape behavior, particularly in the context of psychotherapy (Englar-Carlson, 2014; Mahalik et al., 2012).

Because there are multiple ways of performing masculinity, scholars have more recently argued for the need to take a social constructionist (Addis & Mahalik 2003; Addis, Mansfield, & Syzdek, 2010) and multicultural perspective in considering how context, culture, social class, homophobia, and racism all contribute to how diverse men may be influenced by and perform gender (Wester & Vogel, 2012). Therefore, scholarship on men and masculinity is considered a domain of multicultural psychotherapy competence (Liu, 2005; Wester & Vogel, 2012). In the following sections, we provide (1) an overview of theoretical frameworks for understanding boys and men; (2) a discussion of evidence-based strategies and emergent approaches; (3) a case illustration; and (4) additional resources on boys and men for mental health professionals.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS IN PSYCHOTHERAPY WITH MEN

Essentialist perspectives associated with sex roles have given way to theoretical frameworks that view individuals as gendered beings. Gender is viewed as a fluid constellation of behaviors and attitudes that are learned, constructed, and performed. Two main and related conceptualizations of masculinity that inform clinical practice and research today are grounded in *gender role socialization paradigms* and *social constructionist perspectives* (Wester & Vogel, 2012). In fact, in a recent content and methodological analysis, Wong, Steinfeldt, Speight, and Hickman (2010) reported that the gender role socialization paradigm was used in 53% of all studies published in *Psychology of Men and Masculinity*. Social constructionist perspectives extend masculine gender role socialization approaches to understanding masculinity by situating masculine scripts in context for men. Positive masculinity and intersectionist approaches are emerging approaches to conceptualizing masculinity. A brief overview of these perspectives is provided in the following section.

Masculine Gender Role Socialization Paradigm

To begin to understand the gender role socialization paradigm, there must be an acknowledgment that individuals are socialized to conform to culturally sanctioned gender roles. Boys and men are socialized to conform to masculinity ideologies, which are a set of socially sanctioned expectations for boys and men that are internalized and performed (Levant & Richmond, 2007). The "Sturdy Oak," "Big Wheel," "No Sissy Stuff," and "Give 'em Hell" were some of the labels developed to describe the messages that boys internalize about what being a man entails (David & Brannon, 1976). Men are broadly socialized to avoid femininity, seek adventure, respond with violence when provoked, maintain respect, suppress emotions, and assert dominance. These messages of being strong, tough, and successful while avoiding being effeminate have been described as *hegemonic masculinity*. Boys and men are likely to learn, internalize, and maintain these cultural expectations and "appropriate" behaviors that permeate their lives. Research has indicated that masculinity ideology is associated with a number of psychological outcomes, including limited help-seeking behaviors (Hammer, Vogel, & Heimerdinger-Edwards, 2013) and psychological and interpersonal problems (for a review, see Levant & Richmond, 2007).

The *gender role strain paradigm* (Pleck, 1981) and *gender role conflict theory* (O'Neil, Helms, Gable, David, & Wrightsman, 1986) are two main frameworks by which mental health professionals have sought to understand masculine gender role socialization and their psychological sequelae. Though men are socialized to believe that they are powerful and must exert their control, many do not feel this way (Pleck, 1981). Furthermore, failing to live up to hegemonic masculinity gender prescriptions is often difficult if not impossible. Pleck conceptualized the gender role strain paradigm to describe how boys and men experience negative outcomes as a result of their

gender role socialization. Here, men face a great deal of pressure to conform, as the violation of gender expectations is hypothesized to result in negative evaluation from others and social condemnation. In this model, Pleck proposed three gender-related strains that result from masculine gender role socialization. The first, *discrepancy strain*, describes how men experience distress as a result of trying and failing to live up to internalized prescribed roles for men. The second, *dysfunction strain*, explains how men engage in behaviors that are not healthy in an effort to meet gender role expectations. Men may behave in aggressive or overly competitive ways with others, engage in substance abuse, or participate in other risky behaviors. These behaviors impact the self and others (e.g., partners, children). The third, *trauma strain*, describes how boys and men may experience shame, psychological pain, and, in some cases, violence, as a result of their gender role socialization.

Gender role conflict (GRC) theory was developed as an extension of the gender role strain paradigm (O'Neil et al., 1986) to explain the psychological consequences for men for violating unrealistic and internalized prescriptions of being a man. The consequences can be observed at the cognitive, behavioral, affective, or unconscious level. GRC is comprised of four dimensions: (1) *Success, Power, and Competition*, which reflects concerns over not being able to succeed; (2) *Restrictive Emotionality*, which addresses how men may struggle in expressing feelings other than anger; (3) *Restrictive Affectionate Behavior Between Men*, which describes how men have a difficult time expressing warmth to other men; and (4) *Conflict Between Work and Family Relations*, which addresses how men may have a hard time balancing the demands of work with family (O'Neil et al., 1986). GRC and its dimensions positively correlate with a number of psychological outcomes (e.g., attachment styles, intimacy, violence, anxiety, depression), attitudes (e.g., marital dissatisfaction), and health behaviors (e.g., substance abuse) across diverse populations (see O'Neil, 2015).

Social Constructionist

Although the masculine gender role socialization paradigm has led to a great body of literature that has increased the current understanding of men's psychological health and well-being, Addis and Mahalik (2003) argued that these approaches lend themselves to viewing masculine behaviors from a psychological essentialist perspective. That is, masculinity is viewed as a set of stable traits that men incorporate as a result of socialization. Far from being stable behaviors, however, men vary in their own behavior depending on the context (Addis et al., 2010). There is a diversity of behaviors in which men will engage, depending on the situation and context. Addis and Mahalik further argued that a strong understanding of within-person and across-situation variability is needed in order to facilitate men's help-seeking behavior. From their perspective, gender is actively constructed by individuals and groups and performed differently by an individual depending on his specific context.

In a more recent application of social constructionist approaches to understand men and masculinity, Bosson and Vandello (2011) draw attention to the construct of *precarious manhood*, which describes manhood as a tenuous status that requires frequent actions to demonstrate masculinity to avoid losing one's status. As such, when asked about how to define masculinity, men often defined the status of "men" based upon actions. This suggests a socialized preoccupation with the things that "men *do* rather than the ways that men *are*" (Bosson & Vandello, 2011, p. 83). The anxiety inherent in the consistent tenuous status of masculinity can manifest in negative outlets such as aggression or other physically risky behavior.

Although these linkages between masculinity and health have been identified, the masculine gender role socialization literature in psychotherapy is limited by its emphasis on deficits and correcting problematic male behaviors. As such, *Positive Masculinity* has been proposed as a counterweight to the negative frame by which the masculine gender role socialization literature has conceptualized men's cognitive, affective, and behavioral experiences (Englar-Carlson & Kiselica, 2013). Thus, positive behaviors of men were identified with the purpose of helping practitioners build upon those strengths rather than focus on "curing" problems. In their work, Kiselica and Englar-Carlson (2010) identified the following nonexhaustive list of 10 male strengths:

1. *Male Relational Styles*—How men's relationships are developed through shared activities, which are instrumental or action oriented.
2. *Male Ways of Caring*—How men are socialized to care for and protect their loved ones and friends.

3. *Generative Fatherhood*—How men respond to their children readily and consistently to foster their emotional, educational, intellectual, and social development.
4. *Male Self-Reliance*—How men are socialized to solve problems on their own with input from and consideration of the needs of others.
5. *The Worker/Provider Tradition of Men*—How men are imbued with the cultural expectation to work and to provide for their families.
6. *Male Courage, Daring, and Risk Taking*—How men's socialization to take risks can serve to benefit others (e.g., protecting others, completing dangerous jobs).
7. *The Group Orientation of Boys*—How boys and men are socialized to band together to achieve a common purpose.
8. *The Humanitarian Service of Fraternal Organizations*—How boys and men have historically formed humanitarian organizations to provide service to their communities.
9. *Men's Use of Humor*—How men use humor to cope with problems and to build, maintain, and repair friendships.
10. *Male Heroism*—How boys and men throughout history have demonstrated positive masculinity to overcome obstacles and make extraordinary contributions to society.

Though these traits would appear to reify an essentialist sex role perspective, the traits and behaviors associated with positive masculinity are not male specific or biologically determined (Englar-Carlson & Kiselica, 2013). Positive masculinity is a relatively new theoretical framework that provides an avenue for future empirical testing.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION IN PSYCHOTHERAPY WITH MEN

Therapeutic outcomes are dependent on the therapist, client, and the relationship between the two. In this section, we provide a discussion of some factors important for therapeutic change.

First, therapist factors conducive to change may include knowledge, awareness, and skills. Working with men and boys begins with the therapist's knowledge of theories of gender as well as the basic research on the associations found between masculinity ideologies and mental health outcomes. Therapists with knowledge of the research will be better suited to recognize and appreciate the diverse ways men may express their concerns depending on their socialization. A sound understanding of the stressors and conflicts that masculine gender role socialization brings to the lives of men can also allow mental health professionals to help foster insight into the roots of presenting concerns while exploring the rigid and constricting nature of strict adherence to masculine stereotypes. Therapists should understand that although the research has focused primarily on maladaptive qualities of men, men also demonstrate positive masculinity qualities that may serve to facilitate change.

Therapists also should have an awareness of how gender has shaped their own lives because it may reduce the likelihood of unconscious enactments of assumptions of gender within the therapeutic context (e.g., therapists avoiding emotion-laden exploration with men). This awareness also should provide therapists with greater attentiveness and empathy for their clients' experience of masculinity. Furthermore, awareness of how men and boys may be socialized based upon their unique intersections of identities allows for more open exploration and understanding of unique client presentations. Ultimately, this awareness may allow therapists to conceptualize their clients' presenting problems and develop a treatment plan within the context of gender.

The client must also be ready and receptive to therapy and the therapists' efforts. The socialization of hegemonic masculinity and the pressures and challenges to meet those expectations has significant implications for men's formal help-seeking attitudes and behaviors (Addis & Mahalik, 2003). Mahalik, Good, and colleagues (2003) suggested that the discrepancy between masculine expectations and conceptualizations of mental health may be to blame for men's reluctance to seek treatment and increased likelihood of early termination. Given the importance of these client factors, the likelihood of change may increase if the therapist attends to gendered attitudes early on in therapy (Mahalik et al., 2012). As such, change also requires a skillful therapist. Though there is limited research in this area, recent scholarship has indicated that providing immediate symptom relief, affirming strengths, performing a gender analysis, and being able to identify the right timing and depth of exploration of emotion are important facets of successful therapy with boys and men (Englar-Carlson, 2014).

Finally, the therapeutic relationship also is an important dimension of change. Clarifying roles and establishing goals collaboratively may help to strengthen the relationship, reduce the stigma associated with help seeking (Englar-Carlson & Kiselica, 2013), and serve to reframe therapy from an activity for the weak to one that honors their strengths and abilities as men. This reframing may help men see therapy as an activity consistent with their understanding of their manhood. Therefore, mental health professionals should strive to address and normalize men's concerns about therapy by asking for questions, thoughts, or concerns with the therapeutic environment.

Furthermore, because the therapeutic relationship may be a reflection of the male client's relational patterns outside of therapy, the therapist should attend to how gender manifests during the clinical hour. For instance, men who adhere to hegemonic masculine norms of control and power may unconsciously test their therapists' knowledge and ability. Depending on the client's presenting problems, exploring these relational dynamics may help to lead to client awareness and change outside of therapy.

In sum, change requires a competent and gender-aware therapist and a motivated client, as well as therapist attention to how gender may influence the client and the therapeutic relationship. Suggestions made here are consistent with Addis and Mahalik's (2003) recommendations to create a more comfortable environment for men to seek therapy. Specifically, they proposed that therapists work to increase sensitivity to men's perceptions of presenting issues, increase opportunities for men to be involved in the process and to give back to others who may face similar issues, normalize psychological challenges, and reduce stigmatization of seeking assistance. From these recommendations, psychotherapists may adjust counseling environments to be more in line with masculine expectations (see Addis & Mahalik, 2003). Implicit in this discussion is the need for therapists to consider case conceptualization from a gendered, relational, and strengths-based perspective.

RESEARCH ON EFFICACY AND EFFECTIVENESS OF PSYCHOTHERAPY WITH MEN

The American Psychological Association's Task Force on Evidence-Based Practice (2006) asserted the need for clinical judgment *and* empirical evidence to ground clinical interventions. Although the use of clinical judgment allows for clinicians to customize their approaches to particular clients, these interventions may be influenced by practitioner bias. Given the strengths of the two approaches, we provide an overview of process and/or outcome studies with men and offer a select review of theoretically grounded and empirically derived approaches to working with men. We close this section with a discussion of helpful and harmful practices with men.

Empirically Based Treatments and Processes

Given the androcentric history of counseling and psychology, one would anticipate that the empirical literature on clinical interventions would be deep in its understanding of empirically supported treatments for men. Relatively little research, however, has explored unique factors in the development of a therapeutic alliance with male clients. In fact, at the time of writing this chapter, we identified only three such empirical studies specifically addressing men. These are summarized next.

In a study of counseling processes, Bedi and Richards (2011) found that men in psychotherapy most appreciated "bringing out the issues," "client responsibility," "formal respect," and "practical help." This suggested that men value practitioners that reflect goals, summarize and validate experiences, provide skills, involve the client in the process, and maintain professional, formal, and respectful boundaries. In another study, Syzdek, Addis, Green, Whorley, and Berger (2014) researched the effectiveness of gender-based motivational interviewing for formal and informal help-seeking attitudes and intentions, as well as internalizing and externalizing symptoms in a community-based sample of mostly White men. In their pilot study, they found that gender-based motivational interviewing, which is a single session of assessment and feedback that integrates gender-aware approaches with motivational interviewing techniques, had small to moderate effects on problematic drinking behaviors, anxiety, and depressive symptoms and small effects on hostility. Though the size of the sample limited statistical power, the estimated effects indicate some potential for utility in clinical settings. In a third study, Hopton and Huta (2013) examined the *Men and Healing* program, a theoretically derived

model for treating men who experience trauma as a result of childhood sexual abuse in a community-based sample of men in Canada. The treatment is offered at the group level and is psychodynamically oriented. It integrates empirically grounded approaches to treating trauma along with a focus on masculine gender roles. Their study showed improvements in posttraumatic and depressive symptoms. A comparison group, however, was not included in this study. Together these studies demonstrate the potential utility of incorporating gender-aware approaches to treatment with men.

Emergent Approaches to Psychotherapy With Men

Exploring Gender Roles

In one of the first sets of recommendations for clinical treatment with men, O'Neil and Egan (1992) conceptualized the concept of using *gender role journey* as metaphors to assist an individual's understanding of his personal struggles regarding gender role conflicts and sexism. O'Neil and Egan (1992) built upon Moreland's (1976) conceptualization and presented five phases: (1) acceptance of traditional gender roles, (2) ambivalence, (3) anger, (4) activism, and (5) celebration and integration of gender roles. Through the use of gender role journeys, practitioners can assist clients in better understanding and integrating different aspects of themselves (e.g., both masculine and feminine) throughout their lives, expanding on individuals' abilities to empathize with the sex-based struggles of others, and helping decrease the negative outcomes associated with systemic sexism that inhibits men's ability to validate their feelings, strengths, and personal power (O'Neil & Egan, 1992). More recently, O'Neil (2015) provides a diagnostic schema for clinicians to use in their work to help men understand the role of gender role conflict in the experience of psychological distress.

An alternative to the *gender role journey's* approach is to process male clients' conformity or nonconformity to masculine norms. Mahalik, Talmadge, Locke, and Scott (2005) suggested the use of psychometrically sound instruments to help ground the therapeutic discussion in specific masculine norms. They argued that this approach may not be appropriate for all men but may prove to be useful for men presenting with a variety of issues ranging from substance disorders, relationship problems, depressed mood, anxiety, interpersonal violence, sexual identity, career-related problems, and health issues. The clinician's ability to provide a working hypothesis to the client of how the client's presenting problem may be associated with masculine role norms is critical. They identified the Conformity to Masculine Norms Inventory (CMNI; Mahalik, Locke, et al., 2003) as one potential measure to use for this purpose. Mahalik and his colleagues (2005) suggested that clinicians discuss with their clients the context and meaning of their extreme total and subscale scores. They identified two therapeutic goals for using the CMNI in this process. One goal of these discussions is for the client to become more aware of the costs and benefits of his conformity or nonconformity to masculine gender role norms. A second goal is for the client to be more flexible in his conformity or nonconformity to masculine gender role norms and to reduce the psychological and physical health costs of not conforming to masculine role norms. Cochran (2005) explains that uncovering a male client's conformity to masculine gender role norms may also facilitate discussions about potential barriers to therapy (e.g., shame).

Evidence-based assessment, which is grounded in psychodynamic and masculinity perspectives, has been proposed as a complement to the aforementioned explorations of masculinity in a male client's life (Rabinowitz & Cochran, 2002). From this perspective, clinicians should assess for how male clients have (1) resolved the conflicts that often are associated with psychological and emotional dependency with significant others; (2) learned to cope with, resolve, and acknowledge feelings of sadness, grief, and loss; (3) developed a healthy way of expressing their masculinity and whether they have demonstrated insight into their gendered behaviors and values; and (4) found balance between a state of *being and doing*, as men have come to overvalue doing versus being with family and loved ones. They also suggested that clinicians assess for normative male alexithymia, a term coined by Ronald Levant, to describe how one result of masculine gender role socialization is the difficulty some men may have in identifying and expressing their emotions. In fact, Cochran and Rabinowitz (2003) provided strategies for gender-sensitive assessment of depression in men. Their suggestions reflect their belief that men may express their depression through anger, substance abuse, violence, somatic complaints, decreased

motivation, increased concern with work productivity, and decreased interest in sexual activity.

Working From a Strengths-Based Perspective

The Positive Psychology/Positive Masculinity (PPPM; Kiselica & Englar-Carlson, 2010) presents a model for working with men, which is based on identifying and reinforcing masculine strengths. As such, one of PPPM's goals is to help men foster beneficial and adaptive aspects of their masculinity as a starting point for psychotherapy before progressing toward the exploration of more maladaptive and restrictive aspects of masculinity. This may help reduce the defensiveness of men in therapy and allow for more open exploration of challenges that men face in their personal and interpersonal lives (Englar-Carlson & Kiselica, 2013). Furthermore, PPPM asserts that any work with men's strengths must consider their unique constellation of identities.

Helpful and Harmful Practices

The aforementioned approaches address the potential benefits of fostering men's exploration of varying aspects of masculinity or enlisting men's strengths as a way to help them. In their qualitative study, Mahalik and his colleagues (2012) explored helpful practices for clinicians working with men and found that the practitioner's awareness of factors that may impact or be impacted by masculine identities (e.g., unique cultural values, experiences of racial discrimination or sexism, physical disabilities) facilitated the development of their rapport with clients. Based on the findings of their study, Mahalik and colleagues developed a taxonomy of helpful and harmful practices for clinical work with men and boys. Mahalik et al. (2012) highlighted the importance of attending to gender-sensitive issues and gender socialization in an effort to understand accurately how various aspects of a man's identity permeate his conceptualizations of himself and his environment. Here, it is important to take time to understand in which contexts he finds different aspects of his identity more salient and to recognize that men conceptualize and are impacted by masculine gender role norms and their associated stereotypes differently dependent on their stage of life.

Practitioners also should strive to gain awareness of how gender dynamics are manifested with each individual male client. For instance, practitioners are encouraged to consider how men's socialized drive to be powerful, in control, and competitive may create barriers in treatment for some men. Furthermore, women therapists have noted the importance of their own held stereotypes of men as well as gender dynamics that were specific to their gender dyad with male clients in their work with men (see Sweet, 2012). As such, practitioners should view themselves as gendered individuals and assess their own understandings and conceptualizations of masculinity. From this understanding, practitioners may be able to more easily and naturally explore potential restrictive or rigid pressures placed upon men due to their gender socialization.

In contrast, harmful practices are centered on clinicians' use of stereotypes as well their lack of awareness of gender socialization. Mahalik and his colleagues (2012) found that addressing men as a homogenous group of emotionally suppressed perpetrators inhibited and harmed clinical work with them. Instead, clinicians are reminded to be aware of how their biases may harm their work with male clients and should strive to conceptualize men's behaviors as mutable within-person and across situations. Practitioners should also assess their use of emotional exploration with men. Here, it is important to not underestimate men's abilities regarding emotional expression or push men to explore emotions prematurely. As men approach emotions and interpersonal connections in unique ways based upon their internalization of masculine stereotypes, it is important for mental health professionals to understand and adapt to their male clients' presentations. For example, Levant (1995) suggested that men may present with what appears to be mild alexithymia, which could result in a very different therapeutic environment than one consisting of open and vulnerable emotional exploration. Furthermore, clinicians also are reminded to not evaluate the effectiveness of their therapy with men based simply on the male client's ability to be emotionally expressive (Wong & Rochlen, 2005).

In summary, research on efficacy, let alone effectiveness of treatment with men, is nearly nonexistent. Nonetheless, we believe these emergent models discussed earlier may serve to strengthen clinicians' understanding of the role of masculinity, thereby strengthening clinical judgment and reasoning.

DIVERSITY IN PSYCHOTHERAPY WITH MEN

An *intersectionist perspective* has emerged recently in the study of men and masculinity. Moving beyond examining how men may differ in their expression of masculinity based on race, culture, or sexual orientation, scholars argue that masculinity cannot be explored or understood in isolation of cultural values and sociocultural processes like racism (e.g., Liang, Salcedo, & Miller, 2011) or heterosexism (e.g., Szmanski & Ikizler, 2013). Therefore, consistent with a social constructionist perspective on masculinity, scholars argue that understanding how racial minority and sexual minority men experience masculinity must be done in the context of hegemonic White (European American), heterosexual, middle-class, Western masculinity. In this section, we provide some examples of how masculinity intersects with other dimensions of diversity.

Due to the influence of cultural values on all behaviors, masculinity must be considered in the context of norms and expectations that are culturally specific. Though there is overlap in how masculinity is constructed across cultural groups (i.e., patriarchal), there are some noteworthy differences in the messages men are socialized with across different cultural groups in the United States. For US minorities, their sense of masculinity is informed by expectations of men that are based on values of their culture of origin as well as those gender role norms espoused by the dominant cultural group. For instance, in summarizing the nascent literature on Asian American masculinity, Liu and Chang (2007) reported that Asian American men are socialized with a sense of masculinity that is associated with cultural values of being polite, obedient, and willing to share in domestic responsibilities (Chua & Fujino, 1999), emphasizing group harmony and filial piety (Liu & Iwamoto, 2007), as well as taking risks and displaying courage (Nghe, Mahalik, & Lowe, 1998). Latino men's sense of masculinity is also tied to cultural values and gender role norms that emphasize family, respect for others, honor, and dignity (Torres, Solberg, & Carlstom, 2002). Some empirical evidence supports these contentions. For instance, Torres and his colleagues found that men in their sample identified more with emotional responsiveness, collaboration, and flexible masculine styles. Arciniega, Anderson, Tovar-Blank, and Tracey (2008) reintroduced a multidimensional conceptualization of Latino masculinity that included both traditional *machismo* and *caballerismo*. According to Arciniega and his colleagues, Latino men are not merely the stereotypes associated with traditional *machismo* (e.g., controlling, hypermasculine) but are also socialized to demonstrate respect, emotional connectedness, and chivalry.

Men not only are socialized to different culturally based gender role expectations, but these culturally sanctioned behaviors are also negatively interpreted, labeled, and stereotyped. Stereotypes of men of color may emerge from how different ethnic minority men's culturally sanctioned expression of their masculinity is perceived from what is accepted by the dominant group. In fact, Wong, Horn, and Chen (2013) found that men of color are stereotyped differently based on their perceived racial background. For instance, Black American or Latino men are stereotyped as uneducated, lazy, "deadbeat dads" that engage in delinquent or criminal behaviors, while Asian American men are stereotyped as intelligent but physically weak or effeminate. These stereotypes, which are widely disseminated in popular media, shame men and undermine their already tenuous abilities to live up to rigid hegemonic masculine expectations. Men of color must negotiate their masculinities in the context of cultural differences and stereotypes.

Men of color will engage in masculinity differently based on how, whether, and in what contexts stereotypes are internalized. For instance, Franklin (2004) described how Black men may experience *The Invisibility Syndrome*, a cluster of symptoms that include frustration, anger, pervasive discontent, disillusionment, internalized rage, depression, loss of hope, and substance abuse. Black adolescent males who experience these symptoms may become disinclined to perform well in academic settings in which they are stereotyped as jocks or unintelligent (Franklin, 2004), or they may adopt what they termed "the cool pose" (i.e., ritualized, visible, depictions of pride, control, and strength) to cope with society's perceptions of them (Majors & Billson, 1993). Black men may also engage in John Henryism (i.e., chronically working harder to cope with stressful environments) behaviors (Matthews, Hammond, Nuru-Jeter, Cole-Lewis, & Melvin, 2012) or engage in behaviors that are associated with positive masculinity (Mattis et al., 2009).

Additional research is needed to understand more fully how men of color perceive, respond to, and are impacted by the intersection of their masculinity and culture (Liang, Salcedo, & Miller, 2012).

Practitioners' awareness of masculinity in the context of cultural socialization, negotiations, and racism across the life span and in different contexts is an important component of multicultural competence in working with men. As such, awareness of how racism and masculinity operate in isolation and in tandem can help mental health practitioners gain understanding of their own biases that may impact their work with men and boys, their ability to diagnose accurately (Mandell et al., 2009), or even their capacity to detect early symptoms during critical periods (e.g., autism; Mandell, Listerud, Levy, & Pinto-Martin, 2002).

Yet the complexity of masculinity does not begin or end with racism or cultural differences. Other, seemingly endless constellations of identity intersections can present in the psychotherapy environment. For example, the intersection of masculinity and sexual orientation is important to consider. As such, extant literature has found that while gay and bisexual men place a great deal of importance on maintaining traditional masculine behaviors and images, the preoccupation with hegemonic masculinity and the avoidance of perceived effeminate behaviors were related to negative thoughts about identifying as gay (Sanchez & Vilain, 2012). Gay and bisexual men who perceived themselves as less traditionally masculine experienced more instances of abuse, homophobia, and increased psychological distress (Sandfort, Melendez, & Diaz, 2007). Similarly, experiences of homophobia, and the internalization of heterosexism, may be connected with an increase in depressive symptoms (Szymanski & Ikizler, 2013). Furthermore, the consequences of endorsing and valuing hegemonic masculinity can potentially damage the physical health of gay or bisexual men. For example, the association between masculine conformity and lower rates of HIV testing has been reported (Parent, Torrey, & Michaels, 2012). Men may willingly face these additional risks in an attempt to demonstrate that they are masculine. However, it is also important for clinicians to remember that gay and bisexual men may not endorse hegemonic masculine gender roles and may even assert their nonprivileged masculinity as a way of protesting the societal power of patriarchy (Connell & Messerschmidt, 2005).

Therapists' awareness of potential psychosocial, psychological, and physical ramifications of the extent to which a client endorses hegemonic masculine behaviors may help bolster their work with men (Parent, Torrey, & Michaels, 2012; Sanfort et al., 2007). While we have touched upon only a few of the ways different aspects of identity can intersect with masculinity, mental health practitioners should continue to strive to be cognizant of the different ways that unique constellations impact how an individual learns to express himself, his ideas, his emotions, and his behaviors.

CLINICAL ILLUSTRATION

Aaron, a 21-year-old college senior, is a Black American man born to an upper middle-class family in the United States. He reports that his parents have been married for nearly 45 years and that his father and mother share in domestic- and financial-related responsibilities. His father is a civil engineer who devotes his Saturdays to community service, and his mother is a social worker who works primarily with low-income youth. Aaron is a well-groomed, fashionably dressed, tall, heterosexual man in a long-term monogamous relationship. Aaron began psychotherapy because he had been feeling depressed and frustrated with his interactions with his colleagues. Specifically, Aaron disclosed that he has been feeling frustrated and annoyed with others for asking him what sports teams he plays for or accusing him of "acting White" when he speaks or shares his goals and academic interests. He also shares that he has started having difficulties in his courses after an unpleasant experience when he disagreed with another student's political argument and was called an "angry Black man." Now he reports feeling concerned about speaking up or expressing his opinions in class.

In regard to his romantic relationship, Aaron reports loving Maya, his partner, and feeling satisfied with their relationship. However, Aaron also reports feeling pressure from his friends, who often make fun of him for having "slept" with only one woman. At a recent party, Aaron described meeting a sophomore woman who expressed interest in "hooking up" with him. As they left the party together, Aaron shared that he felt overwhelmed with guilt and could not stop thinking about Maya. Aaron disclosed that he could not bear the thought of hurting Maya, so he walked the sophomore woman back to her apartment, told her he was not feeling well, and left "before anything happened." Now, however, Aaron shares that he's feeling guilty about almost cheating on Maya while also feeling frustrated and

angry at himself for "not being able to do what a man is supposed to be able to do."

Conceptualization

Aaron reports frustration, distress, shame and psychological distress from his perception of not living up to the gendered expectations he internalized for himself. Conceptualizing Aaron within Pleck's (1981) framework suggests that he faces not only discrepancy strain but also trauma strain. A more holistic conceptualization of Aaron can be achieved by drawing from social constructionist and intersectionist perspectives. From this perspectiveit could be hypothesized that Aaron may feel torn between the messages of masculinity he received growing up in an intact, upper middle-class family and those communicated from his peers or from the media. For instance, these strains could be evidenced in the internal conflict Aaron experiences while with his friends, who shame him for only having one sexual partner. More specifically, although he experiences some sense of psychological emasculation from his peers for not being "man enough," he personally values his ability as a man to nurture a monogamous relationship with Maya. In this case, Aaron was able to enlist his strengths to resist the pressure to prove to his friends and himself that he could be a real "guy." Processing his thoughts and feelings with this inner conflict could help him gain better understanding of his relational patterns as well as his strengths and areas of growth as a man.

His experiences also should be understood in the context of his intersecting identities. For instance, whereas he was socialized and rewarded by his parents and educators for demonstrating his intellect, these same behaviors were coded by his White classmate as emblematic of the "angry Black man" stereotype. This experience, coupled with his feelings of being academically and personally dismissed through frequent questions of his athletic abilities, is a source of distress for Aaron. His subsequent disengagement is consistent with what research has indicated to be a consequence for Black boys and men who are exposed to toxic racial classroom climates (Franklin, 2004). It would be important to explore his concerns for his safety and his strong motivation for doing well academically within the context of racism and masculinity. Doing so would engage him in the process of identifying a set of tools he could use to cope with these transgressions against his personal and group identity as a Black man.

First Sessions

As a practitioner working with Aaron, it may be useful to include a discussion of expectations for psychotherapy and potential goals he may have as part of your introduction. This may open the door for an environment where Aaron feels more agency in therapy while adapting relevant and concrete goals that he may actively work toward. It also may help clarify misconceptions Aaron may have regarding the therapy process, while allowing him to discuss intentionally and directly what sort of environment he would feel most comfortable to be in (Mahalik et al., 2012). Furthermore, while the practitioner should enter therapy with an understanding of masculine socialization and how Aaron's various intersections of identity may align, it is important not to remain rigid or have strict expectations as to how he will present. As Aaron reports experiencing ongoing invalidation and conflict in regard to his masculine socialization, further stereotyping and invalidation from the practitioner could cause further distress and potentially result in premature termination.

During the introduction, it may also be useful to acknowledge biases and to discuss any potential discrepancies in identities (e.g., gender, race, etc.) and lived experiences between the clinician and Aaron. This could serve to better frame the therapy environment as one where the practitioner is aware of his or her privileges and biases in addition to remaining open to discussing systemic issues in a nondefensive manner. This may be particularly beneficial in establishing a positive working alliance with Aaron, as he presents with many experiences of invalidation from those in his environment and reported frustration in regard to ongoing gender stereotyping, racial stereotyping, and ethnic discrimination.

Treatment

Work with Aaron could be structured by drawing from Rabinowitz and Cochran's (2002) suggestions for addressing common inner conflicts. Aaron would be

invited to engage in an open dialogue regarding his past and current relationships. Given Aaron's conflict over his need to be approved by his peers, a clinician would work with him to uncover how he relates to others, including the therapist. Does Aaron experience conflicts around psychological or emotional dependency? Is his need to be approved by his Black peers made all the more important by his perceptions of racism on campus? As a second area of exploration, the clinician also would help to explore and expand Aaron's ways of coping with his feelings. He currently feels depressive symptoms and shame in regard to considering infidelity. He also expresses experiencing sadness, anger, and frustration over being labeled as an "angry Black man." He is able to identify and acknowledge his feelings and is open to discussing them. The focus of clinical work, assuming there are no other feelings, is to uncover the ways in which Aaron has coped and resolved feelings of frustration, sadness, and anger. With a client who was less emotionally expressive, a clinician may work on this exploration through a problem-solving approach with less emphasis on sharing of emotions.

A third area to explore with Aaron is his expressions of and understanding of masculinity. A clinician would work here to help Aaron understand different healthy ways of expressing his masculinity and to assess whether he has insight into his gendered behaviors. Here, it would be critical for the clinician to understand not only hegemonic masculinity and family messages about manhood but also how Black masculinity has been socially constructed and internalized as hypermasculine (e.g., sexual prowess and athletic ability). A clinician would work to help Aaron understand such influences on his ideas of masculinity for Black men. A clinician may ask Aaron to talk about the conflicting messages he receives about what it means to be a Black man in America. He may be asked the costs and benefits to his own sense of self to engage (or not engage) in certain behaviors. A discussion of how society views Black men also is critical here and should be coupled with an exploration of healthy ways of coping. Importantly, healthy coping is context dependent. For instance, although strategies such as clowning or using a cool pose may not be helpful in some contexts, it may very well be the most appropriate in other situations.

In this work, practitioners can draw from a strengths-based framework (Kiselica & Englar-Carlson, 2010). Framed within Aaron's strengths and resilience, discussions of the systemic challenges he has faced and will unfortunately likely continue to face may take place. This exploration should at once validate Aaron's lived experiences and frustrations, while also reaffirm his resilience in the face of discrimination and support the accomplishments he has made (e.g., upcoming college graduation).

This framework could not only prove to be normalizing for Aaron (e.g., "It is a common masculine experience to be challenged by rigid expectations for manhood" and "Black men in this country experience racism") but also could provide him a greater understanding of his interpersonal style, an expanded repertoire of coping strategies, and a deeper awareness of how racism and masculinity intersect in his life. With this understanding, he can be more intentional in his gendered behaviors, develop more empathy for his own experience as a Black man in the United States, and resist internalizing racism by understanding the prejudice others hold of Black males. From this, he will gain a deeper sense of control over his own experience and feel more hopeful about his place in a racialized and gendered world. He will understand his depressive symptoms as a manifestation of a world in which gender and race operate in restrictive and oppressive ways.

CONCLUSIONS/KEY POINTS

- The major theoretical frameworks are grounded in assumptions that individuals are socialized to behave in socially sanctioned, gender-appropriate ways.
- Masculinity is not a stable set of behavior, traits, and attitudes but a social construction in which men's performance of gender will vary with the individual and context.
- The intersection of identities must be considered in clinical work.
- Clinicians should strive to be aware of how gender biases may influence (1) their conceptualization of problems men face, (2) diagnosis, (3) treatment planning, and (4) the therapeutic relationship.
- Empirically supported treatments that focus on men are nearly nonexistent. However, several theoretically based and empirically informed interventions have been advanced.

REVIEW QUESTIONS

1. What is the difference between the masculine gender role socialization paradigm and social constructionist perspectives on masculinity?
2. What are the benefits of examining men's experiences in the context of race, culture, social class, and sexual identity?
3. What empirically supported treatments are available for working with men?
4. In what ways can masculinity and gender role socialization be integrated into clinical practice?
5. What are some helpful and harmful practices with men?

RESOURCES

Readings

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Websites

American Men's Studies Association: http://www.mensstudies.org

APA Division 51: http://www.Division51.org

Center for the Study of Men and Masculinities: http://www.stonybrook.edu/commcms/csmm/

The Good Men Project: http://www.goodmenproject.com

Jim O'Neil, Neag School of Education, University of Connecticut: http://jimoneil.uconn.edu/

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22

Psychotherapy With Lesbian, Gay, and Bisexual Clients: Theory and Practice

Peter Goldblum
Samantha Pflum
Matthew Skinta
R. Wyatt Evans
Kimberly Balsam

Abstract
Although advancements in attitudes of acceptance toward lesbian, gay, and bisexual (LGB) people have been well documented in the United States in policy and research, many forms of prejudice and discrimination toward this population still exist (Herek, 2009). This chapter addresses the emergence of specific clinical strategies designed to assist lesbian, gay, and bisexual clients who manifest psychological distress. Consistent with values articulated by the American Psychological Association (APA, 2012), the authors view lesbian, gay, and bisexual orientations as a "natural variant of human behavior" rather than a form of psychopathology. To avoid being overly inclusive without honoring the differences that exist among groups, this chapter focuses on emerging psychological treatment for LGB clients experiencing psychological distress. That said, it is apparent that greater research and clinical attention should be directed toward the transgender community, a population with unique health needs, risk factors, and points of resiliency (Hendricks & Testa, 2012).

Keywords: sexual orientation, lesbian clients, gay clients, bisexual clients, psychological distress, stigma, minority stress

Homosexuality,[1] despite periods and pockets of tolerance, has long been perceived as morally repugnant (Bayer, 1987). Even those who did not align closely with Western Christianity or other religions' condemnation of homosexuality were collusive in their decrying of homosexuality as sinful. In the early 19th century, even medical discussion of homosexuality was highly impacted by the long-standing religious tradition (Bayer, 1987). As the medical investigation of homosexuality gained more sway, the literature framed it as both environmentally influenced and hereditary/genetic but maintained that homosexuality was a perversion of normal human sexuality and closely linked with other forms of pathology.

In the late 19th century, Sigmund Freud pioneered a notable shift in the understanding of the variation of human sexuality (Brill, 2005). Freud denoted a complex interaction of constitutional factors, early attachment, and frustrated sexual development as causal in homosexual orientation; however, he explicitly stated in multiple contexts that homosexuality was not, in itself, an illness. Generally pessimistic

about therapeutic change efforts with regard to sexual orientation, Freud stood apart from many subsequent psychoanalysts who developed theories and techniques for eliciting this change. Even as the schools of thought within psychology and psychiatry began to diversify during the 1950s, consensus generally remained regarding the pathological nature of homosexuality (Bayer, 1987). In 1952, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) included homosexuality among the sociopathic personality disturbances and, even as political challenges arose, the diagnosis was not eliminated until 1973. The subsequent shift has progressed at an increasingly rapid pace toward an acceptance of lesbian, gay, and bisexual (LGB) identity and an affirmative approach to psychotherapy with LGB clients.

Before the 1970s and the shift away from viewing homosexuality as pathology, the primary psychotherapy treatment goal with sexual minority clients was changing their homosexual orientation (Ritter & Terndrup, 2002). The declassification of homosexuality as a mental disorder and the ensuing review and report of the American Psychological Association (APA) (2000) altered the focus of psychotherapy with LGB clients. This change, embraced by proponents of all theoretical orientations except classical psychoanalysis, rested on the affirmation of the sexual identities of LGB individuals (Ritter & Terndrup, 2002). The foci of the early literature in affirmative therapy included addressing the effects of external stressors related to one's LGB identity, the internalization of societal stigma, and specific psychotherapy techniques for problems experienced uniquely by LGB clients (Ritter & Terndrup, 2002). Until quite recently, no systematic approaches to psychotherapy existed specifically for LGB clients. Instead, early affirmative therapeutic efforts appeared more as practices in cultural competence with properly attuned case formulations and selectively targeted therapeutic goals (Ritter & Terndrup, 2002).

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS

Mental Health Disparities Among LGB Populations

Today, most researchers would agree that a homosexual or bisexual orientation itself does not cause psychological disorders, and the majority of sexual minority individuals are healthy, well functioning, and resilient (Savin-Williams, 2005). However, the continued higher prevalence of mental health disorders in LGB populations suggests that something related to belonging to this group contributes to these negative outcomes. Currently the best scientifically grounded explanation for this disparity is that it is due to the extra burden from discrimination, stigma, and prejudice directed toward LGB individuals and community (APA, 2012).

Despite increases in societal acceptance of nonheterosexual identities, LGB people continue to show greater risk for mental and physical health problems. Extant research has documented a higher prevalence of mood, anxiety, and substance use disorders among LGB individuals as compared to their heterosexual counterparts (Cochran & Mays, 2000). This is especially true for LGB people from ethnic minority backgrounds, lower socioeconomic status, and regions of the United States that adhere to more conservative political values (Meyer, Teylan, & Schwartz, 2014). A review and meta-analysis by King and colleagues (King, Semlyen, Killaspy, Nazareth, & Osborn, 2007) revealed that the risk for depression, anxiety disorders, and substance dependence was at least 1.5 times greater in LGB individuals, and that the number of suicide attempts was twice as high as compared to heterosexual individuals. Because of these experiences and disparities, there is a need for clinicians to develop specific cultural competency to work with this client population.

Perhaps relatedly, lesbians and gay men are more likely than their heterosexual peers to seek professional mental health services, regardless of whether they meet criteria for any major psychiatric disorder (Balsam, Rothblum, & Beauchaine, 2005; Cochran & Mays, 2000). This may be due to cultural norms within the LGB community that normalize help-seeking and psychotherapy in particular. These norms likely developed from the needs of gay men who faced the increased psychological burden of coping with the HIV epidemic (Cochran & Mays, 2000; Pobuda, Crothers, Goldblum, Dilley, & Koopman, 2008) and to the self-reflective, introspective nature of coming to terms with a sexual minority identity and developing strategies to come out to others (Meyer, 2003).

Minority Stress Theory

According to minority stress theory, conditions in the social and cultural environment specific to the experience of being a minority group member serve

as sources of stress that contribute to mental health symptoms. Thus, for LGB populations, societal stigma and prejudice that accompany a nonheterosexual orientation lead to negative mental health outcomes. Minority stress, therefore, is conceptualized as "surplus stress experienced by those from stigmatized social categories" as a result of their minority identity (Meyer, 2003, p. 3). Contemporary research consistently indicates that the minority stress theory is a valuable means of understanding the disproportionately high rates of mental health problems in the LGB community (APA, 2009; Cochran & Mays, 2000; Meyer, 2003). Evidence from extant studies supports the minority stress hypothesis that LGB populations are more vulnerable to mental health problems than their heterosexual counterparts. This vulnerability is particularly salient for the higher rates of suicidal ideation and attempts in the LGB population (Cochran & Mays, 2007; Meyer, 2003).

Minority stress is conceptualized as being (a) unique from and additive to general stressors, (b) chronic and stable, and (c) socially based (Meyer, 2003). Minority stress represents a level of stress above and beyond that experienced by all individuals in a particular society, therefore requiring stigmatized minority individuals to put forth a greater adaptation effort than is required of others. The chronicity of minority stress is a result of a stable underlying structure of a society that consistently emphasizes certain values, norms, and customs. Additionally, the socially based nature of minority stress is derived from "social processes, institutions, and structures beyond the individual rather than individual events or conditions that characterize general stressors" (Meyer, 2003, p. 4). Minority stress involves a continuum of distal and proximal processes that consider the impact of social and cultural conditions on individuals (Meyer, 2003). In the minority stress model, distal stressors represent objective events and conditions, whereas proximal stressors are more personal and subjective, relying on individual appraisal. The distal nature of social structures becomes proximal when judged to be psychologically important to a given individual (Meyer, 2003).

Hatzenbuehler, Hilt, and Nolen-Hoeksema (2010) proposed the stress mediation model, an extension to minority stress theory. In this model, LGB individuals experience increased minority status stressors (discrimination, rejection, and negative life events) that negatively impact their ability to cope with a range of general stressors. These authors argue that minority stress impacts general psychological processes, which in turn impact psychological distress. These psychological process deficits include ruminative coping, interpersonal difficulties (e.g., tendency for social avoidance), and negative cognitive mechanisms (e.g., hopelessness, negative self-schemas).

LGB-Affirmative Psychotherapy

At its core, affirmative therapy suggests that the development of a positive sexual identity is essential for LGB clients' development of positive self-esteem. Moreover, problems related to sexual identity confusion are not always the focus of the therapy. The focus may be minority stress, victimization, and subsequent mental health issues resulting from the unique challenges faced by LGB people (coming out, managing same-sex relationships, internalized homophobia). Initial conceptualizations of LGB-affirmative therapy focused on the integration of (1) the therapist's knowledge and awareness of the unique developmental and cultural considerations for LGB individuals, (2) the therapist's own self-knowledge, and (3) the transformation of this awareness and knowledge into successful therapy skills (Perez, DeBord, & Bieschke, 2000).

Following an extensive review of the literature by a task force established by Division 44 of the APA, *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* established a foundation of information for treatment with LGB clients (APA, 2000). Subsequently, the APA guidelines for appropriate therapeutic responses to sexual orientation (2009) and for practice with lesbian, gay, and bisexual clients (2012) further demarcated the shift toward a positive, accepting stance regarding LGB individuals and affirmative therapeutic approaches with LGB clients. This report also warned of the dangers inherent in sexual orientation change efforts (often known as "reparative therapy"), especially with youth.

There is no clear consensus regarding the proper theoretical framework for LGB-affirmative therapy (Johnson, 2012). Pachankis and Goldfried (2013) emphasize the impact of societal and individual "heterocentrism" on therapists' conceptualization and treatment of clients. In doing so, they noted that many clinicians demonstrate a shortsighted, albeit well-intended, belief that LGB clients should be treated in the same manner as heterosexual clients. Similar to the challenges addressed against "color blind" approaches, this perspective fails to take into account the unique issues faced by LGB individuals.

Johnson (2012) conceptualized gay affirmative therapy as a therapeutic approach rather than a specific psychotherapy. Similarly, Alessi (2014) applied the theoretical perspective of minority stress to an integrative approach to affirmative therapy, which incorporated techniques from both CBT and psychodynamic psychotherapy. In describing this approach, Alessi (2014) notes that it is not an independent practice approach, but an enhancement to the therapist's intervention approach and techniques. That said, LGB-affirmative psychotherapy might entail specific techniques, particularly as they pertain to coping with minority stress (Alessi, 2014).

PRINCIPLES OF CHANGE

While the debate regarding the essential elements necessary for change within psychotherapy in general continues to challenge the field (Castonguay & Beutler, 2006), identifying key elements of change specific to working with LGB clients is even more in its infancy. The following recommendations are theoretically derived primarily from the minority stress and affirmative therapy literatures. Several other approaches to the question of key components to affirmative psychotherapy with LGB clients have been posited and are worth the reader's careful consideration: APA Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients (2012) and the ESTEEM model (Effective Skills to Empower Effective Men) for working with sexual minority men (Pachankis, 2014). Although there is broad overlap in the principles identified by each of these approaches, the current list of principles tries to cover all sexual minorities (lesbian, gay, bisexual) and provide specific principles for change among LGB clients.

Establish an Affirmative Therapeutic Alliance

In deciding which form of psychotherapy is indicated for sexual minority clients, Fassinger (2000) recommends that all psychotherapeutic interventions be informed by humanistic principles, especially related to the development of a respectful and accepting therapeutic relationship. In her words, "conditions of societal, institutional, and individual oppression faced by LGB individuals clearly call for the ameliorative effects of a warm, supportive, and unconditionally respectful relationship" (p. 107).

Many LGB clients are highly sensitized to rejection; having experienced homophobic bias and prejudice may make it difficult for LGB clients to discuss their sexual attractions or behavior with a therapist. Clients may also be keenly attuned to subtle forms of stereotype threat, in which therapists unconsciously convey their discomfort with the discussion of aspects of the LGB person's life and signal subtle limiting expectations of their clients' self-improvement (Steele & Aronson, 1995).

Over the past several decades, researchers have tried to determine which therapist characteristics are best suited for LGB clients. Given the significant within-group differences posed by age, race, class, and other demographics, no easy answer can be found for this question. There is some evidence to suggest that many LGB clients prefer their therapist to be LGB identified (Kaufman et al., 1997), while others found that holding an affirming therapy stance is more important than sexual identity matching (Jones & Gabriel, 1999).

In a 2006 study, Burckell and Goldfried investigated therapist characteristics valued by LGB clients. Using Q-sorting methodology, 42 nonheterosexual adults were queried about their past therapeutic experiences and what they would seek in a therapist in the future; and categorized them as unfavorable, neutral, beneficial, and essential. Burckell and Goldfried further divided these answers into two cases: sexual orientation salient and sexual orientation not salient to the presenting problem. They found participants "desired therapists with LGB-specific knowledge as well as general therapeutic skills" (p. 32). This held whether their presenting problem related to their sexual orientation. Having a therapist with a minority sexual identity was more important to clients when their problems related to their sexual identity. On the negative end of the scale, respondents did not feel comfortable with a therapist with little knowledge of sexual minority issues, and felt that this would hamper the free expression of their concerns (Burckell & Goldfried, 2006).

Reduce Minority Stress

The reduction of minority stress is a cornerstone of contemporary affirmative therapy. This model articulates four processes that may be a focus of psychotherapy, listed from distal to proximal: (a) external stressful events and conditions that can be

both chronic and acute; (b) expectations of stressful events, accompanied by hypervigilance to signs of such events (expectations of rejection); (c) internalization of negative societal attitudes, often termed internalized homophobia; and (d) concealment of one's sexual orientation (nondisclosure). For LGB individuals, proximal processes, including internalized homophobia, expectations of rejection, and nondisclosure of sexual orientation, are more closely linked to distress related to one's sexual minority identity (Meyer, 2003). These proximal factors may also be more amenable to change within psychotherapy.

In the mediation model of Hatzenbuehler and colleagues (Hatzenbuehler, Hilt, & Nolen-Hoeksema, 2010), the relationship between minority stress and psychological disorders is best accounted for by the presence of deficits in general psychological processes. By helping to explain the mechanisms that connect the experience of minority stress to psychological disorder, these authors advance the ability of clinicians to be more specific in the targeting of group and individual psychotherapeutic interventions. They also raise the question as to why some individuals who experience minority stressors exhibit psychological distress, while others do not.

Shame has been identified as a common consequence of minority stress. While not a clinical diagnosis, shame has been linked to a number of different problems and psychopathologies, including depression (Orth, Berking, & Burkhardt, 2006), posttraumatic stress disorder (Wilson, Drozdek, & Turkovic, 2006), substance abuse (Dearing, Stuewig, & Tangney, 2005), and suicide (Hastings, Northman, & Tangney, 2000). Shame is created and maintained by our sense of being devalued in the eyes of others and ourselves (Kaufman & Raphael, 1997). Consequently, the reduction of shame held by LGB clients is a mainstay of affirmative therapy. While the minority stress concept of self-stigma focuses on the content of thoughts about one's self, shame is both an affective consequence of those thoughts and a stimulus for self-critical mental content (e.g., "I am damaged").

Few systematic studies of shame and religion among sexual minorities exist. Schuck and Liddle (2001) reviewed the existing literature and conducted a mixed method—qualitative and quantitative—study of 66 lesbian, gay, and bisexuals to understand the conflicts they experience between their sexual identity and their religion. They also investigated strategies that individuals used to reduce these conflicts, such as change religious venues or eliminate religion altogether. Finally, they inquired as to the consequence of their conflictual thoughts and emotions, such as postponing coming out and/or concealment of their sexual identities. Schuck and Liddle encourage therapists to address issues of religious conflicts and their emotional consequences, such as shame and guilt.

Enhance Coping

According to Hatzenbuehler (2009), coping deficits—whether sexual minority specific or general—are more common among sexual and gender minorities. The process of "coming out" or disclosing one's sexual identity has been shown to improve many LGB individuals' abilities to cope with the adverse effects of stress and societal discrimination by affording group-level support and coping (Meyer, 2003). Positive identification with a minority group can provide a corrective emotional experience, aligning minority individuals with similar others and buffering against stigma experienced from the dominant culture. The minority group may subsequently serve to reframe and reappraise an individual's experience of stress and stigma. *Reappraisal* is at the heart of affirmative psychotherapy for LGB individuals, which aims to empower and validate the minority person (Meyer, 2003). In his landmark gay self-help book, *Loving Someone Gay* (1977), Don Clark used humor and wisdom to reframe being gay as something joyful rather than shameful. In this passage from the second edition of his book, Clark (1987) turns shame into pride as he describes what he likes about being gay:

> I like knowing that men are potential love partners rather than competitors or enemies. I like that we Gay people really know it is better to make love than to make war. I like walking down the street and exchanging a glance and a smile with another Gay person, acknowledging that we are related and we know it. (p. 104)

Although Clark's experience represents that of an upper middle-class, well-educated, White male living in San Francisco, his ability to transform negative attitudes toward being gay to positive ones is central to undoing internalized homophobia for all sexual minority people.

Affirmative therapeutic approaches for LGB individuals can serve to bolster both personal and group-level coping strategies to counteract minority stress. As Meyer's (2003) minority stress framework indicates, group-level resources must be accessed and utilized by individuals, potentially limiting the availability of effective coping when these resources are taxed. Some LGB individuals may have satisfactory personal coping skills but lack community-based minority coping resources (Meyer, 2003). Affirmative therapies can increase access to and utilization of both types of resources, thus facilitating personal growth and connection to the minority community.

Improve Interpersonal Relating

Given the increased social and cultural stressors placed on them, it is no surprise that many sexual minority clients experience significant interpersonal challenges. These challenges are often key elements in the etiology and maintenance of psychological distress. As discussed earlier, the internalization of negative attitudes and the expectation of rejection from others are core components of minority stress. Addressing these interpersonal challenges, Hatzenbuehler's (2009) mediation model posits that LGB individuals' ability to access and maintain social support is one factor that differentiates those who experience psychological distress from those who do not. LGB clients may benefit from an assessment of the adequacy and their satisfaction with the emotional support that they receive from other people in their lives, including partners, intimate sexual relationships, friends, biological families, children, coworkers, and participants in their community. A phenomenon known as "family of choice" has been used to describe the importance that many sexual and gender minority individuals place on the support they receive from a group of intimate friends. Loss or conflicts within these close networks may engender stress reactions often reserved for one's biological family (Goldblum & Erickson, 1999).

Great advances have been made over the past 30 years in the acceptance of same-sex relationships, culminating recently in legal victories for same-sex marriage (Perry, 2014). Research comparing the rate of relationship formation and satisfaction between heterosexual and same-sex couples suggests that they are comparable (Balsam, Beauchaine, Rothblum, & Solomon, 2008). Care must be taken, however, not to underestimate the negative impact of minority stress on individuals wishing to establish same-sex relationships or wanting to improve the quality of their current relationship. Fingerhut and Peplau (2013) suggest that one pressure on relationship stability in same-sex relationships not found in heterosexual relationships is that lesbian, gay, and bisexual couples on average are less likely to perceive substantial barriers to ending their relationships, either from the legal system or within their social networks (Kurdek, 2005). Fortunately, this perception may be changing as more states recognize same-sex marriage. Kurdek (2005) expressed a balancing perspective on this finding in expressing his appreciation that same-sex relationships "manage to endure without the benefits of institutional supports" (p. 253).

Research conducted by Frost and Meyer (2009) demonstrates the complex relationship between minority stress (i.e., internalized homophobia, "outness," lack of community connectedness), depression, and relationship strain. These authors discovered that depression mediated the impact of internalized homophobia on relationship satisfaction, noting "internalized homophobia leads to relationship problems primarily by increasing depressive symptoms" (p. 105). Subsequently, clinicians are warned not to overestimate the causal role of internalized homophobia on relationship problems. Furthermore, they suggest that clinicians should not conflate low levels of "outness" with internalized homophobia. An LGB person's decision to come out to others is complicated and is not completely explained by the extent to which they hold negative views related to being lesbian, gay, or bisexual. Although it is essential to avoid overstating the simple relationship between internalized homophobia and intimacy, it is also important to consider the role of sexual minority stress in both psychological distress and relationship problems. To this end, Frost and Meyer (2009) suggest that "clinicians should pay careful attention to internalized homophobia even if the individual has come out to important others and demonstrates positive participation to the LGB community" (p. 108).

Integrated Affirmative Therapy: An Example

To address the need for evidence-based affirmative therapy for LGB clients, clinicians and researchers

at the Center for LGBTQ Evidence-Based Applied Research (CLEAR) are developing integrative affirmative therapy (IAT). Grounded within an evidence-supported, principle-based approach to psychotherapy (Beutler & Harwood, 2000; Pachankis & Goldfried, 2013), IAT assesses LGB clients to determine whether aspects of sexual minority stress (SMS) contribute to their symptoms or block them from meeting their life goals. Three core principles underlie IAT: (1) homosexuality and gender nonconformity are natural variants of human behavior, (2) LGB individuals experience additional stress living in a homophobic society that may have negative psychological and physical effects, and (3) the process of developing a positive LGB identity often necessitates actively undoing internalized homophobic attitudes.

The primary goal of IAT is to identify psychological and social problems that interfere with clients reaching their life goals, and to work collaboratively to find solutions to these problems. IAT therapists value clients' right of *autonomy and self-determination*. Thus, they do not pressure clients into making specific choices about their sexual or gender expression. Clients are encouraged to move at their own rate and to determine their own desired outcomes. This includes how, when, and to whom they wish to share information about their sexual and gender identities.

"*Passing the Test*"

IAT has adapted the term "passing the test" from Weiss (1993) to describe a process in which LGB clients test their therapist's level of comfort with discussing LGB-related topics. Beginning with deciding to reveal one's sexual identity and continuing throughout the course of therapy, clients determine the degree to which they share their vulnerable thoughts and feelings related to their LGB experiences. Strategies that affirmative therapists use to "pass the test" include being curious, empathic, having knowledge about LGB communities and identities, understanding the impact of minority stress, and being knowledgeable and competent in addressing sexual and gender identity issues. Indications that the therapist has passed the test include the client appearing less guarded and tense, speaking more freely, expressing difficult emotions (shame, fear, sadness, or anger), being more willing to discuss conflicts and meaning related to being LGB, and experimenting with new ways of coping with the stress of being a sexual minority.

Integrated Clinical Assessment

An integrated clinical assessment is conducted to identify problem areas in all aspects of a client's life, not just those related to sexual and gender minority issues. Through this thorough review, the clinician balances the threat of overattributing or minimizing the etiology and mechanisms of client problems to issues related to sexual orientation or identity. IAT clinicians strive to understand their clients within cultural and social contexts (e.g., race, age, ethnicity, class), internalized homophobia, and their level of connectedness to the LGB community. A three-part assessment protocol has been developed, starting with a 12-item Minority Stress Scale (MSS) to determine whether more intensive inquiry of minority stress is required. In initial validation studies, MSS was shown to be more effective in predicting psychological distress than sexual identity status alone (Chu et al., 2013). By comparing client raw scores with those on a T-Score chart, clinicians can determine the level of distress on each scale. If the client has elevated scores on a scale, more in-depth evaluation related to minority stress should be undertaken. This will include a clinical interview of experiences related to "coming out," which provides information to locate clients' problems within a five-phased model of sexual identity development and identifies areas of strength and weaknesses. Recently, the minority stress screener has been incorporated within an online system known as InnerLife©, which was developed by Beutler and colleagues (Innerlife.com, 2014) to assist clinicians and their clients in determining treatment goals and strategies that match client characteristics. According to their website, "Innerlife STS is organized around research-established principles that have been scientifically demonstrated to evoke positive changes" (Innerlife.com, 2014). By incorporating both minority stress and general measures of distress, forms of coping, and problem areas, an integrated treatment plan can be devised to address the full range of client concerns. The system can be used for an initial assessment and subsequently utilized to map client progress in therapy.

Integrated Treatment Planning

By understanding LGB clients within a developmental model, clinicians can assess specific problem areas to better determine the focus of treatment and the therapeutic stance (Ritter & Turndrup, 2002). For this purpose IAT has developed a five-phased assessment and treatment model (see Table 22.1). The first

TABLE 22.1 The Five-Phased Treatment Model

Phase 1	*Phase 2*	*Phase 3*	*Phase 4*	*Phase 5*
Awa reness, confusion, conflict	Questioning and experimentation	Acceptance, labeling, disclosure	Living out: meeting life goals	Synthesis: re-examination of previous adaptation
SORT Exploratory	SORT Exploratory	SORT/IAT Exploratory & Affirmative	IAT Affirmative	SORT Exploratory Affirmative
Explore: • Attractions: erotic/ emotional/ lifestyle • Internalized homophobia/ perceived stigma • Family expectations • Clarify values	Encourage: Information seeking, experimenting, decision making, self-labeling, or identity foreclosure	Explore and encourage: Information, models, values, goals work and love, level of disclosure, and "coming out" as a skill. Determine level and satisfaction of outness/ concealment	Identify: Life goals and extent sexual minority stress is barrier to meeting goals. Reduce sexual minority stress: internalized homophobia, perceived stigma, concealment	Clarify values: To determine salience of sexual minority identity in hierarchy of personal identities (e.g., religion, work, family)

two phases are denoted by clients' awareness of same-sex attractions while still identifying as heterosexual. These clients often express confusion and/or conflict about their sexual attractions and whether and how to act on them. During this phase, clients may begin to experiment with same-sex sexual activity. Each of these phases, which may not be strictly sequential and may be revisited periodically, varies in length from short periods to many years. While being transparent about the belief that homosexuality is a natural variant of sexuality, the therapeutic stance during the first two phases is primarily exploratory, helping clients better uncover their attractions and reconcile them with their personal values. For example, clients who adhere to conservative religious teachings may hold strong heteronormative beliefs and experience depression and hopelessness as to being able to reconcile their attractions and these beliefs (Haldeman, 1996). In IAT this phase of therapy has been termed *sexual orientation resolution therapy* (SORT). In phases three to five, clients who are clearer about their sexual orientation and identity are provided a more explicitly LGB-affirmative approach (see earlier discussion of affirmative therapy). Having specific strategies to help clients understand how to manage their life as an "out" LGB person is helpful, including strategies to help clients determine when, where, how, and to whom to disclose their sexual identity. Additionally, a clear understanding of unique and common elements of LGB relationship formation, maintenance, and termination is useful as clients master "being out." A key clinical competency with clients in any of the five phases is the ability to identify shameful experiences and to undo internalized homophobia and perceived stigma. Over time, some clients may reorganize and reconsider the role that their LGB identity plays in their lives. This final phase, termed "synthesis," may represent a readjustment in valence of importance that sexual identity plays in clients reaching their overall goals, in line with their personal values.

RESEARCH ON EFFICACY AND EFFECTIVENESS

In 2007, the British Association for Counseling conducted an extensive review of research literature related to psychotherapy with LGB clients and found the state of psychotherapy research seriously lacking (King et al., 2007). Research reviewed lacked consistent operational definitions, standard psychometric instrumentation, control groups, and prospective designs. The reasons for this lack of competent research on LGB-affirmative therapy are not entirely clear, yet they may be partially explained by the recent focus on public health–oriented research on HIV transmission

reduction and lack of funding for more basic research on psychotherapy with LGB clients. Since King et al.'s work, several studies related to efficacy and effectiveness have been reported.

Cognitive-Behavioral Therapy

Despite the absence of a robust body of literature, there are a number of reasons to view cognitive-behavioral therapy (CBT) as particularly relevant and helpful in working with the LGB population (Balsam, Martell, & Safren, 2006; Martell, 2010). First, outcome research has found that CBT approaches are among the most effective and efficient treatments for disorders with high prevalence among LGB people, including depressive disorders, anxiety disorders, substance use disorders, and posttraumatic stress disorder. Second, CBT approaches emphasize collaboration between therapist and client as well as active participation by clients in setting and achieving therapeutic goals. Such an approach may be particularly empowering for a stigmatized client population and amenable to address culturally specific concerns. Third, contemporary approaches to CBT are well suited to multicultural therapy in general, as they include the social and environmental context in case conceptualization. Fourth, cognitive approaches may be particularly effective in addressing internalized homophobia and transforming a client's negative schemas into positive, affirming ones. Similarly, behavioral approaches typically include direct instruction and practice of coping skills, which may be helpful to clients facing societal prejudice and stigma. Finally, an additional benefit to CBT is that this nonjudgmental approach is appropriate for working with stigmatized populations.

Improve Coping With HIV

Well-designed CBT interventions to enhance coping and reduce negative affect with gay men have been more common in response to the AIDS epidemic. Although the participants were often gay and bisexual men, little effort to apply principles consistent with cultura adaptation was included. Most of these interventions utilized group formats to increase their public health benefits. By and large these intervention studies support the use of group-based cognitive-behavioral techniques such as stress management to increase coping, and decrease depressed mood, among gay men (Carrico et al., 2006). In a randomized control study, Carrico et al. (2006) demonstrated that a 10-week, group-based, cognitive-behavioral stress management intervention was successful in improving coping skills and decreasing depressed mood among HIV-positive gay men. They speculated that the mechanism for improvement included the increase in social support that the group format provided.

Reduce Internalized Homophobia

In one of the few studies that directly evaluated an intervention aimed at reducing internalized homophobia (heterosexism), Lin and Israel (2012) created and evaluated online modules designed to reduce internalized homophobia (IH). A group of 367 college-aged gay and bisexual men completed measures of IH, self-esteem, Outness, and demographics. Using a post-only experimental design, participants were randomly assigned to experimental and control groups. After completing their assigned modules (IH and a control modules), participants took an IH scale. Significant differences were found between the two groups on two of the three aspects of IH measured by the scale. Although this study represents a step in the right direction, several limitations are of concern. The study did not measure the impact that the reduction of IH had on personality variables (self-esteem) or on mood. Furthermore, no follow-up studies were conducted to determine the longer range effect.

Reduce Depression and Anxiety

In the most sophisticated outcome study of affirmative therapy to date, Pachankis and colleagues (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015) conducted a randomized control study of a cognitive-behavior therapy protocol for young adult gay and bisexual men grounded in minority stress theory. The aim of the therapy is to reduce depression, anxiety, and co-occurring health risks (alcohol use, sexual compulsivity, sex without condoms) among this population. The intervention called ESTEEM (see earlier) is a 10-session individually delivered intervention based on the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2010). Adapted for use with gay men, the modules cover client motivation, interoceptive and situational exposure, cognitive restructuring, mindfulness, and

self-monitoring. In the preliminary validation study, all sessions were videotaped and coded for treatment fidelity. The final sample was comprised of 63 sexual minority men, with an average age of 26 years. Participants were randomized into two groups: an immediate experimental group and a waitlist group. Eventually, all available clients were provided with intervention. The outcome measures included LGB-specific measures (gay-related stress, gay-related rejection sensitivity, internalized homophobia, sexual orientation concealment) and general coping measures (rumination, difficulties of emotion regulation, perceived social support, assertiveness). At the end of 3 months, investigators found significant reductions in depressive symptoms, sexual compulsivity, and unsafe anal sex. Improvements in condom use self-efficacy were also measured. Only marginally significant improvements were found in anxiety. Overall, the effect sizes for outcomes were medium to large. Treatment effects were generally maintained at 6-month follow-up. The ESTEEM investigation represents the first published validation study of an individually administered psychotherapy intervention grounded in the minority stress model and serves as a guide to future psychotherapy researchers.

Interpersonal Psychotherapy

Given the increased social and cultural stressors placed on them, it is no surprise that many sexual minority clients experience significant interpersonal challenges. First articulated by Strupp and Binder (1984), time-limited dynamic psychotherapy (TLDP) is an "interpersonal, time-sensitive approach for patients with chronic, pervasive, dysfunctional ways of relating" (Levenson, 2003, p. 300). Through an analysis of maladaptive behavior termed cyclic maladaptive pattern (CMP), clients are encouraged to experiment with alternative modes of relating.

Pobuda and colleagues (2008) studied the effects of the Levenson model of TLDP on reducing the distress of HIV-positive men who have sex with men (MSM) in a community mental health clinic that specialized in working with persons with HIV. A significant reduction of scores on an outcome measure (OQ-45.2) was reported. While this study is limited by the lack of a control group, it represents one of the few psychotherapy outcome studies with MSM that used a standardized pre- and posttreatment measure. Given the fact that much of the data collected coincided with the AIDS epidemic in San Francisco, many of the themes within the therapies reported were related to AIDS bereavement by these men. Other interpersonal themes were related to dissatisfaction with one's ability to initiate or maintain intimate same-sex relationships. Further investigations of the utility of interpersonal therapies to combat minority stress are needed to determine whether cultural adaptations improve the effectiveness of this treatment with sexual minority clients, regardless of their HIV status.

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) works to reduce experiential avoidance and increase psychological flexibility (Hayes, Strosahl, & Wilson, 2011). ACT considers the central experience of avoidance of unwanted emotions, mental content, and verbalizations, as well as efforts to distract or control the moment-to-moment experience of these, as a taxing form of mental behavior that paradoxically increases the subjective experience of stress. Experiential avoidance refers to avoidant behaviors and mental habits that occur in response to inner experiences (Hayes, Strosahl, & Wilson, 2011). For example, a bisexual man presumed to be heterosexual by his friends and family might have a frequent thought such as "I will be rejected by my friends if they knew of my past relationships with men." He might also choose not to disclose sexual or romantic partners, reducing trust and an experience of closeness in meaningful relationships. Psychological flexibility, on the other hand, refers to being fully present in the moment, choosing to act in the service of one's values regardless of difficult internal experiences (Kashdan & Rottenberg, 2010). This might mean choosing to come out to a loved one, even while experiencing fear or thinking this may lead to rejection, in order to have a trusting and vulnerable relationship.

There are few interventions for stigma that have been empirically based and assessed, particularly for stigma as experienced by sexual minorities. Among these interventions, ACT (Hayes, Chun-Kennedy, Edens, & Locke, 2011) has been the most heavily researched for the treatment of self-stigma and shame. ACT has demonstrated effects on emotion regulation, which may make it particularly effective for sexual minorities, given the connection between minority stress

and emotion regulation (Forman et al., 2012). ACT for stigma focuses on the fear, shame, and identification with a stigmatized group that pose as barriers to living a life consistent with one's values. ACT has been demonstrated to reduce shame and self-stigma with substance users (Luoma et al., 2008) and overweight individuals (Lillis et al., 2009). ACT has been used with both the general public and service providers to reduce stigmatizing attitudes toward persons with mental illness (Masuda et al., 2007), substance users (Hayes, Follette, & Linehan, 2004), and racial minorities (Lillis & Hayes, 2007). Most recently, a pilot study with a group therapy format found that ACT successfully reduced self-stigma and depression and increased quality of life and social support among a small sample of gay men and lesbians experiencing conflict over their sexual orientation (Yadavaia & Hayes, 2012).

DIVERSITY

Affirmative Approaches as Cultural Adaptations of Evidence-Based Practices

With the growing prominence of evidence-based practice, the need to examine LGB-specific adaptations to standard evidence-based practice is increasing. Mental health practitioners need a more thorough understanding of whether standard psychotherapy protocols work with LGB clients or whether they require some level of alteration. On the other hand, challenges have been raised to the use of standard research procedures to evaluate psychotherapy with cultural minority populations (e.g., randomized control studies). Bernal and colleagues (2009) recommend cultural adaptation procedures that alter evidence-based treatments to better-fit communities' personal and cultural characteristics. Cultural adaptations may include augmenting recruitment activities, language, intervention procedures, or cultural matching of provider and participant. Other authors, including McHugh, Murray, and Barlow (2009), also question whether strict protocol fidelity may present a barrier for dissemination due to a lack of organizational structures and prohibitive costs. These authors argue that, rather than rigid compliance with treatment manuals, principle-based programs that target specific behavioral goals with more flexible therapeutic procedures may be more adaptable to actual service sites (McHugh et al., 2009).

Intersectionality of Multiple Minority Identities

LGB individuals of multiple minority groups (e.g., an African American lesbian, a physically disabled gay man) may struggle with prejudice and discrimination on multiple fronts, potentially having trouble overcoming negative stereotypes linked to each of their minority statuses (Banks, 2012). This "double jeopardy" hypothesis posits that, as people acquire minority statuses, there may be fewer resources and support systems to address the unique combination of multiple minority identities (Hayes, Chun-Kennedy, Edens, & Locke, 2011). For ethnic minority LGB clients, there may be heightened stress associated with "coming out" to family members, particularly within cultures that emphasize procreation and the continuation of family lineage. Families of LGB ethnic minorities may seek to instill racial and ethnic pride in their children, but they may simultaneously reject or ignore their nonheterosexual identities. LGB people of color must cope with racism in and exclusion from the general heterosexual White community, as well as in the predominately White LGB community (Hayes, Chun-Kennedy, Edens, & Locke, 2011).

Identity *salience* and identity *valence* are two core constructs described in the intersectionality literature (Stirratt, Meyer, Ouellette, & Gara, 2008). Among individuals with multiple minority identities, identity salience indicates the relative importance that each identity has for individuals' overall views of themselves and their self-worth. Valence "refers to the evaluative features of identity and is tied to self-validation" (Meyer, 2003, p. 8). Affirmative psychotherapy can help multiple-minority LGB clients assess the salience and valence of each of their identities and can aid in the healthy incorporation of intersectional identities (Meyer, 2003; Stirratt et al., 2008).

LGB-Affirmative Therapy for Youth

With higher rates of young people publicly identifying as sexual minorities, mental health professionals must be attuned to the specific concerns and considerations of this population. Practitioners can provide a safe space for LGB youth to disclose their concerns

and to affirm their sexuality, but they must first signal that they are open to diversity in sexual orientation and relationships. After "passing the test," professionals may experience increased disclosure of information related to being LGB and increased willingness to discuss concerns related to sexual minority status (Weiss, 1993). Without education and training on LGB-specific issues, health professionals may not have the competencies required to address difficulties that are unique to sexual minorities (APA, 2012).

Affirmative psychotherapy can be particularly important for LGB youth who are gender nonconforming (i.e., do not conform to traditional male-female gender presentations). Compared to gender-typical youth, gender-nonconforming individuals are at greater risk for peer victimization, poor psychosocial adjustment, and suicidality (D'Augelli, Grossman, & Starks, 2006). By the time children begin preschool, they comprehend gender categories and perceive the societal push to conform to gender categories (Toomey, Ryan, Diaz, Card, & Russell, 2010). Gender-nonconforming youth are more likely than their gender-conforming peers to report mental health problems, as well as physical and/or verbal victimization based on sexual orientation (D'Augelli et al., 2006). Among young adult gay men, there is a significant association between childhood femininity and suicidality, a relationship that is mediated by experiences of bullying linked to sexual identity and gender expression (Friedman et al., 2006).

The experiences of gender-nonconforming youth are often characterized by expectations of rejection, hypervigilance to potential discrimination and victimization based on gender expression, and internalization of negative societal attitudes regarding gender nonconformity. These experiences indicate that several facets of the minority stress framework can aid in understanding the mental health disparities among gender-nonconforming youth, particularly those who identify as LGB. An affirmative therapeutic approach with LGB gender-nonconforming youth can bolster personal and group-level coping skills and can aid youth in applying a positive valence to both their sexual identity and gender expression.

CLINICAL ILLUSTRATION

Frederica is a 33-year-old woman who emigrated from Guatemala as a political refugee when she was 19 years old. She witnessed the murder of her cousins in drug-related violence and continues to re-experience this scene regularly. She complains that she has little interest in her work and has difficulty sleeping at night. Frederica states that she is hesitant to attend social events with her family and claims that she is afraid to leave her home. After several sessions with Frederica, she discloses that she is strongly attracted to other women and has little interest in marrying a man (as her family would expect her to). She communicated, "You are the first person I've ever shared this information with." Part of her reluctance to attend events with her family is that they "always try to fix [her] up" with men. She has seen a woman in her neighborhood to whom she is strongly emotionally and physically attracted. She stated she is comfortable with the label "lesbian" yet has no experience in meeting women and forming loving relationships. She is concerned about coming out to her family, as they are devout Catholics and view any nonheterosexual identity as "immoral." Affirmative psychotherapy with Frederica will involve the following components:

1. "Passing the test" by signaling openness to discussing Frederica's same-sex attractions and enabling her to discuss her evolving sexual identity in a nonpathologizing fashion.
2. Understanding the mechanisms that connect Frederica's burgeoning sexual identity with her social avoidance and past trauma. Evaluating the severity and nature of psychological distress (including *DSM*-5 diagnosis) by using an integrated assessment of symptoms of depression and posttraumatic stress disorder, as well as minority stress (sexual minority stress, immigrant stress, and nonspecific stress).
3. Helping Frederica better understand her sexual orientation and identity. Using the structured five-phased clinical interview, Frederica and her therapist will review her sexual identity development, sources of internalized homophobia, rejection sensitivity, and the psychological impact of concealment. To help Frederica understand the interaction between her sexual identity and psychological coping skills, a case formulation will be collaboratively developed.
4. Developing treatment plans that integrate strategies to reduce her psychological symptoms (e.g., techniques from CBT and ACT), increase her self-acceptance and pride, find

effective ways to come out to her family and friends, and establish social goals that are consistent with her own values. Exploring community resources, specifically related to her sexual and ethnic identities. Discussing the psychological impact of potential religious conflict, as well as exploring religious and social support.

5. Evaluating the progress and adjustment of treatment based on Frederica's current and evolving goals.

CONCLUSION AND KEY POINTS

While great strides have been made in the past 30 years in the development of affirmative approaches to LGB psychotherapy, with increased focus on evidence-based approaches, efforts must be made to scientifically study the effectiveness of these approaches. This will require additional efforts to operationally define treatments, to carefully assess clients' progress using coherent treatment protocols, and to disseminate results to clinical practitioners. Whether using standard randomized control groups or observational and process approaches to psychotherapy outcome research, future work must determine whether general cultural adaptations to standard psychotherapy approaches or LGB-specific approaches are more effective, and if so, under what circumstances. Given the history of discrimination and victimization of many LGB individuals, sensitivity to treatment alliance is essential. Measures of treatment alliance and careful clinical exploration may reveal the need to transfer some clients to clinicians more informed and competent in LGB psychotherapy. Approaches that understand the developmental nature of sexual identity may help to focus treatment strategies and treatment stances.

The field of psychotherapy research for sexual minorities is constantly evolving, yet it is troubled by some of the same concerns today that existed in the 1970s when the *DSM* ceased to classify homosexuality as a mental disorder. Few systematic clinical trials to determine the effectiveness of current or novel therapies among sexual minorities exist. For these reasons, and for the near future, it may be that the best recommendations for effective therapy for sexual minorities will be theory driven and not necessarily empirically based. Finally, national funding agencies should be encouraged to heed the recommendations of the Institute of Medicine (2011) in the call for increased funding for clinical research to improve the psychological support to the LGB community.

REVIEW QUESTIONS

1. What are the major historical, social, and political factors that have contributed to the development of affirmative therapy with LGB clients?
2. How does minority stress differ from stress experienced by those in the majority culture?
3. What are some reasons that CBT is considered to be helpful for LGB clients despite a lack of robust empirical evidence?
4. In the five-phased treatment model, what type of therapy is used with clients during the first two phases? What is the clinical utility of this type of therapy during these phases?
5. What are some specific mental health considerations relevant to psychotherapy with LGB youth?

NOTE

1. The term "homosexuality" is used to denote same-sex attractions and behavior in lieu of knowing whether the referred individuals select to self-identify as "lesbian," "gay," or "bisexual."

RESOURCES

Websites

APA Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients: http://www.apa.org/pi/lgbt/resources/guidelines.aspx

Association of Gay and Lesbian Psychiatrists: http://www.aglp.org

Association for Lesbian, Gay, Bisexual & Transgender Issues in Counseling: http://www.algbtic.org

Family Acceptance Project: http://familyproject.sfsu.edu

Lesbian, Gay, Bisexual and Transgender Concerns, American Psychological Association: http://www.apa.org/pi/lgbt/

National Alliance on Mental Illness (NAMI): http://www.nami.org

Parents, Families, Friends, and Allies United with LGBT People (PFLAG): http://www.pflag.org

Southern Poverty Law Center: http://www.splcenter.org/what-we-do/lgbt-rights

The Trevor Project: Crisis Intervention and Prevention Hotline (youth and young adults): http://www.thetrevorproject.org

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23

Psychotherapy With Racial/Ethnic Minority Groups: Theory and Practice

Joyce Chu
Amy Leino
Samantha Pflum
Stanley Sue

Abstract
Over the past four decades, the mental health field has made significant strides toward advancing its understanding and application of culturally competent care with racial and ethnic minorities. Despite advances in research and practice, disparities in access to high-quality, evidence-based, and culturally sensitive psychotherapeutic services continue to exist. Addressing these disparities remains a critical task for the field in order to continue advancing and meeting the growing demand in an increasingly diversified U.S. society. To this end, the current chapter discusses cultural concepts, theoretical perspectives, and case conceptualization approaches one should consider in psychotherapy with racial/ethnic minorities. We address common overarching cultural factors that affect the mental health experience and service use of ethnic minority groups, and we highlight several approaches to case conceptualization and psychotherapy that are particularly fitting for the mental health needs of ethnic minorities.

Keywords: cultural competency, psychotherapy, race, ethnic minorities, mental health disparities

With increasing diversification in the United States and recognition of mental health status and treatment disparities, scholars and practitioners have highlighted a need for psychotherapies that are effective in addressing the unique cultural needs of racial and ethnic minorities (e.g., Arab Americans, Asian Americans, Black/African Americans, Latinos/as, Native Americans/American Indians; Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; US Department of Health and Human Services [DHHS], 2001). Local, state, and national guidelines for culturally competent psychotherapy have been put forth and encouraged within the mental health field (American Psychological Association [APA], 2003; Sue, Zane, Hall, & Berger, 2009). However, research and practice of culturally competent psychotherapies for racial/ethnic minorities is still growing, with advancement needed in development and implementation of effective practices.

This chapter discusses the cultural concepts and theoretical and case conceptualization approaches that one should consider or incorporate in psychotherapy with racial/ethnic minorities, along with a review of the empirical research on psychotherapy efficacy and effectiveness with racial/ethnic minorities. We also address unique considerations when working with specific subpopulations of ethnic minorities such as individuals with multiple intersecting

cultural identities (e.g., mixed-race individuals and LGBTQ ethnic minorities), refugees, and immigrants. To provide context for understanding the theoretical and empirical considerations discussed in this chapter, we begin with a historical overview of the evolution of culturally competent psychotherapy for racial/ethnic minorities.

A HISTORICAL OVERVIEW OF PSYCHOTHERAPY WITH RACIAL/ETHNIC MINORITIES

Psychotherapy with ethnic minorities has progressively evolved over the past four decades. The civil rights movement of the 1960s, the expansion of mental health services into the community, and the increasing diversification within the United States highlighted the need for improved cultural competence in mental health services (DHHS, 2001). In addition, the President's Commission on Mental Health (1978) highlighted two problems in the mental health service delivery system with detrimental clinical effects for ethnic minorities: (a) services were not typically provided in accordance with cultural and linguistic traditions of ethnic minorities, particularly due to the shortage of bilingual and bicultural therapists, and (b) nonminority therapists could hold stereotypes and biases that reflected the nature of race or ethnic relations in society (Sue, 1988). These issues were related to the dearth of research and training received by providers that incorporated racial, ethnic, and cultural issues (Sue, Arredondo, & McDavis, 1992).

In light of social and political movements of the 1960s and 1970s, the professional and scientific literature began to document the effects of client/therapist racial similarity in psychotherapy (Sue, 1988). Research on this "race effect" predominated through the 1970s and 1980s and largely produced conflicting findings (Sue, 1988). In his review of two decades of research, Sue (1988) argued that, in addition to significant methodological limitations, a major flaw in this type of research resided in the research questions themselves. He noted that asking whether ethnic minority clients are as likely as White clients to benefit from psychotherapy, or whether client–therapist ethnic matches are superior to ethnic mismatches, oversimplified the larger picture. Sue suggested that while ethnicity and ethnic match are distal variables, the cultural meanings embedded in ethnicity (i.e., individual differences in language, values, experiences, and behaviors) are proximal variables more likely to permeate the therapeutic relationship and influence therapy outcomes. This more nuanced view of race and ethnicity ultimately paved the way for a new generation of research on culturally competent care.

Through the 1980s and early 1990s, the commonly used "culturally deprived or deficient model" for guiding and conceptualizing research with racial and linguistic minorities gave way to the "culturally different or multicultural model," which argued that difference did not equate with deficiency, pathology, or inferiority (Sue et al., 1992). This new model acknowledged that ethnic minorities function in at least two different cultural contexts, which was seen as a positive and enriching quality. Moreover, it viewed individuals in relation to their environment, including larger social forces such as racism, oppression, and discrimination, among others.

The tripartite model of cultural competency (i.e., awareness of attitudes and beliefs, cultural knowledge, and skills) emerged from this broader, less pathologizing conceptualization of culture (see Sue et al., 1992, for a review). This model responded to the increasing need to move beyond "cultural sensitivity" to a more comprehensive and multifaceted approach to culturally competent care (i.e., acquiring knowledge about a client's cultural worldview, values, experiences, and therapy expectations and implementing culturally appropriate interventions). At present, this is the most widely recognized framework of cultural competency in psychotherapy as it informs much of the standards outlined by prominent organizations (e.g., APA, 2003). While these competencies refer primarily to the four major ethnic minority groups in U.S. society (i.e., Blacks/African Americans, Asian Americans, Hispanics/Latinos/as, and Native Americans/American Indians), they can generally be used for guiding culturally competent care with other cultural groups (Sue et al., 1992).

In a similar vein, early versions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) were criticized for their insensitivity to cultural issues in psychiatric assessment and diagnosis (Lewis-Fernández & Díaz, 2002). In 1991, the National Institute of Mental Health supported the creation of a work group on culture and diagnosis, which advised the *DSM-IV* Task Force on the incorporation of cultural factors into clinical evaluations. This endeavor led to the development of the Cultural Formulation (CF) model in the *DSM-IV* and *DSM-IV-TR*, supplemented by the Cultural Formulation Interview (CFI) in the *DSM-5*

(American Psychiatric Association, 2000, 2013) (see Lewis-Fernández & Díaz, 2002; Lewis-Fernández et al., 2014, for overviews). The CF and CFI have four elements for clinicians to incorporate into a comprehensive cultural case formulation for diagnosis and treatment: (a) cultural identity, (b) cultural explanations of illness, (c) psychosocial environment and functioning, and (d) cultural factors in the therapist/client relationship.

In the 1990s, the empirically supported treatment (EST) movement flourished and contributed to a number of treatments deemed efficacious for various psychological disorders (Chambless & Ollendick, 2001). However, considerable debate has surrounded the generalizability of ESTs to individuals from diverse ethnic groups (Cardemil, 2010). As a result, the cultural adaptation movement attempted to modify ESTs to better fit the needs of ethnic minority individuals (Bernal et al., 2009).

In the past two decades, there has been an upsurge in research on the role of culture in psychological assessment, diagnosis, and treatment with ethnic minorities. As this research has progressed, so has the scope of the field's understanding and incorporation of cultural factors in clinical work. Nonetheless, the field has continued to struggle to define cultural competency as well as to isolate empirically its efficacy in psychotherapy (Sue et al., 2009). Definitions of cultural competency have differed in emphases, such as (a) the kind of person the therapist is, (b) the skills or intervention tactics the therapist uses, and (c) the psychotherapeutic processes involved (Sue et al., 2009). Furthermore, culturally competent care can be instituted and analyzed on multiple levels: (a) therapist and treatment level, (b) agency or institutional level (e.g., the operations of a specific mental health agency), and (c) systems level (e.g., systems of care in a community) (Sue et al., 2009). The first level of competency will be the focus of discussion in this chapter (i.e., cultural competency at the level of therapists and treatments).

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS: ETHNIC-SPECIFIC CONSIDERATIONS

There are broad approaches to case conceptualization and psychotherapy that are particularly suitable to the needs of ethnic minorities. In this section, we discuss several psychotherapy approaches, including feminist, humanistic, cognitive-behavioral, systems, and culturally adapted evidence-based therapy.

Feminist Therapy and Empowerment

Multicultural feminist theory has been used to conceptualize the impact of oppression on health disparities among cultural minorities. This theory states that the "experience of both external oppression (e.g., experiences of invisibility, rejection, prejudice, harassment, discrimination, and violence) and internalized oppression (i.e., accepting negative, devaluing, and limiting oppressive messages about one's minority statuses from the larger culture) can lead to psychosocial distress" (Szymanski & Gupta, 2009, p. 268). Empowerment serves as the primary principle of change in feminist therapy. The empowerment model promotes strengths and assets through social change and advocacy (Querimit & Conner, 2003). Empowering racial/ethnic minorities to understand and combat social inequities and forms of oppression can increase cultural awareness and catalyze therapeutic change. Particularly for women of color, promoting empowerment simultaneously honors their racial, ethnic, gender, sexual, and class experiences. Mental health providers working with racial/ethnic minorities can educate clients about the negative ramifications of racist societal messages and can model activism by speaking out against these messages. By dismantling these negative attitudes, clients can bolster their internal and external strengths and can foster greater health and well-being. Practitioners must also remain aware of how their own cultural identities intersect with those of their clients. Casting awareness of power and privilege is at the forefront of feminist therapeutic work with racial/ethnic minority clients (Querimit & Conner, 2003).

Humanistic or Person-Centered Therapy With Ethnic Minorities

Two central tenets of Carl Rogers's humanistic or person-centered theory are particularly relevant to multicultural psychotherapy. Rogers's approach focuses on therapists (a) identifying their own values and biases in order to assume a nonevaluative and nonjudgmental role, and (b) understanding the client's values, experiences, and worldview through and from

the client's perspective (MacDougall, 2002). These principles are also the essence of *cultural empathy*, a therapist's ability to understand accurately the experiences of a client from a different cultural or ethnic background, effectively convey this understanding, and simultaneously maintain awareness of his or her own cultural sense of self (e.g., biases, attitudes, values, sources of power and privilege) (Chung & Bemak, 2002).

Psychotherapy outcome research has consistently revealed that client-perceived therapeutic relationship factors—particularly empathic understanding and acceptance—are not only positively related to clinical improvement but also generally show stronger associations with improvement than specific therapeutic techniques (Norcross, 2002). While empathy is considered a crucial facilitative condition in psychotherapy in general, it may be particularly important when working with ethnic minorities given the existing treatment and engagement disparities. Research in cross-cultural counseling suggests that when clients viewed their therapists as more culturally responsive (i.e., demonstrating cultural knowledge and acknowledging the role of ethnicity and culture in clients' concerns), they remained in therapy longer and rated their therapists higher in expertise, trustworthiness, attractiveness, unconditional regard, and empathy (Wade & Bernstein, 1991). When therapists practice greater cultural awareness and empathy, clients not only have more positive perceptions and experiences of the therapist and therapy process, but they also feel more understood, which can facilitate treatment.

Cognitive-Behavioral Therapy With Ethnic Minorities

Cognitive-behavioral therapies (CBT) encompass interventions for different types of mental disorders based on principles of behavioral modification and cognitive restructuring or processing. Though CBT interventions include a large proportion of ESTs (Chambless et al., 1998), establishment of efficacy with ethnic minority populations has been challenged by the historical lack of reporting and inclusion of ethnic minorities within clinical trials and ethnic disparities in EST access (see Horrell, 2008, for a review). Yet there is some evidence that CBT is effective for ethnic minorities experiencing symptoms of posttraumatic stress disorder, depression, generalized anxiety disorder, and panic disorder (Horrell, 2008). This effectiveness may be attributable to cultural fit of treatment principles (e.g., directive, goal-oriented, short-term, and problem-solving focused) (Chu, Huynh, & Arean, 2012).

Evidence suggests that CBT with ethnic minorities may need cultural modifications, including ethnic or language matches, psychoeducational orientation to therapy, or an emphasis on somatic symptoms or religious traditions (Hinton & La Roche, 2014). Practitioners who apply CBT with ethnic minorities should attend to variations in the role and nature of beliefs, emotions, coping, behaviors, and other considerations within a client's culture (Hinton & La Roche, 2014).

Ecological Systems Approach to Psychotherapy

A paradigm shift from a conventional intrapsychic perspective to an ecological systems approach to psychotherapy can be useful when working with ethnic minorities. Traditional psychotherapy models that focus on individual and internal psychological processes as primary intervention targets tend to overlook salient cultural differences in social risk and protective factors for mental health (DHHS, 2001).

Certain types of social discord (e.g., family and intergenerational conflict, community disintegration, and familial shame/disgrace) constitute heightened sources of risk among Asian Americans, African Americans, and Latinas/os, which may be explained by more collectivistic values that emphasize relating, attending, and connecting to others. Conversely, these same interdependent values can serve as unique strengths or protective factors if appropriately harnessed and attended to during treatment. Several cultural adaptation studies have integrated discussions of cultural values related to family and interdependence, or they have included family members in treatment when working with ethnic minorities (e.g., Chu et al., 2012).

Systematic Cultural Adaptation of Evidence-Based Treatments

Cultural adaptations are one way of enhancing the cultural competency of mental health services for

racial and ethnic minorities. Cultural adaptations refer to "the systematic modification of an EST or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal et al., 2009, p. 362). Cultural adaptations to treatment structure, delivery, content, and therapist behavior are intended to make interventions more congruent with a client's cultural background, interaction styles, treatment expectations, engagement, and coping styles and can be viewed as a way to approach case conceptualization and treatment with racial and ethnic minorities (Cardemil, 2010).

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION

There are broad approaches to case conceptualization and psychotherapy that are particularly suitable to the needs of ethnic minorities. In this section, we discuss four factors important to the provision of competent psychotherapy with ethnic minorities: (1) acculturation/acculturative stress, (2) minority stress, (3) racial/ethnic identity development, and (4) stigma and treatment engagement. We will also review principles of change that explain why these approaches work well with ethnic minority populations.

Acculturation/Acculturative Stress

Acculturation is a multidimensional construct generally understood to be "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p. 698). Acculturation may influence psychotherapy with ethnic minorities in three main ways. First, acculturation is related to the manifestation of mental health and substance abuse problems, and it should therefore be assessed and addressed. Some have attributed the link between acculturation and mental health challenges to acculturative stress, the increased stress associated with the process of adjusting to life changes inherent to navigating two different cultures (Berry & Annis, 1974).

Empirical support for the link between acculturation and mental health has been mixed, with inconsistencies potentially a result of heterogeneity in operationalization and measurement (Horevitz & Organista, 2013; Koneru, Weisman de Mamani, Flynn, & Betancourt, 2007). Greater acculturation to the host culture has been consistently related to increases in substance use across ethnic minorities, but it has been uncertain in its relationship with other mental health problems like depression, anxiety, eating disorders, or general distress (Koneru et al., 2007). Moderating factors such as ethnic density (i.e., areas with higher proportions of people of the same ethnicity) or ethnic identity may explain the inconsistent relationship between acculturation and mental health (Kwag, Jang, & Chiriboga, 2012; Walker, Wingate, Obasi, & Joiner, 2008).

The relationship between acculturation and mental health also varies across ethnic groups. For example, acculturation is more often related to negative mental health among Latinos/as—a Latino/a mental health "paradox" that suggests more favorable mental health among recent immigrants and a mental health decline linked to longer residence in the United States (see Horevitz & Organista, 2012, for a review). In contrast, lower acculturated Asian Americans and recent immigrants can experience more mental health problems than their highly acculturated counterparts, although this relationship is mediated by intergenerational differences in acculturation, family conflict, and acculturative stress (see Suinn, 2010, for a review). Above all, the vast literature on acculturation and mental health indicates the importance of avoiding broad or simplistic generalizations, since the relationship between acculturation and mental health is complex, depending on group, approach to acculturation measurement, type of mental health outcome, and moderating factors.

A second way that acculturation may influence psychotherapy with ethnic minorities is via awareness of mental health problems, willingness to seek professional help, and familiarity with psychotherapy. Ethnic minorities who are more acculturated may be more aware of psychological issues and subsequently may be more likely to seek help for mental health problems. Results in this domain, however, have been mixed (e.g., Ramos-Sánchez & Atkinson, 2009; Suinn, 2010). For example, among Mexican Americans, adherence to traditional Mexican cultural values may be related to more favorable attitudes to seeking help for mental health issues (Ramos-Sánchez & Atkinson, 2009).

Finally, acculturation may affect the types of psychotherapy or qualities of provider preferred by ethnic minorities. For example, Yang, Corsini-Munt, Link, and Phelan (2009) found that as Asian Americans become more acculturated, they tend to view traditional sources of healing (e.g., Chinese medicine healers) as less helpful for treating psychiatric disorders. Among Latina women, lower acculturation is related to preference for a female provider, a Latino/a provider, and speaking Spanish with the provider (Leybas-Amedia, Nuno, & Garcia, 2005).

Minority Stress, Discrimination, and Racism: Effects on Mental Health

Perceived racial discrimination is associated with a host of negative mental health, academic, and interpersonal outcomes (Chao, Mallinckrodt, & Wei, 2012). These consequences can be understood in the context of minority stress, a theory that implicates environmentally based stigma, prejudice, and discrimination as causal factors in health disparities among minority individuals (Meyer, 2003). Minority stress is chronic and socially based, generated by environmental factors beyond an individual's control. Additive in nature, minority stress requires coping and adaptation processes above and beyond those required of nonminority individuals. This form of stress is also temporally stable, resulting from cultural processes that change little over time (Meyer, 2003). Meyer (2003) developed the minority stress framework to elucidate the socially mediated mental health problems of lesbian, gay, and bisexual (LGB) individuals, but these principles have been extrapolated to address the experiences of ethnic minorities.

Similarly, the racism-related stress model (Carter, 2007) posits that ethnic minorities experience general stress experienced by the overall population, and minority-specific stress resulting from marginalization by the dominant culture. Experiences of stress can result from direct personal experiences of discrimination (e.g., being called a racial slur, being assaulted due to one's race), and they may also stem from living in an alienating, homogenous social environment (e.g., residing in an apartment building with no individuals of the same race) (Carter, 2007; Chao et al., 2012). Institutional racism, illustrated by the unequal occupational, financial, and personal outcomes of minority individuals in social systems and organizations, indicates that prejudice and discrimination can permeate larger institutions (Carter, 2007). Ethnic minorities are stressed by personal, organizational, and cultural experiences with racism, all of which can have an impact on physical and mental health (Carter, 2007).

Despite the cultural decline of overt racism in the United States, ethnic minority individuals are still subjected to racially motivated prejudice and discrimination (Chao et al., 2012). Recent research indicates that experiences of racism among African American college students are quite common, particularly for students attending schools with few African American students (Chao et al., 2012). Perceived racial discrimination has been linked to greater psychosocial distress, lower use of university counseling services, increased anxiety and depression, problems making friends, impaired academic achievement, and suicidal feelings. Moreover, perceived racism and discrimination are often internalized, resulting in poor self-esteem, perfectionism, negative body image, maladaptive eating, and physical ailments (Carter, 2007; Chao et al., 2012). Conversely, identifying positively with one's minority group can increase one's psychological well-being and buffer against racial stigma (Meyer, 2003).

Understanding experiences of minority stress, establishing ethnic equity, and reducing barriers to treatment are central components of comprehensive, sensitive mental health care for ethnic minorities (Carter, 2007; DHHS, 2001). A major contribution to ethnic minority inequities in mental health care is the failure of health professionals to understand the emotional, psychological, and physical effects of racism on ethnic minority clients (Carter, 2007).

Racial/Ethnic Identity Development

Racial/ethnic identity is a complex construct composed of a sense of in-group belonging, understanding of ethnic group membership, perceived importance of group participation, pride in cultural traditions, and appropriate appraisals of ethnic group members (Corenblum & Armstrong, 2012). The process of ethnic identity understanding and development begins in childhood, with increasing cognitive complexity enabling children to recognize behaviors, characteristics, and customs that distinguish ethnic ingroup ("my group") from outgroup ("not my group")

members (Corenblum & Armstrong, 2012). In consolidating their racial/ethnic identity, older children and teens seek to avoid stereotypes and to define themselves in direct opposition to negative stereotypes about their ethnic group (Way, Hernandez, Rogers, & Hughes, 2013). Family support, peer support, and parental racial socialization are associated with youth's healthy racial/ethnic identity development, sense of belonging to one's racial/ethnic group, and positive evaluation of one's minority group (Reis & Youniss, 2004; Way et al., 2013).

Cross (1991) and Helms (1990) established a racial identity model that consists of five stages: pre-encounter, encounter, immersion/emersion, internalization, and internalization-commitment. This model posits that racial/ethnic minority individuals move through a series of experiences in which their minority identity becomes increasingly salient. Environmental stressors such as racism, prejudice, discrimination, and incorrect stereotypes about certain racial/ethnic groups often catalyze positive identity development (Way et al., 2013). Individuals do not necessarily progress sequentially through all of the racial identity stages, but they may express certain characteristics of each stage at various points in time (Sanchez, 2013).

The pre-encounter and immersion/emersion stages of this model are correlated with low self-esteem, perceived discrimination, racism-related stress, depression, anxiety, and academic difficulties (Sanchez, 2013). In contrast, the encounter and internalization stages are associated with positive self-esteem, desire for self-actualization, and healthy psychological functioning (Sanchez, 2013). A strong sense of racial/ethnic identification is linked to psychological well-being, academic engagement, and positive social relationships, also serving as a buffer against discrimination (Sanchez, 2013; Way et al., 2013).

Stigma and Treatment Engagement

Recent endeavors to enhance psychotherapy effectiveness with ethnic minorities have placed a heightened emphasis on engagement issues (Cardemil, 2010). Engagement can be conceptualized as the ability of procedures to successfully enhance treatment awareness, entry, participation, and completion. Service utilization research has revealed important issues related to mental health treatment engagement among ethnic minorities compared to Whites: (a) ethnic minorities are less likely to seek treatment and tend to delay treatment until symptoms are more severe, (b) upon treatment entry, ethnic minorities are more likely to drop out prematurely before adequate treatment dosage is delivered, and (c) ethnic minorities are more likely to seek help in primary care and from informal sources of support (e.g., clergy, spiritual healers, family, and friends) (DHHS, 2001).

The US Surgeon General's Supplement on Culture, Race, and Ethnicity outlines several social, environmental, and systemic barriers to successful treatment engagement commonly faced by ethnic minorities (DHHS, 2001). Although stigma attached to mental health issues and treatment is a widespread public health concern, stigma is even more pronounced among racial and ethnic minority groups. Moreover, ethnic minorities can experience fear and mistrust of the mental health system stemming from struggles with persecution, racism, and discrimination as well as documented abuses and mistreatment by providers. Furthermore, ethnic minorities are often disproportionately impacted by social disadvantages (e.g., poverty, homelessness, lack of transportation, and other resources), which can complicate efforts to engage in treatment. Ethnic minorities may also be reluctant to engage in treatments that are perceived to be culturally incongruent, or with a provider who is not culturally similar.

Numerous strategies have emerged from the cultural adaptation literature and have been gaining empirical support for their effectiveness at engaging ethnic minority groups in mental health treatment (see Cardemil, 2010, for a review). For instance, engagement can be enhanced by conducting outreach and/or providing treatment in centrally located and less stigmatizing settings that match service utilization patterns, such as primary care clinics, community centers, schools, or churches. Providers can also offer small incentives (e.g., child care, public transportation vouchers), remain flexible in scheduling sessions, and supplement treatment with case management services in order to address potential accessibility issues due to socioeconomic barriers. Moreover, extending the psychoeducation and therapeutic alliance-building phase of treatment can decrease the likelihood of premature dropout, particularly among ethnic minority groups who may be less familiar with the psychotherapy process, feel guarded

around mental health providers, or struggle with cultural and familial stigma related to their decision to seek treatment. Incorporating discussions of a client's particular cultural contexts/life circumstances (e.g., family, spirituality/religion, experiences of acculturation, discrimination, and racism) can enhance the cultural relevance of treatment, thus making it more appealing and engaging.

Research on Efficacy and Effectiveness of Psychotherapy With Racial/Ethnic Minorities

Clinical trial research has yielded a bevy of interventions deemed to have strong support and efficacy (i.e., via randomized controlled trials and tested treatment manuals), termed empirically supported treatments (ESTs) (Chambless & Ollendick, 2001). Unfortunately, ethnic minorities experience significant disparities in accessing these ESTs (President's New Freedom Commission on Mental Health, 2003; DHHS, 2001). Some have surmised that low service utilization is in part due to a lack of effectiveness and applicability of ESTs to ethnic minority populations. Whereas a treatment's efficacy relates to how well it leads to desired clinical outcomes (e.g., symptom change), a treatment's effectiveness relates to how acceptable or feasible it is for diverse populations in real-world settings.

A number of limitations in EST research hinder generalizability to ethnic minorities. First, ethnic minorities have been underrepresented in EST clinical trials, which seldom provide information about variance in response to treatment by ethnicity, making it difficult to assess whether efficacy studies generalize to ethnic minorities (Nagayama Hall, 2001). Second, ethnic minority clients often present with complex psychosocial issues and comorbidities that are not reflected in clinical trial samples. More effectiveness trials addressing the acceptability and feasibility of treatments are needed to determine whether ESTs can address the common problem of low participation among minority ethnic groups (Cardemil, 2010). Overall, these insufficiencies in ethnic representation, amount of applicable research, and effectiveness trials preclude definitive conclusions about the effectiveness of ESTs with ethnic minorities (Nagayama Hall, 2001). However, studies examining differential treatment outcome effects by ethnic membership have generally found that around 60%–70% of treatment outcome does not vary based on ethnicity, with the remaining 30%–40% roughly equally split between treatment effects that favor Whites versus ethnic minorities (see Huey, Tilley, Jones, & Smith, 2014, for a review).

In the midst of the debate over EST effectiveness with ethnic minorities, scientists and practitioners also investigated the efficacy of cultural competency in psychotherapy (Huey et al., 2014). Answers to this question can be gleaned from cultural adaptation research. Presumably, psychotherapeutic treatments that are adapted to the cultural needs of ethnic minority clients are modified to be more culturally competent—a proxy measure of overall cultural competency. Several meta-analyses have provided predominant evidence that culturally adapted treatments are effective for ethnic minorities with moderately strong effect sizes, in comparison to traditional treatment, no treatment, and treatment as usual (Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; van Loon, van Schaik, Dekker, & Beekman, 2013). However, results have been mixed (Huey & Polo, 2008; Huey et al., 2014), with considerable methodological limitations. In a recent review of the cultural adaptation literature, Huey et al. (2014) concluded that culturally adapted ESTs are efficacious for ethnic minorities when comparing to no treatment (see Huey et al., 2014, for specific effect sizes of 10 meta-analytic studies). Nonetheless, there remains a mixed picture about the added effects of cultural adaptation (Huey et al., 2014), with a dearth of available treatment trials comparing culturally adapted to nonadapted treatments. Potential mechanisms of change for the effectiveness of culturally adapted treatments may lie in incorporating cultural explanations of illness, language match, the number of adaptations, or targeting interventions toward one particular cultural group (Benish et al., 2011; Griner & Smith, 2006; Huey et al., 2014).

When discussing efficacy, it is worth noting the difference between a *skill-* or *intervention*-level approach (i.e., via a culturally adapted EST), versus a *person*-level approach to cultural competency (i.e., therapists who are culturally sensitive) (Sue et al., 2009). There is little research that directly compares treatment efficacy due to a culturally competent *person* or therapist versus a culturally adapted *intervention*. However, research does suggest that when therapists are "culturally competent"—conveying sensitivity to racial issues like microaggressions,

discrimination, or other types of minority stress—the therapeutic alliance benefits (Chang & Berk, 2009).

As an imperfect proxy of cultural sensitivity within the therapeutic relationship, ethnic and language match can yield greater retention in therapy (Karlsson, 2005), though evidence for the unique contribution of ethnic matching on retention and clinical outcomes has been mixed (Maramba & Hall, 2002). This latter finding may be clarified by the understanding that ethnic matching alone does not ensure cultural sensitivity, as considerable diversity exists within ethnic groups. Rather, ethnic matching is frequently considered to be a proxy for *cultural matching* in psychotherapy with ethnic minorities.

Cultural matching between therapist and client enables clients and therapists to "share similar attitudes, values, and cultural beliefs" about the therapeutic relationship, symptom expression, and expectations for treatment (Ibaraki & Nagayama Hall, 2014, p. 936). Extant literature indicates that cultural matching has positive effects on service utilization, treatment retention, and client ratings of therapist credibility (Ibaraki & Nagayama Hall, 2014; Karlsson, 2005). Additionally, matching may accelerate and intensify self-disclosure by increasing the chances that a therapist may truly understand his or her client's experiences.

Overall, promising evidence points to the effectiveness of cultural competency (via cultural adaptation or sensitivity to race-related stress issues) in psychotherapy with ethnic minorities. However, the paucity of efficacy and effectiveness studies on psychotherapy treatments with various ethnic minorities indicates a need for future research in these areas.

DIVERSITY WITHIN RACIAL/ETHNIC MINORITIES

When working with ethnic minorities, it is important to recognize considerable diversity within such populations. There are multiple national groups within each larger racial or ethnic category (e.g., Mexican, Cuban, Puerto Ricans, Colombian, Salvadoran, etc. under the umbrella of Hispanic or Latino/a). Moreover, there are refugees, immigrants, and individuals with mixed ethnic identities or intersecting identities (e.g., LGBTQ ethnic minorities, older adult ethnic minorities) that deserve particular attention. Though a comprehensive review of all population groupings is beyond the scope of this chapter, we review a few of interest and discuss culturally sensitive psychotherapy considerations for each.

Immigrants and Refugees

Ethnic minority immigrants and refugees represent a special population grouping that face unique mental health challenges and psychotherapy needs. Immigrants are individuals who have permanently relocated from their country of birth to another country, whereas refugees encompass a subset of immigrants who have fled conflict or fear of persecution.

Overall, ethnic minority immigrants may experience heightened mental health benefits and fewer psychological symptoms upon arrival in the country of migration, a "healthy immigrant effect" that results from a strong cultural orientation, social network, or selection of a country's healthiest individuals for the process of immigration (Acevedo-Garcia & Bates, 2008; Kirmayer et al., 2011). These healthier psychological states may be more salient for immigrants who arrive to the United States in preadolescence (Breslau, Borges, Hagar, Tancredi, & Gilman, 2009).

A healthy immigrant effect has been found for Western European, South Asian, Chinese, and Filipino individuals who immigrate to Canada (Omariba, 2015). Emigrants—particularly men—relocating to Spain have also been found to endorse lower prevalence rates of common diseases. The percentage of the Spanish population evincing moderate to high morbidity burdens was significantly higher among native Spaniards than among immigrants (Gimeno-Feliu et al., 2015). The healthy immigrant effect has also been found in breastfeeding mothers in Ireland, with immigrants being significantly more likely to breastfeed as compared to Irish-born mothers. Consistent with the mental health correlates of the healthy immigrant effect in the United States, immigrant breastfeeding rates converge with Irish-born breastfeeding rates as time since migration increases (Nolan & Layte, 2015). These findings suggest that the healthy immigrant effect is a phenomenon found in diverse ethnic groups in countries other than the United States.

However, immigrants' negative mental health symptoms increase over time to match rates of the general U.S. population (Breslau et al., 2007; Kirmayer et al., 2011). Racism, discrimination,

socioeconomic struggles, low English proficiency, and family conflict may play a role in increased risk for mental disorders for different immigrant groups (Cook, Alegria, Lin, & Guo, 2009). Undocumented Mexican immigrants, for example, may experience unique risk factors for psychological burden such as marginalization, isolation, dangerous border crossings, stigma, and exploitation (Sullivan & Rehm, 2005). These risks may also be found in youth seeking permanent US residency through the Development, Relief, and Education for Alien Minors (DREAM) Act, and also in unaccompanied asylum-seeking minors. In developed countries, the population of asylum-seeking minors has dramatically increased over the past 15 years, creating unique challenges for immigration officers, courts, and systems of care. These youth represent a distinct social group at risk for exploitation, homelessness, and unstable foster care placement (Seugling, 2004).

Among refugees, it is important to be aware of stressors and trauma experienced during the multiple distinct phases of displacement: premigration, the migration process, and postmigration resettlement. Exposure to violence during premigration is associated with posttraumatic stress disorder, anxiety, and somatic problems (Fazel, Reed, Panter-Brick, & Stein, 2012). Sustaining one's cultural identity, having social and family support, and securing a stable settlement situation can buffer against mental health difficulties among postmigration refugees (Fazel et al., 2012). Exposure to continuing or cumulative risk factors (e.g., safety concerns, violence exposure) can put refugees at risk for psychological problems, but they can be modified—with the help of culturally and linguistically appropriate psychological intervention—during the postmigration phase. Successful psychological adjustment for immigrants and refugees may result from the encouragement of adaptive coping strategies, belief systems, and interpersonal relationships (Lustig et al., 2004).

Among both immigrants and refugees, service utilization is lower than that of the general population. This disparity is reflective of a combination of structural, economic, and cultural factors like lower service access and less familiarity with Western mental health concepts (Kirmayer et al., 2011). Outreach, education, and culturally competent services are particularly important for this population.

Mixed-Ethnicity Individuals

The double jeopardy hypothesis states that members of multiple minority groups, including individuals of mixed ethnicity, experience levels of psychological distress above and beyond that experienced by members of one minority group (Hayes, Chun-Kennedy, Edens, & Locke, 2011). Although distress may result from the additive effects of being discriminated against based on more than one minority identity, identifying as a multiple minority may also serve as a point of resiliency. The increased psychological risk associated with being a multiple minority may be combated by the development of emotional hardiness, resiliency, and healthy coping skills as a result of exposure to prejudice, stigma, and discrimination (Hayes et al., 2011). Additionally, "intersectional invisibility" theory posits that having multiple marginalized identities (e.g., Chinese Cuban gay man) increases one's invisibility relative to individuals with one marginalized identity (e.g., Caucasian gay man), which can reduce levels of discrimination and prejudice (Purdie-Vaughns & Eibach, 2008). In psychotherapy, these constructs can be addressed by exploring a client's relevant identities and assessing the significance or salience of each identity. As with immigrants and refugees, targeted outreach and culturally competent services are a priority.

Bicultural competence, an important aspect of psychological well-being, describes the ability to live effectively within two cultural groups without abandoning one's personal sense of cultural identity (LaFromboise, Coleman, & Gerton, 1993; Wei et al., 2010). When multiracial individuals feel that they are able to function effectively across cultures, they experience an increased sense of life satisfaction, improved personal competence, and decreased symptoms of depression (LaFromboise et al., 1993; Wei et al., 2010). Bicultural competence also buffers the relationship between minority stress and mental health symptoms, strengthening individuals' abilities to navigate cultural demands. This flexibility can enhance personal and group-level coping skills, strengthen ties with people of varied cultural identities, and reduce multiracial individuals' propensity to depressive symptoms (Wei et al., 2010). Conversely, multiracial individuals with low bicultural competence may feel increasingly isolated from their cultural heritage, have difficulty managing the demands of different cultural identities, feel overwhelmed by

discriminatory events, and be predisposed to depression and anxiety (Wei et al., 2010). As such, practitioners should help facilitate perceived bicultural competence by helping clients establish a cohesive social support network (e.g., of other bicultural individuals who can offer validation and interpersonal learning) and/or develop a deeper understanding of both of their cultural heritages (e.g., history, values, and beliefs) without compromising their identification with either (Wei et al., 2010).

The Intersection of Race/Ethnicity and Sexual Identity

Lesbian, gay, and bisexual (LGB) ethnic minorities face unique challenges in managing stressors associated with their dual-minority statuses. They are often tasked with combating multiple forms of discrimination (e.g., homophobia, racism) that place them at risk for depression, anxiety, substance use disorders, and suicidality (Chen & Tryon, 2012; Meyer, 2003; Szymanski & Gupta, 2009). Chen and Tryon (2012) noted that Asian American gay men who experienced higher levels of stress related to their Asian ethnicity also derived greater stress from their sexual minority identity. For cultures that place high value on family kinship and procreation, coming out as a sexual minority may be seen as shameful and culturally incompatible, resulting in stigmatizing "double jeopardy" for LGB ethnic minorities (Fukuyama & Ferguson, 2000, p. 94).

LGB ethnic minorities must cope with racism and feelings of invisibility in the general heterosexual White community, as well as in the predominately White LGB community (Fukuyama & Ferguson, 2000). As many support groups and national organizations (e.g., the Human Rights Campaign) cater primarily toward middle-aged White gay men, individuals who do not fall into these gender, age, and ethnicity categories must navigate additional stress associated with these marginalized identities (Szymanski & Gupta, 2009). Managing disclosure of one's sexual identity may allow ethnic minority LGBs to experience fewer heterosexist events than racist events, and it can help them feel as though they have some control over the experience of anti-LGB events that negatively impact mental health (Szymanski & Gupta, 2009).

Addressing culturally appropriate support systems for LGB ethnic minorities may reduce the negative effects of minority stress on mental health. As sexual minority individuals are often ostracized by their biological families, it can be useful to support such clients in finding a "chosen" family (e.g., a supportive group of friends who have overlapping cultural identities). For multiple minorities, the confluence of family, community, and cultural norms can invalidate or undermine an individual's multifaceted cultural identities (Fukuyama & Ferguson, 2000). Interventions should also address stress and oppression associated with both ethnic and sexual minority identities, and they should promote an awareness of the potential additive impact of multiple oppressions on psychological distress (Chen & Tryon, 2012; Fukuyama & Ferguson, 2000).

CLINICAL ILLUSTRATION: "JERRY"

The following case illustration of "Jerry" is provided to exemplify the concepts related to psychotherapy with ethnic minorities discussed in this chapter.

Jerry is a 20-year-old Chinese American male who lives at home with his mother. He presents for treatment complaining of depression, anxiety, and feeling that "things will never get better and it is all my fault." Jerry emigrated from Shanghai with his parents when he was 12. In Shanghai, he did well in school, had many friends, and enjoyed playing volleyball on his school team. After his family moved to California, his parents' relationship grew increasingly strained as they dealt with difficulties adjusting to the United States. Jerry did fine in school, but at around age 15 he started to withdraw from both his schoolwork and friends, reporting that he felt "different" from his peers.

Jerry attended a local 4-year university but was expelled 4 months ago when he got into a fight with another student (reasons unknown). He enrolled at a 2-year community college and moved home with his mother, a transition that increased his social isolation. Jerry currently reports having no friends, although he does interact with others at his job as a local chain restaurant host. Jerry says that the only reason he is coming to therapy is because his mother is "making him." In addition to his reported social isolation, Jerry speaks about sometimes feeling numb and "slipping outside [himself]

and viewing life like a movie." In session, Jerry appears anxious and fidgets nervously, and complains of recent sleeping and eating disturbances. He has never received a psychiatric diagnosis before and started experiencing these symptoms for the first time 9 months ago.

At the outset of treatment, Jerry was asked his preference for therapist ethnicity and language of treatment. He stated no preference for ethnicity but preferred therapy in English, so he was matched with an English-speaking Caucasian female therapist. Realizing that Jerry's forced psychotherapy attendance may indicate mental health stigma and unfamiliarity with mental health services common among immigrants, extra time and attention were spent at the beginning of therapy to convey understanding of Jerry's difficulties and to educate Jerry about the process and expectations of therapy. He was told that therapy is often a collaborative process where he would be asked to share his thoughts and feelings, and that progress can initially be slow. This extra time and pretherapy orientation seemed to address Jerry's hesitancy and encourage his engagement with treatment. During these initial sessions, the therapist prescribed behavioral activation assignments and pleasurable activities to establish a more authoritative therapist–client relationship and provide immediate symptom relief, to ultimately engender Jerry's trust and participation.

During the intake assessment phase of treatment, several cultural considerations influenced the therapist's understanding of Jerry's depression, anxiety, and dissociation. The therapist assessed that Jerry's withdrawal in high school was indicative of acculturative stress related to navigating the English language and fitting in with peers. Jerry's continuing social isolation, feelings of being "different," and peer aggression were understood as potential reflections of minority stress or discrimination, as Jerry expressed feeling dismissed and treated like a foreigner by others.

The therapist chose several theoretical approaches, interweaving cultural adaptations as appropriate. She utilized a systems-oriented approach to address environmental factors that have influenced Jerry's difficulty adjusting as an ESL (English as a Second Language) student with few resources and low community support. With Jerry's consent, she reached out to Jerry's parents and offered to integrate counseling support at his community college to make Jerry feel supported by the microsystem of his local community and family. She also utilized cognitive-behavioral interventions for increasing social activities and cognitively restructuring Jerry's catastrophizing and self-deprecating thoughts. Importantly, CBT with Jerry required an understanding that some of his seemingly distorted cognitions about being different from and unliked by his peers were grounded in the realities of his minority and acculturative stress experiences. His thoughts of being a failure were conceptualized in the context of cultural expectations of Jerry as a first-born Chinese son. Finally, the therapist chose to facilitate development of problem-oriented coping behaviors that are culturally congruent with Jerry's nonemotive symptom expression (e.g., sleeping and eating disturbance, dissociation, isolation).

Throughout Jerry's treatment, the therapist's attention to cultural considerations and adaptations (e.g., pretherapy orientation and education, assessing for ethnic and language preference, cultural stressors and expressions of distress, attending to engagement to address stigma, and incorporating cultural beliefs and preferences into choice and delivery of theoretical orientation) facilitated a culturally responsive therapy and culturally adapted treatment. Jerry willingly remained in psychotherapy for 15 sessions, during which he reconnected with several old friends, increased his enjoyment of community college and hopefulness toward going back to earn his 4-year degree, and reported a decrease in his dissociation, depression, and anxiety.

CONCLUSIONS/KEY POINTS

It is important for therapists to understand clients' multiple cultural identities, including the power, privilege, and oppression associated with them. For example, ethnic minorities encompass a plethora of diverse groups (e.g., Arab Americans, Asian Americans, Black/African Americans, Latinos/as/Hispanics, Native Americans/American Indians), each with multiple within-group differences. Special groups of interests may include mixed ethnicity, LGBTQ ethnic minorities, immigrants, and refugees. Though comprehensive coverage of cultural concepts related to psychotherapy with ethnic minorities (e.g., independence vs. interdependence, familism, machismo, spiritualism, etc.) was beyond the scope of this chapter, we reviewed main overarching cultural

factors, including acculturation, acculturative stress, ethnic identity development, minority stress, discrimination, and stigma, that can affect the mental health and treatment engagement of ethnic minorities.

Many theoretical orientations are appropriate cultural fits for ethnic minority populations: (a) feminist therapy can uniquely operate on the need for empowerment among marginalized clients; (b) humanistic therapies may facilitate a feeling of being understood as a cultural minority; (c) CBT addresses some ethnic minorities' preference for skill-oriented, time-limited, and structured treatments, though adaptations may be needed to address cultural variations in beliefs, emotions, coping, and behaviors; and (d) systems approaches may match the interdependent or collectivistic nature of many ethnic minority cultures. All psychotherapy approaches must attend to the need for cultural adaptation in areas such as treatment structure, delivery, content, and therapist behavior.

Cultural adaptation of psychotherapies indicates the need for cultural competency in mental health treatment, and research largely supports the idea that cultural competency in the form of cultural adaptation of evidence-based treatments or sensitivity to race-related stress issues, is effective. However, more research is required to operationalize and examine effective elements of cultural competence within psychotherapy for ethnic minorities.

Key Points

- The mental health field has made strides in culturally competent care with racial and ethnic minorities. Despite advances, disparities in access to high-quality, evidence-based, and culturally sensitive psychotherapeutic services continue to exist. Addressing these disparities remains a critical task for meeting the demands of an increasingly diversified US society.
- Racial/ethnic minorities are affected by acculturation/acculturative stress, identity development, stress/discrimination, and a differential need for treatment engagement. Clinicians should assess and incorporate these factors into psychotherapy with ethnic minority clients.
- Several theoretical approaches may yield cultural fit with ethnic minorities: feminist, humanistic, cognitive-behavioral, and systems therapies.
- Clinicians should be aware of cultural adaptations to psychotherapy in areas such as treatment structure, delivery, content, and therapist behavior.
- Cultural competency as defined by cultural adaptation of evidence-based treatments or sensitivity to race-related stress issues is predominantly effective, though methodological limitations and further need for research prevent definitive conclusions.
- Special groups of interests such as immigrant, refugee, mixed-ethnicity, and LGBTQ ethnic minorities are culturally and psychologically distinct with unique mental health experiences that must inform their psychotherapy.

REVIEW QUESTIONS

1. What are the major historical, social, and political factors that have contributed to the evolution of psychotherapy with ethnic minorities?
2. Explain how acculturative stress, minority stress, ethnic identity development, and mental health stigma, in conjunction with a need for treatment engagement, affect the mental health and psychotherapy experience of ethnic minority clients.
3. What are the primary change mechanisms of feminist therapy, humanistic therapy, cognitive-behavioral therapy, and ecological/systems therapy, and how do they specifically fit the cultural needs of various ethnic minority groups?
4. What do we know about the effectiveness of psychotherapy and culturally competent psychotherapy with ethnic minorities?
5. What are specific mental health–related considerations in work with immigrant, refugee, mixed-ethnicity, and intersecting LGBTQ ethnic minority individuals?

RESOURCES

Readings

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Videos

American Psychological Association Psychotherapy Video Series on Multicultural Counseling: http://www.apa.org/pubs/videos

Websites

Course materials for The Psychology of Race and Ethnicity: http://internal.psychology.illinois.edu/~lyubansk/race/race.htm

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24

Psychotherapy With Immigrants and Refugees: Culturally Congruent Considerations

Melissa L. Morgan Consoli
Sherry C. Wang
Kevin Delucio
Oksana Yakushko

Abstract
This chapter describes the growing immigrant and refugee populations in the United States and highlights the need for culturally congruent psychotherapy with these individuals. Immigration statistics, current trends and history are discussed as are specific barriers, needs, and considerations for this population, with a focus on immigrant and refugee resilience and strengths. Five main areas of research in immigrant and refugee psychotherapy are highlighted: culturally adapted evidence-based approaches, culturally adapted family and group approaches, advocacy and empowerment approaches, language and other logistical considerations, and alternative therapeutic modalities for working with immigrants and refugees. Clinical case examples are also provided.

Keywords: immigrants, refugees, culturally congruent therapy, culturally adapted therapy, therapeutic empowerment

Currently, the United States has more immigrants entering the country than any other nation in the world (Segal, Mayadas, & Elliott, 2010). There are approximately 36.7 million foreign-born (as termed by the US Census) individuals living in the United States, accounting for 12% of the total population, and another 33 million, or 11%, who are native-born with at least one foreign parent—making one in five people in the United States either first- or second-generation immigrants (Jensen, Bhasker, & Scopilliti, 2010). In 2010, Latino/as comprised the predominant US immigrant group (Pew Research Center, 2013), with Mexican-born immigrants accounting for 29.8% of all immigrants, making them the largest national immigrant group (Pappademetriou & Terrazas, 2009). Asian immigrants comprised the second largest group, at approximately 28% (Batalova, 2011). It is important to note that the overall population of US immigrants does not take into account unauthorized or undocumented immigrants, which is estimated to be as large as 11.1 million people (Garcia, 2013). It has been estimated that approximately 76% of the unauthorized immigrant population is of Latin American origin (Pew Research Center, 2009). Since 2011, the

number of children from Honduras, Guatemala, and El Salvador seeking asylum has doubled every year, with the children often leaving to escape violence in their home countries (UNHCR, n.d.). In general, the surge of recent immigrants has been the subject of much debate nationally, with President Obama very recently extending the Deferred Action for Childhood Arrival (DACA) policy protecting these individuals from 2 to 3 years (US Department of Homeland Security, n.d.).

Immigration has been a cornerstone of US history. Mainstream history refers to the "exploration of the new world," which resulted in genocide and forced relocation for American Indians; this history essentially describes the first immigrants (Bankston & Hidalgo, 2006). Since that time various waves of immigrants from different lands have become a core of US society. Immigration occurs for a variety of reasons. Three factors have been identified as contributing to larger scale migrations: family reunification, search for work, and humanitarian refuge. Immigration motivated by family can relate to reunifying with members who may have migrated previously (e.g., parents before their children). Family motivations may also relate to an individual migrating in search of work, or "economic migrants," as people may seek better pay to support their families in the home country. Immigrants seeking refuge in the United States (i.e., asylum seekers) are often motivated to leave their home countries during war, or after environmental catastrophes or persecution due to identity/identities. Refugees, those asylum seekers that have been granted protection by the United States due to threat of serious harm if they remain in their home countries, originate from many different countries all over the world and most often seek asylum from refugee camps in the country of first asylum or after arriving in the United States (APA, 2012).

GENERAL STRESSORS/CHALLENGES FACED BY IMMIGRANTS AND REFUGEES

Immigrant and refugee populations face multiple challenges, including the process of immigration itself (Hovey, Magaña, & Booker, 2001) and discrimination (Yakushko, 2009). Such stressors are often not the same as those faced in the country of origin and are therefore likely to be new and unfamiliar to the immigrant or refugee. Attempting to cope with these additional stressors, while simultaneously dealing with everyday life challenges, may create a very high level of stress. Such stress has been associated with mental health problems, including depression, anxiety, and suicide. However, immigrants and refugees typically do not seek mental health services. This tendency might be due to factors such as preference for alternative forms of treatment, perceived and actual cultural insensitivity of mainstream services, language barriers, and inaccessibility of services (Bemak & Chung, 2008).

STRENGTHS AND RESILIENCE OF IMMIGRANT AND REFUGEE POPULATIONS

Despite facing many adversities, immigrants and refugees in general have been found to display many aspects of resilience (Morgan Consoli et al., 2011). Defined as the ability to overcome adversity and continue normal development (Garmezy, 1993), resilience is a construct that clearly underlies a strengths-based view of adaptation to risk. Strength-focused interpretations of immigrant cultures have been very limited in the professional literature; instead, deficit-focused interpretations have dominated (Aguirre & Baker, 2000). Early research examining the psychological needs of immigrants, refugees, and minorities have historically focused on challenges associated with adjustment and adaptation to the host or mainstream society, such as acculturation and its associated stress (i.e., acculturative stress) (Berry, Kim, & Boski, 1988). As such, resilience literature directly related to immigrants is limited. However, the themes of acculturation, family and social support, spirituality, and self-concept are all factors present in the immigrant literature and have been shown to be associated with resilience.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS

Psychotherapy with immigrants and refugees has rarely been conceptualized outside of a Western framework, yet it is an undertaking that requires much cultural sensitivity, cultural humility, specific skills, and general awareness of historical and worldwide traumas that immigrants and refugees may have

experienced. The extant literature reveals five main areas, among others, in which immigrant and refugee mental health work is being conducted: culturally adapted evidence-based treatments, family and group treatments, advocacy and empowerment treatments, language and other logistical considerations in therapy with immigrants and refugees, and alternative treatments. In the following we will summarize the current findings and practices in these areas.

Culturally Adapted Traditional/ Evidence-Based Treatments

The cultural adaptation of evidence-based treatments (EBTs) is a recent phenomenon. This entails incorporating elements such as cultural beliefs and values into more traditional cognitive-behavioral therapy (CBT). Several studies have reported successfully adapting EBTs. For example, Hwang (2009) positively adapted a CBT treatment model for Chinese American adolescents by incorporating the role of family and the issue of difficulty discussing feelings with a therapist. Similarly, Nicolas, Arntz, Hirsch, and Schmiedigen (2009) culturally adapted group therapy for Haitian American adolescents. A meta-analysis of culturally adapted treatments by Griner and Smith (2006) suggested favorable results. It is noteworthy that many of these adaptations include community components (Hwang, 2009), indicating the importance of community to immigrants.

CBT has perhaps been the most researched of the culturally adapted treatments. Culturally responsive CBT (CR-CBT), one type of culturally adapted therapy, seeks to identify which part of the client's presenting problem is external or environmental and which part is internal. It is particularly important to determine such sources of the problem, as trying to change a client's beliefs about an oppressive system would be inappropriate (Hays, 2008). This involves validating clients' experiences of racism or oppression first and foremost, with the challenging or questioning characteristic of CBT reserved for later. Moreover, cultural influences must be identified to develop a treatment plan (Kelly, 2006). Problems external to the client may call for environmental changes, and problems internal to the client may call for cognitive restructuring. All interventions and goals should be worked on collaboratively with the client. Interventions may involve assessing "helpfulness" of thoughts (rather than "rationality" or "validity") and homework assignments (Hays, 2008).

Culturally Adapted Group and Family Treatment

Many group and family treatments have also been adapted for work with immigrants and refugees. For example, group therapies that include multiple families have been adapted for torture survivors (Kira, Ahmed, Mahmoud, & Wassim, 2010) such that treatment is extended beyond individual empowerment to include community healing through a group format with an expectation of sustained support even beyond the termination of the group. In such therapy, attending to collective trauma is necessary. Multiple-family group therapy (MFGT) is a modality that has been shown to be successful for refugees and torture survivors by "increas[ing] support for the family members' primary and secondary torture victims and . . . adjustment to new multi-systemic cultures" (Kira et al. 2012, p. 73).

Theories and concepts that are considered to be globally applicable are also important to adapt when working with immigrant families. Mirecki and Chou (2013) used a case conceptualization of a Bosnian family to highlight the ways in which attachment theory, one of the most prominent and long-standing theories in psychology, can and should be redefined to account for contextual, social, and developmental considerations when working with refugee and, more broadly, immigrant families. The authors argued that in spite of the global application of attachment theory, the expression of attachment sensitivity may be conceptualized differently for families; furthermore, attachment theory is also interpreted within a cultural context based on the expectations of the clinician (Mirecki & Chou, 2013). Clinician self-awareness is therefore critical when working with immigrant families, given that both parties can operate from different cultural contexts, experiences, and expectations in defining what is considered to be "appropriate." Acknowledging the value-laden nature of supposedly global theories therefore requires clinician awareness of the cultural and moral assumptions underlying psychology.

To illustrate, positive psychology has been defined as pertaining to the development of the self, and it has been considered to be strength-based and universally applicable. However, Christopher and Hickinbottom

(2008) among other scholars have critiqued positive psychology for its Western-based assumptions, noting that conceptualizations of the "self" as well as notions about having "a good life" are based on ideas that are rooted in American cultural values and ideologies. Including indigenous frameworks and constructs when working with immigrant families can offer a more culturally sensitive approach that validates the experiences and perspectives of those from other cultures. For example, Chao's (1994) seminal work on cultural differences between Chinese immigrant parenting and European American parenting underscored the differing cultural frames of reference used when interpreting parental control, such that the terms used to describe Chinese parenting are "ethnocentric and misleading" when interpreted from parenting typologies developed from Western culture (p. 1111). Chao (1994) advocated instead for the use of indigenous constructs to understand Chinese immigrant parenting, and since her publication, there has been a growing body of literature focused on culture-specific concepts in immigrant parenting. There has also been recognition that the measures designed to assess parenting practices have been predominantly based on the experiences of European American, middle-class families and that there is much less understanding of the experiences of immigrant families, both in terms of the intention and expression of parenting in ethnic subgroups (cf. Chao & Kaeochinda, 2010).

Advocacy and Empowerment Treatments

Given the frequency and magnitude of adversities that immigrant and refugee populations face once they migrate to the United States, it is important to understand the feelings of powerlessness that often accompany their positions in society. In particular, practitioners must strive to acknowledge the context from which migrant individuals originated, compared and contrasted to the one in which they currently exist, and the systemic and institutional oppressions they may face in their adjustment to the United States. In addition to the aforementioned approaches, empowerment-based treatment modalities may prove beneficial for these populations. Before detailing the different techniques and/or strategies suggested by empowerment-based models, it is important to delineate what empowerment means.

Empowerment is often introduced and/or promoted as a way to work with marginalized and oppressed populations, yet an all-encompassing operational definition of empowerment still remains to be formulated adequately (Cattaneo & Chapman, 2010). Without a globally agreed-upon definition, a number of different outcomes have been used to signify empowerment in therapy and research settings, including improved decision-making skills, perceptions of control, and participation in community groups/organizations (Cattaneo & Chapman, 2010). This is not to say that these outcomes are not a result of increased empowerment among clients, but rather that researchers and clinicians may not all be in agreement as to what constitutes true empowerment. Cattaneo and Chapman (2010) have proposed "the empowerment process model" and defined empowerment as a process in which "a person who lacks power sets a personally meaningful goal oriented towards increasing power, takes action towards this goal, and observes and reflects on the impact of this action, drawing on his or her evolving self-efficacy, knowledge, and competence" (p. 647). Their definition touches on each component of the model: setting personally meaningful, power-oriented goals; self-efficacy; knowledge; competence; action, and impact. While all of these components lend themselves well to practice with immigrant populations, the first component related to goals may be the most critical. Goals are a fundamental piece of therapy and, from an empowerment standpoint, goals are best determined through a collaborative process between the client and the therapist. This collaborative style is similar to feminist and multicultural approaches (e.g., Nakamura & Kassan, 2013) wherein power differentials between client and therapist are made explicit and are minimized and/or diminished to the extent possible. The goals created to empower are contingent on the client's self-efficacy, knowledge, and competence to follow through with a proposed action. Therefore, it is important for therapists and helping professionals to truly understand the immigrant client's context and abilities. Cattaneo and Chapman (2010) note that a therapist may perceive his or her work as empowering to the client (e.g., perceptions of control, ability to mobilize resources); however, if these actions are not in line with a client's personally meaningful goals or context (e.g., systemic/institutional barriers), then this "empowerment" may actually backfire, hinder the therapeutic

process, and create more stress for the client. For example, when working with undocumented immigrants, a therapist may assume lack of career mobility to reflect a client's lower levels of capability without taking into consideration legal and systemic barriers that limit career opportunities even for those in higher education (Ortiz & Hinojosa, 2010).

Clinicians have to work to understand what "power" means to the client, or otherwise be in danger of imposing their own or even a Western sense of empowerment onto clients. This is particularly relevant when it comes to immigrant individuals and communities because they may be in positions (e.g., unauthorized status) where increased visibility or increased community action may put their lives in jeopardy. Clinicians may therefore have to reformulate their conceptualizations of empowerment to create a sense of agency in interpersonal relationships and goals that may only affect a client's immediate social networks (Cattaneo & Chapman, 2010; Khamphakdy-Brown, Jones, Nilsson, Russell, & Klevens, 2006). Thus, a therapist must work to understand the immigrant's sense of identity and in which communities he or she feels comfortable, in order to create a beneficial working relationship that is truly empowering.

Nakamura and Kassan (2013) outline a theoretical approach that integrates multicultural and feminist frameworks when working with migrant clients. They specifically detail considerations when working with sexual minority immigrant women. They discuss the idea of "women in context" and recommend making sure that clinicians are aware of the sociopolitical issues facing their clients, as well as their own contexts that influence the client. Ideologically, this may be expanded to immigrant populations as a whole, in which clinicians work to understand the "migrant in context" and what factors are contributing to negative mental health. Furthermore, feminist frameworks have not typically included immigrant narratives and experiences in their conceptualizations; however, multicultural psychology is evolving toward understanding intersecting identities, which may lead to a broader multicultural approach in working with immigrant individuals (Nakamura & Kassan, 2013). The proposed integrated approach identifies five categories, or factors, that may help therapists in their conceptualization of immigrant client issues: cultural, personal identity, contextual, ideological, and universal. Cultural factors include group affiliations (e.g., gender, age, sexual orientation); personal identity factors relate more to developmental and biological aspects; contextual factors refer to historical, political, social, and economic realities; ideological factors signify "mainstream culture's discourse around issues of power and privilege" (Nakamura & Kassan, 2013, p. 257); and universal factors address aspects of experience that are shared across all people. When working with immigrant clients in the United States, it is important to take note of all of these categories and assess which appear to be most salient to the client.

Helping professionals must also acknowledge the potential for fluid identities in immigrants and refugees. In acknowledging this fluidity, clients may be empowered to share their stories, and themselves, on their own terms in light of societal norms that strip them of this agency. Additionally, when it comes to discussing ideological factors and issues relating to privilege, clinicians can help clients identify aspects of privilege held in their countries of origin and how these translate in the host country. Similarly, it should be determined whether immigrants continue to have and/or develop privilege in the host country (e.g., through education), and how they understand these positions of privilege (Nakamura & Kassan, 2013).

Most empowerment-based interventions have targeted women (e.g., Khamphakdy-Brown et al., 2006) and lesbian, gay, bisexual, and/or transgender (LGB/T) asylum seekers/immigrants (e.g., Reading & Rubin, 2011). For example, in the "empowerment program," which is an outreach program for refugee and immigrant women, the fact that many refugee and immigrant women migrate with a history of trauma and domestic violence is highlighted (Khamphakdy-Brown et al., 2006). Women may be particularly vulnerable to postmigration stressors and hesitate to approach mental health settings due to cultural barriers. This approach to empowerment focuses on women expanding their inner "power" and recognizing the contextual barriers (e.g., sexism, xenophobia, socioeconomic status) that may be affecting them. It may also be beneficial to weave components of Western therapy approaches into treatment in a subtle and respectful manner, thus possibly normalizing and destigmatizing the experience.

Similarly, Reading and Rubin (2011) describe a group approach for LGBT asylum seekers in the United States and detail the empowerment experience as one in which these individuals engage in community methods, such as organizing political

action events. These individuals may also arrive to the United States having experienced higher incidence of trauma, especially around "demonstrating" their sexual orientation to be granted asylum. Not all of these individuals are "out" about their sexual minority identities in their home countries for fear of persecution, thus presenting their case may actually put them in danger of being "outed" and/or retraumatized. As such, a group approach and involvement in LGBT community organizations may be associated with publicizing an identity that is not "public" knowledge. Thus, while community empowerment strategies may be helpful for some individuals, it is also important to remember that not all LGBT migrants respond well to these techniques, especially when navigating multiple, marginalized identities.

A helping professional seeking to utilize empowerment-based approaches should keep the following considerations in mind. First, working with migrant clients under an empowerment framework may necessitate that the therapist step outside of the traditional therapy role and into a greater advocacy role (e.g., Vera & Speight, 2003), requiring the therapist to connect the client to external assistance such as immigration lawyers, interpreters, and community organizations. Second, ecosystemic, feminist, and/or multicultural approaches may help in understanding the client's context and which systems the client can target in terms of increasing a sense of empowerment. Third, therapists should keep in mind that a number of internal factors and external factors have the potential to impact how a client can exercise his or her power and build it in a way that is personally meaningful (e.g., Cattaneo & Chapman, 2010). In addition to these conceptual considerations, there are also a number of logistical considerations helping professionals can keep in mind for effective therapeutic practices, as discussed next.

Language and Other Logistical Considerations in Psychotherapy Process

As mentioned earlier, attention to cultural diversity and cultural complexity is essential in the treatment of recent immigrants and refugees. For a therapist to accomplish this, several features of psychotherapy with this population distinguish it from other groups. Although access to bilingual services and bilingual supervision is paramount, the tremendous diversity of immigrants' origins and lack of bilingual clinicians lead to one of the most distinct aspects of psychotherapy with immigrants: working through an interpreter (Miller, Martel, Pazdirek, Caruth, & Lopez, 2005; Yakushko, 2009).

In contrast to behavioral and mental health treatment literature, access to services by limited English proficiency (LEP) patients has been recognized as an important area of research and policy development within the medical field (e.g., Au, Taylor, & Gold, 2009; Brach, Fraser, & Paez, 2005). Specifically, medical scholars emphasize that a language barrier is directly linked to negative treatment outcomes such as medical complications and lower access to care (Jacobs, Chen, Karliner, Agger-Gupta, & Mutha, 2006). Medical health systems often include professionally trained medical interpreters as well as detailed policies on the use of interpreters, which have been shown to improve the accuracy of medical communication utilization, treatment outcomes, and satisfaction with care, not only for LEP clients but also for their health service providers (Karliner, Jacobs, Chen, & Mutha, 2007).

Undoubtedly, in the provision of psychotherapeutic care to LEP clients, the use of interpreters is especially vital. Sentell, Shumway, and Snowden (2007) stated that with immigrant and refugee clients "language barriers may be particularly problematic in mental health care because much of mental health diagnosis and treatment relies on direct communication rather than objective tests or medication" (p. 290). Although the American Psychological Association's *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists* (2003) featured language limitations in working with LEP clients, the field of psychology has continued to lack systematic guidelines and standards, including those for clinicians and the interpreters (in contrast, see the National Code of Ethics for Interpreters in Health Care and the National Standards of Practice for Health Care Interpreters; National Council on Interpreting in Health Care [NCIHC], 2004, 2005). Several states, such as California, have issued policies and guidelines for creating thresholds of care for LEP clients, which in turn influenced the rates of mental health utilization when such policies were implemented. However, the creation and maintenance of such policies is nonuniform and appears to apply only to state and federal institutions that utilize Medicare and

Medical reimbursement, which require equal access to services under Title VI (Civil Rights Act of 1964) of the US Constitution (Snowden, Masland, Peng, Wei-Mien Lou, & Wallace, 2011).

Utilization of an interpreter in psychotherapy can take many forms. Based on work with Asian LEP immigrants, Lee (1997) suggested several models applicable to psychotherapy practice: the approximate-interpreting model relies on an interpretation by whomever is available and can speak the language; the tele-active model employs telephone or computer-mediated interpretation services; the bilingual worker/interpreter model emphasizes hiring clinicians or paraprofessional aids that speak the language; the volunteer interpreter pool model relies on hiring interpreters on an as-needed basis; and the staff interpreter model requires inclusion of interpreters who are formally trained as part of clinical staff. The range of models points to the complexity of working with interpreters in psychotherapy. Parameters of working with interpreters are not only guided by clinicians' own decisions regarding how to utilize such services but also by such factors as work settings (e.g., independent practice versus outpatient clinic), communities (e.g., large metropolitan versus rural areas), and available resources (e.g., reimbursement for interpreters).

Several challenges exist in the use of interpreters such as building empathy within the context of language interpretation in psychotherapy (Pugh & Vetere, 2009). Mental health interpreters may also experience concerns such as being overvalued or devalued by clients, perceiving opposing expectations from therapists and clients, and being viewed as a rival or an adversary by the clients (Sande, 1998). It has been suggested that certain personality characteristics (e.g., flexibility, openness to challenges) as well as specialized training (e.g., multicultural training with focus on immigrant communities, skills in working with interpreters) are essential for successful therapeutic treatment for LEP clients (Yakushko, 2010).

Structural challenges facing clinicians and service organizations that serve LEP communities also exist (Yakushko, 2010). One of the most evident problems is lack of training as well as federal or state certification in the United States for mental health interpretation. Similar certification for other fields, such as medical interpretation, emphasizes linguistic accuracy, confidentiality, neutrality, respect, attentiveness to cultural differences, boundaries, professionalism, and continued training. Such guidelines exist in other countries; for example, the Australian Psychological Society's (2013) guidelines for interpretation in mental health fields, which emphasize collaborative therapy frameworks, the importance of both interpreter and therapist supervision, considerations of vicarious traumatization, and the occurrence of multiple levels of transference and countertransference. Similarly detailed attention to requirements are lacking in the United States.

Additional challenges encompass lack of consistent insurance reimbursement for interpretation services, timing of psychotherapeutic services that does not account for interpretation (i.e., 50-minute hour versus expanded sessions), and continued invisibility of services to diverse LEP clients in training across the United States. Despite these challenges, the awareness of the need for language assistance during mental health services with LEP clients is growing. Because of the rapidly shifting demographic landscape of the United States, which includes a significant number of individuals and families with limited proficiency in English, attention to the use of the interpreters in psychotherapy is likely to increase (Yakushko, 2010).

Alternative Therapeutic Modalities

Significant scholarly attention has been given to alternative therapeutic modalities, understood as therapeutic practices falling outside of traditional, Western approaches, in working with recent immigrants and refugees. This is particularly true for those who have survived trauma, including torture. This literature highlights the importance of the cultural emphasis on mind–body approaches to understanding trauma (Jaranson et al., 2004). Specific modalities utilized with traumatized immigrants and refugees include meditation, yoga, massage, dance, homeopathy, Reiki, traditional Chinese medicine, religious practices, music, t'ai chi, and acupuncture, among others (see Longacre et al., 2011, for review). Such mind–body approaches are viewed as especially fitting for treating sequela of trauma among immigrants and refugees because in addition to indicators typical for Western expressions of posttraumatic stress disorder (i.e., depression, anxiety, upsetting thoughts or memories about the traumatic events, "flashbacks," avoidance, sleep disturbances), chronic pain has

been shown to be a key symptom for almost 80% of clients who are torture survivors (Piwowarczyk, 2007). In addition, studies show that traumatized immigrants and refugees especially respond to such alternative mind–body treatments, particularly as many immigrants may conceptualize their difficulties as pain. For example, a study by Highfield et al. (2012) reported that refugees that had a history of trauma and sought treatment from a hospital specifically for symptoms of physical pain responded well to acupuncture.

Although indigenous healing practices are often a first recourse for non-Western immigrants and refugees for their mind–body needs, such emphasis on cultural healing methods does not preclude individuals from also seeking traditional Western help (Berthold et al., 2007). However, a study by Ahn and colleagues (2006) of approximately 4,500 Asian immigrants who received physical and mental health treatments in community centers revealed that while two thirds of the participants used complimentary culturally based therapies, only 7.6% ever discussed this use with their Western clinicians. This finding suggests that it is important for therapists to be knowledgeable and ask directly about what other forms of treatment are being used concurrently by their clients.

Among developing talk-based approaches to working with trauma among immigrants are narrative exposure therapy (Halvorsen & Stenmark, 2010), group therapy with a focus on indigenous healing strategies (Kira et al., 2012), and community-based psychosocial interventions (Stepakoff et al., 2006). Bolton and colleagues (2007) also described the development of interpersonal therapy as applied to group psychotherapy treatment utilized in cross-cultural settings.

Other alternative approaches have emphasized arts, play, and drama therapies in the treatment of mental health concerns of recent immigrants and refugees. For example, art therapy has been used in addressing the needs of the Latino/a community (Bermudez & ter Maat, 2006), and a story quilt group was employed in the treatment of Bosnian immigrant women (Baker, 2006). Rousseau and colleagues (2007) described a pilot study of classroom drama as a way of addressing the mental health needs of recent immigrant and refugee children. Other related modalities have been developed specifically based on the cultural practices of particular immigrant groups. For example, *Cuento* therapy was described by Costantino and colleagues (1986) as an approach to working with immigrants from Puerto Rico, focusing on folk tales and craft-making as therapeutic practices. However, despite the wealth of indigenous healing approaches found around the world, very limited attention has been given to the application of these modalities in Western psychotherapy clinical practice, research, or training (Comas-Diaz, 2006).

Those working from postcolonial perspectives contrast the importance of attending to the cultural assumptions behind Western emphases in psychology (i.e., control of cognitions and behaviors) with emphases on meaning and liberation, which may include working with local and indigenous forms of knowledge, making visible unconscious patterns of internalized and external oppression, and involving sociopolitical change processes rather than individually focused remediation (Hollander, 1997; Hook, 2012). Lastly, practitioners and scholars have highlighted that Western approaches to treatment tend to de-emphasize the role of religious and spiritual significance of mental health difficulties, whereas most non-Western immigrants and refugees view these as central to their identities and healing (Comas-Diaz, 2012; West, 2010).

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION

Principles of Change

There are many principles of change that therapists should keep in mind when working with immigrants and refugees that have been referenced in the aforementioned practices. Therapists should familiarize themselves with culturally adapted forms of treatment that may be appropriate for working more effectively with immigrant and refugee clients, thus making change a culturally congruent process. Similarly, therapists should be mindful of not imposing Western-based frameworks of empowerment onto clients. They should instead collaborate with the client to understand how the client will truly feel empowered. It may be necessary for therapists to enter an advocacy role with the client, as working with immigrant and refugee populations often necessitates going beyond the traditional therapy role, thus potentially helping to influence systemic change. Integrating various systems, or context-based

approaches, may also be beneficial when working with immigrants and refugees, and therapists should attend to strengths, in both individuals and families, so that skills learned in group therapy settings serve as a way for clients to provide support to one another beyond the therapeutic setting. Finally, when working with LEP clients, recognizing the impact of interpreters on work with the client and understanding how to effectively use this resource is vitally important to aspects related to the change processes such as therapeutic alliance, management of the triadic nature of interactions, attention to dynamics of multiple or dual roles, and the need for interpreter training and supervision (Miller et al., 2005).

With regard to their own personal work toward being an effective change agent, therapists should strive for ongoing awareness of their own understandings of what is "normal" or developmentally appropriate, as these processes may differ across cultures, families, and individuals. They should pursue training in therapeutic approaches and strategies that foster greater access to psychotherapy by immigrant and refugee clients, especially those who have limited English proficiency and lack familiarity with traditional, Western psychological practices. Additionally, therapists should engage in an exploration of alternative approaches to care, which emphasizes mind–body integration as well as utilization of culturally relevant and indigenous forms of healing.

Case Conceptualization

It is recommended that all immigrant and refugee case conceptualizations start with a diversity perspective, essentially identifying the important identity, cultural, and strengths-based components that will frame the conceptualization. This will include taking into account any preconceived ideas on the part of the client about US-based, mental health treatments. In determining therapeutic needs and goals, it will be important to collaborate regularly with the client, thus empowering the client to be the "expert" on his or her culture and to work toward addressing any power differentials. Of primary importance is a therapist's openness and flexibility in conceptualizing a "problem" or giving a diagnosis, given the cultural relativity of such a designation. It is important to consult the client, the literature, and other knowledgeable professionals in these determinations.

Research on Efficacy and Effectiveness of Psychotherapy With Immigrants and Refugees

Not all therapies used with immigrants and refugees have been subject to efficacy or effectiveness studies. Some that have, to varying degrees, are outlined in this section: culturally adapted CBT, CBT-based group therapy, empowerment models, and narrative exposure therapy with youth.

Studies of CBT with immigrant populations abound, with efficacious results ranging from CBT in Cantonese with Chinese immigrants in Canada (Shen, Sochting, Alden, & Tsang, 2006) to culturally adapted CBT with Latino/a immigrants in the United States for reducing depression (Organista, Muñoz, & Gonzalez, 1994; Roselló & Bernal, 1999). Similarly, CBT has been evaluated as a therapy for refugees, with effect sizes for reducing symptoms of trauma and stress >.05 (Murray, Davidson, & Schweitzer, 2010). Additionally, Reading and Rubin (2011) highlight that CBT-based group therapy and its interpersonal aspects have been found to be effective in treating symptomatology consistent with complex trauma, which is particularly applicable for refugee populations.

Efficacy and effectiveness studies on empowerment treatments in general are fairly limited, and even more so with immigrant and refugee populations. However, components of empowerment treatments have been shown to be effective with marginalized populations (Cattaneo & Chapman, 2010; Reading & Rubin, 2011). For example, Cattaneo and Chapman (2010) elaborate on goal-setting and note that creating personally meaningful goals has been shown effective in a therapy setting.

There is also a growing body of literature examining the efficacy of trauma treatment for refugee youths. Child-centered play therapy has been shown to be as effective as trauma-focused CBT in reducing trauma symptoms for traumatized refugee children (Schottelkorb, Doumas, & Garcia, 2012). Ruf and colleagues (2012) have also shown that narrative exposure therapy can be helpful for treating refugee children, as clinicians help clients construct their chronological narratives while focusing explicitly on the trauma exposure. At the end of treatment, clients receive a written document outlining their experienced trauma, which can be used for assistance in asylum seeking and advocacy. Additionally, the children can also develop language to capture what they

have experienced, and they can do so through playing games that facilitate their memory reorganization. It is important to note that in Ruf et al.'s (2012) study, a limitation was not being able to delineate differences in efficacy between treatments offered with or without interpreters. Finally, attention to the role of interpreters should be incorporated into efficacy studies with immigrant and refugee populations.

DIVERSITY

Immigrants and refugees themselves are a very diverse population, which includes diversity between immigrant groups as well as within each group. For example, immigrants from Eastern Europe may have very different values and needs than those from Asia or South America. Similarly, immigrants from Central American Latino/a countries may have quite different cultures than those from South American Latino/a countries. Then, even within the same culture, individual differences exist, which must be carefully explored and honored in treatment.

In understanding the needs of immigrant and refugee communities, it is important to recognize the limited knowledge about the intersections of multiple identities among immigrant experiences. For example, with regard to broader groups such as immigrant families, much of what is known has been focused primarily on the experiences of heterosexual couples so that even when multiple aspects of identities are examined, such as race, ethnicity, gender, socioeconomic status, and spirituality, the experience of families is limited to only male–female partnerships (cf. Tarver & Harden, 2011). A small, but burgeoning body of literature examines the intersections of sexual orientation and immigration (e.g., Hernandez & Curiel, 2012), though much more needs to be understood about the experiences of gay and lesbian immigrant families (Tiven & Neilson, 2009), as well as other intersecting identities.

Therapists should pay particular attention to situations or contexts in which certain aspects of an immigrant or refugee's identity may be more salient. For example, upon arrival to the United States, sexual minority immigrant individuals may hold a strong identification with the country of origin, but after time they may begin to identify strongly with and/or integrate other aspects of their identity (e.g., sexual minority). Similarly, research has been conducted with female immigrants exploring the impact of immigration on their roles as mothers and in the family. Multiple systemic factors influence this experience, sometimes providing a catalyst for change in such beliefs and values (e.g., traditional gender roles may be challenged and reevaluated) (Yakushko & Morgan Consoli, 2014).

CLINICAL ILLUSTRATIONS

The following case examples are meant to highlight some of the considerations discussed herein and to illustrate therapeutic approaches to working effectively with immigrant or refugee clients.

From El Salvador to Kansas: The Case of Juan

Juan is a 34-year-old male who is an immigrant to the United States from El Salvador. He left his wife and two young children in El Salvador to seek better wages to provide for his family. He hopes to save up enough money to bring his family to the United States, although it is quite expensive since he will have to pay *coyotes* to bring them first through Mexico and then to the United States. He also worries about the danger of such a journey for his family.

Juan reports difficulty sleeping most nights and bouts of tearfulness during the day. He misses his family and does not know when he will be able to reunite with them. He is unable to visit them because he is an unauthorized immigrant and to leave the United States for a visit would risk him not being able to return. He is making better wages working in a meat-packing plant in Kansas, and he sends money to El Salvador regularly. With that income he has been able to help his wife and children and, to a lesser extent, his parents and several aunts and uncles and their children. He states that he misses the food of El Salvador and the familiarity of his hometown, a small village in northern El Salvador. He "hates" that his children are "growing up without (him)." He believes he is doing what is best for his family by continuing to work in the United States, but he often feels it is "too much" and has to force himself to continue each day. He has made a few friends in the factory where he works, but they are often so tired after a long shift that they go straight home to sleep. Thus, he has little outside social activity.

Juan sought treatment because his sadness is getting in the way of his work. His psychotherapist

focused on ways to address his apparent depressive symptoms in a culturally congruent way, helping him to understand the source of his feelings and symptoms as well as the trauma that he has been through in his immigration experience and being separated from his loved ones. She did this by helping Juan to focus on his strengths, such as determination and perseverance, courage and hope. Through exploring some of this with Juan, he was able to see the strengths in his actions and focus on the choices he had before him, thus feeling more empowered than when he began therapy.

Integrating East, West, Past, and Present: The Case of Dinesh

Dinesh, now 22 years old, immigrated with his parents and two older brothers to the Midwestern United States from Sri Lanka when he was in his early teens. Although he was finishing his college degree in electrical engineering and dating a South Asian woman, he began to withdraw from his family and friends. Dinesh told his family that he was busy with completing his school projects, but his girlfriend discovered that Dinesh had stopped attending classes and started to binge drink. When she expressed concern about his behavior, Dinesh broke off their relationship. Dinesh was required to seek treatment when he was stopped for drunk driving.

During an intake at a drug abuse and rehabilitation center, Dinesh was asked about a possible history of trauma, to which Dinesh vaguely described being detained and tortured by Sri Lankan authorities along with his brothers and father for their participation in political protests. The drug abuse counselor referred Dinesh for psychotherapy to a local psychotherapy center that specialized in treatment of trauma as well as encouraged him to attend an AA group connected to the local Asian community. Meanwhile, Dinesh's family, concerned with his behavior, sought treatment from a doctor they knew who practiced Ayurvedic medicine. After a consultation with the family regarding their history and constitution, the traditional healer began to meet with Dinesh to help him toward achieving mind–body balance through prescription of medicinal plants and practices (e.g., oil massage, cleansing), dietary changes, and regular meditation. Dinesh was also asked to devote himself to consistent spiritual practices, which were required to cleanse his spirit.

Dinesh, however, was interested in pursuing the suggestion to seek therapy at a trauma center. He believed that this "Western" treatment may offer him something in addition to traditional approaches. His initial sessions, however, were frustrating to him because he felt pushed to disclose information about himself and his family to a female counselor. After being reassigned to a male counselor, who invited Dinesh to participate in determining the course of his treatment, Dinesh began to slowly disclose his history of persecution and torture as well as his growing sense of disconnection from his family and his culture. In addition to relational and cultural approaches to helping Dinesh understand the impact of his trauma, Dinesh's psychotherapist focused on ways that Dinesh could begin to integrate his past into his present mode of being and his relationships. At Dinesh's request, he invited his girlfriend to attend therapy sessions with him, and, at a later point, invited his family members as well as his Ayurvedic doctor.

CONCLUSIONS/KEY POINTS

Several features of effective therapy with immigrants and refugees have been identified throughout the chapter.

- Fundamental to effective therapeutic practice is the principle that therapists should recognize that universal concepts and developmental processes have different meanings in different cultures and that it is important to understand (or be open to learning about) cultural values and ideas which may be expressed differently from or similarly to mainstream culture. Therapists can achieve this through their own self-exploration and openness to alternative cultural views and healing forms.
- Therapists may be able to effectively adapt more mainstream therapies to be culturally congruent. Explicit attention to the particular cultural needs of the client is paramount and may make the difference between effective and ineffective treatments for immigrants and refugees.
- Several existing therapies have been culturally adapted for immigrant and refugee populations, with varying degrees of efficacy and effectiveness studies for each. Culturally adapted CBT, empowerment therapies, and group therapies

are among those most frequently utilized with these populations. Therapists working with immigrants and refugees should familiarize themselves with these treatments as at least a starting point for their work.

REVIEW QUESTIONS

1. Under the "empowerment process" model, what constitutes empowerment? Does this definition of empowerment fit with your ideas of empowerment; how so or how not?
2. How might the clinician's own cultural experiences influence his or her conceptualization of what is appropriate when working with immigrant and refugee populations?
3. How might concepts that are considered to be universal differ across cultures?
4. In what ways do the needs of recent immigrant and refugee clients, especially those who have limited English proficiency, challenge traditional therapeutic modalities employed in the United States?
5. How can "alternative" healing modalities be integrated with "traditional" Western models in the treatment of recent immigrants and refugees?

RESOURCES

Videos

American Family (Directed by John Fortenberry, 2007); Dirty Pretty Things (Directed by Stephen Frears, 2002); *El Norte* (Directed by Gregory Nava, 1984); God Grew Tired of Us (Directed by Christopher Dillon Quinn and Tommy Walker, 2007); Joy Luck Club (Directed by Wayne Wang, 1993); Made in Argentina (Directed by Juan Jose Jusid, 1987); Neurorican Dream (Directed by Laurie Collyer, 2000); *Sin País* (Directed by Theo Rigby, 2010); The Visitor (Directed by Tom McCarthy, 2008).

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25

Psychotherapy and the Schizophrenia Spectrum: Theory and Practice

Will D. Spaulding
Mary E. Sullivan

Abstract
Psychotherapy is one component of *psychiatric rehabilitatio*n, a holistic multimodal approach to treating disorders in the schizophrenia spectrum. Other modalities include social, occupational and living skills training, psychoeducation, supported education and employment, and neurocognitive therapy. The purposes of psychotherapy and all other psychiatric rehabilitation modalities are heavily informed by the concept of *recovery*, most basically the idea that severe mental illness is a disability to be overcome, not a disease to be cured. Recovery-oriented outcome goals of psychotherapy include recruiting the person to the treatment and rehabilitation agenda, identifying and committing to recovery goals, improving self-regulation, and improving interpersonal functioning. A range of psychotherapy techniques and modalities have been developed and validated for these outcomes. Any psychotherapist working with people with schizophrenia spectrum disorders must be prepared to collaborate with interdisciplinary teams systematically pursuing interrelated recovery goals according to an integrated treatment and rehabilitation plan.

Keywords: serious mental illness, psychosis, recovery, psychiatric rehabilitation, psychosocial rehabilitation, interdisciplinary teams, CBTp

In a single lifetime, mainstream ideas about schizophrenia and its treatment have undergone pervasive changes and, in some ways, complete reversals. Today psychotherapy for people with schizophrenia occurs in the context of a broader system of treatment, rehabilitation, and support services, extremely variable in availability and quality. There is no simple boundary between "psychotherapy" and other, closely related psychosocial treatment modalities. Nevertheless, "psychotherapist" is often a distinct role performed by a specific practitioner as one member of an interdisciplinary treatment-and-rehabilitation team. Other members of the team may also use psychotherapy principles and techniques in their roles. This chapter focuses on modalities administered primarily in a dyadic or single-family psychotherapy format, by a therapist who is ideally one member of a treatment team. Evidence-based practices in the broader service array for schizophrenia are reviewed elsewhere (e.g., Silverstein et al., 2006; Dickerson et al., 2011), and are evolving so rapidly that such reviews must be frequently updated. It is imperative that practitioners who provide psychotherapy to people with schizophrenia and related disorders be familiar with the broader treatment and rehabilitation outcome literature.

THE HISTORICAL PERSPECTIVE

The origins of modern psychotherapy for schizophrenia are arguably in social reform movements in Europe and North America in the 18th century (Grob, 1983). Patients were released from chains and cages to live and work in urban or rural communal settings, where caretakers endeavored to treat them with compassion and dignity, while being matter of fact about their functional limitations. By the early 20th century these humanistic practices had been largely abandoned. Psychiatry had become divided into a psychoanalytic paradigm associated with Freud and his successors, and a medical paradigm associated with Kraepelin and his successors (although modern apologists argue that Kraepelin's view was "cognitive;" Kahn, 2013). Although Freud believed schizophrenia is beyond the reach of psychoanalysis, many of his successors did not, and psychoanalysis or psychodynamic therapy was in widespread use for schizophrenia until after mid-century. The therapy was generally provided in long-term hospital-like institutions, in an otherwise medical model of psychopathology and treatment.

By the late 1970s there was deep and widespread skepticism about the value of psychotherapy for schizophrenia. The skepticism grew in part from research findings, most notably Carl Rogers's (1967) limited success with nondirective therapy in his explorations at Mendota Institute in Madison, Wisconsin, and controlled (but conceptually flawed) outcome trials by Philip May at UCLA, showing no benefit (May, Tuma, & Dixon, 1981). In addition, the 1970s also saw a general resurgence of biological reductionism in psychiatry, fueled by the discovery of antipsychotic drugs and reflected in the 1980 edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*; Kutchins & Kirk, 1997). Biological reductionism encouraged a view of schizophrenia as simply a neurological disease, beyond the reach of any psychological approach. Psychoanalysis was marginalized within the academic psychiatry community, as were the existentialist/humanist movement, applied most famously to schizophrenia by Laing (1960), and the "anti-psychiatry" movement. The new leadership, characterized as the "neo-Kraepelinians," did not recognize nonmedical interventions as treatment (Klein, 1980). The zeitgeist was such that large segments of the mental health scientific and professional communities ignored dramatic findings from rigorous research, supporting psychological treatments derived from learning theory (Ayllon & Azrin, 1968; Paul & Lentz, 1977).

Biological reductionism was unfortunately also embraced by a generation of aggrieved parents who had been told by their doctors in the 1950s and 1960s that their emotional coldness and other flaws were the cause of their children's schizophrenia. Fairly or not, "schizogenic mother" theories were associated with psychotherapy in general. For more than a decade, the organized parent/family advocacy community promoted the idea that "mental illness is biologically based," on the mistaken premise that this would reduce stigmatization and promote better treatment. If anything, this reinforced the very stigmatizing stereotype of schizophrenia as an incurable medical condition.

Ironically, even as the neo-Kraepelinian era reached its zenith, there were new concerns across the mental health policy community about the failures of *deinstitutionalization*, a national effort to end lifetime incarceration in state hospitals as the modal treatment for schizophrenia (Bachrach, 1978; 1983). These failures stemmed in part from reductionist views of mental illness and naïve (in retrospect) expectations about antipsychotic drug effects. William Anthony's (1979) translation of rehabilitation psychology into the psychiatric context was a timely catalyst for a new treatment paradigm (Bachrach, 1980). The rehabilitation perspective on schizophrenia, as a *disability to be overcome* rather than *a disease to be cured*, accommodated the increasingly indisputable biological dimensions of the condition (after all, rehabilitation had originally addressed physical injuries), but at the same time defined domains of intervention and outcome meaningful to psychological treatment approaches. The new paradigm of *psychiatric rehabilitation* provided a framework for building on the legacy of psychotherapy research. The subsequent decades saw an acceleration of research on psychological techniques for realizing the core goals and principles of the rehabilitation paradigm as applied to schizophrenia (Spaulding, Sullivan, & Poland, 2003; Liberman, 2008).

A complementary development during the same period was the emergence of the *recovery movement* (Davidson & Strauss, 1995), a consumerist movement that rejected the inadequacies and abuses of

the mental health service system. This rejection included pointed critiques of the neo-Kraepelinian preoccupation with diagnostic symptoms, especially the exclusive focus on symptoms as outcome criteria. Anthony (1993) anticipated the convergence of the recovery movement's values with psychiatric rehabilitation and characterized recovery as rehabilitation's ultimate objective. Although there is considerable variance in how recovery from severe mental illness is defined, some definitions clearly lead to a scientific agenda for psychological treatment (Silverstein & Bellack, 2008). Although it is not widely acknowledged in the recovery discourse, the issues now being raised about the nature of recovery and means for achieving it have been repeatedly addressed, albeit in other contexts, throughout the history of psychotherapy research (Spaulding & Nolting, 2006).

Prejudice, discrimination, and stigmatization toward people with mental illness have long been recognized as social problems, and in the recovery movement, recognized as key barriers to recovery (Deegan, 1997). As in other areas of application, two levels of solution evolved. At the sociocultural level, stigmatization became a target for public education and policy reform (Penn & Martin, 1998). After the Americans With Disabilities Act of 1990, severe mental illness was increasingly seen as comparable to physical disability, with respect to people's rights to accommodation and access to public resources. The Mental Health Parity and Addiction Equity Act of 2008 was intended to end discrimination in the health care insurance industry. At the level of the individual patient, preventing internalization of stigmatization and neutralizing its effects on the person became a target for psychotherapy (Yanos, Roe, & Lysaker, 2011) and a concern for psychotherapy supervision (Deegan, 1997; Lysaker, Buck, & Lintner, 2009).

The neo-Kraepelinian era ended in 2013 with publication of the *DSM-5*. Schizophrenia and related conditions are now understood as having indistinct and overlapping boundaries, due to myriad etiological and developmental dimensions, at all levels of human functioning. With the change in *DSM* assumptions, the evolution of psychotherapy is less constrained by the arbitrary boundaries on research and clinical practice that biological reductionism and neo-Kraepelinian diagnostic categories impose.

For the time being, the voluminous research on treatment that uses "schizophrenia" as an inclusion criterion provides a rough approximation of what works and what doesn't for this diverse population. The term *schizophrenia spectrum disorders* (SSDs) is preferred for present purposes, because it does not carry the connotations of a distinct disease category. Many people who "almost but not quite" meet *DSM* criteria for schizophrenia have the same treatment and rehabilitation needs as those who do. For that reason, *people with SSDs* will be used hereafter to name the group that is the subject of this chapter. Research has identified many measurable dimensions of "schizophrenia" that reflect important characteristics and individual differences within that group. As the next part of our discussion explains, the near future for psychotherapy for people with SSD will hinge on a sorting out of what active ingredients of what therapy approaches work for what individuals with what particular problems at what point in time, *within* the schizophrenia spectrum.

THE CONTEMPORARY CONTEXT: THEORETICAL, METHODOLOGICAL, AND PRACTICAL ISSUES

Psychotherapy research and practice for people with SSD are best understood in a context set by several current conceptual, methodological, and practical issues. Some of these issues are familiar in other areas of application and have long histories in psychotherapy research, though they have unique implications for the schizophrenia spectrum.

Defining the Recipient Population

The heterogeneity of the SSD population creates methodological complications for inclusion criteria. Unrepresentatively "high-functioning" samples can be readily created with individuals who otherwise meet all *DSM* diagnostic criteria, with misleading implications for generalization of treatment effects across the population. Conversely, failure to distinguish subgroups having different sensitivity to a specific treatment results in spuriously low effect sizes, and it may lead to discarding treatments having high effectiveness for identifiable subgroups.

Human Development and Longitudinal Course

SSDs are *neurodevelopmental disorders*. Although they are not assigned to the *DSM-5* family of neurodevelopmental diagnoses, which is reserved for those with childhood onset, they are in the adjacent family, "schizophrenia spectrum and other psychotic disorders" (APA, 2013). They share a genetic vulnerability pool with childhood-onset neurodevelopmental disorders, including autism and attention-deficit/hyperactivity disorder, and also with depression, bipolar disorder, obsessive-compulsive disorder, and alcoholism. Onset is usually in late adolescence or early adulthood, but vulnerability-linked impairments can be detected in childhood (even when no disorder of any kind is diagnosed). Many of the features of SSDs are usefully understood as impaired acquisition of adult abilities in adolescence, especially in the domains of executive neuropsychological functioning, social cognition, and psychophysiological and emotional self-regulation. Accordingly, one purpose of psychiatric rehabilitation is to foster acquisition of those abilities. A related purpose is to neutralize the negative psychological consequences of the developmental failures, including low self-efficacy, demoralization, learned helplessness/hopelessness, institutionalization, social marginalization, impoverished or maladaptive cognitive schemata and social roles, and internalized stigmatization.

The onset of an SSD is defined as the onset of psychotic symptoms. However, the role of vulnerability-linked impairments and *prodromal* changes in functioning indicate that any single onset criterion is somewhat arbitrary. Both the distinctiveness of the onset and the age at which it happens are sources of substantial within-group variance. In fact, historically, subtypes of schizophrenia have been proposed based on onset-related parameters (Spaulding, 1986). *Premorbid functioning*, the quality and maturational level of personal and social functioning before onset, is a factor of obvious relevance to psychotherapy and is also a source of within-group variance. Relatively sudden deterioration of cognitive functioning occurs before and after onset (Kahn, 2013), although its severity is another source of within-group variance. In all types of treatment for schizophrenia, including psychotherapy, strategies and tactics based on previous functional baselines must be continuously reevaluated.

Schizophrenia-spectrum disorders are *episodic*, with periods of elevated symptoms and impairments, whose frequency, severity, and quality are sources of within-group variance. Episodes punctuate periods of more stable but still impaired functioning. The term *acute psychosis* is also used to describe episodes, although "acute" loses meaning as psychotic symptoms persist. *Actively psychotic* is a better term when the episode persists so long it is functionally continuous. Treatment goals are different at different points in this course, and so treatment is expected to be different. Treatment must be sensitive to the long-term course as well, just as any psychotherapy must be tuned to a person's life-span development.

Some practitioners who are otherwise supportive of psychotherapy or other psychosocial treatment for people with SSD believe that it is inappropriate during exacerbated episodes. Long-term goals must sometimes be put on hold, and specific techniques adjusted, but there is substantial evidence that psychosocial treatments can contribute importantly to the resolution of episodes (e.g. Mosher, 1999). These are mainly programmatic, milieu-based modalities (e.g., residential or inpatient treatment programs) not provided in a psychotherapy format and therefore not further discussed here. The degree to which dyadic psychotherapy can continue uninterrupted through an episode is subject to individual and circumstantial variability, and decisions must be made on a case-by-case basis.

There is currently intense research interest in *early intervention* (also known as *first-episode) treatment programs*, integrated combinations of related modalities designed for people still within a year or so of their onset, or for high-risk populations before onset (e.g., Ventura et al., 2011). They usually include skill training in management of the illness, therapy for neuropsychological and social cognitive impairments, interpersonal skills training, family therapy, systematic psychopharmacology, and supported work or school attendance. One or more members of the treatment team provide much of the treatment in a dyadic or single-family psychotherapy format. Research has moved beyond controlled outcome trials to issues of dissemination and cost-effectiveness (Hastrup et al., 2013). The purposes of the psychotherapy component include engagement of the client in treatment; this is especially challenging because lack of awareness of functional failure is a hallmark of the prodrome

and early course. Also, other components usually delivered in a group format are provided in a more psychotherapy-like dyadic format. This further blurs the distinction between psychotherapy techniques and other techniques in the psychiatric rehabilitation toolbox. Integrated psychotherapy for the prodrome and early course of the schizophrenia spectrum may be one of the most important developments in mental health of the coming decade.

The Mandate for Evidence-Based Practices in Health Care

The growing demand for *evidence-based practices* (EBPs) in health care (see Machado, Chapter 19, this volume) has been timely for psychiatric rehabilitation. The demand reached its current levels in the 1990s, at a time when new psychological treatments for the schizophrenia spectrum were beginning to proliferate. Treatment development and controlled outcome research has continued at a relatively fast pace since then. The scope of psychiatric rehabilitation's treatment array expanded, to include domains of functioning often addressed in psychotherapy for other disorders, such as emotional and psychophysiological self-regulation, plus others that are fairly unique to SSD, such as the neuropsychological level of social perception and cognition. The result is an evolving toolbox of treatment modalities that address specific problems under the broader SSD rubric, many of which are not unique to SSD.

The Problem of Common Factors and Nonspecific Treatment Effects

The history of common treatment factors and nonspecific effects in psychotherapy research (Orlinsky, Chapter 2, this volume) repeats itself for the schizophrenia spectrum (Spaulding & Nolting, 2006). Meta-analysis of psychological and psychosocial interventions indicate an overarching common factor, incorporating engagement with a caregiver or helper, social support and assistance with the activities of daily living, and adherence to treatment (Mojtabai, Nicholson, & Carpenter, 1998). Sadly, such treatment is considerably more than what is usually available to people with SSD, due to severe resource shortages and public policy that does not sufficiently address the population's needs (Wang, Demler, & Kessler, 2002). Methodologically, this has implications for the appropriate features of control conditions in experimental trials. "Treatment as usual" is a regimen of antipsychotic/mood stabilizer medication plus "case management," meaning assistance accessing entitlements, health care, and social support (such minimal help might be better described as "NO treatment, as usual"). At least since the 1990s new psychological modalities have been held to the standard of demonstrating outcome superior to that of enriched psychosocial treatment and rehabilitation (e.g., Spaulding, Reed, Sullivan, Richardson, & Weiler, 1999). Superiority to "treatment as usual" is at best preliminary support for an EBP for SSD.

Multiple Practitioners, Modalities, Targets, and Outcomes

The psychiatric rehabilitation toolbox contains many specific psychosocial modalities that address various targets, at psychophysiological, cognitive, behavioral, and socioenvironmental levels of functioning. Some modalities use familiar psychotherapy formats such as dyadic interviews or structured group activities, while others are outside the conventional therapy rubric, such as in vivo coaching and support in occupational activities. Each modality has a limited scope of treatment targets and, accordingly, outcome goals. The holistic perspectives of rehabilitation and recovery demand that these goals be pursued in an integrated, coordinated manner. More than in most other applications, the psychotherapist must collaborate with an interdisciplinary team, including the patient, in joint pursuit of recovery goals. In addition to the obvious logistical challenges, this presents a central methodological difficulty for establishing EBPs. We saw in the 1970s that pursuing the treatment goal of psychopharmacology, reduction of psychotic symptoms, did not lead to independent personal and social functioning (Bachrach, 1980; Karon & VandenBos, 1970). Decades later, we see that achieving particular psychotherapy goals, such as reducing cognitive impairments, correcting misattributions, gaining self-acceptance, improving interpersonal skills, has important but limited benefits that must synergize with all other aspects of rehabilitation to promote recovery.

Dissemination

Adoption of new treatment technology is notoriously slow in the quarters of the service system that serve people with schizophrenia spectrum disorders (Dickerson & Lehman, 2011). The reasons for this are multiple (e.g., Liberman, 1979; Reddy, Spaulding, Jansen, Menditto, & Pikett, 2010; Tarasenko, Sullivan, Ritchie, & Spaulding, 2013), and include:

- residual reductionist skepticism about psychosocial approaches,
- a disinclination of psychotherapists to accept patients with schizophrenia,
- regulatory mechanisms that do not hold providers accountable for serving the population or providing appropriate services,
- stigmatization in the professional community of practitioners who do serve the population ("the only therapists who do that are those who can't get any other job"),
- the second-class status of nonmedical practitioners in medically dominated treatment settings,
- conflicts between medical and nonmedical service models, and
- inadequate coverage of severe mental illness in professional training programs.

Health insurance reforms that demand parity of coverage for mental illness may improve this situation, but with such multiple causes, improvement will be slow and gradual at best. In the near future, research on dissemination of proven modalities will be at least as important as invention of new ones (Wykes & Spaulding, 2011).

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION

Psychiatric rehabilitation draws heavily on social learning theory, in keeping with its rehabilitation psychology roots. It subsumes members of a larger family of psychosocial treatment paradigms that share the social learning influence, ranging from advanced versions of token economy programs to cognitive-behavioral therapy, to dialectical and mindfulness therapies, to social skills training, to interpersonal problem solving. A key benefit of this shared influence is the capacity to conceptualize virtually any behavioral ability as a skill to be learned and performed. This is much more appealing than a focus on symptoms to be suppressed or deficits to be managed, especially in the context of recovery. Personalized psychiatric rehabilitation consists of targeting particular skill domains for strengthening, and applying psychosocial treatment accordingly. The skill domains of most specific relevance to psychotherapy in the familiar dyadic format are emotional self-regulation, psychophysiological self-regulation, stress management, personal and interpersonal problem solving, and effective participation in other treatment and rehabilitation activities. Even the neuropsychological impairments of schizophrenia can be treated in a skill-training framework (Kurtz, 2003).

Psychiatric rehabilitation is also pervasively influenced by client-centered therapy principles and techniques. Much of this is due to the same reasons as the client-centered perspective's influence on other social learning approaches: its respect for the dignity of the client, its utility for building rapport and recruiting the client to a therapeutic agenda, and the helpful role of empathic reflection and nonjudgmental responsiveness in building self-regulation skills. These benefits were well recognized in rehabilitation psychology, and in psychiatric rehabilitation they were put to comparable use in *rehabilitation counseling* (Anthony, 1979; to be discussed further in the next section). Client-centered principles are very pertinent to the values of the recovery movement and can be a potent antidote to unhelpful medical model practices, in fostering autonomy, preserving dignity, acknowledging client needs beyond practitioners' primary interests, avoiding condescending and paternalistic practices, avoiding coercion, and validating the client's subjective experience.

Psychodynamic influence is not very evident in modern psychotherapy for the schizophrenia spectrum, and psychodynamic approaches do not appear in listings of EBPs for SSD. On the other hand, some psychodynamic principles may usefully inform the therapist about a client's idiosyncratic communication, often a problem with SSD. This can facilitate rapport and even resolve problems. For example, Silverstein (2007) demonstrates a useful application of Jungian ideas about symbol and self in resolving a patient's seemingly delusional ideas and behavior, and in a way quite consistent with recovery values. As recovery proceeds, as a person's growth and development are less eclipsed by the disorder and its

impairments, psychodynamic approaches might be expected increasingly to contribute benefits comparable to those found in other populations. The seven distinguishing features of psychodynamic therapy identified by Blagys and Hilsenroth (2002) are logically consistent with the goals and values of recovery. Techniques derived from principles of adult attachment may also be useful in therapy with people with SSDs (Gumley et al., 2014). The near future may include more synthesis of psychodynamic and related ideas with psychiatric rehabilitation and recovery (Spaulding & Nolting, 2006).

Case Conceptualization

Case formulation (Persons, 2008) can be adapted for psychiatric rehabilitation. Spaulding et al. (2003) describe a comprehensive, systematic approach to case formulation in the treatment and rehabilitation of people with SSD. In that approach, one significant addition to conventional case formulation is a set of specifically defined *problems*, reflecting scientifically understood conditions that pose barriers to recovery. These problems span the full range of functioning, from neurophysiological to socioenvironmental. The problems are identified based on inferences about causal processes, as understood in the psychopathology of SSD, not just behavioral topography (as in psychiatric diagnosis and functional behavioral analysis). Particular clinical presentations may appear very similar, yet very different with respect to underlying determinants. For example, as Silverstein (2008) demonstrated, "delusional" behavior, usually presumed to be driven by acute neurophysiological dysregulation and reflexively treated with drugs, may in fact be driven by idiosyncratic use of language and symbol, or even by simple interpersonal contingencies (one insightful patient told the first author of this chapter that without delusional behavior, nobody would find him interesting).

Choosing the best treatment approach requires an initial hypothesis about factors driving a cognitive, behavioral, or environmental problem, informed by the practitioner's understanding of psychopathology and whatever information is initially available for functional analysis. Failing to test hypotheses about underlying causes, especially hypotheses about drug responsiveness, is a pervasive barrier to effective treatment and rehabilitation of schizophrenia. Failure to look beyond drugs for solutions artificially inflates the perception of schizophrenia as resistant to treatment (Silverstein et al., 2006). In medical model perspectives, "treatment-resistant schizophrenia" literally means resistant to *drug* treatment. In real-world treatment settings, it often falls to the psychotherapist to alert the treatment team to possible nonphysiological causes and treatment alternatives.

Experience with the Spaulding et al. (2003) case formulation system indicates that psychiatric rehabilitation regimens usually address 6 to 10 semi-independent problems at a time, across all levels of human functioning. Psychotherapy is the best option for some problems, regardless of the role of drugs or other treatment modalities for other problems. A case conceptualization approach for the schizophrenia spectrum must have the capability to manage these complexities.

RESEARCH ON EFFICACY AND EFFECTIVENESS

For the purposes of outcome research, psychotherapy for SSD usefully organizes itself into five categories of techniques, for (1) recruiting the client to the rehabilitation agenda, (2) identifying and committing to recovery goals, (3) improving interpersonal functioning, (4) improving emotional and psychophysiological self-regulation, and (5) resolving family conflicts. In contemporary research, outcomes of these techniques are generally evaluated as unique contributions in a psychiatric rehabilitation regimen that also includes neurophysiological stabilization (drug treatment), improvement of basic self-care and independent living skills, and improvement of social, occupational, and leisure skills.

Recruiting to the Agenda

A first step in recruiting the patient to the rehabilitation agenda is straightforward information, about the illness, the disabilities it causes, and the prospects for recovery. It is usually provided in group-format psychoeducation about SSD and psychiatric rehabilitation, presented in a neutral, matter-of-fact tone that avoids conflict and dispute over whether any individual person has a mental illness. Empirical demonstration of benefits first appeared in the early

1990s, and psychoeducation is now considered an essential element in the psychiatric rehabilitation array (Dickerson & Lehman, 2011). Education of families is also demonstrably beneficial (Halford & Hayes, 1991). Dyadic and single-family psychoeducation formats are also used, especially in early intervention/first-episode programs. Multifamily groups also have demonstrated effectiveness, and they have the added advantage of fostering social support networks (McFarlane, Link, Dushay, Marchal, & Crilly, 1995).

In Anthony's (1979) formulation of psychiatric rehabilitation, there is a (largely) nondirective counseling process, *rehabilitation counseling*, designed to help the client identify undesirable circumstances in a way that leads to constructive solutions. There have been no controlled experiments to affirm the unique contribution of rehabilitation counseling, probably because it is difficult to envision the rehabilitation process without it. The introduction of motivational interviewing (MI; Miller & Rollnick, 2002), arguably a synthesis of nondirective and cognitive-behavioral techniques, gave additional structure to the rehabilitation counseling process. MI is designed for use with people who are not initially enthusiastic or even voluntary therapy participants, that is, people with substance abuse problems who have been coerced into treatment by family or the legal system. In this regard MI is advantageous in application to SSD, because people with SSD are often in comparable circumstances. The original MI application for substance abuse works well with people who also have an SSD (e.g., Kelly, Daley, & Douaihy, 2012), and it also serves the broader purpose of fostering the person's engagement in rehabilitation and commitment to recovery, independent of substance abuse issues (e.g., Bechdolf et al., 2012). Variants of MI in medical settings that focus on drug compliance may have generalized effects on engagement in rehabilitation (e.g., Lasser et al., 2009). Another variant is specialized for recruiting the families of veterans with SSD to a collective rehabilitation agenda (Sherman et al., 2009; family therapy is discussed further, later in this section).

Identifying and Committing to Recovery Goals

Trans-theoretical models (Beutler, Clarkin, & Bongar, 2000; Prochaska & Norcross, 2006) stimulated awareness of the difference between engaging in treatment versus pursuing its purposes and possible outcomes. Progress through such stages in therapy was anticipated in the original psychiatric rehabilitation counseling approach, in which the therapy agenda moved rather directly to identifying incremental functional goals, reminiscent of the stepwise process of regaining motor function after physical injury. Dialectical variants of CBT, most notably acceptance and commitment therapy (ACT; Bach & Hayes, 2002), contributed further structure and technique to this dimension of psychotherapy. There is some limited evidence that ACT reduces distress and rehospitalization in people with SSD (Bach & Hayes, 2002; Gaudiano & Herbert, 2006). However, in those studies the focus of therapy was on reducing the distress caused by psychotic symptoms and related phenomenology—more emphasis on acceptance than commitment. Qualitative analysis of patients' accounts suggests that they do respond to ACT in ways consistent with committing themselves to recovery goals (Bacon, Farhall, & Fossey, 2013), but so far there has been no systematic study of ACT in the context of contemporary psychiatric rehabilitation and recovery.

Additional evidence-based techniques for fostering commitment to recovery goals, and available to the individual therapist, derive from *relapse prevention* (Marlatt & Gordon, 1985), originally developed for use with substance abuse. Preventing a *psychotic relapse* (i.e., an episode of severe symptom exacerbation and functional impairment) has some principles in common with preventing a relapse of substance abuse, and adaptations to SSD have demonstrated effectiveness (e.g., Klingberg et al., 2010). Of particular importance in this approach is formulation of a *relapse prevention plan*, which identifies both long-term strategies for reducing risk for episodes and detailed procedures to be performed upon appearance of the early signs of a relapse. A similar approach, closely associated with the consumerist recovery movement and disseminated mostly through channels outside the professional and scientific community, is that of *wellness and recovery action plans* (WRAPs; Copeland, 2008). WRAP groups, led by nonprofessionals with personal experience with SSDs, produce reductions in symptom severity and increased hopefulness and quality of life, compared to "treatment as usual" (Cook et al., 2012). For some, the nonprofessional nature of WRAP and the social support network it fosters is an important feature. For others, involvement of a professional in the relapse

prevention plan is important. They are not incompatible, but must be integrated and coordinated, as with the rest of the psychiatric rehabilitation array.

Improving Self-Regulation

The early psychoeducation packages evolved into more complete self-regulation skill-training curricula, mostly focused on symptoms and medication, with components on behavioral self-observation, assessing medication effects and side effects, and even pertinent social skills like getting an appointment with the psychiatrist from a recalcitrant receptionist. Evidence for effectiveness in promoting treatment adherence, reducing distress, forestalling relapse, and promoting recovery is robust (Mueser et al. 2002). Research has moved beyond demonstrating effectiveness to specialization for subgroups (e.g., older people) and integration with related rehabilitation modalities (e.g., Mueser et al., 2010).

The psychological construct *emotional dysregulation*, ubiquitous across areas of psychotherapy research today, reflects a 50-year evolution of ideas that first took form as biofeedback, deep muscle relaxation, and stress management (Woolfolk & Lehrer, 1984). These developments were incorporated in psychosocial treatment of SSD from the beginning. Interest was stimulated by the evolving view of SSD in general, and psychotic episodes in particular, as stress sensitive. Demonstrations of effectiveness of psychophysiological skill training (e.g., Spaulding, Storms, Goodrich, & Sullivan, 1986) and other self-regulation techniques (e.g., Lukoff, Wallace, Liberman, & Burke, 1986) led to integrated modalities (e.g., Starkey, Deleone, & Flannery, 1995). Today stress management is a major component of dyadic CBT specialized for problems associated with SSD (*CBT for psychosis*, "CBTp"), along with social skills, interpersonal problem solving, and symptom management components. CBTp shows robust superiority to treatment as usual and smaller but still significant superiority for specific problems, compared to other psychosocial interventions (e.g., Newton-Howes & Wood, 2013). Research has progressed beyond questions of efficacy to effectiveness and dissemination (e.g., Lincoln et al., 2012; Morrison et al., 2004; Pinninti, et al., 2010).

Revelations about the role of neglect, abuse, and trauma in SSD have stimulated incorporation of dialectical and mindfulness-oriented techniques originally developed for emotion dysregulation associated with other disorders (Dickerson & Lehman, 2011). Meta-analysis of 13 outcome studies indicates benefits (Khoury, Lecomte, Gaudiano, & Paquin, 2013), but the role of improved emotional regulation in the treatment effect remains unclear.

CBTp and related dialectical/mindfulness techniques have become a diverse family of modalities, all still arguably under the self-regulation rubric, but differing in emphasis on treatment targets (e.g., psychotic symptoms vs. problem-solving skills; interpersonal vs. intrapersonal focus). In the United States the schematically oriented therapy associated with Aaron Beck and his colleagues, which has evolved in parallel with social learning-based CBT, is currently being developed for people with SSD, and controlled trials have begun to appear, initially comparisons to "treatment as usual" (Grant, Huh, Perivoliotis, Stolar, & Beck, 2012). There are comparable developments in the United Kingdom (Chadwick, Hughes, Russell, Russell, & Dagnan, 2009).

Improving Interpersonal Functioning

The emergence of behavior therapy in the 1960s had a fairly immediate impact on treatment of SSDs. Interestingly, a landmark publication on a social skills training application for SSD, named *personal effectiveness* (Liberman et al., 1975), appeared in the same year as another landmark publication on social skills training for neurosis, *assertiveness training* (Smith, 1975). Today group-format social skills training specialized for SSD is universally accepted as an essential EBP in the psychiatric rehabilitation toolbox (e.g., Kurtz & Mueser, 2008).

Like other behavior therapy applications, social skills training for people with SSD has taken on cognitive dimensions. Early on, the principles of *problem-solving therapy* (Spivak, Platt, & Shure, 1976) were incorporated into a group-format social skills training modality, produced and disseminated by the UCLA Center for Psychiatric Rehabilitation. As appreciation grew for the role of cognitive and neuropsychological factors in SSDs, techniques for reducing their impact on social skills training were incorporated. By the 1990s cognitive and neuropsychological impairments were being directly targeted in treatment, in separate modalities, and in

group-format modalities that combine cognitive and neuropsychological therapy and social skills training. The cognitive and neuropsychological components of these modalities make unique contributions to overall outcome (Kurtz, 2003; Spaulding et al., 1999), but the benefits also synergize with the broader rehabilitation array (Bowie et al., 2012). Integration of social skills training principles and cognitive and neuropsychological techniques continues today, with increasing levels of sophistication (e.g., Penn et al., 2005). All can be adapted to the dyadic therapy format. As research articulates the particular individual characteristics that respond differentially to these various techniques, treatment teams and therapists will have multiplying options for matching patient needs to specific EBPs in the course of personalizing treatment.

Resolving Family Conflicts

By the 1980s it was very clear that family interaction characteristics play a significant role in the course of schizophrenia. The psychological construct of *expressed emotion* (EE; Hooley, 1985), quantitatively assessed through interview and behavioral observation, provided a convenient and meaningful target for behavior change. Families with high EE tend to be more critical of and/or overinvolved with the identified patient. Longitudinal studies showed remarkable correlations between high EE and relapse, even when the identified patient does not live with the rest of the family. Conventional behavior therapy and family therapy techniques were integrated into modalities designed to reduce EE. There was a short-lived backlash from some in the advocacy community who saw this as a return to "blaming the parents," but in the psychiatric rehabilitation paradigm that interpretation is not very compelling. Meta-analysis confirmed the benefit of reduced EE, which is most prominently reduction in risk for relapse and rehospitalization (Lam, 1991). Outcome has proved robust (Pilling et al., 2002) and today behavioral family therapy is a universally acknowledged EBP in the psychiatric rehabilitation toolbox.

The original objective of reducing EE has expanded, to broadly include identification of conflicts between family members caused or exacerbated by the disorder, and resolution through interpersonal problem solving, behavior management, and mediated dispute resolution. In this regard, the evolution of family therapy has converged with the evolution of mediation as an alternative to litigation and other legal processes (Spaulding et al., 2014).

DIVERSITY

People with SSD are diverse on every personal characteristic and dimension pertinent to health care. There are complex gender differences in course and morbidity. Age is a powerful mediator of expression of the disorder and context of treatment. Although schizophrenia is generally thought to have uniform incidence rates across cultures, morbidity may be higher in more industrialized cultures. Differences in family characteristics are generally thought to be important factors in morbidity of SSD across cultures. Psychiatric rehabilitation is proving quite adaptable to different cultures, creating wide demand for cultural sensitivity.

Some problems associated with SSD, such as paranoia (Whaley, 1998) and hallucinations (Bauer et al., 2011), may require interpretation in racial/ethnic contexts. Logically, the treatment team and the individual therapist should consider all these factors in formulating rehabilitation strategies and choosing treatment tactics. Therapy for schizophrenia can be systematically adapted for particular groups (e.g., Weisman et al., 2014), although there is as yet no empirical evidence about the effectiveness of such adaptations. In fact, studies of racial and ethnic differences among Americans' response to standard psychiatric rehabilitation are just beginning to appear (Gallegos, 2014), and the findings are complex. Nevertheless, it behooves the therapist to be familiar with cultural features that may impact treatment. For that matter, dimensions that show differences between cultural groups inevitably contribute to individual differences within groups as well. These individual differences may be as important as cultural differences.

For the time being, the major diversity issue for SSD, at least within the United States, is health care disparities. The very limited data suggest that diversity factors interact with SSD and access to treatment in complex ways that future research will have to sort out. Ironically, disparities may be less of a factor in SSD than other areas of health care, because very few people of any cultural group, including the

mainstream majority, have decent access to services for SSD (Wang et al., 2002). If this situation improves, cultural differences will become more visible.

CLINICAL ILLUSTRATION

The following case illustration is a composite that includes key features and therapy issues in early-course SSD. The patient is a 23-year-old White male, referred for individual psychotherapy by the interdisciplinary treatment team of a residential psychiatric rehabilitation program. He was recently released from the state hospital after about 6 months of inpatient treatment under civil commitment. He meets diagnostic criteria for schizophrenia and appears to have been actively psychotic since onset around age 19. Before release he had been determined eligible for a Social Security disability pension and Medicaid. Upon referral he was under outpatient commitment to the residential program.

The comprehensive treatment plan formulated by the treatment team identified three problems of immediate and pressing concern: (1) while acute psychosis had dissipated over the inpatient stay, he still had a high level of positive and negative symptoms, frequent confusion and misperception of social situations, and emotional instability; (2) although he had said what was required to be released from the state hospital, he remained ambivalent about taking medications and dismissive of psychosocial treatment; and (3) his diurnal cycle and ability to perform routine daily activities remained seriously disrupted. Longer term concerns included (1) no history of occupational functioning since graduating from high school and no interest in having any; (2) severe conflict with parents and siblings over what support the family will provide if he continues to refuse to engage in rehabilitation.

The comprehensive plan included (1) pharmacological treatment to continue resolution of the acute psychosis; (2) contingency management and environmental structure in the residential setting to re-establish normal diurnal functioning and performance of routine self-care and home care; (3) group-format social skills, interpersonal problem solving, and cognitive remediation, initially to facilitate further remission of the acute psychosis, later to address developmental deficits in those domains; (4) group-format psychoeducation and training in illness/wellness management skills; (5) individual psychotherapy to recruit him to the rehabilitation and recovery agenda and help him identify recovery goals of value to him; (6) family psychoeducation and behavioral family therapy to resolve the family conflicts.

Over the next 6 months his overall functioning improved, to the degree that he was reliably performing daily routines, although staff assistance and programmed behavioral contingencies were clearly crucial in achieving and maintaining that. His psychotic symptoms and cognitive impairments showed modest decreases in severity. His attendance and engagement in psychoeducation and treatment also improved. He demonstrated acquisition of knowledge about SSD and its treatment, although he continued to insist it did not apply to him. In individual therapy he gradually abandoned a compulsive recitation that his hospitalization had been caused by listening to heavy metal radio. He agreed to exposure-based desensitization to stop some ritualistic avoidant behavior associated with radios, and it was successful. He identified release from the outpatient commitment as his main recovery goal. Very gradually he identified operational criteria for making that happen. Without agreeing with the mental health board about his diagnosis, he came to understand their concerns and what he could do to palliate them.

As his recovery proceeded, he became more aware of the severity of his deficits, and individual therapy was increasingly focused on identifying solutions to specific problems rather than becoming demoralized by their enormity. In family therapy, the parents and siblings acquired a more realistic and circumspect understanding of his disorder and adjusted their short-term expectations. By the twelfth month the focus of individual therapy had shifted to self-regulation issues. It became possible to talk rationally about what could be done to prevent relapse (still without fully acknowledging that he has a mental illness). He began to see that release from the outpatient commitment was within his reach, but that meant he also had to take responsibility and plan out his transition from the residential program. His ambivalence about autonomy became an issue for therapy. Concretely, he had to sort out the pros and cons of increasing his work hours versus losing his disability pension. He saw his relationship with his family as significantly improved, but his realization that his parents could become his legal guardian and

he could lose even more autonomy weighed against his dependent inclinations.

By the eighteenth month, mainly with the help of his individual therapist, he had worked out an agreement to end his outpatient commitment and move to independent living with continuing case management. He agreed to continue individual therapy, in part because he felt less isolated and stigmatized by his experience and more interested in developing a new set of friends, and wanted help with this. During this period the focus of therapy was largely interpersonal, especially about understanding and appreciating other people's perspective, avoiding stereotypic thinking about people and situations, how to make good judgments about who to seek and accept as a friend, and limits and boundaries of friendship. His increased social contacts were crucial in providing material to process in therapy.

Two years after release from the state hospital, he was living on his own with minimal assistance, mostly in personal financial management, from his case manager. He discontinued individual therapy, with his therapist in agreement, because he felt he had met his recovery goal, was happy with his new situation, and was confidently managing his risk of relapse.

CONCLUSIONS

Psychotherapy in dyadic and single-family format is a key component in the comprehensive treatment and rehabilitation for people with SSD. There is substantial overlap, in technique and treatment goals, between psychotherapy and related modalities usually provided in other formats, including psychoeducation, group skill training, in vivo coaching, and in the ambient milieu. Depending on individual circumstances and needs, dyadic or single-family format is often the preferred choice, and for some purposes always the preferred choice. The overarching task of the individual and family therapist is to collaborate as one member of an interdisciplinary treatment team, which also includes the identified patient, to integrate and coordinate the purposes and goals of therapy with the rest of the treatment and rehabilitation plan, toward a holistic goal of recovery. Ultimately, this means that the purpose of psychotherapy, and of psychiatric rehabilitation in general, is to help people manage the symptoms and impairments of their disorder; overcome the consequent disabilities; achieve a sense of selfhood and self-efficacy; to have friends, relationships, and social support networks; and to participate in community life.

REVIEW QUESTIONS

1. How did biological reductionism discourage development and application of psychotherapy during the neo-Kraepelinian era?
2. How did the *DSM-5* change the context of research on psychotherapy of schizophrenia?
3. How did the translation of rehabilitation psychology into a psychiatric context change the evolution of treatment and rehabilitation of schizophrenia spectrum disorders?
4. What are the essential components of a modern psychiatric rehabilitation service system?
5. In what areas within psychiatric rehabilitation is individual and single-family psychotherapy most expected to make key contributions to overall recovery?

RESOURCES

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Websites

Bazelon Center for Mental Health Law (advocating for the legal rights of people with mental disabilities): http://www.bazelon.org

Center for Neurocognition and Emotion in Schizophrenia, UCLA: http://www.semel.ucla.edu/schizophrenia

Center for Psychiatric Rehabilitation, Boston University: http://cpr.bu.edu/

Center for Psychiatric Rehabilitation, University of Chicago: http://www.uchicago.edu/research/center/center_for_psychiatric_rehabilitation

Consumer Information Clearinghouse: http://www.schizophrenic.com

Maryland Psychiatric Research Center, University of Maryland: http://www.mprc.umaryland.edu/default.asp

NIH materials on schizophrenia: http://www.nimh.nih.gov/health/publications/schizophrenia/index.shtml

The NIMH Research Domain Criteria (RDOC) Project: http://www.nimh.nih.gov/research-priorities/rdoc/index.shtml

The National Alliance on Mental Illness (nation's largest schizophrenia advocacy organization): http://www.nami.org

Psychiatric Research Center, Dartmouth University: http://prc.dartmouth.edu/

Wellness Recovery Action Plan (WRAP) www.mentalhealthrecovery.com/wrap/

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26

Psychotherapy With Military Personnel and Veterans: Theory and Practice

Uri Kugel
David Giannini
Victoria Kendrick
Morgan Banks
Larry James
Bruce Bongar

Abstract
Whereas the majority of military personnel will not develop mental health problems, psychotherapy with military personnel and veterans can often be a complex process affected by numerous situational constraints, in addition to comorbidity, physical injuries, and severe mental trauma. This chapter discusses the historical development of psychotherapy with military personnel and veterans from ancient times to modern-day. It examines the unique stressors that the military environment presents, the common mental disorders associated with military engagement, the psychological aspects of killing, the application of various theoretical orientations and psychotherapies to working with military personnel and veterans, the unique barriers to treatment, and the diversity issues present in the military.

Keywords: military personnel, veterans, barriers, trauma, treatment

Some of the greatest breakthroughs and innovations in the field of psychology can be traced back to developments that originated in the field of military psychology. The needs and challenges that armies, military personnel, and veterans around the globe faced required creative interventions and new theories that later on rippled to the civilian realms of psychology. To understand the development of psychotherapy with military personnel and veterans, it is important to appreciate the historical context of military and veteran psychology.

Enduring a military lifestyle, which compounds many hardships, is not a simple task. In addition to the danger of losing one's life, limbs, or getting injured, service members also endure long periods of separation from family and loved ones, the threat of losing comrades in arms, witnessing horrors, and frequently delivering suffering and death to other humans beings. Such hardships have always been a part of the lives of soldiers around the world. Even when active duty and deployment end, those who served return to civilian life often changed by their experiences, for the rest of their lives. As veterans, they must learn to cope with the changes they and the world went through and find a way to reintegrate to life in the civilian world.

Testimonies regarding the negative effects of combat on soldiers exist as early as 3000 BC. It is evident that Egyptian, Persian, Greek, and Roman soldiers suffered from syndromes such as combat shock, exercised self-mutilation in order to escape battle, and experienced anxiety and depression. As Gabrial (1988) sums it: "Fear and madness have been man's companions in war since the beginning of recorded history and, most probably, before that" (p. 46). In fact, it could be argued that inducing fear and madness among the enemy is one significant tactical goal of combat.

In modern times, military psychology began to develop as a formal field of practice in World War I and was initially used primarily for screening and selecting military personnel. However, the use of psychology in military settings dates back to ancient times and was commonly used for psychological warfare. For instance, during the American Revolutionary War, leaflets intended to cause demoralization were used to discourage troops and encourage defection among the enemy (Kennedy, Hacker-Hughes, & McNeil, 2012).

The American Civil War was one of the first occasions when military physicians documented several conditions such as nostalgia, phantom pains in amputees, acute and chronic mania, suicidal behavior, alcoholism, and substance abuse and dependence to drugs such as chloral hydrate, cocaine, morphine, and opium. It is unfortunate that most negative reactions to combat among troops were often treated as cowardice or as a defect of character. Thus, no proper systematic treatment was designed to attend to these individuals. However, during this time, there was extensive recognition that chronic substance abuse problems were often related to combat experiences and pain resulting from injury. This was also one of the first times that substance withdrawal was addressed. After the war, there were neither many institutions nor systematic plans to address the needs of veterans who returned physically and mentally scarred from that war. Most were treated at home or held at local jails and insane asylums to keep them and others safe. One exception to this was the United States Government Hospital for the Insane (St. Elizabeth's Hospital) in Washington, D.C., which was created for military patients in the mid-1800s and is still currently active.

World War I constituted a great leap forward in the field of psychology. Intelligence tests and screening instruments were developed to keep out inappropriate candidates and to identify promising individuals for professions such as pilots and intelligence officers. Additional mental health conditions were identified. These included shell shock, gas hysteria, and disordered action of the heart (DAH), also known as the Da Costa's syndrome, which is a psychosomatic manifestation of symptoms such as exhaustion, dizziness, sleep difficulties, joint pain, breathlessness, and heart palpitations.

During World War I, British psychologists began to provide clinical care in combat zones, often working in field hospitals and casualty clearing stations. They developed early-intervention techniques addressing shell-shock cases which used principles of cognitive restructuring. These interventions preceded the development of formal cognitive theory by several decades. World War I also saw the establishment of forward psychiatry and the implementation of the Proximity, Immediacy, and Expectation of recovery model (PIE), which succeeded in returning 40%–80% of shell-shock cases back to combat duty. These early interventions and the PIE model still stand at the core of contemporary combat stress interventions in many militaries around the world. In addition, World War I saw the beginning stages of developing a systematic approach which addressed the mental health needs of soldiers and veterans. During and following World War I, a large number of hospitals and facilities dedicated to the treatment of mental health–related injuries were built in the United Kingdom and France.

World War II instigated another great leap in the field of military psychology. Additional psychometric tools that were aimed at selection of Special Forces, submarine personnel, and pilots were developed. The first book on military psychology including psychotherapy sections was published by Boring (1945). New mental health conditions were labeled, including combat fatigue, combat exhaustion, and combat stress. During World War II, the US military did not employ forward psychiatry and instead preferred using psychological screenings to identify personnel who would be more susceptible to negative psychological reactions to combat. In addition, head injury rehabilitation was developed, which constituted the beginning of the field of neuropsychology.

As a result of the large number of troops suffering from adverse psychological reactions to the war both in active duty and after their discharge, it was

finally established that combat stress reaction was not an unusual response to combat which indicated a defect of character, but rather a very common consequence of participating in a war theater. By the end of World War II, the field of clinical psychology in the United States affirmed its position as a mental health force due to the progress made in the military and the decentralization of the US Department of Veteran Affairs (VA), which had grown now to service 15 million World War II and 4 million World War I veterans.

New challenges during the war in Korea (1950–1953) prompted the development of the Survival Evasion Resistance and Escape (SERE) training, which partially taught service members how to cope with the physical and mental challenges of captivity and torture. The US Air Force had the first permanent SERE program, followed by the Navy, with the Army not setting up its permanent program until 1986. In the beginning of the Korean War, partly due to the intensity of the battles, the PIE model was rarely implemented. As a result, a large number of troops (25%) were taken off combat duty due to combat fatigue. After the deployment of mental health providers closer to the frontlines, 80%–90% of combat fatigue cases fully returned to combat duty. The Korean War also saw the initiation of a 9-month rotation as a preventive measure for troops' exhaustion.

The Vietnam War (1956–1975) saw a significant increase in the service of military psychologists in forward operations bases and combat zones. This was translated into the lowest psychiatric casualty rates in comparison with all previous American wars. In the Vietnam War, the rate of troops which were relieved from combat duty due to combat fatigue was 10–12 per 1,000 per year in comparison with 37 per 1,000 during the Korea War and 28–101 per 1,000 during World War II (Kennedy et al., 2012). However, during the Vietnam War, there was a tremendous increase in heavy substance abuse among troops in all branches of the military. This became a focus of research and intervention during the war and in its aftermath.

The field of military and veteran psychology continued to develop in recent conflicts. Operations Desert Shield and Desert Storm saw a new category of diagnoses, such as Gulf War syndrome. Military psychologists were, for the first time, stationed onboard aircraft carriers. In Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), military and veteran psychology focused more on head injury as a result of the frequent use of improvised explosive devices by insurgents, Al-Qaeda, and the Taliban. Additional interventions such as exposure therapy, cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR) were integrated into military and veteran settings.

During OIF and OEF, over 30% of troops suffered posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), or chronic pain (Cifu et al., 2013; Litz & Schlenger, 2009). These rates were especially high among personnel who served multiple tours of duty. Multiple deployment has been found to be associated with greater risk for developing PTSD (Interian, Kline, Janal, Glynn, & Losonczy, 2014) and suffering other physical or mental injuries. In operation OIF and OEF, approximately 35% of the personnel (Litz & Schlenger, 2009) were deployed at least twice. This pattern of service is very different from the one seen during the Vietnam War in which the vast majority of American soldiers served a year-long single deployment. Furthermore, during these conflicts, there was a large increase in completed suicides among US military active-duty personnel and veterans. In fact, military suicides reached a three-decade high in 2008 (Gomulka, 2010). Among veterans, the problem became so prominent that during 2010, 18 veterans died each day from completed suicides (Brenner & Barnes, 2012). Thus, over the last few years, a special focus was put on prevention and early detection of suicidal ideation among active-duty personnel and veterans.

Effects of Military Service on Mental Health

The effects of serving in a military setting are varied and deviate quite significantly from most work settings in the civilian world. The first consideration is the effect of combat on military personnel. Combat-related stress could arise from experiences such as being involved in a firefight, an ongoing high risk of death or injury, the risk of losing a unit member and friends, witnessing the injury or death of enemy troops or civilians, and handling the aftermath of a combat scene (e.g., removing human remains and destroyed vehicles). Although most soldiers are able to cope adequately with actual combat, about 10%–30% develop a psychological dysfunction known

as combat stress reaction (CSR) (Neria, Solomon, Ginzburg, & Dekel, 2000). CSR usually includes symptoms such as restlessness, psychomotor deficiencies, withdrawal, increased sympathetic nervous system activity, stuttering, confusion, nausea, vomiting, and paranoid responses. Ultimately, soldiers with CSR are at high risk to cease to function militarily and act in a manner that endangers themselves and their fellow unit members.

Combat stress has been found to be related to a variety of mental health conditions such as depression, anxiety, PTSD, substance use disorders (SUDs), and psychosis. In addition, combat stress was also found to be related to a decline in physical health and an increase in use of health care resources (Kelly & Vogt, 2009). It is important to remember that the majority of military personnel who are exposed to active combat do not develop CSR, PTSD, or further psychological trauma (Neria et al., 2000). Those who do develop a stress reaction often make a recovery within a short period of time.

Some factors that are correlated with higher rates of PTSD among military personnel who were exposed to trauma include younger age, ethnic minority status, being a female, less education, lower socioeconomic status (SES), and lower intelligence. Rates of PTSD and other mental disorders change from conflict to conflict due to a variety of reasons, including assessment and diagnosis standards, nature of the conflict, and other factors that are not completely understood.

One initial focus of psychotherapeutic interventions in the military was on returning personnel to active combat duty. Currently, this focus has evolved to also consider short- and long-term consequences that military service compounds. The military is a high-stress work and living environment. As such, stress is often perceived to be a normal and expected part of any military lifestyle characterized by a unique combination of stressors such as long and strenuous working hours, loss of personal freedom, demanding training and discipline, family separation while being deployed, sexual harassment and assault, guilt, and familial hardships. These non-combat-related stressors are linked to higher rates of mental health disorders among military personnel in comparison with civilians (Kelly & Vogt, 2009). These disorders include depression, anxiety spectrum disorders, substance abuse, attention-deficit disorder, and intermittent explosive disorder. However, recent research has raised the possibility that high rates of mental health disorders among military personnel in comparison to civilians could be explained by the fact that military lifestyle is attracting individuals who might have diagnoses or underlying conditions that preceded their active service (Kessler et al., 2014).

Trauma Diagnosis

The US military commonly uses the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (American Psychiatric Association [APA], 2013) to provide mental health diagnoses among active-duty personnel and veterans such as major depressive disorder, generalized anxiety disorder, and trauma-related disorders such as acute stress disorder (ASD) and PTSD. Grossly speaking, the major differences between the two diagnoses are that ASD can only be diagnosed if the symptoms persist for at least 2 days and only up to 1 month following the trauma, whereas PTSD can only be diagnosed if symptoms persist for at least 1 month. The *DSM-5*, compared to the *DSM-IV-TR* (APA, 2000), moved both disorders out of the anxiety section and inserted them into a trauma section of its own. The *DSM-5* criteria are more detailed and occasionally more stringent compared to version IV.

While some militaries in the world use the *DSM*, other militaries employ the World Health Organization's (WHO) International Classification of Diseases (ICD). The ICD-10 uses similar diagnoses: acute stress reaction (ASR) and PTSD. Despite the similarities between the diagnoses across these two systems, there are some differences in criteria (especially regarding PTSD criteria). Briefly, the *DSM-IV-TR* has more stringent criteria when diagnosing PTSD in comparison with the ICD-10. In contrast with the ICD-10, the *DSM-IV-TR* criterion A requires fulfillment of two conditions: exposure to a traumatic event and a fear response. In addition, it requires at least 1 month duration, more avoidance criteria, and impairment in functioning. Several studies found a low concordance (as low as 35%) between the two diagnoses systems (Andrews, Slade, & Peters, 1999; Rosner & Powell, 2009). This low concordance raises some questions regarding the reported rates of military-related PTSD around the world.

Psychological Aspects of Killing

Soldiers on all sides are trained and serve for the purpose of defending their country and to kill or capture the enemy and occupying areas using deadly violence and fear-inducing threat of deadly violence. Such acts of aggression are conducted at times of conflict consistently, systematically, often on a large-scale basis, and constitute a state of normality. Nevertheless, the act of killing another human being can be profoundly problematic and may encompass short- and long-term mental and emotional consequences that might become very difficult even to the highly selected and trained soldiers such as special-forces members and pilots. Such difficulties often contribute to CSR, troop exhaustion, behavioral problems, substance abuse, and other problems mentioned earlier in this chapter (Miller, 2010). Addressing the issue of killing is an important treatment facet and must be considered in order to resolve further complications such as guilt and depression. This also promotes the processing of the war experience and normalizes the individual's reactions to the act of killing.

Family and Relationship Issues

In addition to the high-stress job environment of military personnel, the physical distance from family members, friends, and the social support system at home adds another layer of stress, discomfort, and emotional pain to the service member. Furthermore, many active-duty personnel create psychological distance between themselves and their loved ones at home in order to shield them from the hardships and threats they experience on a daily basis. This can create a sense of separation and blocked communication between partners, friends, and family. Protective behavior on the soldier's part can often be made more complicated by advanced technological devices such as satellite phones, video telephones, and chat services, which enable real-time communication with home. This creates an environment in which a soldier needs to respond both to deployment stress and to the challenges of maintaining relationships with their loved ones. Further complications can include intimate partner violence, child abuse, and special needs of children in military families. In addition, multiple deployments often make it more difficult for the service member who needs to readjust to his or her home role and then again to a military lifestyle. This has been found to contribute to an increased risk for homefront stressors and for PTSD (Interian et al., 2014).

Lastly, when returning home, service members often must make a difficult transition from a high-risk lifestyle where people get killed and injured to a civilian lifestyle, which commonly includes family and personal concerns. In addition to this difficult transition, the service member may have to reconnect emotionally to family members and friends with whom he or she may have been distanced emotionally in addition to physically for a significant period of times. Many service members report concerns regarding being misunderstood by their loved ones and civilian society when returning home.

Traumatic Brain Injury, Other Injuries, and Comorbidities

Another unique feature to the work with military personnel and veterans is the issue of traumatic brain injury (TBI) and other physical injuries. Soldiers are often prone to head injuries from blasts, shrapnel, and motor vehicle accidents. TBI can cause symptoms that overlap with the physical, cognitive, and emotional presentation of PTSD, depression, and other mental disorders. TBI often complicates the clinical picture of diagnosis, case conceptualization, setting realistic expectations, and designing a sound treatment plan. Thus, it is important to rule out TBI and evaluate the medical history of service members who present for psychotherapy. Current and future research of TBI includes MRIs, which might enable clinicians to distinguish between TBI, depression, and PTSD. In addition, clinicians must take into account the personal and cultural implications that other forms of injury have on their clients such as amputated limbs, facial disfiguration, scars, and a decrease in physical level of functionality.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS

In the United States, current Department of Defense (DoD) and VA clinical practice guidelines require providers to use evidence-based treatments and recommend several trauma-focused psychotherapies

for PTSD and other trauma-related disorders. These therapies must include components of exposure, cognitive restructuring, and often incorporate various self-soothing techniques. Both the DoD and the VA use several manualized treatment protocols such as CPT, exposure therapy, and EMDR (Wilk et al., 2013).

In this section, we outline several of the more prominent psychotherapy treatment models, which are used both with active-duty military personnel and veterans. However, given the complexity of personalities, cultural considerations, disorders, and the various stressors of military service, not a single treatment model is sufficient to address all of these factors. Therefore, it is essential to focus initially on case conceptualization, define treatment goals, establish a treatment plan, and find a good match between the therapist, the therapist's respective treatment specialty, and the client's needs and preferences (Meichenbaum, 2009).

Cognitive-Behavioral Therapy

It is important to mention several cognitive-behavioral therapy (CBT) principles as these lie at the core of many treatment modalities.

Assessment

Assessment of the client and establishing baseline and end-of-treatment symptomatic presentation is an important part of treatment. It is also crucial to monitor the client's symptoms throughout the treatment using standardized measures that can redirect the course of therapy if needed and provide valuable feedback to both the client and the therapist. Examples of validated measures include the PTSD Checklist Military version (PCL-M) for PTSD symptoms, Patient Health Questionnaire (PHQ-9) for depression, and General Anxiety Disorder (GAD-7) for anxiety symptoms (www.phqscreeners.com).

Case Conceptualization

CBT relies heavily on case conceptualization. The core of case conceptualization is developing an understanding of the client's cognitive schema. This allows a better focus in the treatment and the targeting of cognitive distortions and self-schemas that negatively impact the client's personal and professional life areas. Case conceptualization is preferably developed through collaborative work with the client. Such collaboration induces insight and meta-learning of how the client developed his or her specific problem set, and it provides valuable psychoeducation about the therapeutic process itself. Clients learn coping skills that they can use as relapse prevention measures and as tools in challenging situations. The identification of cognitive schemas is often conducted using thought logs in which the client provides detailed information about specific events, negative automatic thoughts that arose during those times, associated emotions, and the client's behaviors and reactions to these events.

An effective case conceptualization should take into account treatment goals and expectations, time availability, the client's and therapist's strengths, level of insight, the client's openness to treatment, past successes or failures with psychotherapy, the severity and chronicity of the pathology, and cultural considerations. Freeman and Moore (2009) describe a dynamic CBT model that can be modified in a structured manner by emphasizing and de-emphasizing several dimensions to match clients' needs, strengths, and treatment goals. These dimensions include active versus passive treatment, motivational, directive, collaborative, problem-oriented, solution-focused, here-and-now, psychoeducational, time-limited, culturally adapted, empirically supported, integrative, and single-session treatment (beginning, middle, and end). The case conceptualization should allow flexibility in the treatment as new information is revealed and take into account the reactions of the client to the treatment process.

Treatment Process

CBT treatments usually include the following steps: (1) establishing rapport and developing collaborative relationship; (2) case conceptualization; (3) inducing motivation for treatment; (4) collaborative formulation of the problem; (5) setting treatment goals; (6) introducing the cognitive model; (7) employing CBT interventions focusing on changing cognitive schemas; and (8) finalizing treatment and relapse prevention. Due to the focus on PTSD and other traumatic issues, while working with military personnel and veterans, CBT techniques will often focus on normalizing

the war experience for the service member, on the use of imaginary and in vivo exposure, and on self-soothing techniques training.

Efficacy

CBT has been shown to be efficacious for treatment of military personnel and veterans, particularly those diagnosed with PTSD, depression, and anxiety. This efficacy includes both trauma-focused and skills-focused CBT (Monson, Rodriguez, & Warner, 2005). CBT has also been used for treatments of other problems such as insomnia and aggressive driving (Khoo, Dent, & Oei, 2011; Margolies, Rybarczyk, Vrana, Leszczyszyn, & Lynch, 2013; Strom et al., 2013). A study by Margolies et al. (2013) examined the use of CBT with veterans for insomnia and nightmares, which are core components of PTSD. Using this treatment, effect sizes for reduced insomnia severity and increase in sleep quality were large. The majority of the participants also showed a significant improvement in their sleep outcomes. Khoo et al. (2011) researched the 1-year outcomes of combat veterans with PTSD after CBT treatment. The majority of participants showed a decrease in PTSD symptomatology 1 year post treatment. Strom and collaborators (Strom et al., 2013) examined risky driving practices among participants recruited from VA hospitals in the Midwest. Using a CBT-based group approach, the participants showed a strong decrease in driving-related anger, risky driving behaviors, and overall aggression in combat veterans.

There is a surprising scarcity of information regarding the use of CBT with active-duty military personnel. In one of the few published studies, Lanche, Perkins, and Stoltzfoos (2008) examined the differences between supportive listening and a CBT-based skills therapy in an active military sample. Both of these therapies were Internet-based interventions. The experimenters found that PTSD symptomatology showed larger decreases with the CBT component of the treatment (Lanche et al., 2008).

Seeking Safety

Seeking Safety is a CBT-based variation for the treatment of comorbid PTSD and SUD. Each week, the session is focused on a theme related to PTSD and SUDs, as well as a CBT-based skill to learn. For each individual, the treatment is divided into five separate sections. These include an individual interview prior to treatment, an individual HIV risk counseling session, two sessions of introduction, seven sessions of behavioral skills, six sessions of cognitive skills, and three sessions including review and termination. Seeking Safety has been found to be a significantly effective addition for treatment as usual (TAU) for reducing both PTSD symptoms and alcohol abuse. Additionally, subjects in Seeking Safety groups were found to have noticeably better attendance, coping skills, and treatment satisfaction as compared to TAU (Boden et al., 2011).

Cognitive Processing Therapy

Cognitive processing therapy (CPT) is a manualized treatment adaptation of CBT tailored to focus on recovery from PTSD and other trauma-related mental disorders. CPT generally involves 12 treatment sessions, which can be delivered either in group or individual formats. This treatment approach stipulates that traumatic events create strong negative emotions which prevent accurate processing of traumatic memories and natural emotions emanating from the event. This, in turn, provides a fertile ground for developing negative cognitive schemas about the self-structure and the world. In addition, an ongoing use of avoidance as a coping strategy prevents clients from a healthy processing of the traumatic memories and associated emotions. CPT often involves writing and reading exposure components in addition to several other elements such as the following: (1) providing psychoeducation about trauma-related disorders, symptoms, and treatment theory; (2) increasing awareness to thoughts, feeling, and patterns of reactions and avoidance to triggering stimuli; (3) introducing and learning coping skills that help clients to deal with their specific symptoms and problems in life; (4) and inducing changes in maladaptive cognitive schemas using cognitive restructuring. CPT has been shown to be effective in treating PTSD with veterans and active-duty military personnel (Chard, Schumm, Owens, & Cottingham, 2010; Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012).

Exposure Therapy and Prolonged Exposure

Exposure treatments have been designed to reduce symptoms of PTSD and other related disorders, such as depression. Exposure assists in helping clients confront traumatic memories, feelings, and stimuli and thereby reducing maladaptive avoidance behaviors. Exposure includes both imaginal exposure, which consists of revisiting the memory of the traumatic event, and in vivo exposure, which consists of actual exposure to triggering stimuli such as photographs, loud noises, videos, virtual reality, and confrontation with similar situations, which are technically safe. The principle of change in this approach is the desensitization of the client to the triggering stimuli and the breaking of the avoidance-negative reinforcement cycle. Studies have found that treatments which include both types of exposure therapies tend to be more effective. Specifically, optimal treatment outcomes will be reached by combining cognitive therapies with exposure therapy (Bryant et al., 2008). Prolonged exposure (PE) therapy is simply one form of exposure therapy, which focuses on continuous flooding of the client with feared stimuli by using both imaginal and in-vivo exposure. In addition, PE employs other elements such as psychoeducation, self-soothing exercises, and real-world practice. It has been found to be efficient with a variety of trauma-related disorders and PTSD (Foa, Gillihan, & Bryant, 2013).

Numerous controlled studies have shown exposure therapy to be an effective part of a treatment modality or as a standalone approach with a variety of military populations. This includes reduction in PTSD, depression, and anxiety symptomatology (Rademaker, Vermetten, & Kleber, 2009; Strachan, Gros, Ruggiero, Lejuez, & Acierno, 2011).

Exposure may also be a preferred treatment with active military service members. For instance, one study found that deployed soldiers hypothetically preferred exposure therapy to the prospect of medications (Reger et al., 2013). There is some indication that virtual-reality graded exposure had better treatment effects in comparison with the other contemporary treatment modalities, including "normal" exposure therapy, EMDR, CPT, and medication (McLay et al., 2011). Lastly, in a meta-analysis of both CPT and PE, both therapies appear to be significantly effective with active-duty military personnel and veterans without a significant difference between the treatment approaches (Zinzow et al., 2012).

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is a focused, manualized treatment modality that combines CBT, person-centered therapy, mindfulness, and the use of bilateral rapid eye movements. The theory behind EMDR, named adaptive information processing (AIP), proposes that traumatic events in PTSD are improperly stored as incomplete memories. When traumatic experiences are not fully processed, they become the basis of dysfunctional reactions, such as PTSD symptomatology. This is particularly true of the more intrusive symptoms of PTSD, such as nightmares and reexperiencing the event in flashbacks (Shapiro & Maxfield, 2002). EMDR enables the client to process traumatic memories and by doing so reducing their emotional and symptomatic effect, and instigating development of adaptive coping skills. This is achieved in a formalized eight-phase protocol in which the client recalls traumatic memories paired with negative cognitive or emotional association. Then, by engaging in bilateral rapid eye movements, the client severs the connection between the memory and the negative cognitive and emotional association. The eight treatment phases include the following: (1) history gathering, (2) client preparation, (3) assessment, (4) desensitization, (5) installation of positive cognitions, (6) body scan, (7) closure, and (8) reevaluation.

EMDR is particularly well suited for use with veterans and service members because of its effectiveness. An analysis of the treatment of 63 veterans by recently trained EMDR clinicians showed that war-wounded veterans needed an average of 8.5 sessions to eliminate combat-related memory disturbances (Russell, Silver, Rogers, & Darnell, 2007). In a meta-analysis by Bisson and Andrew (2007), EMDR was found to be as effective as or better than TAU, trauma-focused cognitive-behavioral therapy (TFCBT), and stress management (SM).

Psychodynamic Therapy

Psychodynamic therapies include many treatment approaches. Most of these theorize that pathology

takes place due to developmental issues and the use of maladaptive psychological defenses. The primary principle of change in psychodynamic therapies is often the therapeutic relationship itself (Sharpless & Barber, 2011). These therapies have not been extensively studied in controlled outcome studies with active-duty military personnel or veterans, but there is no current data to show that these are less effective in comparison with CBT approaches in the treatment of PTSD (Sharpless & Barber, 2011).

A randomized clinical trial showed some benefit by brief psychodynamic therapy when compared to wait list controls with individuals suffering from disorders stemming from traumatic events. In fact, clinically significant differences were shown in over 60% of subjects (Brom, Kleber, & Defares, 1989). An important aspect of psychodynamic treatment is that it is less concerned with the diagnosis but rather emphasizes the individual as a whole human being. This may be a more fruitful and effective way to treat veterans who often suffer from a multitude of problems in their lives following their service. There is very little research regarding the efficacy and efficiency of psychodynamic therapies with active service members. However, it is important to remember it is possible that CBT and other behavioral techniques are preferred because they are studied most often, and not necessarily because they are inherently better treatments (Kudler, 2011).

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION

During deployment and combat, the principle purpose of psychotherapy in the military is aimed at returning soldiers to full combat duty and to provide relief and prevention for the development of CSR, acute stress disorder, and PTSD. In addition, many current military programs are designed to identify potential suicidal soldiers, prevent suicides, and handle the aftermath of a completed suicide and/or loss of unit members in battle due to death or injury. Previously, following traumatic experiences, it was a common practice to use single-session individual-debriefing in order to reduce psychological distress and prevent the onset PTSD. However, a study from 2002 strongly indicated that there is no evidence that debriefing is a useful treatment for the prevention of PTSD, for the reduction in general psychological morbidity, and that in some cases it actually increases the risk for developing PTSD (Rose, Bisson, Churchill, & Wessely, 2002).

Forward Psychiatric Services

Forward psychiatric services are the first line of intervention, which are commonly provided on the frontline to soldiers who develop CSR. In most militaries, these services are based on the PIE model (Proximity, Immediacy, and Expectation of recovery), which was initially developed during World War I. The main purpose of this model is to refit CSR casualties to full combat duty and return them to the frontline. A stay of several days at a PIE model setting will usually be sufficient to return most CSR casualties to active duty at the frontline (Jones & Wessley, 2003). The model includes the following elements: (1) Proximity—states that the treatment setting should be as close as possible to the combat zone while providing a safe haven. Remaining close to the frontline maintains the psychological state that the soldier is still a part of the unit, still participating in the war effort, and thus it sustains the soldier's professional role. It also provides access to unit members and promotes opportunities to share experiences with other soldiers, receive support, and maintain an emotional commitment to the unit. Remaining close to the combat zone also normalizes the experience and keeps it within context. (2) Immediacy—states that CSR casualties should be treated as soon as possible after the onset of CSR. There is a correlation between the immediacy of the treatment and better short- and long-term mental health outcomes. (3) Expectancy of Recovery—is aimed at setting the expectation right from the treatment onset that the solider is expected to return to combat following recovery. This promotes a continuation of the psychological state of being a soldier at war and prevents a change in the state of mind of the casualty.

In addition, the PIE model usually includes two additional foundations: (1) Simplicity—this entails stressing the simplicity of the treatment. It is focused on providing the soldier with a safe environment, hot shower, food, drink, and sleep. This is often augmented with providing the opportunity to discuss the traumatic events with a professional mental health or medical provider if desired. (2) Centrality—refers to centralizing screening

and assessment of CSR causalities by experienced mental health providers who can screen potential complicated cases and evacuate these soldiers to an appropriate treatment setting. This also prevents unnecessary evacuation and overloading the system.

Postcombat Psychotherapy

Recent years have seen several instances of violence and mass shootings among veterans. Well-known examples include the Fort Hood 2014 shooting, which left three dead, and the 2008 case of Sargent Dustin Thorson, who murdered his two children and committed suicide following a domestic dispute with his wife. These tragic cases constitute rare incidents and do not represent the vast majority of the 2.6 million American veterans who served in the US Armed Forces since 9/11. Nevertheless, it is important to note that recent research indicates that anger is a substantial difficulty for many Afghanistan and Iraq war veterans, many of whom do not suffer from PTSD or TBI (Worthen & Ahern, 2014). This important issue is drawing a great deal of public concern, and recent years have seen an increase in research of anger and violence among veterans and in resources dedicated for suicide prevention and mental health treatment of veterans.

The multitude of problems can often cause *symptom profusion* (Freeman & Moore, 2009), a situation in which a patient presents with multiple problems and diagnoses. This might confuse any given therapist. Another crucial complication is the fact that many clients are referred to treatment by their superiors, commanders, family, and friends and are often under coercion or threat to comply with the treatment or they might suffer professional, relational, and emotional repercussions. This could debilitate the therapeutic alliance and the motivation of clients to adhere and participate fully in their treatment.

Stigma

Stigma constitutes another major barrier to treatment for members of the military and veterans. Stigma can be potentially psychologically damaging and often consists of embarrassment, perceived lack of confidence, and a threat to the individual's career. Despite having an elevated risk concerning mental health, service members with a psychiatric condition are less likely to seek care than those without a mental health issue (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). Pietrzak et al. found this to be frequently caused by factors such as embarrassment, being perceived as weak, not knowing where to get help, and having difficulty scheduling an appointment. In fact, mental health stigma has been found in some studies to be the most important and damaging barrier to mental health care for soldiers (Britt et al., 2008). One common concern of service members that leads to an increase in the stigma associated with seeking treatment is a misconception over the possible effect on their security clearance. Even though the US military has gone to great lengths to encourage them to seek treatment when necessary (Claassen & Knox, 2011), there is a strong perception that seeking treatment will result in a loss of their security clearance. Despite the fact that this is not factually accurate, it is still a very strong perception that should be addressed proactively.

Stigma manifests differently across military branches and deployment status. In a study about the differences in stigma perception between National Guard and active-duty soldiers it was found that active-duty soldiers reported more mental health issues and greater levels of stigma as compared to those in the National Guard (Kim, Thomas, Wilk, Castro, & Hoge, 2010). This difference may be explained due to active-duty soldiers' more intense focus on the organizational hierarchy (Kim et al., 2010). Soldiers in postcombat status reported a great deal of stigma. This especially holds true when the soldier reports low levels of unit cohesion and low levels of belief in the leadership skills of their commanding officer (Wright et al., 2009). In summary, therapists will often see service members who have been dealing extensively with the stigma and its implications. This issue should be addressed in the early stages of the treatment and in the development and implementation of prevention programs.

DIVERSITY AND CULTURAL CONSIDERATIONS

The military culture is a diverse environment often regarded as a melting pot where individuals from

very different backgrounds meet and collaborate as a team. This is enabled by instilling a unique set of core values, including honor, courage, loyalty, integrity, and commitment, which serve as a basis for understanding the world during active duty.

The US Military 2012 demographics report (US DoD, 2012) lists approximately 1.39 million active-duty military personnel. Such a large group of people is varied across many different variables which should be taken into account while conducting assessment, designing preventative measures, and engaging in actual psychotherapy. The report details several important variables across all active-duty military personnel, which include the following: (1) membership level and ranking—82.8% are enlisted members, 17.2% officers; (2) gender—14.6% are female; (3) education—only 5.9% of enlisted soldiers have a bachelors degree or higher in contrast with 82.4% among officers, 98.9% have high school diploma or a GED; (4) marital and familial status—56.1% are married, 36.8% are married with children; and (5) race and ethnicity—69.7% are Caucasian, 16.8% African American, 3.7% Asian American, 3.2% mixed race, 1.5% American Indian, 1% Pacific Islanders, and 11.3% of all groups self-identified as Hispanic or Latina/o.

Before the 1990s, gender was not given considerable attention in the military, but as an increasing number of females began to join the military over the last two decades, gender emerged as an important topic. This is also true as females are projected to make up 11% of the entire veteran population by 2040. As such, the VA has begun to adapt and include gender as an important cultural factor in psychotherapeutic settings (Saha, Freeman, Toure, Tippens, Weeks, & Ibrahim, 2008).

Lorber and Garcia (2010) studied gender role norms and how they play an important role in psychotherapy among military personnel. It was found that men in the military avoided facing emotions and therefore limited the development of emotion regulation skills. Furthermore, with power and independence that is fundamental in military culture, men in the military tend to conceal psychological symptoms because such symptoms are perceived as a sign of weakness. This can be effectively countered with psychoeducation and normalization processes in individual and group therapy.

Another important example of cultural consideration can be seen in the treatment of alcohol and drug dependence, which is a significant problem within military personnel. When treating alcohol use disorder (AUD) and PTSD, it is important to take gender into consideration due to differences in presentation of the disorders. Men with AUD and PTSD tend to develop AUD before the PTSD and women with AUD and PTSD tend to develop AUD after PTSD. In psychotherapy, for men the AUD should be treated first, whereas the PTSD should be treated first in women (Kaysen et al., 2014).

Military as a culture in itself is an important aspect to consider in regard to psychotherapy. Position, rank, hierarchy, and status are all important aspects within military culture. For civilian therapists working with veterans, the aspects of rank and power that accompany higher ranks can be misunderstood or disregarded all together. Two critical implications for practice with military veterans include understanding military language and hierarchy as well as avoidance of assumptions regarding military life and culture (Stack, 2013).

In addition to the aforementioned factors, other cultural information that should be taken into account while conducting psychotherapy or any other psychological intervention with military personnel and veterans includes but is not limited to socioeconomic status, religiosity or spirituality, level of language, immigration background, level of acculturation, familial history in the military, sexual orientation and identity, disability, and having a history of physical and mental illness. Many treatment protocols such as cognitive processing therapy and exposure therapy include cultural consideration in their formulation. However, it is essentially the responsibility of the therapist to be mindful of such factors and increase the awareness of clients to this important issue. Most important, while conducting therapy, it is important for the therapist to be aware of his or her biases toward the client, the client's background, and how the client understands his or her own sources of power privileges and minority stress. Individuals who typically hold a minority status in the military include ethnic groups such as African American and Hispanics, women, and gay men. Minority status may lead to increase in stress due to social rejection and discrimination in duty opportunities and accommodation conditions. This is extremely impactful in the military culture where being a part of the unit is critical to the soldier's morale and to the cohesion and effectiveness of the unit. In contrast, individuals

with power privileges are those who enjoy better treatment and attitude by their comrades, superiors, and the military system in general. Such individuals could be soldiers or officers with higher rank, seniority, and members of certain military professions such as pilots and Special Forces. Having such privileges might at times impair the motivation of the individual to receive mental health treatment due to fear of stigma and of losing the privileges that service members hold.

CLINICAL ILLUSTRATION

John is a 26-year-old Caucasian male who returned 6 months ago from Afghanistan after his second tour of duty. John's last tour ended when he was injured during a firefight in which he sustained a TBI from a mortar blast. In the combat zone, John was immediately evacuated to a military hospital and as a result he was not treated by the PIE model. However, following medical intervention, he was placed in a safe nurturing environment and was encouraged to discuss his combat experience with a professional mental health provider. Two weeks following his injury, John underwent a psychological assessment, which indicated he was suffering from an acute stress disorder. Upon returning home and discharging from his service, John presented to treatment at a private practice with depression, anxiety, difficulties concentrating, headaches, nightmares, chronic pain related to his injury, and interpersonal problems, including marital problems. He did not want to be treated in the local VA facility because he was afraid that discovery of his mental health problems by the VA staff might jeopardize his veteran benefits. John's case presents several classic complications, which include fear of stigma, comorbidity across a wide range of mental problems, and a TBI which could have effects that overlap with depression and PTSD symptomatology. His case will require intensive risk management, proper assessment, and ruling out several problems such as TBI effects, pain medication interactions, and substance and alcohol abuse. Probable diagnoses for this case will include major depressive disorder and PTSD. Initial assessment should be followed by case conceptualization that will take all of the aforementioned factors into consideration and, in collaboration with John, will set realistic and detailed treatment goals. Based on his openness to treatment and match with the therapist, CPT may be a viable treatment approach because it will target his traumatic experiences, depressive and anxiety symptoms, and his interpersonal problems. John should also be referred to psychiatric evaluation for medication consultation and to a neurological assessment to evaluate the extent of the TBI effects. Lastly, as John is a veteran, his diagnosis and treatment should take into account additional factors that might complicate the picture. For example, in the United States, a diagnosis of PTSD or TBI by the VA can merit significant financial gains. As such, cases of malingered PTSD and veterans with economic hardships might show different symptomatic presentation and motivation to get better. This is a major difference in the treatment between active-duty military personnel and veterans.

CONCLUSION

Psychotherapeutic treatment of military personnel and veterans can often be a complicated process due to various situational constraints, in addition to comorbidity, physical injuries, and severe mental trauma. Since World War I, the science of military psychology has been on the frontlines of developing psychotherapeutic modalities and procedures that can enable service members to return to active duty and to assist veterans to recover from mental injuries and reintegrate them successfully into civilian life. Currently, there are various types of available psychotherapies for the treatment of active-duty military personnel and veterans. Treating military personnel begins on the frontlines when soldiers with combat shock or exhaustion are seen by behavioral health providers. Other available treatment modalities used at the home base or in civilian life are often focused on recovery from PTSD, depression, anxiety, alcohol and other substance abuse; difficulty in interpersonal relationships; and on reintegration into society. Some of the best evidence-based treatments supported by empirical studies include CBT, CPT, exposure therapy, and EMDR. Nevertheless, despite the effectiveness of these treatments, many veterans and active-duty military personnel do not receive treatment due to a multitude of barriers, such as stigma and fear of repercussions. In addition, recent years have seen a sharp rise in suicidality among active-duty personnel and veterans and in rates of homelessness among

veterans. Furthermore, many veterans with chronic mental illness are resistant to contemporary treatment and require other forms of intervention. With these challenges, research into psychotherapeutic interventions is still an ongoing process. Current and future developments in this field include the use of mindfulness techniques, experimental Schedule I drugs such as MDMA in conjunction with psychotherapy, and technology as a medium in e-therapy and virtual reality.

REVIEW QUESTIONS

1. What are the common disorders prevalent among military personnel and veterans?
2. What makes the treatment of military personnel and veterans often complicated?
3. Name at least one barrier to mental health treatment among military personnel and veterans.
4. Which system of diagnosis is more stringent in diagnosing PTSD?
5. What are the most prominent evidence-based treatment approaches used with military personnel and veterans?

RESOURCES

Readings

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20/20 Report on EMDR: http://www.youtube.com/watch?v=GTLLfdcJE0Q

CPT:http://www.youtube.com/watch?v=Tx3KdKDZOS8

EMDR by Francine Shapiro Ph.D.: http://www.youtube.com/watch?v=ADzQ0QnxTkg

Exposure Therapy: http://www.youtube.com/watch?v=\SVkRutP7skI

Personal Stories of Veterans with PTSD: http://www.ptsd.va.gov/apps/aboutface/Index.html

PTSD Checklist (PCL): http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Treating PTSD with MDMA-assisted psychotherapy: http://mdmaptsd.org/

Virtual exposure therapy on CNN: http://www.youtube.com/watch?v=M1orx97sFGc

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Psychotherapy With People Exposed to Mass Casualty Events: Theory and Practice

Lisa M. Brown
Larry E. Beutler
Jennifer H. Patterson
Bruce Bongar
Lori Holleran

Abstract
The development of treatments for mass casualty events was underlined and forced into the collective awareness of behavioral health practitioners and scientists by the 9/11 terrorist attacks on the United States. In response to the call for help by the American Red Cross and other emergency response groups, hundreds and probably thousands of mental health practitioners merged in the affected areas of New York City, Washington, DC, and Upstate Pennsylvania. Despite their well meaning efforts and even though the American Psychological Association had initiated a Disaster Response Network to train and certify emergency responders, the services provided by hundreds of volunteers were initially disorganized, inconsistent, and confusing. Shortly following 9/11, research began to emerge pointing out that many procedures that were widely used were ineffective and even harmful, setting in motion a widespread effort to develop more effective treatments for survivors. In this chapter, we review progress and the current status of these efforts.

Keywords: mass casualty events, trauma, crisis intervention, psychological first aid, psychological recovery skills

In the wake of the 2001 attacks on New York and Washington, DC, and the intentional crashing of United Airlines flight 93 in Pennsylvania, it became apparent that the systems that were in place to help survivors of trauma were largely designed to address individual trauma rather than that which occurred en masse. Moreover, scientists, practitioners, and federal authorities were confronted with the unpleasant fact that most treatments then being used to address mass casualty events had either not been tested for efficacy or had proven to be ineffective or harmful (Litz & Gray, 2004; Rose et al., 1998, 1999). A hurried effort to review literature in the hope of finding a proven intervention that could serve a large number of people revealed that while many treatments were touted, scientific evidence of efficacy and effectiveness was absent for nearly all of them, a condition made all the more salient by the almost total lack of attention that

had been paid to the unique effects of terror-based traumas (Housley & Beutler, 2007). In response to this need, treatment models and numerous forms of intervention and treatment have evolved and been promoted by behavioral health researchers during the past decade.

Mass casualty events adversely affect both individuals and the community. People who directly experience mass traumatization are likely to suffer intense reactions to witnessing death, physical injury, mutilation, and prolonged suffering. Posttraumatic stress disorder (PTSD), depression, anxiety, and chemical abuse are the most common diagnoses made post event (e.g., Galea et al., 2002, 2003; Neria, Nandi, & Galea, 2008). A host of other, subsyndromal, "stress-related" problems is also likely to manifest in response to mass trauma, and although not meeting full criteria for a formal diagnosis, many will require treatment when some aspect of normal functioning is impaired. In recognition of the disproportionally high incidence of psychological distress relative to physical casualties after major disasters, the efforts and resources dedicated to developing behavioral health care programs have dramatically increased since the terrorist attacks of September 11, 2001, and Hurricane Katrina in 2005 in the United States (Acierno et al., 2007; Bourque, Siegel, Kano, & Wood, 2006; Shubert et al., 2008).

Historically, the behavioral health approaches promulgated by relief organizations and government agencies have varied by the rigor used in developing the interventions, the intended recipients (e.g., survivors of combat, sexual assault, natural disasters, terrorism), the selection and training of volunteers and personnel responsible for delivering behavioral health care, and the evidentiary base demonstrating that positive and desired outcomes were achieved. Although variations still exist today, there is a growing emphasis on the need for relief organizations and behavioral health providers to use evidence-based practices. Moreover, there is an increasing appreciation of the need to evaluate the effectiveness of evidence-informed interventions and treatments used with traumatized people in real-world settings.

Although the terms *intervention* and *treatment* are frequently used interchangeably in the disaster behavioral health literature, some distinction between them is warranted. In the context of behavioral health, *intervention* can be defined as interacting, intervening, interfering, or interceding with the intent to change the person's current cognitive, behavioral, physiological, or emotional *state*. For example, disaster relief workers who are trained to provide psychological first aid (PFA) might use a simple relaxation technique, like breathing exercises, to bring considerable relief to those who are distressed by reducing their physical tension and feelings of overarousal. Breathing exercises are an intervention that reduces the symptoms of stress-related discomfort. Although PFA is not a treatment for psychological problems, its techniques can be effective in fostering adaptive functioning behaviors and enhancing positive, active coping strategies among those who are reacting to a stressful situation. PFA (*intervention*) can be provided by a mental health professional, but it is usually delivered by a trained layperson or disaster responder with limited psychological knowledge or education.

In contrast, psychological *treatment* is provided by highly trained, licensed professionals such as psychologists, psychiatrists, psychotherapists, professional counselors, or social workers, who are able to treat a much wider range of mental health conditions than those who only have PFA training. *Treatment* is the application of formal mental therapies, such as cognitive-behavioral therapy, with the goal of stopping, reversing, or controlling diseases, disorders, or dysfunctions and may address *traits* as well as *states*.

The concept of PFA is similar to medical first aid. Medical first aid consists of a series of simple techniques that require minimal equipment and can be applied by a trained layperson in response to an injury or illness until formal medical treatment, if necessary, can be obtained. In many instances, minor injuries or illnesses may not require medical treatment beyond the medical first aid intervention. A premise of PFA is that appropriate, early intervention for traumatic distress can mitigate functional impairment and reduce the potential for more serious and enduring mental health problems, such as PTSD and depression that require psychological treatment. Early intervention has been defined as "any form of psychological intervention delivered within the first four weeks following mass violence or disasters" (National Institute of Mental Health, 2002). Often, acute distress reactions can be mitigated by providing education and information about stress reactions and coping. Relief workers and disaster responders trained to use PFA should possess fundamental knowledge about acute distress, mitigation techniques, and basic concepts pertaining to adaptive functioning and coping.

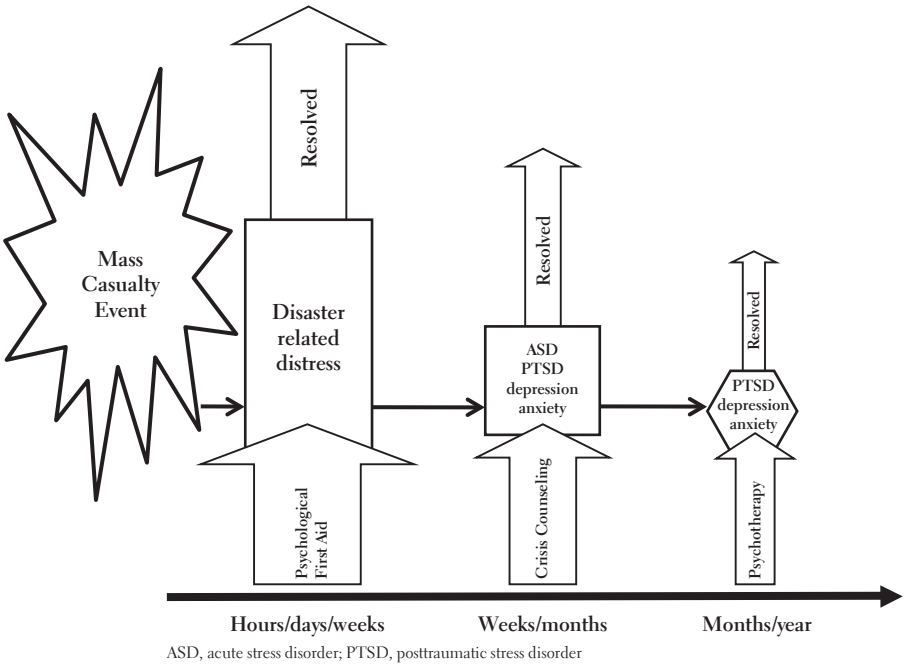

FIGURE 27.1 Stepped Care Delivery of Disaster Behavioral Health Services.

PFA is typically a one-time, undocumented, short-term intervention that is administered in response to a mass casualty event near the location where it occurred. At the other end of the continuum, formal behavioral health *treatment* is usually multisession, documented, and delivered to people with chronic or serious behavioral health problems who may require short- or long-term care in the weeks and months of the recovery process. Rather than considering these various levels of intervention to be competitive or equivalent, it is appropriate to view them as a continuum of services that are applied sequentially as needed. Although each of these "talking therapies" holds a key place on the continuum of care for trauma survivors, each differs significantly in its history and development; optimal timing, duration, and location of services; training and skills required of providers; intended recipients; and outcome goals. Figure 27.1 illustrates the continuum of behavioral health care during the recovery process.

In essence, this continuum is embodied within a stepped care model of treatment. Moving from intervention to formal treatment, there is an escalation in the intensity of care and an increase in the skill of the provider. A stepped care framework matches presenting needs with the least intensive therapy that is expected to provide significant and beneficial outcomes and is adjusted or increased in steps based on lack of effect or failure of lower intensity therapies. As no method presently exists for tracking referrals made from lower levels to higher levels of care, it is unknown how many survivors consecutively use all three steps of care after mass casualty events.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS

Most contemporary models for delivery of services to mass trauma survivors include three or four levels of care. Each level uses a different set of assessment procedures and interventions that are applied to an increasingly select group of survivors (Brewin et al., 2008; Housley & Beutler, 2007; Inter-Agency Standing Committee, 2007). The philosophy underpinning the delivery of most postevent mental and behavioral health care is the military PIES model. PIES proposes that services be provided based on their *p*roximity, *i*mmediacy of response, *e*xpectancy of recovery, and *s*implicity. Typically, most models include an

acute support stage using PFA techniques, an intermediate support stage that includes both community rebuilding strategies and crisis counseling, and a long-term recovery stage where traditional psychotherapy is provided to survivors.

A majority who are subjected to mass trauma will experience transitory, intense distress that passes with time if offered adequate formal and informal support. Consistent with the general literature on trauma, symptoms of mental health distress were most likely to be evident during the first year post disaster with 70% of the affected population improving without formal intervention (Brewin, Rose, & Andrews, 2002). Intervention offered during the acute stage is designed to provide structure, reassurance, and education to those who are affected in addition to identifying people who need immediate psychiatric treatment and those who may be at risk for needing assistance in the future. During this stage watchful waiting occurs and PFA is offered. Although most people are resilient and will recover without formal treatment, some people will experience debilitating symptoms during the weeks to come. The presence of continued intrusive recollections of the disaster differentiates survivors who will eventually develop PTSD from those who do not. By identifying level of risk in the first supportive contact, the pool of survivors who will likely require more intensive intervention can be reduced substantially from the entire population who were affected by the event.

During the intermediate recovery phase, providers with additional expertise than those who provide the PFA are often needed. In some models, this stage includes treatment in the form of learning coping skills and strategies to face up to illogical fears. At this point, community intervention also takes place to help affected populations return to normal functioning as quickly as possible. Types of community development activities that are usually run by aid workers include social meetings, sporting events, community projects, and publication of newsletters designed to inform and unite people. Using a strengths-based approach, crisis counseling is offered during the intermediate stage to provide "at risk" individuals with four to eight sessions to help survivors learn to cope with stress and to reduce anxiety- and depression-related symptoms. Counselors are trained to identify key symptoms and patterns that are highly predictive for developing full-blown psychiatric or substance abuse disorders. At-risk individuals are then referred for more intensive and traditional medical and psychological intervention over an unspecified period of time. Mental and behavioral health professionals provide formal care during the ongoing treatment or long-term recovery stage. As noted, each stage is aimed at an increasingly select group of individuals and is associated with a distinctive assessment procedure. Table 27.1 shows the similarities and differences between the three stages by delineating the key characteristics of each therapeutic approach.

Psychological First Aid

During World War II, combat-related PTSD was referred to as *battle fatigue*. The concepts of proximity, immediacy, and expectancy were recognized as critical elements in providing care to combat-fatigued soldiers. To rapidly return combat distressed soldiers to duty, psychological intervention was provided as close to the front line as possible. Toward the end of World War II, the concept of PFA was first introduced (Jacobs & Meyer, 2006).

In 1954, the general public became aware of PFA from a pamphlet, *Psychological First Aid in Community Disasters*, produced by The American Psychiatric Association and the Committee of Civil Defense (Jacobs & Meyer, 2006). In addition to describing various reactions to a nuclear attack, the pamphlet described the four general principles of PFA as (1) accept every person's right to have his or her own feelings, (2) accept a casualty's limitations as real, (3) size up a casualty's potentialities accurately and as quickly as possible, and (4) accept your own limitations in a relief role (Jacobs & Meyer, 2006). These principles form the foundation of today's PFA interventions.

After mass casualty events, PFA is the intervention of choice for the American Red Cross, the Medical Reserve Corps, and state departments of health. The goal of PFA is to reduce stress and increase adaptive coping by offering direct support, guidance, and referral. The single-session intervention consists of help with securing medical assistance, finding lost loved ones, obtaining safe shelter, navigating needed services, and obtaining community and family support. Many of the PFA components are not psychological per se, but are crucial for maintaining mental health functioning and well-being. From an assessment perspective, at this stage the responder attempts to

TABLE 27.1 Differences and Similarities Between Psychological First Aid, Crisis Counseling, and Psychotherapy

	Psychological First Aid	*Crisis Counseling*	*Psychotherapy*
Perception of person receiving service	Emergency survivor	Accidental client	Intentional patient
Antecedent to service use	Seeking food, water, shelter, or practical assistance at a public shelter	Self-identifies as having disaster-related distress	Self-identifies or is medically recommended or court ordered to obtain treatment because of emotional, interpersonal, or mental illness
	Available licensed clinicians not on scene or insufficient numbers to provide care to all who are adversely affected	Insufficient numbers of licensed clinicians who are able to provide care to all who seek services	Sufficient number of licensed clinicians in most private practice and clinic settings
Setting	Services offered at the scene of the event or in a public shelter	Services offered in the home or community	Services offered in the office or clinic
Provider	Nonexpert who is trained	Degree-holding adult who has received specialized training in crisis counseling	Licensed clinician with education, training, and experience
	Malpractice insurance not needed	Malpractice insurance usually purchased by the agency	Malpractice insurance purchased by the provider
Survivor access to services	Services are provided to survivors who congregate in shelters and other emergency facilities	Services are made available in community settings where location and existing infrastructure affects ability of clients to use services	Survivors use services at providers' office where location and transportation affect ability of patients to use services
Cost to survivor	Free	Free, if funded by FEMA or SAMHSA	Fee, insurance, or pro bono
Goal	Stabilize (if needed), promote adaptive coping	Restore functioning to predisaster level	Enhance functioning
Approach and procedures	No informed consent	Informed consent	Informed consent
	Unobtrusive triage	Triage and treatment	Diagnosis and treatment
	Content is accepted at face value	Content is accepted at face value and is strengths based	Content and process can be examined
	Psychoeducation, needs assessment, connection to social supports and services, supports adaptive coping, stabilization (if needed)	Includes key components of psychological first aid, helps survivors understand their disaster recovery options, promotes resilience, empowerment, and recovery	Psychotherapeutic focus using evidence-based treatments
	Intervention developed by responding organization and is based on expert consensus or is evidence informed	Program is structured and implemented for a specific period and according to federally established guidelines	Treatment is selected, evaluated, and refined by the clinician
	Undocumented	Undocumented	Always documented
Duration	Short term—single or multiple interactions spanning a week	Short term—multiple interactions spanning weeks	Short or long term—spanning weeks or months

identify level of risk for prolonged symptoms by observing the status of certain predictor characteristics (e.g., prior mental health problem, direct exposure to the trauma, lack of social support) and to obtain basic personal information.

Thus, most survivors receive PFA intervention within 3 days of a mass casualty event because effective and timely psychological intervention is thought to mitigate adverse, long-term effects such as anxiety, depression, and PTSD that can become extremely

difficult to resolve as time passes. The screening and assessment that take place during administration of PFA are concurrently conducted and are designed to inform and guide the selection and delivery of needed assistance. Assessment is conducted not to generate a clinical diagnosis but to identify three, functionally discrete subgroups of disaster survivors. Those who are well-functioning and not in need of immediate assistance, those who are acutely distressed and exhibiting a temporary reduction in functionality, and those who are dysfunctional and not able to execute basic activities of daily living. In the immediate aftermath of a disaster, it may be difficult to differentiate those who are temporarily dysfunctional from those who are not functional. Responders are trained to discern if the person has the ability to perform basic activities of daily living or is oriented to person, place, and time. Ideally, those who appear significantly impaired are quickly seen and assessed by a behavioral health specialist.

In recent years there has been a proliferation of PFA interventions developed by a variety of organizations for specific subgroups of the population. Not surprisingly, these approaches have varied learning objectives, training methods, program content, and underlying pedagogical principles—differences that are understandable given the heterogeneity of individuals, organizations, and institutions developing the respective PFA programs. Examples of PFA programs with a specific population focus include the homeless, elderly, families of deployed troops, and religious organizations. The goal of the early PFA programs was to have a single program that met the needs of all people regardless of differences. It soon became apparent, however, that specific populations would benefit from tailored intervention.

Crisis Counseling

Initial shock followed by a honeymoon period, a time when resources arrive from outside sources to assist affected populations, occurs during the weeks and months after a mass casualty event. It is at this point when many people begin to deeply experience their personal and collective losses or find themselves devoid of personal resources to redress ongoing symptoms of depression, anxiety, and substance abuse. Assumptions made about safety, sense of security, and normalcy are shaken, a sense of self is threatened, and one often becomes demobilized and ineffective as self-efficacy declines. Destruction of the built environment, loss of life, and changes in employment and in the community become apparent. Acts of intentional human malevolence are particularly difficult to resolve as ongoing feelings of vulnerability, uncertainty, and anxiety contribute to psychological stress and slow the recovery process.

Those who require or desire more assistance with psychological recovery are offered crisis counseling. Crisis counselors can play a key role in helping survivors prioritize needs and activities, secure transportation, complete paperwork for assistance, and reestablish social connections. If the problems appear to be more closely related to the absence of skills by which to cope with increasing or persistent symptoms of depression, anxiety, and substance abuse, then some direct training in coping skills is offered during crisis counseling.

After mass casualty events, crisis counseling is offered free to affected populations. In the United States, the Federal Emergency Management Agency (FEMA) funds and has oversight for crisis counseling programs. In 1974, the Robert T. Stafford Disaster Relief and Emergency Assistance Act authorized FEMA to fund mental health assistance and training activities in presidentially declared major disaster areas. Crisis counseling programs are managed by a designated state agency (i.e., department of health or child and family welfare) and delivered at a variety of nontraditional sites (i.e., schools, homes, mental health clinics, community centers) located in the affected community. Crisis counseling services are delivered by laypeople who have attended a multiday training workshop. The goal is to help survivors cultivate adaptive coping skills and recover to their predisaster state of functioning. Crisis counselors do not make diagnoses and no records of the sessions are kept. The counselors meet people where they are and tailor their treatment accordingly. People who need more intense treatment are referred to licensed clinicians who can deliver formal behavioral health care.

Modern crisis intervention theory evolved from Lindemann's (1944) classic study of acute grief reaction after the 1942 Coconut Grove nightclub fire in Boston, Massachusetts. Lindemann (1944) delineated five related normal grief reactions: (1) somatic distress, (2) preoccupation with the image of the deceased person, (3) guilt, (4) hostile reactions, and (5) the loss of patterns of conduct (p. 142). The extent

of the individual's grief reaction was influenced by the degree of successful readjustment to the environment without the loved one, the ability to free himself or herself from the deceased, and the ability to develop new relationships.

Until this time, personality disorders or biochemical illnesses were thought to be the cause of grief-related depression or anxiety, and the provision of therapy to treat these symptoms was considered to be the exclusive domain of psychiatry. Notably, in the aftermath of this tragedy, Lindemann came to accept that community paraprofessionals and clergy could be just as effective in providing crisis intervention services as psychiatrists. Subsequent to the disastrous Coconut Grove fire, Lindemann and Gerald Caplan founded the Wellesley Project, a community mental health program in Cambridge, Massachusetts, to provide crisis intervention and community outreach. An equilibrium/disequilibrium paradigm was developed to depict the process of crisis intervention in treating an individual's reaction to a traumatic event. Timing for delivery of crisis counseling is based upon psychological readiness, with the goal of facilitating transition from the disillusionment phase to the reconstruction phase (the four phases of recovery post disaster are often described as heroic, honeymoon, disillusionment, and reconstructive; Myers & Zunin, 2000). If there is, at this point, evidence of continuing flashbacks, dissociation, or derealization experiences, then the survivor is likely to require more intensive psychological care. These three signs are strong indications of the need for extended care by a behavioral health specialist (Marmar, Weiss, & Metzler, 1997). Furthermore, these signs, coupled with a history of past difficulties and lack of social support, suggest that preexisting physical or mental illness is exacerbating current distress and indicates that the survivor requires more intensive medical or psychiatric care. Additional details about crisis counseling can be found in Table 27.1.

Psychotherapy

After mass casualty events, most people will not require any psychological intervention beyond PFA or crisis counseling. Only a small, but significant minority of people will need formal psychotherapy. Although not all people experience enduring physical and psychological deterioration in the aftermath of a catastrophic event, it is widely recognized that trauma exposure is a risk factor for a wide range of psychiatric disorders. Researchers estimate that approximately 6% to 20% of the trauma-exposed population develops PTSD (Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

For those who do develop symptoms significant enough to warrant treatment, any treatments delivered post event should be informed by a thorough assessment and selected according to the individual's needs. Should formal treatment be warranted, the clinician must choose an appropriate treatment approach. There are numerous evidence-based and evidence-informed treatments available for the variety of conditions that can result following mass casualty events (e.g., PTSD, depressive disorders, anxiety disorders, substance use disorders). The following presents an introduction to treatment approaches commonly considered for those who have been exposed to trauma and experience resulting challenges.

Cognitive-behavioral therapy is a broad category under which treatments like cognitive processing therapy and prolonged exposure therapy fall. Its core components include psychoeducation; skills training; and identifying, evaluating, and restructuring maladaptive thoughts. Cognitive-behavioral therapy has been found to be effective in a variety of settings with a variety of populations and for a variety of conditions. For example, it has been used, and shown to be an effective treatment, following terrorist events such as 9/11 (Karr, 2011).

Cognitive processing therapy is an empirically supported treatment for PTSD that includes psychoeducation, cognitive restructuring, and exposure (Peterson, Luethcke, Borah, Borah, & Young-McCaughan, 2011). This therapy assists survivors to become aware of their thoughts and emotions, question/challenge their posttrauma thinking, and learn to cope with their trauma and associated thoughts and emotions in a new way that lessens related distress.

Perhaps one of the most researched approaches to PTSD treatment, prolonged exposure therapy, is considered the gold standard for PTSD treatment. This approach helps the individual process the trauma and address painful and distressing trauma-related thoughts, emotions, or situations that the individual may be avoiding as a result. This treatment includes psychoeducation, breathing retraining, imaginal exposure, and in vivo exposure (Foa, Hembree, & Rothbaum, 2007). Via this treatment the survivor confronts memories of

the trauma through repeated exposure to his or her story of the trauma and to situations that elicit fear and avoidance behaviors. Additionally, prolonged exposure therapy has been shown to be effective in combination with cognitive therapy, and in treating acute stress disorder (Peterson et al., 2011).

Eye movement desensitization and reprocessing (EMDR) incorporates components of multiple other therapies and is considered an integrative treatment approach. The goal of the eight phases of treatment in EMDR is to address issues that interfere with coping and resilience and trigger symptoms. Research has shown EMDR to be effective in treating PTSD, and perhaps as efficacious as CBT (Karr, 2011). While studies evaluating EMDR post mass-casualty events are limited, there is evidence that EMDR has been efficacious in addressing traumatic reactions for people after natural disasters (Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997).

Acceptance and commitment therapy (ACT) posits that distress arises from an individual's efforts to avoid emotional pain. Primary goals of this therapy are to reduce experiential avoidance and increase psychological flexibility. Although research on ACT after a mass casualty event is limited, this approach is emerging as an effective treatment for PTSD (Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009).

It is important to note that risk factors may increase the likelihood of longer term challenges following mass casualty events. These risk factors include history of mental health disorders, prior trauma, resource loss, severity of exposure, low level of social support, dysfunctional cognitions, childhood abuse, and low self-esteem (Boscarino & Adams, 2008; Hobfoll et al., 2007; Housley & Beutler, 2007). Additionally, studies have found that individuals who seek mental health treatment following terrorist attacks are often those who sought and used treatment prior to the event. Those who may have benefited from treatment though did not seek services included minority group members, those without health insurance, and those who may have solicited social support from nonprofessionals such as friends (Boscarino & Adams, 2008).

While historically it was feared that treatment in the presence of ongoing threats (such as terrorist activity) would limit benefits of treatment, a study of CBT for PTSD in Thailand revealed that treatment could successfully treat PTSD under such circumstances (Bryant et al., 2011). In this study, treatment was adapted to meet the needs of individuals, and it included focus on evaluating absolute risk and benefits of taking reasonable risks. This study noted that exposure therapy achieved extinction learning despite ongoing reminders of actual threats, that lay counselors can be trained to deliver treatment, and that CBT improved complicated grief reactions (Bryant et al., 2011). This research also highlighted the importance of adapting treatments to culture and considering cultural factors when delivering such treatments.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION

Intervention and treatment offered in the aftermath of a mass casualty event seek to address both stress and traumatic stress by promoting the use of stress management strategies and techniques to prevent PTSD. Stress theory posits that the external demands resulting from a mass casualty event (i.e., primary stressor) result in a loss or decrease of symbolic (e.g., assumptions, beliefs) or concrete (e.g., financial, social support) resources (i.e., secondary stressors) accompanied by the presence of extreme physiological arousal (Hobfoll, 1989). These secondary stressors further adversely affect the recovery process. Survivors' behavioral and emotional responses to these stressors deplete internal resources, becoming tertiary stressors. To diminish the impact of primary, secondary, and tertiary stressors, the goals of PFA and crisis intervention are to provide survivors with tangible (e.g., physical safety) and intangible (i.e., feelings of social connectedness) resources to facilitate coping and recovery and ameliorate the effects of the stressors. Perceived support and instilling hope for a positive outcome in time influences survivors' perception of and responses to an event. Techniques such as diaphragmatic breathing help to reduce and control physiological arousal.

If secondary and tertiary stressors persist, and are accompanied by a lack of resources, onset or exacerbation of psychiatric symptoms, or uncontrolled distress, crisis counseling is designed to assist survivors with identifying their concerns as well as their strengths, setting goals, and developing pragmatic recovery plans. By helping people to actively manage their daily hassles and disaster-related adversities, the chain of mutually reinforcing reactions that are eventually consolidated into memory and result in PTSD is disrupted.

The cognitive model of trauma supports the use of psychotherapy that focuses on correcting negative appraisals and distinguishing past trauma associations of threat with present circumstances (Ehlers & Clark, 2000). The premise is that PTSD is maintained when several conditions are met, including persistent and negative appraisal of the traumatic event, disturbed memory processes (e.g., contextualization, weak elaboration, strong associative memory), and perceptual priming. The goal of psychotherapy is to treat propositionally, analogically, and schematically encoded memories that have been integrated and stored at multiple levels (e.g., verbal, visual, auditory, olfactory, gustatory). The Schematic, Propositional, Analogue, and Associative Representational System model accounts for differential responses to psychotherapy and informs the selection of treatment (Dalgleish, 2004). Preexisting conditions, personal history, personality, and worldview all influence how the traumatic stressor is experienced and processed. As information moves between analog, prepositional, and schematic systems, treatment planning should consider how the trauma is represented and should focus on addressing dominant symptomology via appropriate verbal and sensory systems (Brewin & Holmes, 2003).

Some approaches (e.g., Housley & Beutler, 2007 have been proposed to describe principles of change and guide case conceptualization for those who develop PTSD and other symptoms of chronic trauma (Houseley & Beutler, 2006). These approaches tend to eschew theoretical approaches in favor of those that can be used across theories. For example, the Acute stage of post trauma response may be governed by principles that guide relationship development and maintenance; the Intermediate stage may be guided by principles that guide skill development and symptom change; and the psychotherapy stage may be guided by principles that fit and match the treatment to the individual patient (Castonguay & Beutler, 2006).

RESEARCH ON EFFICACY AND EFFECTIVENESS

Psychological First Aid

Although the adoption and use of PFA is widespread and still growing, the practices being advocated and widely disseminated have not been systematically studied to assess effectiveness. PFA is an evidence-informed or consensus-derived intervention and not an evidence-based practice (Bisson et al., 2010; Kelly, Jorm, & Kitchener, 2010; Vymetal et al., 2011). Efficacy and effectiveness studies have not been conducted on PFA for a number of reasons such as difficulties in conducting research in the immediate aftermath of a mass casualty event, lack of support for developing evidence-based practices, and measurement issues related to the varied ways that PFA is implemented in real-world settings (Dieltjens, Moonens, Van Praet, De Buck, & Vandekerckhove, 2014).

It is unknown how trained, nonexpert laypeople are delivering PFA to people who have experienced a potentially traumatic event. Consider that relief workers typically attend a 1-day workshop to learn how to identify psychological problems, select core components to use with distressed people to obtain optimal outcomes, and maintain some level of fidelity while delivering the core components after a mass casualty event. Although a growing number of relief workers have been trained to use PFA, because disasters are low base-rate events, it is likely that these learned skills deteriorate over time if not used regularly. Skills that are rarely used, such as cardiopulmonary resuscitation by trained non–health professionals, often require recertification training. At present, PFA recertification classes are not offered or required. Although PFA is now considered the gold standard for disaster-affected populations, formal studies of PFA with disaster-exposed populations have not been conducted to examine what is actually occurring in real-world situations. In short, the efficacy of PFA has not been scientifically established.

Crisis Counseling

The evidence base for crisis counseling programs that provide short-term intervention for people experiencing psychological sequelae from disasters is scant. Although crisis counseling programs have been offered for several decades, research examining the effectiveness of these programs is minimal. Often program evaluations of crisis counseling programs are not published. Although Project Liberty conducted numerous and extensive evaluations that examined client satisfaction with treatment and outcomes, prior to the evaluation of the 2005 Hurricane Katrina crisis counseling programs, the focus and methodology

used for disaster crisis counseling evaluation was determined by the grantee. It is typically challenging to obtain client perspectives via a written questionnaire as most survivors are overwhelmed by completing required paperwork such as aid applications, insurance forms, and needs assessments. Moreover, because state-operated programs are encouraged to tailor their programs to meet the needs of affected populations, there is substantial variability in the delivery of services, outreach practices, average length of sessions, promotion of follow-up sessions, and location of services.

A recent meta-analysis of crisis intervention programs administered during nondisaster times revealed that most were implemented without use of outcome measures or an evaluation component (Roberts & Everly, 2006). Moreover, the effectiveness of delivery modalities such as in-person or telephone crisis intervention had not been systematically or rigorously studied. To date, a systematic review of published disaster crisis counseling programs has not been conducted.

An evaluation of the crisis counseling program of Project Liberty implemented after 9/11 found that the services offered were accessible and used by people of diverse age, race, and ethnic backgrounds that reflected the local demographics (Donahue, Lanzara, Felton, Essock, & Carpinello, 2006). People who reported pervasive distress, predispositional risk factors, or greater attack-related exposure were more likely to be referred for intensive treatment to treat persistent traumatic symptoms. A majority of clients (89%) rated Project Liberty services as "good" or "excellent." In general, the services offered by Project Liberty were sufficient for most people to return to predisaster levels of functioning after 9/11 (Donahue et al., 2006).

Research evaluating the effectiveness of the crisis counseling programs implemented after Hurricane Katrina found that clients who received care in areas where providers reported high levels of stress rated the benefits they derived from the crisis counseling program lower than survivors who received services in low-stress areas (Norris, Hamblen, & Rosen, 2009). Counselors' job stress levels were also significantly correlated with the areas' severity of losses and work resource quality. Recommendations for improving crisis counseling services included more intensive sessions with follow-up and referrals to psychological services. Intensive sessions are not defined as increasing the number of people served or expanding session length, but having counselors spend more quality time in session exploring issues related to clients' needs and distress. In addition to adequate support and resources, this evaluation also suggested that mental health clinicians provide supervision to counselors as a way to reduce their stress (Norris et al., 2009).

A study examining Project Recovery crisis counselors' assessment of suicidal behavior among Hurricane Katrina survivors reported that clients' reactions to the hurricane interfered with their personal and professional lives and resulted in substantial distress. Consistent with other studies, a majority of clients had significant trauma and depressive symptomatology. Those who reported suicidal ideation often had symptoms of PTSD. Although some of the counselors indicated that they had received some education in suicide risk assessment prior to their employment with Project Recovery, most desired additional training as well as a protocol that could be used to evaluate client risk for suicidal behaviors (Brown, Framingham, Frahm, & Wolf, 2015). Because crisis counseling programs are based on a counseling model and not a clinical model, as well as employ a mix of professional and paraprofessional counselors, it is key to train all counselors in basic suicide assessment techniques and management strategies.

Psychotherapy

Randomized clinical trials with survivors of industrial accidents, motor vehicle accidents, and nonsexual assault indicate that four to five sessions of cognitive-behavioral therapy with components of psychoeducation, anxiety management, imaginal and in vivo exposure therapies, and cognitive restructuring is most likely to prevent PTSD (Bisson, Shepherd, Joy, Probert, & Newcombe, 2004; Ehlers et al., 2003). A systematic review and meta-analysis of 38 randomized controlled trials of psychological treatments for PTSD revealed that the clinical benefits of trauma-focused cognitive-behavioral therapy exceeded that of wait-list or usual care on symptom measures (Bisson et al., 2007). However, the authors reported limited clinical benefit for stress management and group cognitive-behavioral therapy and no benefit for supportive or psychodynamic therapies that did not focus on trauma. The limited benefit of group cognitive-behavioral therapy after disasters is concerning as it is likely that after a mass casualty event demand for

treatment might exceed availability of trained clinicians to provide individual trauma-focused cognitive-behavioral therapy. Future research should examine use of a common elements approach when developing new treatments for groups after mass casualty events.

The findings from a second systematic review of 70 studies that evaluated reduction of severity of PTSD symptoms also found that individual trauma-focused cognitive-behavioral therapy and EMDR were more successful in regard to treatment outcomes (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013). The authors recommended that individual trauma-focused psychological treatment be offered to people with chronic PTSD. For patients who do not respond to treatment, they recommended that clinicians consider extending the number of sessions, using pharmacological treatment, and trying alternative forms of trauma-focused treatment. A recent meta-analysis found that pharmacological interventions were not as clinically beneficial as trauma-focused psychological treatment and recommended that they should be used only as a second-line treatment (National Collaborating Centre for Mental Health, 2005). Prolonged exposure therapy and cognitive processing therapy have been evaluated in numerous, rigorous randomized clinical trials. Among adults, both have demonstrated equal efficacy on trauma-related symptoms (Foa et al., 2005; Resick et al., 2012). There is a significant body of research that demonstrates that evidence-based treatments are more effective than supportive counseling, psychosocial programs, and wait-list control conditions (Freeman & Power, 2007; Weisz & Kazdin, 2010).

Treatment studies completed to date after mass casualty events have included a relatively small set of potential approaches, and there is still much to be learned. Conducting this research, however, is quite challenging. The risk of retrospective recall bias, difficulties in assessing degree of exposure to trauma, tracking survivors and outcomes longitudinally, availability of trained providers and multiple potential mediating factors (e.g., perceived risk) all present challenges to conducting disaster-related research (Neria, DiGrande, & Adams, 2011). Despite these challenges, progress is being made and efforts to explore best methods for disseminating evidence-based practices after mass casualty events are being identified and evaluated (Foa, Gillihan, & Bryant, 2013).

DIVERSITY

Evidence supports the conclusion that psychological care provided in response to situations involving mass trauma must promote five key factors: safety, calm, self- and collective efficacy, connectedness, and hope (Pfefferbaum, Reissman, Pfefferbaum, Klomp, & Gurwitch, 2007). Fostering collective efficacy and connectedness both require an understanding of the affected individuals' shared cultural identities, and they may involve various strategies for groups with different values and norms. For instance, connectedness relates to an affected group's ability to unite in efforts to recover from a traumatic event, and it may have varying degrees of relevance depending on whether individuals are from collectivist- or individualist oriented-cultures (Oyserman, Coon, & Kemmelmeier, 2002). Furthermore, recovery often requires interpersonal cooperation, which is influenced by personal motivations that differ across different cultures, such as collectivist versus individualist cultures (Chen, Chen, & Meindl, 1998). Thus, the culture of affected individuals needs to be considered when providing psychological services, to encourage connectedness and to foster a desire to act cooperatively.

Communities rely on various members to recover effectively from mass trauma events, including the involvement of community leaders and professionals to guide goal-setting and increase a sense of unity, as well as active participation of citizens to enhance overall resilience (Pfefferbaum et al., 2007). Both the occurrence of a mass trauma and the influx of outside aid can cause disruption to the community by changing social roles and organization, rules governing behavior, and the distribution and use of resources. These changes may result in differences in the way affected individuals relate to each other, and they can pose a threat to the community's ability to function (Pfefferbaum et al., 2007). Accordingly, psychological interventions, particularly when coming from outside the community, must be implemented with sensitivity to the influence that the sudden inflow of outside aid has on the community. This concern is especially relevant in cases where a disaster impacts a minority group, who must rely on outside aid provided by majority or privileged groups.

Following Hurricane Katrina in 2005, Black survivors were more likely to report greater stress levels following the disaster and identified using religious faith over friends and family as a source of hope (Elliott

& Pais, 2006). Furthermore, Black people of lower socioeconomic status were the group most likely to remain in the city of New Orleans throughout the storm and its aftermath (Elliott & Pais, 2006). The authors suggest that addressing cultural factors could help improve assistive service provision.

Tailoring service provider training, including translating manuals, involving national and local organizations, and adding specific cultural factors to align with the circumstances, has exhibited value (Akoury-Dirani, Sahakian, Hassan, Hajjar, & Asmar, 2015). By developing and imparting culturally competent training, providers' preparedness and knowledge significantly improved. Providers should consider clients' particular experiences and situations in a holistic manner (James & Prilleltensky, 2002) and actively strive for cultural competence, including cultural awareness, knowledge, and skills (Sue, Zane, Hall, & Berger, 2009). Furthermore, psychological symptoms do not always manifest similarly across cultures. Particularly relevant to the study of psychological intervention for mass casualty events is the fact that PTSD may present with differing idioms of distress in individuals from different parts of the world (Hinton & Lewis-Fernandez, 2010). For example, Southeast Asian refugees were found to frequently experience tinnitus and specific "khyal" attacks (similar to panic attacks) as a response to traumatic experiences (Meyer, Robinson, Chhim, & Bass, 2014).

A final consideration is the effect of modern technology on disaster response and delivery of psychological mental health services. Contemporary technology is changing the definition of community and the ways in which people feel connected (Pfefferbaum et al., 2007). Evidence suggests that providing timely information through social media increases connectedness and acts as a form of psychological intervention (Taylor, Wells, Howell, & Raphael, 2012). The use of social media after mass casualty events is an area for further research. The medium has the potential for improving accessibility of PFA, crisis counseling, and psychotherapy to diverse communities after mass casualty events.

CLINICAL ILLUSTRATION

Juana is a 63-year-old Hispanic woman who witnessed the fall of the Twin Towers in New York City during the 9/11 terrorist attacks. She saw people entering and exiting the buildings just minutes before the first plane hit. At the time, she had been scanning a newspaper for work; she had just moved to town following a divorce and needed to find a job to get back on her feet. As the first plane hit the tower, she initially experienced shock and disbelief and then an overwhelming sense of horror. She saw people running from the scene, covered in dust, bleeding and screaming. When she noticed others around her fleeing from falling debris, she too began finding her way out of the area. She heard sirens as she hurried away to safety. She did not go to any shelter or help station, and instead went home to her apartment, where she watched the unfolding events on the news.

Over the next several days, she had intrusive thoughts and vivid memories of the event and struggled with sleep as a result of nightmares. She continued to watch the news, which replayed videos of the event regularly. She called her best friend (who lived out of state) several times to talk over her fears, and eventually, her friend recommended she consult a mental health provider, given that these issues were interfering with Juana's functioning (i.e., she had stopped looking for work).

By the time she had her initial appointment with a mental health provider, it had been approximately 3 months since the trauma. Her intrusive thoughts and nightmares were significantly reduced, but she was confused as to why this might be and what it could mean. She also had started having more nightmares related to childhood physical abuse. She was unsure whether she wanted to engage in any therapy because she didn't think she was "crazy," but she was willing to hear the provider's recommendations.

During the assessment, the mental health provider learned that Juana was rarely leaving her apartment, avoided newspapers, no longer watched the news, and started smoking cigarettes again, after having quit for 4 years. Juana communicated a negative self-concept, perceived the world as unsafe, and took every possible step she could think of to limit possible exposure to additional trauma (e.g., took a route to the grocery store that avoided all government buildings and offices, though it took nearly triple the amount of time to do so). Juana believed those behaviors to be perfectly reasonable and strongly believed her perceptions were rooted in fact. Her mood fluctuated significantly throughout the day, and she often cried in the evenings when she thought of the pain other people suffered as a result of the terrorist attack and how she had "gotten away unharmed." She has not had any thoughts of harming herself or anyone else, and she

tells her therapist that she is not sure why she deserved to survive when others did not.

Juana presented with several risk factors that could increase the likelihood of her having longer term challenges (e.g., limited social support, history of childhood trauma, proximity to the event). Juana communicated symptoms of avoidance and changes in emotions, behaviors, and thoughts. Importantly, these symptoms are negatively impacting her functioning. Her self-care and health behaviors also changed; she restarted smoking, and she was upset at feeling so "weak" and perceived herself as unable to cope with her problems without nicotine.

Juana was not entirely sure she even needed therapy, nonetheless a therapy with the word "prolonged" in the title. The therapist explored Juana's interest in, and motivation to, engage in therapy. Through this effort, and in collaboration with Juana, it became clear that Juana's functioning and quality of life were being significantly impacted by her avoidance symptoms. She told her therapist that while she believed the changes in her behavior were entirely reasonable, she would like to be able to leave her apartment more often and "get back into my life."

Because her symptoms had persisted past the acute and intermediate stages, and because of the nature of her symptoms and her stated goals, the therapist discussed the option of prolonged exposure therapy with Juana. Crisis counseling and PFA were determined inappropriate given the stage of her symptoms and though some symptoms have improved, additional symptoms had developed and were likely to continue and/or worsen given her patterns of avoidance. Thorough time was taken to ensure Juana understood why the therapist was recommending treatment, normalizing trauma reactions and ensuing challenges, explaining the nature of this therapy and discussing expected outcomes, potential challenges, and Juana's concerns. The therapist communicated that PE is an evidence-based, time-limited therapy. Ultimately, Juana decided to engage in treatment.

Juana's course of therapy included education, skill training, exposure (in vivo, imaginal), homework, and relapse prevention. Through education, she was taught about trauma reactions, PTSD, symptoms and how therapy seeks to address those symptoms. She learned breathing retraining as a skill to manage acute distress. Through exposure exercises, the distress she experienced in association with certain situations and memories was reduced. She was regularly assigned (and completed) homework to help her practice what she was learning and to conduct exercises that would help reduce anxiety over time. Her therapist worked with her to proactively consider factors that could contribute to exacerbations of symptoms or relapses.

Within 12, 90-minute, office-based sessions occurring on a weekly basis, Juana addressed the cognitive and behavioral avoidance symptoms that were negatively impacting her functioning, learned to differentiate safe and unsafe situations, and experienced reduced distress associated with the trauma by the end of her treatment. While she continued to experience some level of anxiety associated with memories of the trauma, she rated them as significantly lower than prior to therapy. She believed she reached her goal to "get back into her life" as evidenced by increased frequency of leaving the apartment, longer durations of excursions away from her apartment, and increased engagement in meaningful activities that were previously prevented as a result of avoidance.

CONCLUSIONS AND KEY POINTS

This chapter reviewed the evolution of treatment approaches to aid survivors of trauma, largely motivated by the dearth of evidence-based techniques that were present during past mass casualty events, including Hurricane Katrina and the 9/11 terrorist attacks. Mass traumatic events impact individuals and communities, leading to increased prevalence of psychological distress and mental illness, and require effective evidence-informed approaches to adequately address the presenting concerns. Trauma response approaches typically rely on the PIES model and incorporate acute, intermediate, and long-term interaction stages.

Furthermore, central interventions and treatments were examined to emphasize their role in the provision of services to traumatized individuals. PFA is a short-term single intervention, which is proximally administered within the acute stage in response to mass traumas. Affected individuals are provided support and education to assist them in resuming their daily lives and usual functioning, or they are identified as persons potentially needing further assistance and more thorough treatment. Community interventions are implemented during the intermediate stage in an attempt to restore individuals to their previous level of functioning. During this period "at-risk" individuals can be provided crisis counseling, consisting of four to eight sessions during the weeks and months following the traumatic event. Crisis counseling aims

to increase one's available coping skills, decrease symptomatology, and ultimately avoid the development of a psychiatric disorder.

More formal mental health treatment, or traditional psychotherapy, may be provided during the long-term recovery stage. Only a fraction of the population experiencing the trauma will consequently need these services, but for the individuals that do, their symptoms can be severe and encompass a wide array of disorders. During this stage, treatment is typically provided by licensed clinicians and utilizes evidenced-based approaches, which are targeted to the specific symptoms being experienced by the individual. These stages represent the spectrum of treatment that can be provided to individuals who have experienced a mass casualty event.

REVIEW QUESTIONS

1. What are the goals of psychological first aid?
2. How does intervention differ from treatment for mass casualty events?
3. What indicators should be considered to determine if a person receiving crisis counseling might need more intensive, longer term treatment?
4. How do the qualifications of the service providers differ across the spectrum of clinical involvement?
5. If Jane had been provided psychological first aid, what components might have been used, and what would the goals of this intervention have been?

AUTHOR NOTE

The views expressed are the views of the author(s) and not that of VHA.

RESOURCES

Websites

American Psychological Association, Disaster mental health training opportunities: http://www.apa.org/news/press/response/disaster-training.aspx

American Red Cross: http://www.redcross.org/tn/knoxville/disaster-services/dat/mental-health

David Baldwin's Trauma Information Page: http://www.trauma-pages.com/disaster.php

FEMA: http://www.fema.gov/recovery-directorate/crisis-counseling-assistance-training-program

HHS Disaster Behavioral Health Concept of Operations: http://www.phe.gov/Preparedness/planning/abc/Documents/dbh-conops-2014.pdf

Medical Reserve Corps: http://www.medicalreservecorps.gov/HomePage

National Center for PTSD: http://www.ptsd.va.gov/public/treatment/therapy-med/disaster_mental_health_treatment.asp

Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov/find-help/disaster-distress-helpline

United States Centers for Disease Control and Prevention: http://www.emergency.cdc.gov/mentalhealth

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Psychotherapy in Clinical Emergencies: Theory and Practice

Danielle Spangler
Lori Holleran
Bruce Bongar

Abstract
For individuals working in clinical practice, it is likely that these clinicians will face clinical emergencies during their career. Therefore, it is necessary for clinicians to competently prepare for working with patients who may become suicidal, patients who might threaten violence toward others or the clinician, and patients who report being victims of violence. In this chapter we describe how ongoing risk assessments, proper interventions, adequate documentation, and frequent consultation have been found to improve the clinician's ability to make decisions regarding patients' potential risk and harm levels. Additionally, this chapter will examine avenues through which clinical emergencies influence health care providers.

Keywords: suicide, violence, victim, victimization, risk factors, emergency, documentation, management, assessment

The section for Emergencies and Crises (section VII) within the Society of Clinical Psychology (Division 12) of the American Psychological Association (APA) defines a clinical emergency as an event in which a patient is at risk for acting in a way that will result in serious harm or death to self and/or others, unless an intervention occurs (Kleespies, 2000). The present chapter considers ways in which clinicians evaluate, manage, and provide services to patients who are in the midst of a clinical emergency. This chapter focuses primarily on suicide, as it is the most common clinical emergency (Bongar, 2002). It also explores clinical emergencies with violent patients and patients who are victims of violence.

Throughout history, psychotherapy during clinical emergencies has aimed to provide patients with immediate treatment, in order to reduce and remove harm while also ameliorating symptoms of distress (Bellak & Small, 1965). Although the goal for treatment has remained consistent over the past 50 years, several advancements in the treatment and protection of patients who experience a clinical emergency have progressed. For example, the use of electroconvulsive therapy (ECT) for the treatment of suicidal patients has advanced across decades. In the mid-1960s, ECT was used when clinicians believed that patients had a high risk for harming themselves and did not trust the use of psychotherapy alone (Bellak & Small, 1965). In fact, many psychiatrists during this time preferred ECT to psychotropic medication as an intervention, when aiming to avoid hospitalization. Although ECT continues to be utilized today, the American Psychiatric Association Practice Guidelines have established the support of this

treatment for patients who have been resistant or unsuccessful with alternative forms of treatment first, or for suicidal patients who are pregnant and psychotropic medication is not recommended (Jacobs & Brewer, 2004).

In addition to advancements in treatment, there have been advancements in legislation regarding work with patients during clinical emergencies. Laws have evolved to protect patients who present to treatment with a clinical emergency, as well as to protect their community. In the case of *Dillmann v. Hellman* (1973), a clinician was found to have "failed to protect" a patient from committing suicide due to an inadequate risk assessment. After this tragedy a shift in treatment and documentation occurred, which placed a major focus on protective measures for patients. The "standard of care" is the term used to define the legal yardstick by which professional actions are measured (Jobes & Berman, 1993). Foreseeability is the reasonable assessment of risk for a patient. Clinicians are now expected to evaluate a patient's degree of risk based on clinical judgments, known risk factors, and mental status. Reasonable care is the extent to which the therapist takes the necessary precautions and appropriate interventions to keep the patient safe after assessing risk. Negligence occurs when the therapist does not act appropriately or does not act at all to keep the patient safe (Bongar & Greaney, 1994). The California Civil Code section § 56.10 (2009), states that professional negligence is a "wrongful death" caused by a therapist's negligent act or omission to act in providing adequate services that are within the therapist's scope of practice.

Other advancements regarding safety surfaced following another tragedy in history, where an innocent individual was killed after a patient voiced his intent to kill during therapy. From this case was the Tarasoff decision, which established the clinician's "duty to warn and protect" (Tarasoff v. Regents of the University of California, 1976). This ruling established that clinicians have the responsibility to warn an identifiable victim or victims to a threat of harm, based on threats made by their client, and to notify the police who are ultimately responsible for the protection clause under the Tarasoff decision. Today, the specific action(s) required by the clinician varies across states. It has become exceedingly important for clinicians to be familiar with the governing laws regarding their state-specific responsibilities.

With the evolution of psychotherapy in clinical emergencies and advancements in legislation, language and the differentiation of commonly used terms have also evolved in recent years (Callahan, 2009). Callahan (2009) found various inconsistencies throughout the literature, where the terms "clinical emergency" and "clinical crisis" had been used interchangeably. A "clinical emergency" involves the threat of danger or harm to an individual, and therefore requires immediate intervention, whereas a "clinical crisis" involves the "loss of psychological equilibrium or a state of emotional instability that includes elements of depression and anxiety" and requires prompt intervention (Callahan, 2009, p. 15). The urgency of intervention for a patient who experiences a clinical emergency is greater than a patient who experiences a clinical crisis; therefore, it has become necessary that these terms are understood and used as distinct clinical states.

MAJOR THEORETICAL DEVELOPMENTS AND VARIATIONS OF PSYCHOTHERAPY IN CLINICAL EMERGENCIES

Several psychotherapeutic developments have been established regarding clinical emergencies. These include systematic treatment selection (STS; Beutler & Clarkin, 1990), counseling on access to lethal means (CALM; Johnson, Frank, Ciocca, & Barber, 2011), and dialectical behavior therapy (DBT; Linehan, 1993). STS is a principle-driven, integrative treatment approach (Beutler, Harwood, Bertoni, & Thomann, 2006). It promotes a combination of therapeutic techniques, drawn from various theories, in order to provide services that best match the needs of the patient. The goal of STS is to identify interventions that will benefit a particular patient, through the completion of a computerized assessment (Beutler, Williams, & Norcross, 2008). This assessment measures various predictive dimensions, including risk status. Additionally, the assessment includes items that measure depression, hopelessness, thoughts of harming one's self, and thoughts of harming others (Beutler et al., 2008).

Another major development in clinical emergency psychotherapy is known as means restriction counseling. Means restriction counseling involves educating a dangerous or suicidal patient about the risks of having lethal weapons readily available

within a household (Bryan, Stone, & Rudd, 2011). Using means restriction counseling, the clinician provides the patient with psychoeducation regarding risk factors associated with easy access to lethal weapons, and also assists the patient in developing a plan for reducing access or removing the weapon(s) from the home. One program specifically focused on examining and reducing access to lethal means is CALM (Johnson, Frank, Ciocca, & Barber, 2011). CALM is a 2-hour online course that teaches clinicians how to ask suicidal patients about their access to lethal weapons, and also how to work with patients and their families to reduce access to such objects.

DBT is another psychotherapy that has been used during clinical emergencies. DBT was created specifically for working with suicidal patients diagnosed with borderline personality disorder, and it is the gold standard for this population (Linehan, 1993). DBT was adapted from cognitive-behavioral therapy and works toward assisting suicidal patients by teaching four behavioral skills: mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation. Mindfulness encourages the patient to be fully aware and present in the moment. Distress tolerance teaches patients how to cope with unpleasant situations without changing them. Interpersonal effectiveness trains patients how to advocate for themselves and set boundaries without rupturing relationships with others. Emotional regulation focuses on ways that patients can manage and change their emotions.

PRINCIPLES OF CHANGE AND CASE CONCEPTUALIZATION

There are various principles of change associated with the patient's risk of presenting to treatment during a clinical emergency. It is necessary that the clinician be able to conceptualize the patient's risk by exploring factors that impact the client's likelihood of engaging in and falling victim to dangerous behaviors. In doing so, suicidal and homicidal patients, as well as patients who are victims of violence, must each be understood based on the factors that increase the likelihood of presenting to treatment with a clinical emergency.

Suicidal Patients

Suicide was the 10th leading cause of death in the United States in 2010 (Heron, 2013), and it is a major mental health concern worldwide. The Center for Disease Control and Prevention (CDC) determined that nearly 40,000 individuals completed suicide in the United States in 2011 (CDC, 2011). Themes in the literature suggest that any patient may develop suicidal ideation; thus, all therapists must be prepared to respond to this clinical emergency (Bongar, 1991). It has been found that up to 22% of psychologists reported losing a patient to suicide during the course of their professional career (Chemtob, Hamada, Bauer, Torigoe, & Kimmey, 1988). Accordingly, it is imperative for all clinicians to be aware of the particular factors that increase and decrease the patient's risk for engaging in such behavior.

Risk Factors

There are many risks related to suicidal behavior in patients. Gordon and Melvin (2014) highlighted that some risk factors are static, whereas others are considered to be dynamic. Static risk factors are described as the variables in a patient's life that remain the same over time such as past attempts and family history. Dynamic risk factors, however, are variables that can be changed through treatment like suicidal ideation, and current stressors.

Bongar and Sullivan (2013) identified the following risk factors with strong empirical support: mental disorders, previous suicide attempts, and psychosocial dimensions. Current psychiatric diagnosis increases the patient's risk of suicide, particularly for patients with mood disorders. Nearly 86% of suicide completers examined had a psychiatric diagnosis (Parra Uribe et al., 2013), approximately 60% of whom presented with mood disorders (Molero et al., 2014). Furthermore, a patient's risk for suicide is increased if he or she had previously attempted suicide (Jacobs et al., 2003). Therefore, it is necessary that clinicians consider the patient's history of suicide attempts, and psychiatric diagnosis(es) at the onset of treatment. Additional risk factors for suicide include psychosocial dimensions such as lack of support, stressful life events or life changes, unemployment, and familial stress. These dimensions should be assessed throughout treatment (Jacobs et al., 2003).

Protective Factors

Family and social supports, along with religious beliefs, have been described as protective factors.

However, it is the quality of these relationships that determine the degree to which these domains bolster one's resiliency (Bongar & Sullivan, 2013). Individuals with positive familial relationships and a strong connection to their faith or religious group are likely to benefit from these protective factors. Conversely, individuals who develop a sense of disconnection from these networks may have an increased risk for suicide, particularly when feeling rejected and hopeless. Other protective factors involve positive (i.e., healthy, well-developed) coping skills, socialization, and positive problem-solving skills (American Psychiatric Association, 2003).

Violent Patients

Encountering a violent patient in clinical practice is a distressing clinical emergency for many professionals for a multitude of reasons. It was found that nearly 90% of psychologists had a fear that their patient would assault an outside party during treatment (Pope & Tabachnick, 1993). These fears are not necessarily unfounded when recognizing that approximately 60% of psychologists may be treating patients who have previously assaulted another person. Furthermore, personal safety is a potential concern with 50% of psychologists reporting being threatened by a patient, and 40% reporting having been physically assaulted (Guy, Brown, & Poelstra, 1990). However, mental health professionals who are most at risk for assault by a patient are novice therapists, either in their graduate study or during the first 5 years of their clinical training (Guy et al., 1990).

Correlates of Risk for Violence

There are various risk factors that may make a patient more likely to commit interpersonal acts of violence. McNeil (2009) indicated that risk factors could best be understood by examining personal history variables, clinical variables, and situational variables. Personal history variables involve the person's history of violence, history of victimization, age, gender, socioeconomic status, and level of intelligence. Clinical variables involve the patient's diagnosis(es), symptoms, and treatment adherence. Situational variables consist of various life circumstances that potentially increase the patient's risk of engaging in violent acts toward others. This involves the patient's level of social support, or a lack thereof, his or her access to firearms, his or her relationship with the potential victim, the availability of the potential victim, and whether the patient has stable housing.

Personal Variables

Specific variables associated with a patient's personal history have been found to increase the likelihood of engaging in violent acts toward others. Having a history of violence toward others increases the likelihood that a patient will act violently in the future (McNeil, 2009; Monahan et al., 2001). A patient's history of victimization may also increase his or her risk of future violence (McNeil, 2009). Additionally, research has found that young males between the ages of 18 and 29 years are most likely to commit acts of violence against others (Swanson, Holzer, Ganju, & Jono, 1990). Another variable that influences a patient's risk of violence involves the patient's socioeconomic status, with lower socioeconomic status indicating a potential increase in engaging in acts of violence due to increased likelihood of previous exposure to violent behaviors (Swanson et al., 1990).

Clinical Variables

Clinical variables such as the patient's diagnosis(es), symptoms, and adherence to treatment influence his or her risk for engaging in aggressive and violent behaviors. Patients with mental illness engage in violent behaviors at a greater rate than individuals within the same community not experiencing mental illness (Steadman et al., 1998). Particular disorders associated with an increased risk for violence include substance use disorders and personality disorders (Andrade, O'Neill, & Diener, 2009; Monahan et al., 2001), specifically antisocial personality disorder and borderline personality disorder (McNeil, 2009). A socially deviant lifestyle (i.e., promiscuity, impulsivity, substance use), superficial interpersonal relationships, and an inability to take responsibility for one's own actions are specific traits among these latter disorders that increase the patient's risk for engaging in violent behaviors.

Apart from specific diagnostic risk factors, patients who present with specific symptoms have an increased risk for violence. Patients who are aggressive or hostile are particularly at risk due to their tendency to experience challenges managing emotions

(McNeil, 2009). Additionally, individuals who experience violent command hallucinations, which instruct the patient to behave in a particular way, have an increased risk of violence toward others (Monahan et al., 2001). Furthermore, patients who are treatment resistant or nonadherent to their treatment plans may also have a higher risk for violence due to potential skills deficits for managing stressors (Andrade et al., 2009; McNeil, 2009).

Situational Variables

There are specific life situations that have been found to increase the patient's risk for engaging in violence toward others. Patients are more likely to commit an act of violence toward others with whom they have a relationship (Monahan et al., 2001). Therefore, it is important to assess for interpersonal conflict when meeting with patients to gain an understanding of the dynamics of their social relationships. Other risk factors involve the availability of the potential victim. Patients with an identified victim or access to their victim have an increased risk for engaging in violent behavior (McNeil, 2009). Additionally, patients with access to weapons have a much higher risk for acting violently, particularly for patients who struggle with impulsivity (Riggs, Caulfield, & Fair, 2009).

Victims of Violence

In the United States, 50%–70% of individuals will become victims to at least one violent event during the course of their lifetime (McCart, Fitzgerald, Acierno, Resnick, & Kilpatrick, 2009). When considering the influence of victimization within a clinical setting, it has been found that nearly 80% of clinicians fear that their patient will be a victim of violence (Pope & Tabachnick, 1993).

Risk Factors

The CDC defines intimate partner violence (IPV) as acts of emotional or verbal abuse, physical violence, or sexual assault. Specific situational factors have been found to increase a patient's risk for falling victim to IPV (Riggs et al., 2009). Relational conflict or verbal disputes precede 80%–90% of violent interactions between intimate partners (Cascardi & Vivian, 1995). Another situational factor that increases the likelihood of IPV is alcohol use. Similarly, problematic alcohol consumption increases the risk for IPV, with alcohol consumption present in approximately 25% of IPV incidents (Riggs et al., 2009). Moreover, relationship termination increases a patient's risk for IPV. Specifically, women are at an increased risk for experiencing IPV when attempting to leave their relationship (Campbell et al., 2003).

RESEARCH ON EFFICACY AND EFFECTIVENESS OF PSYCHOTHERAPY IN CLINICAL EMERGENCIES

Effective psychotherapy is imperative when patients are facing a clinical emergency. Fortunately, research aimed at finding effective treatments for clinical emergencies continues to grow and evolve. Many of these findings have assisted in the creation and improvement of effective interventions, whereas other findings have discredited interventions that are ineffective.

Suicide

Psychotherapy practices that implement dialectical behavior therapy, means restriction, and an assessment of hopelessness are particularly effective when treating suicidal patients. Dialectical behavior therapy has been found to decrease a patient's likelihood of requiring hospitalization due to suicidal ideation and decrease the likelihood of attempting suicide (Linehan et al., 2006). Furthermore, providing patients and families with education about the benefits of reducing access to lethal means within the home serves as a protective factor for individuals who are suicidal (Brent, Baugher, & Birmaher, 2000). Hopelessness has been repeatedly shown to be a predictor for suicidal ideation and attempt. Similarly, interventions geared toward instilling hope (i.e., behavioral activation) have demonstrated that decreases in hopelessness lead to reductions in suicide ideation (Hopko et al., 2013). Many assessments for detecting suicidal ideation now have items that directly assess for hopelessness, which are particularly useful in tracking the patient's emotional state and providing appropriate interventions.

Violence

There are various effective interventions used in psychotherapy for violent patients (McNeil, 2009). One effective intervention for treating violent patients is the use of verbal interventions, such as limit setting. Verbal interventions with violent patients are increasingly effective when the clinician employs clear communication regarding expectations and the reasons why certain behaviors are unacceptable. Anger management interventions are also used for treating violent patients. Techniques such as progressive relaxation and cognitive therapy have been found to be effective in decreasing the patient's risk for future violence (McNeil, 2009).

Victimization

Psychological first aid is an effective treatment intervention following a traumatic event (National Institute of Mental Health, 2002). This particular psychotherapy intervention has been found to be effective in treating victims of violence (as outlined in the treatment section that follows). Critical incidence stress debriefing (CISD) has previously been used following various different traumatic events (Mitchell & Everly, 1996). CISD is an intervention provided to patients 24 to 72 hours following exposure to a traumatic event, typically at or near the place to which the trauma occurred. Although this was once a commonly used intervention, Division 12 of APA has since concluded that the research does not support the use of this treatment; in fact, they have determined that it is potentially harmful to the patient as it may interfere with a patient's natural ability to recover from trauma (Van Emmerik, Kamphuls, Hulsbosch, & Emmelkamp, 2002).

DIVERSITY AND PSYCHOTHERAPY IN CLINICAL EMERGENCIES

The CDC (2010) reported that the highest suicide rates in the United States were among American Indians (approximately 17.5 per 100,000), followed by suicide rates among non-Hispanic Whites (~16 per 100,000), Hispanics (~7.25), Asians (~6.5), and non-Hispanic Blacks (~6). When considering adolescents and young adults, American Indians are 2.5 times more likely than the national average to commit suicide. Additionally, males are four times more likely to commit suicide than females. Men most commonly use firearms to commit suicide, although females more commonly use means of poison. These findings demonstrate that American Indians and Caucasians have a disproportionately higher risk of suicide when compared to any other race in the United States. Furthermore, males are much more likely than females to complete suicide, although females account for significantly fewer suicides, which may be related to the disparities regarding choice of means utilized between genders.

It is necessary to account for cultural diversity when working with patients during a clinical emergency. There are various risk factors specific to cultural minorities that went undetected in suicide risk assessments prior to the development of the Cultural Assessment of Risk for Suicide (CARS; Chu et al., 2013). Specific culture-bound factors were identified as having an impact on suicide risk for African Americans, Asian Americans, Latina/o Americans, and sexual minority patients (Chu, Goldblum, Floyd, & Bongar, 2010). These risk factors inform culturally relevant themes: cultural sanctions, idioms of distress, minority stress, and social discord, which are assessed through the CARS. The CARS is a 39-item self-report questionnaire that was designed to assess the risk factors of suicide in marginalized populations, through the use of a Likert scale.

With respect to violence, men and women from low socioeconomic status and who are under the age of 45 are most likely to be perpetrators of violent acts (Rueve & Welton, 2008). Gender, age, and race are all factors that have been found to correlate with victims of violence (Catalano, 2006). Additionally, young patients have an increased risk for victimization. Among all individuals who were victimized by rape, robbery, or assaults, over 45% of the patients were between the ages of 12 and 24 years (CDC, 2003). With regard to ethnicity, men and women that are African American or Hispanic are more likely to be victims of violence than Caucasians. Additionally, gender is correlated with the type of violent act that is committed against a patient. Women are more likely to experience violence in the form of sexual assault, whereas men experience violence in the form of physical assault and robbery.

TREATMENT

The following section is divided into three parts, which address the treatment of patients who

experience a clinical emergency. First, this section will identify various steps that a clinician may take in order to aid in the management of clinical emergencies with patients presenting for treatment. Second, measures that are used for assessing risk are considered. Assessments are particularly valuable as they provide information that the patient may not disclose during a psychotherapy session. Finally, particular treatment interventions used to manage a clinical emergency are addressed.

Managing Clinical Emergencies

Documentation

Documentation is an important ethical practice for working with patients and a crucial step for effective risk management during clinical emergencies (Lee & Martlett, 2005). In effective risk management, clinicians will have detailed written statements specific to working with each patient during a clinical emergency. These statements should include documentation of assessments, evaluation, consultation and supervision reports, progress notes, and the formal treatment plan (Jobes & Berman, 1993; Lee & Martlett, 2005). It is necessary to document each action taken by the clinician to ensure adequate care is demonstrated (Jobes & Berman, 1993). Therapists who are able to demonstrate that they took preventative measures based on the patient's identifiable level of risk are less likely to be found liable for the patient's actions, such as suicide (Bongar & Greaney, 1994). It is for this reason that documentation is crucial, particularly when working with patients who are in an emergency state.

Consultation

Consultation is extremely important when managing clinical emergencies. When treating a suicidal patient, it is crucial to consult with a trusted colleague regarding any uncertainty (Bongar & Sullivan, 2013). Patients who have made the decision to commit suicide may not reach out to their therapist. Conversely, patients who have thoughts of suicide might look to the therapist for support, become demanding on the therapist's attention, and make frequent calls to the therapist (Bongar & Sullivan, 2013). For this reason, it is important that the therapist is connected to a competent colleague who can be consulted to gain a more objective assessment of patient risk and therapist intervention strategies (Lee & Martlett, 2005). Similarly, colleagues are resources that can be used to consult with further about ethical and legal issues within the treatment of a specific case (Jobes & Berman, 1993).

Similarly, consultation is important when managing violent patients. Clinicians who are unsure of the accuracy of their risk assessment might consult with a colleague to gain a second opinion with regard to risk (McNeil, 2009). As outlined earlier in the chapter, improper assessment of risk could potentially impact the clinician's decision to report the threat of harm, and as a result an identified victim might be harmed in the process. It is best that clinicians seek consultation from a trusted colleague to ensure that they are providing the highest quality of care for the patient and for any potential victim.

Consultation is also useful for clinicians who have patients that are victims of violence. Victims of numerous violent acts may express homicidal or suicidal ideation (McCart et al., 2009). It is necessary for clinicians to take these claims seriously and to conduct a risk assessment to determine the severity of these claims. Consultation may also benefit clinicians who have limited experience working with victims of violence. Although clinicians may not break confidentiality when a patient experiences victimization, they can seek consultation from trusted colleagues to better assist the patient during a clinical emergency.

Knowledge of Community Resources

In order to be adequately prepared for clinical emergencies, clinicians should have an up-to-date list of varied resources. A referral list must be updated often and consist of references that are reliable (Jobes & Berman, 1993). Community resource services might include outpatient therapy, day treatment centers, inpatient psychiatric evaluation, 24-hour crisis centers, and hotlines (Bongar, 1991; Jobes & Berman, 1993). Most communities have crisis centers that provide services for clinical emergencies such as rape, suicide prevention, homelessness, and domestic violence (Brown, Frahm, & Bongar, 2012). Another aspect of this list may include the numbers for appropriate mobile crisis intervention teams. Additionally, the list

may include the contact information of specific colleagues whom the clinician can consult with about the patient's risk and intervention strategies.

Integrating Multiple Systems Into Care

There are various safeguards that a therapist can set in place during clinical emergencies. These might include arranging that a therapist will be available for the patient to call 24 hours a day, increasing the client's number of sessions per week or extending the length of sessions, closely monitoring medication, and implementing more frequent assessments (Lee & Martlett, 2005). Furthermore, when the patient is in a clinical emergency, mental health professionals may need to involve the patient's family members or other social supports as part of the treatment and the resolution of the crisis (Bongar & Sullivan, 2013). This intervention is optimal when the therapist and patient collaborate and agree to the family's participation (Lee & Martlett, 2005). However, the APA ethics code (2002) states that a therapist has the authority to disclose confidential information without consent in order to protect patients from harming themselves or others. It is important that mental health professionals also collaborate with family and social supports because interpersonal relationship difficulties increase the patient's risk for suicide (Jacobs et al., 2003).

Furthermore, involving families in treatment can be particularly effective for violent patients. McNeil (2009) has indicated that providing a patient's family with education about warning signs of decompensating, and coaching them on ways to de-escalate conflicts, aid in reducing the patient's likelihood for engaging in violent behaviors.

Means Restriction

Restriction of means is a crucial part of managing patient risk for both violent and suicidal patients. Having the means to complete suicide, or to commit a violent act toward another individual, greatly increases the risk for fatal results (Brent & Bridge, 2003; McNeil, 2009). Death through the use of a firearm is the leading cause of completed suicide in the United States (Bryan, Stone, & Rudd, 2011) and accounts for 51% of all suicides (CDC, 2012). Patients with access to firearms within their household, who also have an increased degree of impulsivity, have higher suicidal risk (Brent & Bridge, 2003; McNeil, 2009). In 2012, the Web-based Injury Statistics Query and Reporting System (WISQARS) determined that the prevalence of completed suicides through the use of firearms accounted for more than 20,000 deaths (CDC, 2012).

Violent and suicidal patients are unlikely to report that they have access to firearms, unless directly asked by a professional (McNeil, 2009). For this reason, it is necessary that clinicians directly inquire about the patient's access to firearms (Bongar & Sullivan, 2013). Clinicians must work with patients who report having firearms within the household to develop a plan for removing these weapons from their household or removing personal access. This safety plan must never involve the therapist storing such objects. Although patients might show initial hesitation and resistance, it is important to note that means restriction is temporary. Clinicians must establish that the goal of means restriction is not to remove the patient's autonomy or sense of control, but instead is used to ensure safety during a clinical emergency (Bongar & Sullivan, 2013). Similar to the patient's clinical emergency, means restriction is also time limited. Restricting the patient's access to lethal means during a clinical emergency is both crucial and necessary for adequate risk management.

Duty to Protect

As mentioned earlier in the chapter, clinicians have the important duty to protect patients from harming themselves. Additionally, clinicians have the responsibility to protect identified victims from potential harm caused by their patient. It is necessary for clinicians to adequately utilize risk assessment procedures in an attempt to properly determine the presence of risk among their patients.

Assessment Measures

Assessment Tools for Suicidal Patients

There are various assessment tools a clinician may utilize to appraise a patient's suicidal thoughts and behaviors. Currently there fails to be a standard measure for suicidal behavior; therefore, clinicians potentially use a multitude of measures to assess patient suicidality. Common measures used include the following: Beck Depression Inventory-II

(BDI-II; Beck, Steer, & Brown, 1996), Beck Scale for Suicide Ideation (BSS; Beck & Steer, 1991), Firestone Assessment for Self-Destructive Thoughts (FAST; Firestone & Seidan, 1990), Linehan Reasons for Living Inventory (LRFL; Linehan, Goodstein, Nielsen, & Chiles, 1983), and as outlined earlier in the chapter, the Cultural Assessment of Risk for Suicide (CARS; Chu et al., 2013).

The Beck Depression Inventory (BDI-II) was designed to assess whether the patient has experienced depressive symptoms over the past 2 weeks (Beck, Steer, & Brown, 1996). The BDI-II also measures the severity of the patient's current depressive symptoms, as it has been determined that patients who are depressed have an increased risk for suicide. Bolton, Pagura, Enns, Grant, and Sareen (2010) examined the specific symptoms of depression in patients who attempted suicide. The results from the study determined that anhedonia, worthlessness, and guilt, as well as the total number of depressive symptoms endorsed by patients had a significant association with patient suicide attempts. In addition to depressive symptoms, one item on the BDI-II specifically asks about the patient's "suicidal thoughts or wishes." Another measure used to assess for suicidal behavior is the Beck Scale for Suicide Ideation. This scale is a 21-item measure that assesses the severity of suicidal ideation, plans, and preparation over the past week (Beck & Steer, 1991).

The Firestone Assessment of Self-Destructive Thoughts (FAST) was developed to address the belief that self-destructive behavior is influenced by a negative thought process (i.e., negative inner "voice") (Firestone & Seidan, 1990). The FAST assesses the level of self-destructive thoughts that a person experiences. It can be used as a screener or to measure changes in self-destructive behaviors over time. The 84 items on the assessment highlight the self-destructive thought patterns that influence the patient's behavior. Patients report the frequency that each negative thought occurs through the use of a 5-point Likert scale. This information is then used to tailor treatment interventions.

Another assessment tool is the Linehan Reasons for Living Inventory (LRFL). There are two versions of this assessment, a 48-item and a 72-item self-report measure. The LRFL measures the patient's strength of commitment *not* to die. This assessment was created under the notion that failing to have a positive reason to live is as strong of a contributor for patient suicide as the patient's desire to die (Linehan et al., 1983). Using a Likert scale, patients are asked to rate various different reasons for not killing themselves (1 = not at all important, 6 = extremely important). The different subscales of this assessment include Survival and Coping Beliefs, Responsibility to Family, Child-Related Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objections.

Assessment Tools for Violent Patients

Risk assessments may be used to assist in predicting the patient's short-term and long-term risk for violence (Andrade et al., 2009). Common measures that assess a patient's risk for engaging in violent behavior include the Historical, Clinical, Risk Management- 20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997), the Hare Psychopathy Checklist-Revised (PCL–R; Hare, 1991, 2003), and the Violence Risk Appraisal Guide (VRAG; Quinsey, Harris, Rice, & Cormier, 1998). Additionally, assessment tools for measuring recidivism for perpetrators of IPV have been developed. The Spousal Assault Risk Assessment (SARA; Kropp & Hart, 2000) and the Danger Assessment (DA; Campbell, 1986) are assessment tools that were design to gather information about perpetrators of violence to determine their likelihood of future recidivism.

The HCR-20 is a 20-item structured professional judgment tool designed to assess three major areas of risk for violence: historical factors, clinical factors, and risk management factors (Webster et al., 1997). The HCR-20 has 10 items that assess historical variables, 5 items that assess clinical variables, and 5 items that assess risk management factors. Items are scored as *not present* (0), *possibly present* (1), or *definitely present* (2), producing a score from 0 to 40. This tool assesses patient risk based on severity (low, moderate, or high). The HCR-20 has been found to be effective in assessing risk for future violence (Webster et al., 1997).

The PCL-R is a 20-item checklist assessing for psychopathology (Hare, 1991). It was developed from Cleckley's model of psychopathology as described in *The Mask of Sanity* (1941), while also incorporating the behavioral focus that characterizes the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). The PCL-R relies on information gathered through file review, interviews, and collateral sources to inform ratings on the 20-item checklist encompassing four factors: Interpersonal, Affective, Lifestyle, and Criminal History (Hare, 2003). Although the

PCL-R was not originally constructed as a risk assessment, it has become a measure that is often used to assess for recidivism of violent offenses, with higher psychopathy scores being presented as higher risk for reoffense (DeMatteo et al., 2014). Although factors 2 (Affective) and 4 (Criminal History) of the PCL-R may accurately provide information regarding potential recidivism, evaluators should interpret PCL-R findings with caution when providing statements regarding future risk (DeMatteo et al, 2014; Hawes, Boccaccini, & Murrie, 2013).

The VRAG is a 12-item actuarial measure utilized to predict risk in mentally disordered offenders (Quinsey et al., 1998). This brief measures estimates violence risk within a specific time frame following release. The VRAG relies on information gathered through clinical record review rather than interview or questionnaires to produce a score identifying the probability of future violent recidivism. The VRAG encompasses the PCL-R into its calculation of risk. Violence Risk scores range from –24 to 32, and they are classified into low (–24 to –8), medium (–7 to 13), and high (14–32) categories of risk (Quinsey, Harris, Rice, & Cormier, 2006).

The SARA (Kropp et al., 2000) predicts recidivism over a 4-year period, by examining the perpetrator's criminal and psychological history, along with the history of engaging in IPV.

Unlike the other measures, the DA is actually administered to patients who were victims of violence (Campbell, 1986). The DA is a 15-item checklist that collects information regarding the perpetrator's substance abuse, threats, and escalation patterns, and determines the likelihood that the perpetrator will engage in acts of violence again.

Assessment Tools for Victims of Violence

Currently there is a paucity of assessment tools that measure a patient's likelihood of being a victim of violence. This is due to the inconclusive results of specific characteristics that increase a patient's risk for victimization. However, assessment tools for measuring recidivism in perpetrators of IPV have been developed, as outlined previously.

Psychotherapy in Clinical Emergencies

Arguably, the most important role of a clinician is to observe patient behavior and assess whether the patient poses a threat to himself/herself or others. After the initial assessment, the clinician must then determine how best to manage whatever risk is presented. Although clinical emergencies are stressful situations for both seasoned and novice therapists, it is necessary that the therapist be able to provide support for the patient.

Psychotherapy for clinical emergencies is distinct from traditional psychotherapy in that it is time limited and is aimed toward assisting the patient's return to the level of functioning that he or she was at prior to the event (Brown et al., 2012). Although it is not uncommon for a patient to present to individual treatment facing a clinical emergency, it is much more likely for a clinical emergency to occur outside of the therapy room. As such, interventions most frequently take place at the site of the traumatic event or within a community mental health agency.

Kleespies and Richmond (2009) suggest that there are four important steps to effectively manage a clinical emergency. First, the clinician must be able to contain the patient's emotional reactions. Second, the issue that the patient is distraught about must be correctly identified. The clinician must quickly assess risk to determine whether the patient appears to have immediate risk to self or others. Finally, the clinician must determine the appropriate next steps to provide the patient with adequate care. These steps will rely heavily on the clinical emergency they are facing.

Brown and colleagues (2012) indicate that there are five steps involved with planning and implementing psychotherapy, after the emergency had been assessed. The clinician must first establish therapeutic rapport with the patient. Afterward, the clinician must assist the patient with describing the problem and determining a solution. Next the clinician must assist the patient to identify available resources, ways of coping, and sources that can provide them with support. Then the patient will determine one or two very specific, time-limited goals that will consider the patient's family, social network, and lifestyle. Finally, the clinician will assist the patient to implement the plan and determine a way for them to evaluate the effectiveness of the plan.

Clinical Risk Management

Although clinical risk management is extensively covered in the research on suicidal patients, the main aspects outlined in this section can be applied

to any clinical emergency. Clinical risk management involves treatment planning that optimizes clinical outcomes for suicidal patients (Bongar, 1991). A patient can become suicidal at any point; therefore, all clinicians must become competent in both the clinical and legal standard of care for working with suicidal patients (Bongar & Greaney, 1994; Jobes & Berman, 1993). Jobes and Berman (1993) urge each clinician to know the legal statutes relevant to suicide. Additionally, Bongar and Greaney (1994) advise all psychologists to have a knowledge base of what may constitute negligence and malpractice actions, along with an understanding regarding their responsibility to prevent a patient's suicide through specific intervention and assessment practices.

Clinical risk management begins during the initial session, where the clinician will explain the informed consent and limitations to confidentiality, along with screening the patient for risk and suicidal ideation (Pope & Vasquez, 2011). Patients who do not report suicidal ideation in the initial session still have the potential to become suicidal during therapy. Therefore, to maintain the highest level of care, suicide assessments should continue to occur periodically throughout treatment. Apart from risk assessment measures, various other sources of information can provide the clinician with insight regarding the patient's level of suicide risk (Bongar & Sullivan, 2013). This information consists of patient demographic variables and clinical interview outcome measures, along with family consultation and collaboration.

Interventions for the Suicidal Patient

Pope and Vasquez (2011) identified specific interventions for decreasing a patient's risk for suicide during clinical emergencies. One important intervention is for the clinician to establish clear communication early on. Another intervention relies on the clinician to encourage constructing a safe home environment for the patient. As mentioned earlier, this may include the removal of weapons from the home. Additionally, this may involve having a trusted friend or family member stay with the patient for a period of time. Other interventions that clinicians may implement involve the patient identifying reasons to live, as well as the clinician evaluating the patient's beliefs about suicide.

Interventions for the Violent Patient

Specific interventions have been used to decrease the risk that a patient will respond violently toward others (McNeil, 2009). As indicated earlier in the chapter, one intervention is the use of verbal interventions, such as limit setting, with another intervention being the use of anger management techniques. Anger management techniques such as progressive relaxation and cognitive therapy can be used to maintain patient safety. Cognitive restructuring can be used with the client to identify alternative ways of reacting to anger. Additionally, clinical emergencies that involve a patient being at a particularly elevated risk of harming others can be mediated through use of pharmacological interventions such as an antipsychotic (McNeil, 2009). Pharmacological interventions would require consultation with a mental health practitioner whose license and scope of practice include prescription privileges, typically a psychiatrist.

Interventions for Victims of Violence

There are several interventions that can be used to treat patients who are recent victims of violence. Among these, psychological first aid and helping to overcome PTSD through empowerment (HOPE) are commonly used interventions. Psychological first aid is believed to be the most advanced treatment intervention following a traumatic event (National Institute of Mental Health, 2002). Psychological first aid utilizes four techniques to increase the patient's safety and to address immediate problems following the traumatic event. These techniques include information gathering, safety planning, practical assistance, and providing psychoeducation on coping. This can be particularly useful for a spouse who decides to leave the home after an experience of interpersonal violence. HOPE (Johnson & Zlotnick, 2009) is a cognitive-behavioral treatment developed for battered women with concerns about safety. It is used to target cognitive, behavioral, and interpersonal dysfunction, while also prioritizing the patient's safety needs. This treatment empowers the

patient to make personal choices throughout the treatment.

THE IMPACT OF CLINICAL EMERGENCIES ON CLINICIANS

Clinical emergencies may evoke stress for both the patient and the clinician. The clinician's ability to empathize creates vulnerability for experiencing distress while working with a patient during clinical emergencies (Kleespies & Dettmer, 2000). The clinician may experience feelings of inadequacy, vulnerability, or even secondary traumatization, depending on the clinical emergency that he or she is faced with.

Clinicians who have lost a patient to suicide may develop a sense of personal failure or inadequacy (Kleespies, 2000). It is for this reason that clinicians who work with suicidal patients may experience mental, physical, and emotional exhaustion (Fox & Cooper, 1998). Experiencing a patient suicide may also produce a sense of helplessness, loss of motivation, or even lead to burnout for the clinician.

Working with violent patients has also been shown to elicit various emotions for the clinician. Guy, Brown, and Poelstra (1991) found that approximately 40% of clinicians who have experienced patient violence report having elevated feelings of vulnerability and fear in their professional life. Many clinicians reported feeling as though the violence may have been predicted or even avoided if they had handled the situation better. This indicates a great deal of personal responsibility that clinicians place on themselves in terms of predicting and managing a patient's behavior.

Clinicians who work with victims of violence have also been found to experience personal distress, and at times they even experience vicarious traumatization (Kleespies, 2000). Some studies have indicated that a clinician's personal trauma history might increase his or her vulnerability for experiencing secondary trauma (Pearlman & Mac Ian, 1995). Additionally, clinicians who are new to working with victims of violence have been found to experience increased emotional difficulty (Pearlman & Mac Ian, 1995).

Researchers have examined how clinicians respond to clinical emergencies, and ways to protect themselves in the future. Clinicians are encouraged to use supervision and consultation to address issues of countertransference and secondary traumatization (Kleespies, 2000). Clinicians may also attend personal therapy to cope with their feelings and explore their concerns (Guy et al., 1991). Developing and utilizing social supports is also necessary for the clinician's self-care. It is common for clinicians to take steps to protect themselves against particular clinical emergencies. Clinicians may decide to refuse certain patients who are more at risk for suicidal ideation or patients who present with violent tendencies (Guy et al., 1991). Clinicians might also increase their personal security after experiencing a clinical emergency by expanding their privacy settings and limiting personal information from public websites. Achieving a sense of physical and psychological safety is necessary for all clinicians, particularly after experiencing a clinical emergency.

CLINICAL ILLUSTRATION

Emily is a 24-year-old Korean woman who presents to treatment based on a recommendation provided by her primary care physician. She notes that she visited her primary care doctor because of some physical aches and pains she had been experiencing, but that no physical cause for these symptoms could be identified. During the intake, Emily shares that lately she has been feeling "down," which she describes as wanting to "be alone," feeling "tired," and not being "hungry." Furthermore, Emily acknowledges that she was recently fired from her job because she had not been showing up to work. Emily is hesitant to discuss specifics about her symptoms and notes that she doesn't "talk about this stuff" in her normal life.

Through a basic interview, the psychotherapist discovers that Emily's romantic relationship ended approximately 2 weeks ago. She had been in this relationship for 4 years and is currently experiencing distress related to its termination; she also reports that her partner was "abusive." Emily shares that she sustained physical abuse throughout the latter 2 years of her relationship, and that at times she engaged in physically aggressive acts toward her partner, which were "usually" attempts to protect herself from harm. Emily reports "dreaming" of her partner being severely injured, noting "he has it coming."

Furthermore, Emily states she is a first-generation Korean American and often argues with her mother about social behavior and roles. Emily felt pressured to remain in her abusive relationship based on expectations of her mother and extended family. When

inquiring about the presence of Emily's father, she reports that he's "not around," later indicating that her father committed suicide when Emily was 13 years old. She states she doesn't "want to talk about him, though." Although Emily reports discord in numerous social areas (e.g., romantic and familial relationships), she notes attending church "biweekly" and believing that God is always "there for me." Additionally, she identified "a handful" of close friends, reporting that she could share "anything" with these individuals.

Because Emily has sustained chronic physical abuse, which just recently ended, the therapist utilizes HOPE as the treatment approach in working with Emily. Throughout the intake the therapist gathers information about the traumas she has sustained, and a recent relationship termination; however, Emily is somewhat apprehensive to provide specific details regarding this event. Due to previous experiences she reports and her familial history, the therapist is concerned about Emily's risk for dangerousness, both toward herself and others. The therapist utilizes the CARS to assess for risk of suicide, and the HCR-20 to examine risk for violence. These assessments indicate that Emily is at low risk for violence toward others, but that she is at risk for suicide and has endorsed numerous critical items.

Based on these findings, the therapist emphasizes the importance of safety planning. This includes providing Emily with crisis referrals if she needs to access services when the therapist is unavailable and identifying community resources, specifically a domestic violence group. This group provides psychoeducation regarding victimization and assists Emily in building additional support since her social support has recently diminished and her Social Discord scale within the CARS was significantly elevated. Moreover, the therapist discusses with Emily access to lethal means and learns that Emily moved in with her brother following her relationship ending, and although she does not own firearms, her brother has a firearm in his home. Fortunately, he stores his gun in a safe, which Emily does not have access to.

The therapist and Emily involve her brother in subsequent sessions so that he can be made aware of her current desires to harm herself and can learn how to effectively assist in keeping dangerous means out of her environment. Furthermore, the therapist provides Emily (and her brother when he is present) with psychoeducation regarding depression, somatization, suicidality, and posttraumatic stress disorder. The therapist also begins to target Emily's cognitive distortions and ineffective behaviors to aid her in stabilizing her current environment and managing her symptoms. Targeting these factors, along with interpersonal difficulties, is aimed at empowering Emily and ultimately improving her overall functioning.

CONCLUSIONS/KEY POINTS

This chapter outlines various forms of clinical emergencies that may be faced in clinical practice. As indicated previously, clinical emergencies can arise at any time. It is important that all practicing mental health providers are prepared to treat patients who may become suicidal, patients who might threaten violence toward others or toward the clinician, and patients who report being victims of violence. Clinicians, specifically those who are prepared for clinical emergencies, should be able to provide ongoing risk assessments, implement clinically proven interventions, maintain proper documentation, seek consultation, and access appropriate community resources. Although it is the role of the clinician to keep the client safe during a clinical emergency, it is also necessary that the clinician maintain a sense of physical and psychological safety through the use of self-care practices. Future directions should focus on enhancing and developing assessment measures to more effectively appraise factors associated with clinical emergencies. Assessments that target specific groups or specific behaviors will be necessary for detecting and preventing future clinical emergencies.

REVIEW QUESTIONS

1. What constitutes a clinical emergency?
2. How does psychotherapy for clinical emergencies differ from traditional psychotherapy?
3. When considering factors that may increase the presence of risk, which factors (a) generalize across presentations (risk to self and risk to others) and (b) are distinct among risk presentation?
4. If you were treating Emily, would you have included additional assessments? If so, which assessments, and why?

5. Based on your conceptualization of Emily's current functioning and level of risk, identify (a) what additional information you would like to gather and (b) which factors you would look for to indicate that her functioning was improving.

RESOURCES

Websites

American Association for Suicide Prevention: http://www.afsp.org

The National Child Traumatic Stress Network: http://www.nctsn.org/content/psychological-first-aid

The Suicide Prevention Resource Center: http://www.sprc.org

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PART III

Research Methods and Randomized Clinical Trials, Professional Issues, and New Directions in Psychotherapy

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Research Methods and Randomized Clinical Trials in Psychotherapy

Paulo P. P. Machado
Larry E. Beutler

Abstract
The ultimate goal of psychotherapy research is to determine what psychotherapeutic treatment works for whom under which conditions. Psychotherapy research is probably the best example of applied psychological research. The variables studied are widely distributed among participants, interventions, and contextual factors; and most of the time data are collected, not in controlled laboratory conditions but in naturalistic settings. In those settings, even the most highly controlled studies raise considerable challenges. The variety of issues addressed in psychotherapy research requires the use of a wide diversity of methodological and statistical approaches. In this chapter we introduce the reader to the field of psychotherapy research, its methods, and some of the critical decisions one has to make when planning a research study in psychotherapy. In addition, we present a critical discussion of the traditional methods used in psychotherapy research and highlight recent methodological developments.

Keywords: outcome research, randomized clinical trials, outcome study design, methodological issues, alternative designs

In the mid-1980s, a significant shift occurred in the objectives and structure of psychotherapy research. Until that time, research had been primarily devoted to understanding what factors contributed to change, and the targets of this research were embodied in the characteristics of the therapists that were "therapeutic" (e.g., Rogers, 1957) and the qualities that constituted a therapeutic relationship (e.g., Meltzoff & Kornreich, 1970). By the late 1970s, however, the health care industry in the United States was becoming increasingly concerned that the efficacy of psychotherapy may be more a function of the idiosyncratic views and skills of the therapist than of a replicable set of interventions. Over the next decade the National Institute of Mental Health (NIMH) launched the Treatment of Depression Collaborative Research Program (TDCRP) that introduced the use of randomized clinical trials (RCTs) research paradigms to psychotherapy. Following the general format of research that was used to assess psychopharmacological treatments, the focus of research shifted from the roles of the therapist, patient, and therapeutic relationship to the interventions themselves. RCT research attempted to hold the role of the therapist, patient, and therapeutic relationship constant by selecting and training therapists to similar levels of compliance in order to perform the interventions and by homogenizing the patients used in the treatment samples. To ensure that interventions were independent from therapists, manuals

were used to train therapists and to guide treatment. Every effort was made to ensure that therapists successfully completed a course of training in the use of the manuals and came to perform in highly correlated ways with one another. Indeed, in the decade preceding the turn of the 21st century, RCT methods were accepted as the gold standard for clinical trials in psychotherapy. In contemporary psychotherapy research, the use of RCT methods continues to be highly valued, although as we discuss in later sections, the exclusiveness given to this methodology has come into question.

OUTCOME RESEARCH

The Emergence of Clinical Trials Research

Psychotherapy outcome research focuses, although not necessarily exclusively, on the impact of psychotherapy on the mental health, emotional, and behavioral problems of clients (or patients). Typically, an outcome research study is one designed to evaluate the impact of a psychotherapeutic intervention on clients' behavior, their symptom distress, and/or their social, emotional, and/or cognitive functioning. Contemporary outcome research designs tend to maximize the potential effect of treatment as compared to no-treatment and/or an established treatment for a specific disorder, problem, or condition.

These studies are usually called clinical trials (National Institutes of Health [NIH], 2015; World Health Organization, 2015), a designation that underscores its medical research origins. A clinical trial, or intervention study, is one in which participants are assigned to receive different interventions (or in some studies, no intervention) so that one can evaluate its effects on outcomes (NIH, 2015). The main objective of a clinical or intervention study is to evaluate the impact of treatment or intervention, in this case a psychotherapeutic one, as compared to no treatment (a control condition) or an existing form of treatment (comparison condition). The impact or effect of treatment is measured by the patient response to the treatment, typically measured by assessment of pre- to posttreatment change on one or more measure of patient symptom or functioning.

These research designs try to separate the proportion of change that is due to treatment from other change that might be caused by external, therapist, or client factors. In a most simple study, two groups, one that receives treatment and another from which treatment is withheld, are compared on pre- and posttreatment measures. This design assumes that all other conditions are equal or can be made to be equivalent (this assumption is discussed further, later in this chapter). Indeed, in clinical trials research, it is a necessary assumption that any difference in the amount of change from pre- to posttreatment in the groups studied is attributable to the treatment received by the intervention group. In pharmaceutical studies, this assumption is bolstered by the use of double-blind procedures—that is, those that ensure that neither the patient nor the clinician providing the treatment knows which treatment is being administered to a given patient.

Clinical trials then include (1) a specific treatment condition; (2) a control or comparison condition; (3) one or more measures used to assess the impact of the intervention in each condition; and (4) a reasonable assumption that all other factors are either controlled or eliminated via the research method used.

Concerns With Randomized Clinical Trial Methods

With the extrapolation of RCT research designs to psychotherapy, the main goal of psychotherapy research shifted to establishing causal links between manual-driven interventions and outcomes among a diagnostic class of clients. Specifically, the RCT designs were constructed to focus on the contributions of interventions to change in symptoms at the expense of the contributions by participants and contexts. Thereby, the objectives of research shifted from the effort to define the paths that led to change in well-being to the more direct and limited question of whether the given treatment produced the intended changes in symptoms (Kazdin, 2007). Nondiagnostic patient factors, individual therapist factors, and contextual factors were held constant (hopefully) or randomized out of importance, being relegated to the estimates of error variance. Nonetheless, in spite of efforts to control therapist and patient effects on outcomes, it rapidly became apparent that large therapist effects still were present in RCT research (Crits-Christoph & Mintz, 1991). As RCT designs gained a foothold that virtually compelled the use of the same standard methodology in all funded research,

critics soon appeared. These critics argued that RCT research made assumptions that were unwarranted as applied to psychotherapy. For example, Seligman (1995) observed that RCT designs imposed structures that were inconsistent with psychotherapy practices at the time. In the service of maintaining control over extraneous variables, RCT methodologists advocated for strategies that depart from how psychotherapy is usually provided in clinical settings. For example, common time limits were set across treatment types, even though different treatments tend to propose different lengths of treatment (e.g., cognitive-behavioral therapy [CBT] vs. psychodynamic psychotherapy). Therapist judgment was overridden by the need to maintain treatment fidelity (i.e., adhering strictly to a treatment manual). Patient homogeneity was assumed to be adequate if all patients shared the same diagnosis, ignoring important personal differences. Standardization of treatment was assumed to be maintained by working with samples with single diagnoses (e.g., major depression), ignoring both the great differences that existed among individuals with these diagnoses as well as the more frequent comorbidity (i.e., two or more diagnoses) among psychiatric patients in treatment. Comparable outcomes were often sought by reducing all change to symptomatic intensity, ignoring other possible and important changes in interpersonal difficulties, or emotional awareness.

Schoenwald and Hoagwood (2001) captured many of the concerns with RCTs as the exclusive method of defining effective psychotherapy when they described RCTs as providing a "test tube" environment, whose focus only on interventions inappropriately implies that treatment is a separable phenomenon from the therapist, nondiagnostic client factors, the relationship, and the context in which the treatment is conducted. Thus, it is argued that RCT research ignores participant and relational variables (Norcross, 2011; Wampold, 2001; Wampold & Imel, 2015), that RCT studies have poor external validity and, thus, generalizability (Norcross, Beutler, & Levant, 2006), and that the manuals which ensure standard treatment impose countertherapeutic levels of rigidity on the therapist's acts (Seligman, 1995). The decision to select samples by diagnosis, moreover, makes the unwarranted assumption that a client's diagnosis determines the most important aspects of human differences that impact psychological treatments. It also implies that a particular set of manualized interventions are the most important contributions to the treatment, while factors such as client motivation, therapist skill, personal beliefs, and the fit of the client and the treatment selected are to be considered noise or error (Beutler, 2009).

Although researchers who are devoted to the RCT paradigm as the gold standard for psychotherapy research have proposed changes to address some of these latter concerns (e.g., Cooper & Reeves, 2012; Kendall & Beidas, 2007; McHugh, Murray, & Barlow, 2009), there remain important criticisms that are difficult to address without rejecting or substantially reducing the rigor that was sought in the use of RCT designs. One notable alternative to the RCT's focus on broad brands of treatment and diagnostic groupings of patients is embodied in the emergence of integrationism (Castonguay & Beutler, 2006; Beutler, Consoli, Lenore, & Sheltzer, Chapter 14, this volume). The several models that are identified with this movement have in common the view that effective treatment is not to be found in the broad theories of psychotherapy or in the even broader collapsing of individual differences under diagnostic terms. Instead, they propose that effective treatment will be found to the degree that the particular treatment used is adapted to the specific and individuating qualities of patients and the equally specific qualities of treatment. It is proposed that constructs and generalizable principles applied to these individual patterns of "fit" cut across conventional models and labels. Indeed, the dimensions of "fit" are sufficiently well specified that one can effectively assign a different treatment to each patient. In fact, there is now ample evidence available to give this view considerable credibility (Beutler, 2009, 2014; Constantino, Castonguay, & Beutler, in press).

The implications of this approach are quite significant in terms of desirable research methods. Some have argued for the need to expand the array of "acceptable" research paradigms in order to include the study of variables that cannot be randomized easily (e.g., therapist factors, culture, expectations, personality, life stress, etc.) (e.g., Beutler & Forrester, 2014; Budd & Hughes, 2009) and in terms of the degree of "fit" existing between the treatment offered and the patient proclivities (Beutler et al., 2003; Beutler, Forrester, Gallagher-Thompson, Thompson, & Tomlins, 2012). From a methodological perspective, these designs yield results that seem to be much stronger than the traditional RCT designs,

bringing together common factors such as relationship qualities and the more specific role of moderating variables (e.g., Beutler, 2014; Laska, Gurman, & Wampold, 2014).

Not surprisingly, in the face of such developments and criticisms as the foregoing, many clinicians disagree with the designations of specific therapies as "empirically supported" or "validated," although they accept the importance of ensuring that the psychotherapy that is practiced and paid for is ideologically and empirically sound (e.g., Beutler & Harwood, 2000; Levant, 2004). They consider such lists as potential threats to the flexibility and clinical judgment that they deem to be necessary in practice (Chambless & Ollendick, 2001; Wilson, Armoutliev, Yakunina, & Werth 2009).

Collectively, the problems that potentially limit the usefulness of RCT designs can be reduced to (1) lack of attention to therapist, relationship, and patient variables that are not subject to randomization; (2) the lack of comparability between research and clinical samples; (3) inconsistency in the demand characteristics of research and clinical environments; and (4) the need for flexibility of applications of therapies without losing treatment fidelity.

Beutler and Forrester (2014), speaking from an integrationist perspective, suggest that the adoption of methods that may resolve these problems must begin with finding a common definition of what is psychotherapy, one that lays claim to a broader set of predictor variables than merely the interventions provided by the therapist. They suggest that psychotherapy is the totality of factors that can be employed by a therapist to foster beneficial changes and that can be studied in a scientifically acceptable manner, taking into account the nature of the variables studied, rather than simply the cluster of interventions employed by the therapist. Such a definition would encourage researchers to broaden their perspective on the nature of therapeutic influences and to the measurement of at least one participant or environmental quality that is not easily subject to randomization and which is likely to either mediate or moderate treatment efficacy. Measures of the developing patient–therapist relationship, participant preferences, personal styles of therapist or patient, social support, and many others are examples of variables whose study along with interventions could extend knowledge about how personal and formal therapeutic influences interact to enhance efficacy (i.e., the degree to which a treatment works under experimental conditions). Moreover, adding to the number and types of predictor variables subject to study in psychotherapy research on efficacy would also require that researchers become more inclusive in their use of multivariate statistical and modeling procedures that would be required to analyze moderator and mediator influences. This could not help but improve the predictive validity of research.

Along with addressing the question of efficacy, one must also address the question of effectiveness (i.e., how well the treatment works in practice; Maltzman, 2012). Studies in clinical practice settings are seldom able to comply with RCT methodological criteria, using instead a variety of quasi-experimental or observational designs (Howard, Lueger, Maling, & Martinovich, 1993; Howard, Moras, Brill, Martinovich, & Lutz, 1996). This introduces some ambiguity to the study conclusions, and causation cannot clearly be determined (Ablon & Jones, 2002; Howard et al., 1996).

The question of adapting an empirically supported treatment (EST) to fit the peculiarities of a particular clinical setting or individual client naturally leads to a discussion of treatment fidelity. In the case of manualized treatments, fidelity to the protocol refers to how closely the treatment delivered matches the treatment described in the manual (Kendall & Beidas, 2007). In contemporary RCT research, treatments are analyzed as fixed variables, but in fact they are composed of many discrete events. Furthermore, fidelity exists more on a continuum than as a binary event. One way to approach this problem is to break down the intervention into their underlying principles. Several theorists (e.g., Beutler, Clarkin, & Bongar, 2000; Malik, Beutler, Gallagher-Thompson, Thompson, & Alimohamed, 2003; Norcross, 2011; Prochaska, 1984) have suggested that research shift from assessing fidelity from a focus on therapist compliance to a focus on the acquisition of patient–treatment fit. In this model, treatment components are each represented both in terms of their frequency of use and their fit with patient characteristics that differentiate outcomes (e.g., severity, coping style, etc.). For example, a patient with a particularly high level of impairment in social functioning might be offered treatments that includes other people to help the patient modulate and monitor his or her behaviors. Another patient who is very defensive might be

treated with a nonconfrontative set of interventions to reduce the likelihood of dropping out.

Beutler et al. (2003) have illustrated how fidelity estimates can be derived by measuring therapist compliance with the strategies or principles of treatment fit as well as by the use of more narrow techniques or broader models of change. Moreover, they demonstrate that measures of strategic compliance can account for much larger portions of variance among predicted outcomes than the usual method of measuring the use of interventions alone (Malik et al., 2003).

Given the complexity of psychotherapy, designing and carrying out a psychotherapy research study can, then, be a daunting task. And there are several decisions along the way that will impact the possible interpretation of the final data. In principle, there are no "good" or "bad" research strategies or methodologies, but there are methodologies that are more adequate or less adequate to the research questions that psychotherapy researchers want to address with a particular research project. This being said, it might not be appropriate to critique a specific methodology or study for not answering a research question that it was not designed to answer, but it is adequate to challenge a conclusion that is extracted from the data or design used. For example, as noted previously, RCTs have limitations and do not allow us to respond to all research questions of interest. For example, some contributors to change cannot be randomized. Although one can randomly assign people from a given ethnicity to the treatments of interest, ethnicity itself is only one of many interacting variables that comprise "culture." There are wide differences among and within cultures, and random assignment does not help us learn about these intricate interplays of factors. Nonetheless, if one focuses only on interventions and can be assured of reasonable fidelity of application, RCTs are still one of the most potent ways of assessing the efficacy of new treatment approaches.

Areán and Kraemer (2013) have discussed variations that can be applied to clinical trial research, ranging from observational trials to RCTs. Observational trials in psychotherapy research are those where the researcher interferes the least in the course of treatment offered to patients. These designs usually require sampling patients and assessing them at least before and after treatment, and comparing those with a control/comparison condition. One of the problems with observational designs is that if we compare treatments in two different sites (e.g., two clinics in different cities, or geographical areas) the groups drawn might be different to start with. This would result in biased observation on whatever result obtained. That means that any difference observed might be attributable to existing initial differences in the groups or to exposure to events other than treatment. Kirchmann and colleagues (2012) provide an example of an observational trial that studied the impact of treatment on patient attachment patterns. In their study, data were collected at pretreatment, posttreatment, and 1-year follow-up and compared with data collected at the same time intervals in a control group of students in order to assess the impact of treatment on attachment characteristics.

Studies can also be differentiated by where they locate in the efficacy and effectiveness continuum. A pure efficacy study tries to answer the question, Does the treatment work? An "effectiveness" study tries to answer the question, Does the therapy work in a regular setting?

Mixed efficacy/effectiveness trials are those that incorporate characteristics of both efficacy and effectiveness trials. By including characteristics of effectiveness trials on an efficacy study, researchers are able to increase the external validity of the study. This could be achieved for example by comparing a new manualized treatment to the treatment as usual (TAU) in a clinical setting. After monitoring usual changes achieved by therapists in a given clinic, the local therapists would receive training in the new procedures and would be closely monitored and supervised to ensure adherence to the "new" treatment. Comparisons between before and after the new treatment would offer some indication of whether the new one was more effective. Of course, this level of control and clinical supervision is likely unavailable either in the original TAU or the "new treatment" when the study terminates. These factors pose questions regarding the generalizability of the results in a naturalistic setting.

ORGANIZING AN OUTCOME RESEARCH STUDY: METHODOLOGICAL CONSIDERATIONS

Any research study, whatever methodology, must pay attention to factors that threaten the study's utility and value. In this section we address some of

the most important aspects of organizing a psychotherapy research study. We have tried to present it in a straightforward and simple way. We hope that this will help graduate students and early-career professionals to design their own research projects and to read critically the results of psychotherapy research studies.

Validity

The critical importance of the validity of research findings as a direct function of the methodological adequacy of the research design cannot be underscored enough. All methodological decisions involved in planning a study have an impact on one or more forms of validity. Campbell and Stanley (1966) introduced an important distinction between internal and external validity in all studies. Internal validity refers to the degree to which causality can be inferred from the study. Cook and Campbell (1979) argued that three conditions should be met before we can claim that causality exists: (1) changes in the presumed cause must be related to changes in the presumed effect; (2) the presumed cause must occur prior to the presumed effect; and (3) the presumed cause must be the only reasonable explanation for changes in the outcome measures. In experimental terms, this means the degree of certitude that changes in the dependent variable (the one being assessed; e.g., in a psychotherapy trial, a symptom measure) is attributed to manipulation of the independent variable (the one controlled by the researcher; e.g., the treatment vs. control condition) and not to other potential effects.

External validity, on the other hand, refers to the degree to which results from a particular study can be generalized to other situations (e.g., time, setting, participants with different characteristics). External validity is closely related to the ecological validity of a study, meaning how distant measures and procedures are from naturalistic settings, sometimes called "real-world" conditions.

The more experimental control we bring to a study, the more internal validity we attain, but, on the other hand, these laboratory-like conditions come with a price: lowest external validity and eventual lack of ecological validity. Two additional validity concepts, construct validity and statistical conclusion validity, are discussed later in this chapter.

As previously stated, in designing a research study, one comes across several methodological decisions that impact the validity of the study and consequently the level of confidence in the observed results. In the following sections we address some of the most important design-related decisions and how they might impact the study results and the conclusions drawn from it.

The Clinical Sample

Carefully defining the target population from where the sample is going to be drawn is one of the first and one of the most important steps in planning and designing a research study. How well the sample represents the population from which it is going to be drawn will ultimately impact the ecological validity of the study. This is also the reason why research articles must describe in great length the participants' characteristics. Given this information, the reader can critically assess how likely the results of a given study can be generalized to another population or pool of participants with diverse demographic and/or clinical characteristics (e.g., different age, socioeconomic, gender, ethnic group; presence of comorbidity; or different level of symptomatic severity).

Several issues should be considered that will impact the possible interpretation of the study results: (1) homogeneity of the sample; (2) eligibility criteria; (3) sampling strategy; and (4) sample size.

One of the first decisions in determining the sample characteristics of a study is the extent to which we want a homogeneous sample. Sample homogeneity reduces group variance and increases power for detecting treatment outcome by reducing within-group variance. Sample homogeneity increases the internal validity of the study and increases the likelihood of results being reproduced with similar samples, but it reduces the ecological validity of the study. This means that if the study assessed the effect of a treatment on a sample of college-educated Caucasian males, results might not be reproduced in samples with different demographic characteristics. Moreover, sample homogeneity reduces the probability of finding treatment outcome predictors. Probably the most used eligibility criterion for sample selection in psychotherapy research studies has been a diagnosis, based either on the *Diagnostic and Statistical Manual of Mental*

Disorders (*DSM*) or the International Classification of Diseases (ICD).

However, many integrationists believe that this is not an optimal choice as applied to psychotherapy because diagnosis is a weak contributor to differential outcomes and because diagnosis obscures the role of many nondiagnostic patient characteristics and interventions that fit them. Thus, diagnosis may not be the most important of client variables to either interact with treatment or help us understand how best to help people. Other considerations for homogenizing variables may include using a sample of treatment referrals or volunteers that respond to an advertisement, or even better, contrasting groups of individuals who have specific qualities that are known to affect psychotherapy (e.g., contrasting coping styles or levels of problem severity, etc.; Norcross, 2011).

Sample size should be determined almost by power analysis. We can only draw reliable conclusions with adequate sample sizes. For any predetermined alpha level (i.e., the probability of a type I error or the rejection of the null hypothesis when it is true), effect size (i.e., a measure of the strength of the association between variables), and number of variables to be included in the analyses, the larger the sample size required to detect differences. Low statistical power makes it difficult to interpret nonsignificant results, because we could have power to detect only very large effects; on the other hand, very high power makes small and non–clinically significant results (small effects) statistically significant.

Group Assignment

Once participants are recruited, they have to be assigned to either the experimental/treatment condition(s) or to the control/comparison condition. A first characteristic and a requirement for a randomized controlled trial, as the name suggests, is for this process to be random. This means that each participant has an equal chance of being allocated to the treatment or the comparison condition. Random distribution is not to be confused with random selection. Random selection is seldom used or even possible, and it means that every member of the population would have an equal chance of being selected for the study. Random distribution or assignment, on the other hand, means that each individual of the selected sample has an equal chance of being allocated to the study's conditions.

Random assignment of patients to interventions is considered to be a crucial characteristic of RCTs because it is assumed that all variables that could potentially affect the result of the study will be equally distributed between all conditions. However, if one is persuaded by the logic of integrationists, it becomes clear that such randomization is not ideal. Instead, one should look at treatment along a different dimension, specifically, the fit of treatment and patient. Constructed in this way, the question of randomization becomes more difficult. One may randomize patients into well-matched and poorly matched groups, but this approach is not ideal if one adheres to the integrationist view that each patient (ideally) receives a substantially different treatment. Nonetheless, recent research has shown that if therapists are specifically trained to use cross-cutting principles to adapt to each patient, they get significantly and meaningfully stronger effects than if they go through less focused and usual training (Beutler et al., 2014; Holt et al., 2015).

Beutler et al. (2003) demonstrated an alternative strategy, the use of statistical procedures to partial out the distinctive roles of patient factors, interventions, contextual factors, and the fit of patient to treatment as an alternative to a study of diagnosis by intervention effects alone. This study revealed that if the researchers: (1) measured actual therapist behaviors rather than allegiance to a particular model; (2) included the assessment of nondiagnostic patient traits; (3) randomly assigned therapists (rather than treatments) to patients; and (4) included measurement of both participant and contextual (i.e., relationship) factors along with interventions, one could reliably and accurately predict patient change at a much higher level than if one used intervention and diagnostic groupings alone.

One should note that although the homogenizing effects of random assignment is an assumption, randomization does not guarantee similar groups across conditions, but it is a way of assuring that the researcher did not bias the distribution. One of the reasons why random assignment does not guarantee similar groups is the fact that sample sizes are usually small in psychotherapy research trials. However, not to randomize participants per condition raises a series of other issues generating potentially biased results. For example, if participants were able to choose

between two treatments, each group might have characteristics that would interact with treatment and were not assessed or controlled for.

In pharmacological research, three controls are possible that cannot be provided in psychotherapy research. Specifically, first, the personal background of the clinician or the way of manufacturing two equivalent-looking pills exerts little effect on treatment. Second, the clinician administering the treatment can be kept "blind" as to the ingredients used. Third, the patient can also be kept blind as to the nature of the treatment. None of these assumptions are possible in psychotherapy research. In addition, it is not likely that all patients who have developed the disorder under question share identical (or even very similar) historical and personal experiences. Neither are all of the therapists' allegiances to the same brand of intervention likely to have reached that point via the same shared experiences. The personal history and background of diverse patients and therapists will interact in the psychotherapeutic endeavor in ways that do not happen when the treatment is a pill. Thus, it is often necessary to approximate randomization or to group participants by selecting for particular background factors. Moreover, these conditions in which randomization cannot be expected to operate as a sufficiently homogenizing force require that we find alternative ways of extracting and analyzing data even when equivalence cannot be assumed. Using convergent research designs across studies is one helpful way of compensating for the failures of randomization. For example, one might be interested in studying the impact of culture in the outcome of cognitive therapy. One way of accomplishing this would be to employ a naturalistic design that maps how different contributors to "culture" (e.g., language or country of origin, time in the United States, adherence to traditional cultural values) influence psychotherapy sessions and outcomes. If the investigator finds a set of cultural factors that correlate with change, and are better than the broad grouping of "culture," the following clinical trial may be able to hone in on a more specific and meaningful role of "cultural factors" beyond language in a way that lends itself to a better study of culture as a mediator of cognitive therapy effectiveness.

Other methods to include in a broad view of psychotherapy are the use of meta-and mega-analytic procedures that generate large enough samples that one can extract and compare different mixes of interventions and patient/therapist factors (see, for example, Beutler, 2012; Norcross, 2011; Wampold, 2001; Wampold & Imel, 2015).

Control/Comparison Conditions

A second important characteristic of an RCT is the requirement of a control or comparison condition that will be used to control for all other factors other than the one of interest (most of the time a specific treatment). If participants were randomly assigned to treatment and control conditions, then all differences found between groups at end of treatment or thereafter will be explained by the difference in treatment. There are several alternatives that are used for a control or comparison condition, and selecting one will have implications on the answer to the initial research question.

The most common strategies in psychotherapy research are (1) no treatment control; (2) wait-list control; (3) attention-placebo control; and (4) standard treatment or treatment as usual.

The no-treatment requires participants in the control condition to be assessed with the same schedule as those assigned to the treatment condition but no other contact with a therapist or member of the research group. As it can be easily imagined, there are not a lot of situations where treatment can be denied, unless under extreme conditions.

Wait-list control condition is a variation of the no-treatment condition, and it entails that treatment is withheld until the end of the treatment period for the experimental condition. Participants are assessed with the same measures and schedule of those in the treatment condition, and treatment is offered at the end of the experimental period. This strategy has some advantages when compared with the no-treatment control; first, it controls for expectations related to treatment; and second, treatment is not denied to study participants. The former aspect is a potential confounding variable in psychotherapy research, as there is evidence that when people decide to engage in or are offered treatment there is some degree of symptomatic change. The latter is easily understandable on ethical grounds; however, delaying treatment for an extended period of time raises ethical questions.

Attention-placebo control is a designation used to describe minimum attention and contact provided

by a therapist or research staff. This corresponds to the potentially psychotherapeutic equivalent of a pharmaceutical placebo (a medication or pill without the active ingredient). However, what is considered placebo in psychotherapy is controversial. This concept has been equated with the common factors of psychotherapy, which is, in our opinion reductionist, because it considers the active ingredient of psychotherapy to be the specific techniques or strategies of a specific treatment and does not include what could be considered the essence of psychotherapy. As Shapiro and Morris (1978) pointed out, both psychotherapy and the placebo effect function primarily through psychological mechanisms. Other less structured placebo control conditions include minimal attention by a research staff involved in a casual conversation with the participant.

There are times when it might be unethical to use either a pill placebo or an attention placebo control. If patients are very depressed, potentially dangerous, or likely to regress, then the best comparison may be some other treatment. This can take the form of a standard treatment that has been previously established as effective, minimal or supportive care, or the treatment that is usually given in the particular clinic or hospital (i.e., TAU). For that matter, if we believe that a certain constellation of patient and treatment factors comprise a better treatment than some other collection of factors, a suitable comparison may be of well fit and poorly fit treatments. Of course, all of these alternatives change the question one can address. One cannot logically conclude that Treatment X is more effective than doing nothing unless the control condition is one of doing nothing. Comparisons of Treatment X and Treatment Y address the question of the relative efficacy or effectiveness, keeping in mind that neither may be better than the TAU. Thus, the question one wants to address determines a great deal about the nature of the control or comparison condition to be used.

Treatment Administration

Psychotherapy research outcome studies, namely randomized clinical trials, rely heavily on treatment manuals. As mentioned before, these studies are designed most of the time to determine the impact of an intervention. Integrationist theorists have adapted this model to provide a manual for applying principles of treatment fit rather than principles of a theoretical model. In either case, this means that it is crucial that the intervention is applied both consistently across participants and that it reflects the kind of intervention being studied. A treatment manual is one of the strategies used to assure that all participants receive the same treatment.

Treatment manuals, although not immune to critiques, contribute to the internal validity of the study and allow comparison between studies. In addition, therapist manuals facilitate training and treatment dissemination once it has proven useful. Treatment manuals usually include (1) a specific disorder, patient characteristic, or problem to be addressed by the treatment; (2) the underlying mechanism of change; (3) the specific techniques or strategies that patient and therapist are to engage in; and (4) the treatment characteristics (i.e., guided self-help, individual therapy, group therapy), including length of treatment (i.e., number of sessions), frequency of sessions, and treatment setting (e.g., inpatient or outpatient).

Although treatment manuals have been accused of limiting therapist creativity and restricting adaptation to the patient's individual characteristics, treatment manuals have evolved considerably since they were first introduced. Recent advances have led to the development of manuals that tend to be transdiagnostic in their approach and include special sections on how to adjust treatment to individual characteristics of patients (e.g., Barlow et al., 2011; Fairburn, 2008).

Therapist

One of the most striking differences between pharmacological and psychotherapeutic RCTs is that in psychotherapy clinical trials the therapist (i.e., the person that delivers the treatment) is an active ingredient of the treatment being studied as opposed to what happens in pharmacological treatment trials where the effect of the person delivering the treatment is negligible (i.e., the active ingredient is in the medication). In other words, psychotherapy treatment is greatly affected by the person delivering it. All these aspects can affect the integrity and validity of the study. For example, if the therapist does not follow the intended procedures or is especially skillful or unskillful in administering that particular treatment, all this will affect the integrity of the study.

Researchers go to great lengths to address this issue. The measures taken depend on the research question being addressed. If therapists' characteristics are a variable of interest, then the research design might want to include therapists with somewhat different characteristics and analyze their effect (e.g., therapist with different levels of training, or diverse demographic or ethnic characteristics). Like the example given previously of studying aspects of culture, this type of study might be done by using a naturalistic design. This allows one to look at different aspects of the therapist as it varies in nature rather than simply classifying it as present or not. A follow-up study using more rigorous controls might then be used to maximize treatment effect. In that case, therapists' variables may be controlled for by grouping according to similarities (e.g., therapists with similar levels of training) or compared by contrasting the effects of different levels of training.

Some authors (e.g., Areán & Kramer, 2013) have argued that an intervention that is very vulnerable to therapist effects that one cannot control for are weak interventions, mainly because they have little generalizability and will be difficult to disseminate. In contrast, investigators that compare brand names of different therapies using RCT designs (i.e., theorists who are interested mainly in the therapy brands) may find that their findings get generalized easily even when not warranted. One may conclude that cognitive therapy is a good treatment for depression, but forget that not all cognitive therapies for depression may be alike or similarly effective (Malik et al., 2003). Those who advocate for taking a more nuanced view of psychotherapy, one that includes patient, context, relationship, and interventions (e.g., Beutler, 2009; Beutler et al., 2000; Norcross, 2011), argue that restricting the study of psychotherapy to only the intervention used focuses on the least powerful of therapeutic forces and ignores the controllable, predictable, and unavoidable influences of therapist, patient, and contextual factors. These authors suggest that the very definition of psychotherapy be changed to reflect the entire range of factors that are all or partially under the influence and at the disposal of the therapist and patient to effect change. Such a definition would emphasize the multiplicity of contributors to change and transform the study of psychotherapy from an illness model to the more promising public health view of health services.

Strategies used to address treatment delivery integrity include careful therapist training, introducing measures to assess treatment fidelity, and arranging for systematic supervision. All these are likely to increase the treatment fidelity and the internal validity of the study. In addition, because therapist variables can affect treatment outcome, it is crucial that the study includes more than two therapists. There is no consensus as to whether different therapists should be assigned to different treatment conditions or if all therapists should deliver all treatments. Assigning therapists to the treatment they prefer guards against the effects of allegiance—one gets the results that favor their own viewpoint—but eliminates the advantages of randomizing therapists to control extraneous therapist factors. Alternatively, having all therapists use all therapies introduces allegiance bias as an uncontrolled factor while reducing extraneous variance associated with therapist effects. These arguments illustrate the continuing struggle within the research field as to the role of the therapist—as an important factor in effecting change or as a source of error that is to be controlled.

In a related way, assigning a single therapist to each treatment minimizes the impact of therapist preferences that might affect differences among therapists, but it ignores wide therapist differences in how treatments are applied. This procedure raises the problem of confounding variables, as some of the personal characteristics, preferences, and personal views of the therapist are very likely to be responsible for a share of the observed outcome. It is also important to ensure that therapist characteristics are equally distributed between treatment conditions (e.g., training level, years of experience, and all other demographic variables thought to interact with treatment and impact final outcome). If not, confounding variables, like variations in the level of expertise of the therapist, might influence results.

Assessment

Another set of important decisions are related to choosing the assessment tools that will be used. In other words, which assessment battery is to be used to evaluate change on symptoms or problems targeted by the intervention?

The outcome of psychotherapy, the independent variable of the study, can hardly be measured by a

single assessment instrument. Rather, there is a need to rely on multiple instruments assessing several domains from different perspectives. For example, measures of symptomatic distress, functional impairment, well-being, and quality of life are used to assess outcome. These measures tend to include client self-report, clinician ratings, independent researchers' ratings, family members' ratings, and indirect indicators of functioning (e.g., missed days at work, visits to health care centers, etc.).

Another consideration aside from number of measures is the assessment schedule. When will participants be assessed? Traditionally, RCTs used pre-post treatment designs, where patients would be assessed before and after treatment, and again at a previously determined follow-up period. Most recent statistical analysis procedures, like hierarchical linear modeling, allow and benefit from multiple time point measurements (e.g., weekly assessments with measures of symptomatic distress), making it possible to assess, for example, the trajectories of change.

A similar array of decisions come into play when one decides whether or not to include measures of qualities of therapist and patient that are outside of the usual ones captured in RCT comparisons of different models. Beutler and Forrester (2014), as noted previously, have suggested the routine inclusion of at least one non–randomly distributed therapist, patient, and contextual (e.g., relationship) characteristic that has been identified as a mediator or moderator of treatment-induced change. Such an inclusion would allow a broader than usual view of psychotherapy, one that includes variables with proven effects but that is not defined narrowly as an "illness X treatment brand" model of psychotherapy. Beutler and colleagues (Holt et al., 2015) have used a cloud-based, multidimensional assessment system that is specifically designed to identify the level of fit of a given treatment. The system is programmed to develop an individualized treatment plan, and it can be used to train therapists in applying these integrationist principles.

Additional considerations regarding assessment in psychotherapy research would include the procedure for collecting the data and the timing of it. Although the most common procedure is a face-to-face interview as well as self-report assessments, there are several alternatives, including telephone or video-call interviews, Internet-based questionnaires, and portable devices for randomly assessing behaviors or mood (e.g., Wonderlich et al., 2014). In addition to pre- and posttreatment assessments, psychotherapy outcome studies include at least one assessment that is administered a specific amount of time after end of treatment. These assessments, called follow-ups, are particularly important in psychotherapy research because they evaluate the maintenance of therapeutic gains.

Attrition

Attrition is an inevitable occurrence in any clinical trial. One can expect a certain percentage of patients to drop out of treatment for different reasons, which should always be recorded. Reasons for dropout include change in living conditions, moving to another location, and the fact that patients who get considerably worse might need to be pulled out of the study for ethical reasons.

Attrition raises a series of methodological problems. First, we can easily assume that those participants who drop out of treatment might not be similar to those who remain in treatment. These dropouts might represent a most severe subsample or a specific characteristic that makes them unfit for that particular treatment. In methodological terms, there are two situations that cause the most serious problems for data analysis: (1) when a large number of participants drop out; and (2) when there is differential attrition (i.e., when the number of dropouts is significantly different across conditions).

Addressing Missing Data

A topic related to attrition is how to handle missing data. Although dropouts do not account for all missing data, their impact on the data analysis is significant. There are several methods of addressing and handling missing data that we describe and discuss next.

To address the attrition, researchers can present two sets of analyses: (1) completers' analysis and (2) intent-to-treat analysis. Completers' analyses use only the data produced by those participants who completed the study, and they measure the effect of treatment on those who received the full treatment package. Intent-to-treat analyses use the data of all participants who were randomized to any of the

conditions. Intent-to-treat analyses include participants who never initiated treatment and those who dropped out at some point without completing the treatment. These tend to produce more conservative estimates of treatment effect than completers' analyses. It is now common to include both analyses, as well as a detailed description of the participants' flow along the study (CONSORT diagram; Schulz, Altman, & Moher, 2010).

Selecting a method for handling missing data should be done carefully, as it impacts the final results and might not be appropriate for specific patterns of missing data (see Shafer & Graham, 2002, for patterns of missing data). Researchers handle missing data in different ways: (1) case deletion, an analysis based only upon a subset of the total sample; (2) data imputation, where missing data are replaced with values based in a specific rule or method; (3) data analysis, the use of analytical techniques that allows for missing data (e.g., HLM); and (4) statistical adjustments based upon the probability or pattern of missing data.

A popular method of data imputation is last observation carried forward (LOCF), where missing data are replaced with the last available valid assessment. LOCF analysis assumes that participants who drop out remain constant on the outcome variable and do not change after they abandon treatment. However, this strategy has several problems, especially if the data are not missing completely at random. For example, it confounds treatment effects with time effects, and constant value imputation underestimates variance, which might introduce bias in the outcome results.

Recent developments in data analysis allow more efficient and reliable methods of dealing with missing data. For example, with multiple imputation methods (see Schafer & Graham, 2002) each missing value is replaced by a list of simulated values, producing several different data sets that will be analyzed separately. The results are then combined arithmetically, reflecting the uncertainty about missing data.

Finally, data analytic strategies that can handle missing data are particularly useful, especially if there are multiple assessment points (e.g., weekly assessments). For example, HLM allows one to (1) analyze datasets with different numbers of observations per participant; (2) measure participants at different time points; (3) include subjects with missing data; and (4) handle missing data when they are missing at random.

Data Analysis

Once all the research data is collected, one is faced with the task of analyzing the data. Data analysis strategy is conditioned by a study design, its outcome measure, and the structure of the data (e.g., normally distributed or not). Data analysis and its interpretation allow the researcher to address the initial research questions. Most of the time this entails testing the initial hypotheses, although some research projects might have a more exploratory nature and are not designed to test a specific predetermined hypothesis.

In any case, researchers need to select a data analytic strategy that fits their study design and data structure. In clinical trials, the most common and traditional approach to data analyses are those that compare mean scores of group participants, both within (e.g., differences from pre- to posttreatment), and between groups (e.g., differences between treatment groups). The choice of a statistical test is beyond the scope of the current chapter; however, statistical tests of mean differences are usually considered significant if the magnitude of the difference exceeds what would be expected at a 5% chance level ($p < .05$).

For example, one of the most commonly used statistical tests, the Analysis of Variance (ANOVA), does exactly this. In its simplest form ANOVA expands t-tests to more than two groups, and it tests if the means of two or more groups (e.g., control condition and treatments) are equal. If not, then we assume statistically significant differences between groups.

The most recent statistical data analyses procedures are becoming more commonly used. For example, to measure group change, instead of the traditional repeated measures ANOVA analysis, researchers can use multilevel modeling (MLM) for testing differences across the time points of assessment (e.g., before treatment, end of treatment, and follow-up). In MLM analyses, the variation of responses within subjects over time is at the lowest level (level one), and the variation of the underlying mean responses between subjects is at level two. Multilevel modeling includes all participants with at least one assessment in time, which is consistent with an intention-to-treat analysis. There are many advantages to MLM, including no need to delete cases in a list-wise manner due to missing data. These analyses allow for use of all available data for all participants, and they offer advantages over other methods

of imputation for missing data in repeated measures designs (Gueorguieva & Krystal, 2004).

Statistical significance of a difference alone does not imply evidence of clinical significance. This is due to the fact that statistical significance depends on thresholds that are affected by statistical power, which in turn is affected by sample size, number of variables, effect sizes of interest, and significance level. Put it in a simple way, with a large enough sample size (i.e., lots of participants) small effects can be significant yet clinically meaningless.

To measure individual change after treatment, researchers often used the criterion of clinical significance proposed by Jacobson and Truax (1991). This criterion is actually a clever way of translating statistical significance into clinical significance. Clinically significant change requires that two criteria are met: (1) that a participant's initial score falls into the dysfunctional range while the end score falls in the functional range; and (2) that the change in the score was of a reliable magnitude (i.e., it exceeds the error of the measure). This means that a clinically significant change occurs when an individual in the beginning of treatment has a score that puts him or her closer to the mean of the clinical population than to the mean of the normative population; at the end of treatment is closest to the mean of the normal population (i.e., crossed a significant cutoff score of a symptomatic measure); and the magnitude of the observed change exceeds the standard error of the measure.

Moderators and Mediators of Treatment Response

In RCT comparisons, after the initial hypotheses are tested, researchers conduct exploratory analyses of their data. The focus is not on hypothesis testing but on analyzing effect sizes of treatment and the impact of specific and extraneous variables on outcome. These analyses might be important for new hypothesis generation and/or for a better understanding of the study results, but because they are post hoc, they do little for testing a priori hypotheses. However, if one considers some of the suggestions here for using converging research methods rather than a single RCT method as evidence of causal chains, the problem of extraneous variables becomes less important. Converging research strategies consider the effects of interest to be the potential moderators and mediators of change (Kazdin, 2007) and believe that accumulating data over studies is as strong an indicator of causal links as RCT studies, which, as we have noted, are imperfect as applied to psychotherapy. The alternative offered by the integrationist view is to build hypotheses and specific methods around detailed hypotheses about the roles of individually identified mediators and moderators. To the integrationists, these are the effects of most interest. In fact, the roles of these effects in outcomes seem to far surpass the differences attributable to a variety of brand-named approaches (Beutler, 2009; Beutler et al., 2003).

A moderator of treatment is a variable that suggests for whom or under what conditions a particular treatment or limited intervention has an effect on outcome. A moderator precedes treatment (and obviously outcome) and does not correlate with treatment. It is ideal if one can identify moderators that distinguish between the effectiveness of one treatment over another. Several patient variables have been found to systematically moderate between the efficacy of such intervention classes, such as a directive versus nondirective stance, insight-oriented versus symptom-oriented strategies, and an intensive or less intensive intervention (e.g., Beutler et al., 2000). Such moderating patient factors work better when the interventions studied are not whole theories, but more limited acts of the therapist that cut across different approaches but are used in different ways in different approaches. Moreover, the effect size of treatment depends on what the moderator is. Individual characteristics of the patient (e.g., gender) might be moderator variables if they impact the effect of treatment.

On the one hand, a moderator analysis can be very important for the interpretation of results, because in hypotheses testing of mean differences the effect size tested is not the effect on individual participants but the mean effect on the participants' group. Let us consider the example provided by Areán and Kraemer (2013) and consider that gender might be a moderator of treatment, whereas treatment has a positive effect size on women and a negative effect size on men. If groups had an equal number of men and women, the overall effect size would be zero. If groups had an unequal distribution by gender, then effect size would be either positive or negative, depending on the gender most represented. It is easy to understand the clinical implications of not considering moderator analysis and of making conclusions

only on the basis of statistical significance. In this particular case it would be important not to control or adjust for gender but to explore the moderator effect of the variable. Gender, age, ethnicity, socioeconomic status, educational level, symptom severity, and comorbidity are usual candidates for moderator variables that impact treatment outcome.

On the other hand, mediator variables of treatment are those that explain how and why treatment might work. In this case, treatment precedes the mediator variable and correlates with it; the effect of treatment on outcome can be explained by the effect of treatment on the mediator variable. Knowledge about mediators increases our understanding about how treatment might work and will lead to most effective interventions. Examples of mediator variables are dysfunctional eating restriction on CBT of bulimia nervosa; and, catastrophic interpretations of bodily sensations on CBT treatment of panic disorder.

Drawing Conclusions From the Data Analysis

The next logical step in psychotherapy research is drawing conclusions from the data analysis. Having examined the significance of the results, the next step is to interpret them. This brings our discussion to issues of validity that have not yet been discussed. Methodological decisions try to address threats to both external and internal validity; however, two concepts are important on this last stage, namely statistical conclusion validity and construct validity (Cook & Campbell, 1979). Statistical conclusion validity refers to the degree to which conclusions about the relationship among variables based on the data are correct and how well the study can detect relationships among variables when they exist. Construct validity pertains to the aspects of a given intervention that were the causal mechanisms of change; that is, what is the conceptual or construct explaining the observed effect (e.g., change in depression severity was caused by change in negative thinking as a result of CBT).

Drawing conclusions about the observed effect should be done in the context of an evaluation of the strengths and limitations of the study. All previously discussed issues are relevant for this task, namely issues of internal, external, statistical conclusion, and construct validity. Moreover, in addition to statistical significance, it is particularly relevant to psychotherapy research to address clinical significance.

CONCLUSIONS

As asserted throughout this chapter, there is no perfect design or study that can answer all research questions of interest. In fact, science advances through a group of studies, using different methodologies that collectively increase our understanding of complex phenomena. The same applies to psychotherapy research.

The matters addressed in this chapter alert the researcher to some of the important issues to consider when designing a research project and when critically evaluating previous research. It was not intended to be a comprehensive analysis of all methodological issues involved but an introduction to psychotherapy research methods and randomized clinical trials in psychotherapy.

KEY POINTS

- Psychotherapy outcome research focuses, although not necessarily exclusively, on the impact of psychotherapy on the mental health, emotional, and behavioral problems of clients (or patients).
- An outcome research study is one designed to evaluate the impact of a psychotherapeutic intervention on clients' behavior, their symptom distress, and/or their social, emotional, and/or cognitive functioning.
- Outcome research designs tend to maximize the potential effect of treatment as compared to no-treatment and/or an established treatment for a specific disorder, problem, or condition.
- RCTs have limitations and do not allow us to respond to all research questions of interest. Nonetheless, if one focuses only on interventions and can be assured of reasonable fidelity of application, RCTs are still one of the most potent ways of assessing the efficacy of new treatment approaches.
- However, RCT designs have been criticized because of (1) lack of attention to therapist, relationship, and patient variables that are not

subject to randomization; (2) lack of comparability between research and clinical samples; (3) inconsistency in the demand characteristics of research and clinical environments; and (4) the need for flexibility of applications of therapies without losing treatment fidelity.

- The validity of the research findings is a direct function of the methodological adequacy of the research design.
- All methodological decisions involved in planning a study have an impact on one or more forms of validity.
- Carefully planning and designing a research study includes a series of decisions that will impact results and conclusions that can be drawn from data.

REVIEW QUESTIONS

1. What are the major advantages and disadvantages of an RCT in psychotherapy research?
2. What alternatives are there to using an RCT to assess causal chains of influence in psychotherapy?
3. What is the difference between process and outcome research in psychotherapy?
4. What is the difference between clinical and statistical significance?
5. How are "integrationist" viewpoints of psychotherapy different from other views from which research is conducted?
6. How is a moderating variable different from a mediating variable associated with psychotherapy change?

RESOURCES

Readings

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The Training and Development of Psychotherapists: A Life-Span Perspective

Andrés J. Consoli
Héctor Fernández Álvarez
Sergi Corbella

Abstract
Psychotherapists seek to ameliorate their clients' suffering and to enhance their clients' quality of life by facilitating human change and stability processes. Psychotherapists do so through an affirmative and emancipatory therapeutic relationship and through the expansion of clients' coping strategies, emphasizing recovery, resilience, and wellness. How are such professionals trained to accomplish these activities, and how do they develop over time? We critically review the scientific and professional literature on the training and development of psychotherapists by following a professional life-span framework. Training, competence, and expertise in psychotherapy are conceptualized as lifelong endeavors that require nondogmatic dedication, flexibility, openness to feedback, a reflective practice, and much humility. We emphasize the importance of a diverse psychotherapy workforce that mirrors the demographic of the population that it ought to serve and, most important, a workforce that is culturally competent and prepared to address the needs of an increasingly diverse population.

Keywords: psychotherapist training, professional development, competence, expertise, life-span perspective

Psychotherapy can be defined as a helping relationship where a trained mental health professional seeks to bring about amelioration of suffering and enhancement in the quality of life of a fellow human being, a couple, a family, a group, or a community. Psychotherapists concern themselves with people's difficulties as well as with their strengths. Psychotherapeutic work involves human change and stability processes that are facilitated and supported through a therapeutic relationship that brings about recovery, resilience, and wellness. Contemporary perspectives of psychotherapy place it among the health service professions, in their broadest sense, as psychotherapists involve themselves not only with disease and disorders but also with health and well-being, and are, therefore, health service providers (American Psychological Association [APA], 2013). The strategies, interventions, and techniques utilized in psychotherapy are quite extensive and affirmed by a large body of research as well as by an accumulated body of community standards of practice, ethical principles and code of professional conduct, sophisticated clinical judgment, and cultural competence.

Psychotherapy is employed by a range of mental health practitioners, including but not limited to

pastoral, rehabilitation, and professional counselors, psychiatric nurse practitioners, marriage and family therapists, clinical social workers, psychologists, and psychiatrists. Moreover, the diversity and complexity of psychotherapists' scope of practice has increased exponentially in recent decades. Mental health practitioners can be found providing services in the most varied of contexts and sets of circumstances, and for a vast array of intricate complaints, concerns, and aspirations. We focus this chapter on those professionals who by a function of their degrees and licenses devote most of their time to the provision of psychotherapy services, and we refer to them as psychotherapists. We begin by discussing graduate training and follow by addressing licensing, practice and expertise, and retirement.

GRADUATE TRAINING

In this section we discuss admissions into training and the training itself, specifically the models of training, curricula inclusive of cultural competence and humility, and the effectiveness of training. Furthermore we address the role of personal therapy as well as supervision and its effectiveness.

The training of psychotherapists has been markedly influenced by recent, significant changes in professional psychology that have emphasized performance in contrast with a historical accent on theory. Over the past two decades there has been a steady movement toward specifying core competencies, organized into a taxonomy of foundational and functional professional competencies, according to level of training (Rodolfa et al., 2005). The specified foundational competencies for professional psychologists include professionalism, reflective practice, scientific knowledge and methods, relational abilities, individual and cultural diversity, ethical knowledge and comportment, and interdisciplinary abilities, whereas the functional competencies include assessment, intervention, consultation, research, supervision, teaching, management-administration, and advocacy. Competencies are translated into defined and measurable expected learning outcomes, which are assessed at landmarks of professional development beginning with professionals-in-training before their practicum experiences, then before their internship, and finally, before their entry into practice (Fouad et al., 2009). Moreover, pertinent competency assessment toolkits have been made available in an effort to specify the essential components and their behavioral indicators (Kaslow et al., 2009). Although there is a notable, recent, marked trend toward specification and accountability, it is also fair to say that there is an overall trend toward joining theory, research, and practice with the values and principles of the profession.

Qualifications at Admission Into Training in Psychotherapy (i.e., Selection)

In the United States, the independent practice of psychotherapy can be carried out by a diverse group of mental health practitioners at the doctoral level (e.g., PhD, PsyD, EdD, MD), as well as at the master's level (e.g., MA, MS, MEd, etc.). The criteria for admission to graduate-level degree programs that will fulfill the educational requirements for the independent practice of psychotherapy are quite diverse and vary, to some extent, on whether the degree sought is at the master's or doctoral level. Elements of the criteria can be broadly described as "objective" and "nonobjective" (Norcross, Hanych, & Terranova, 1996). The objective elements may include a relevant undergraduate degree with an acceptable grade point average from undergraduate studies and a minimum score on a standardized test such as the Graduate Record Examination (GRE). Some programs may require a standardized writing sample such as the Graduate Essay Test. The nonobjective elements of admission may include letters of recommendation; curriculum vitae detailing relevant work, clinical, and/or research experience; a face-to-face or phone interview; and an essay written by the candidates addressing their interest in the degree program sought as well as their goals and objectives. Some programs are more likely to request that the essay be autobiographical, reflecting on how the candidates' life experiences have shaped their personal, educational, and career objectives and aspirations. Programs committed to social justice recognize the importance of training a psychotherapy workforce that mirrors the communities it will serve, and therefore these programs emphasize the recruitment of diverse candidates, particularly from underrepresented minority groups, as well as multilingual candidates who can become multilingual professionals through proper

training. These programs are trying to respond proactively to a significant problem in the education pipeline. For example, in California, while 38% of its population is Latina/o, only 12% of the graduates of doctorate and master's-level clinical, counseling, and general psychology programs were Latinas/os in 2006 (Lok & Chapman, 2009). Nonetheless, this problem extends beyond graduate students and involves the current faculty composition. Although ethnic minorities make up approximately 38% of the US population, only 14% of faculty members in graduate departments of psychology in the United States are ethnic minorities (Hart, Wicherski, & Kohout, 2011).

The European Federation of Psychologists Association (EFPA; www.efpa.eu) guidelines emphasize the importance of trainees' personal suitability at the point of admission into training as assessed sometimes, though not always, through personal interview and then throughout training by their supervisor or educational institution. Most European psychotherapists have been trained as psychiatrists or psychologists, yet their educational system is different from that of the United States. A salient difference is that the undergraduate work in Europe tends to be more focused in psychology, whereas in the United States it emphasizes general requirements. EFPA has sought to develop a common standard for professional psychology across its 36 member countries. EFPA's guidelines for training standards for psychologists specializing in psychotherapy include basic qualifications (5 years of university studies on academic and applied psychology), and 3 years of full-time training in psychotherapy that includes, at the very minimum, 500 hours of supervised practice and 150 hours of supervision.

In Latin America the criteria and regulatory norms in the training and supervision of psychotherapists are in an initial phase of development. At the moment, there are no Latin American norms and even the national norms have a limited degree of formalization. The strictest of criteria correspond to a few associations that espouse particular therapeutic foci. For example, in the case of psychoanalysis, there are some shared standards within the Latin American Psychoanalytic Federation. In psychotherapy in general there have been some recent attempts at creating shared regulations through the Latin American Psychotherapy Federation, though the Federation itself is still being constituted and several countries are not yet represented in it.

Surprisingly, the topic of selection has received limited attention in the scientific and professional literature. The extent to which the requirements identified herein are predictors of success in graduate studies has received some attention, though practically none with respect to success in professional practice. We recommend that the findings from psychotherapy process and outcome research be used to create more explicit guidelines for the selection of graduate school applicants. For example, important psychotherapist attributes from the literature that are strongly associated with positive psychotherapy outcome are empathic capacity and intellectual curiosity, flexibility, and latitude of acceptance (Beutler et al., 2003; Hill & Knox, 2013). Moreover, selection committees can refer to the competency benchmarks in their considerations, particularly with respect to psychotherapists'-in-training expected developmental level before practicum. For example, behavioral anchors such as demonstrating honesty, taking responsibility, exhibiting organizational skills, displaying initiative to help others, and conveying compassion, among others, can all be used as part of the selection process. Furthermore, candidates' awareness of themselves as socially responsible and responsive cultural beings is an important characteristic to consider. Finally, the markedly limited diversity and multilingual abilities among the existing psychotherapy workforce requires a proactive response on the part of admissions' committees.

Training

We address here the most common models of training, the most salient curriculum items, and the effectiveness of training.

Models and Methods

The two, most established applied psychological training models in the United States are the *scientist-practitioner* (Raimy, 1950) and the *practitioner, practitioner-scientist, practitioner-scholar, professional-scholar,* or *practitioner as a local scientist* (Trierweiler & Stricker, 1998). The *scientist-practitioner* model distinguishes itself from another model, the *scientist* model (or *clinical scientist* model), for its emphasis on application. The degree most closely associated with the

scientist-practitioner model in psychology is the PhD, whereas the PsyD is most closely associated with the *practitioner-scientist* model. Typically, although not exclusively, the former are granted at university programs and the latter are given at professional schools.

The *scientist-practitioner* model is also known as the Boulder model in reference to the 1949 conference on Graduate Education in Clinical Psychology that took place at the University of Colorado in Boulder, and where many of the details of the model were finalized, based on an educational plan previously developed by David Shakow. The emphasis of the model has been on science and practice addressed equally during training (though in that order) to produce scientist-practitioner psychologists. Although some have been critical of the model and have asked for its dismissal or replacement (Snyder & Elliott, 2005), claiming that it is unrealistic, others have been quite affirmative of it (Drabick & Goldfried, 2002), considering it not only attainable but most desirable.

Meanwhile, the *practitioner-scholar* or *practitioner-scientist* model is also known as the Vail model in reference to the 1973 professional psychology training conference that took place in Vail, Colorado. It should be noted that this type of professional study was first suggested as early as 1918 by Leta Hollingworth, signified by a degree she abbreviated as PsD. The Doctorate of Psychology degree recognizes those who are primarily interested in the delivery of mental health services such as psychotherapy. Moreover, specific programs operating under either model vary significantly in their emphases on research, and/or practice and the provision of services. Regardless, effective psychotherapy requires an integrative stance with respect to science and practice, where scientific methods frame professional practice and where practice generates evidence as well.

The educational methods employed in the training of psychotherapists have included instruction, modeling, formative feedback, summative evaluation, rehearsal, case notes, case formulation, and supervision. Additionally, the use of audio and video recordings, one-way mirrors (i.e., live observation and vicarious learning), live supervision, and co-therapy have been part of the range of methods employed by many psychotherapy training programs.

Training Curricula

In the United States, the accreditation standards put forth by APA are framed as principles and guidelines. They are broad and general rather than narrow and technical and are expressed as domains that are "considered essential to the success of any training program in professional psychology" rather than as a "check-list of criteria" (APA, 2013, p. 4). One of these domains concerns curriculum plans, which are expected to address aspects of scientific psychology, including the biological, cognitive, affective, and social aspects of behavior; the history and systems of psychology; psychological measurement; research methodology; and techniques of data analysis. Training programs are also expected to cover the foundations of practice, including individual differences in behavior, human development, dysfunctional behavior or psychopathology, professional standards and ethics, theories and methods of assessment and diagnosis, effective intervention, consultation and supervision, and evaluating the efficacy of interventions (APA, 2013).

Although there has been much debate as to what should be part of the training curricula, the overall consensus in training psychotherapists points to at least three, overlapping content and competency areas: adequate and improving interviewing abilities; sound ethical judgment informed by the existing code of ethics and the laws regulating professional practice; and cultural competency, inclusive of cultural humility and advocacy. We now address these three content and competency areas.

Interviewing Skills Training

The training of psychotherapists is anchored on interviewing skills, developing candidates' abilities to attend to verbal and nonverbal communication, as well as to content (what is and is not said or done), process (how something is said or done), and praxis (who is saying or doing what) during an interpersonal encounter. Formerly referred to as therapists' ability to be participant-observers, this ability is currently framed as the capacity to be a participant-conceptualizer; in other words, therapists are trained to engage and remain engaged while seeking to make sense of facilitative and impeding factors in the process. Moreover, therapists are expected to attend to not only the impact that their actions are having on

the client but also to the impact that the client's actions are having on them. To the extent that these interviewing skills are therapeutic they are referred to as helping skills (Hill, 2014).

The most frequently utilized paradigm to train aspiring therapists on interviewing skills can be broadly referred to as microskills training, where therapists receive instruction on specific, discrete therapy behaviors over time. This training paradigm, introduced in the late 1960s, sought to overcome the gap between theory and practice apparent in prior training models, which had relied largely on theoretical training but only minimally on applied training. Within this microskill paradigm one finds, at least in the United States, the Human Resource Training/Human Resource Development by Robert Carkhuff (Truax & Carkhuff, 1967), the Microskills Counseling Training developed by Allen Ivey (Ivey, Ivey, & Zalaquett, 2013), the Interpersonal Process Recall by Norman Kagan (1984), and the Helping Skills: Exploration, Insight, and Action by Clara Hill (2014). To a large extent these four models evolved from Carl Rogers's early formulations on the "necessary and sufficient conditions of therapeutic personality change" (Rogers, 1957), and they hone in on the skills that constitute the common factors approach in psychotherapy (Norcross, Goldfried, & Zimmerman, Chapter 13, this volume).

Ethics and Laws

In the United States, national professional associations develop codes such as the Ethical Principles and Code of Conduct by the APA and the Code of Ethics by the American Counseling Association (ACA), in an effort to set shared standards for the profession (Hummel, Bizar-Stanton, Packman, & Koocher, Chapter 31, this volume). Individual states typically refer to those national codes as the bases on which to judge ethical behavior. Training programs are mandated by state licensing boards and by national accreditation standards to train their graduates on national ethical standards as well as state laws regulating professional practice. APA's ethics code is organized into ethical principles and a code of conduct. The ethical principles are aspirational in nature and include beneficence and nonmaleficence, fidelity and responsibility, integrity, fairness and justice, and respect for people's rights and dignity. The code of conduct contains enforceable standards that require specific actions by the psychotherapist such as maintaining confidentiality, securing informed consent, and not engaging in sexual intimacies with current patients and their relatives, research participants, and supervisees (American Psychological Association, 2002/2010).

In Europe, EFPA developed a European Meta-Code of Ethics (2005). The Code serves as a basis for National Codes of Conduct and Ethical Principles among European member associations. The European meta-code proposes a set of four foundational and interdependent principles, including respect for a person's rights and dignity, competence, responsibility, and integrity. Similarly, a meta-code was developed in Latin America; it contains the four principles mentioned in the European meta-code and adds a fifth principle: social responsibility (Comité Coordinador de Psicólogos del Mercosur y Países Asociados, 1997).

Building upon the European and the Latin American meta-codes, the International Union of Psychological Science and the International Association of Applied Psychology established the Universal Declaration of Ethical Principles for Psychologists (known as the UD) (Gauthier, 2008). The UD outlines a moral framework and four fundamental ethical principles intended to guide psychologists in their scientific, academic, and professional endeavors. The four ethical principles are as follows: respect for the dignity of persons and peoples; competent caring for the well-being of persons and peoples; integrity; and professional and scientific responsibilities to society. These principles are then further specified through related values (e.g., dignity of persons and peoples specified by respect for dignity and worthiness of all human beings, nondiscrimination, informed consent, freedom of consent, privacy, protection of confidentiality, and fair treatment/due process). The principles and related values are general and aspirational rather than specific and prescriptive.

The expected outcome of training is the achievement of ethical psychotherapists over time. Such psychotherapists are knowledgeable of the scope of practice of their profession, that is, what they are permitted and expected to do within their professional practice as defined by law, professional standards, and guidelines. Ethical psychotherapists systematically apply an ethical decision-making process that involves self-examination as well as consultation

when appropriate. Moreover, they conduct themselves ethically by abiding by ethical, legal, and community standards.

Cultural Competencies

In the United States, this area of competency is part of the "cultural and individual differences and diversity" requirement set forth by APA's Committee on Accreditation. Some training programs have used a single-course approach to address this requirement, whereas others have implemented an infusion strategy that incorporates cultural content across all courses. The infusion strategy has resulted at times in diffusion of content, and therefore programs have adopted a stance that includes specific courses addressing diversity and at the same time explicitly outlining how all its courses address diversity matters. Although initially focused on race and ethnicity, diversity and cultural competencies are currently umbrella terms that also encompass age, sex, gender, gender identity, ethnicity, culture, national origin, religion, sexual orientation, (dis) ability, language, and socioeconomic status (APA, 2003, 2002/2010).

Most cultural competency curricula have been organized around three areas: self-awareness (particularly of one's culture, power dynamics, and privilege), knowledge (of the other who is different from ourselves), and relevant skills (Sue, Arredondo, & McDavis, 1992). Culturally competent therapists are to become knowledgeable and aware of themselves as cultural beings and in that process gain a sense of their own assumptions about human behavior, their values, beliefs, cultural heritage, class, and privilege. They are to learn about their biases, preconceived notions, personal limitations, gender identity, and how the intersectionality of these dimensions may influence their professional work. This intense process of self-examination is expected to lead to self-humility, which in turn can help build bridges of empathy and understanding toward others such as their clients. With respect to knowledge, psychotherapists understand their practice as a historically and culturally embedded profession, and appreciate clients as cultural beings with their own set of values, beliefs, and attitudes toward life and toward the services being offered. Moreover, psychotherapists develop relevant, culturally congruent skills and practices to work effectively with culturally diverse individuals, groups, and communities so as to serve as advocates (Fouad & Arredondo, 2007).

Beyond these specific content areas, a crucial matter in psychotherapy curriculum concerns the training of aspiring therapists in evidence-based therapies. Although initially some programs advocated for training their graduates in empirically supported, manualized treatments, more recently such emphasis has been complemented with empirically supported therapy relationships, where therapists-in-training are asked to focus on the therapeutic alliance, empathy, and goal consensus and collaboration while tailoring the treatment to clients' variables beyond diagnosis such as resistance and functional impairment (Norcross, 2011; Wampold & Imel, 2015). Moreover, and as indicated previously, several other content areas covering functional competencies have been identified (e.g., assessment, consultation, management, administration, etc.) (Rodolfa et al., 2005), yet those are more closely associated with professional psychologists and are beyond the scope of this chapter, which focuses on psychotherapists.

The Effectiveness of Training

The improvement of psychotherapy training programs is a critical matter requiring much effort among therapists and researchers alike. Although psychotherapists and those devoted to their training may conclude that training is necessary, such a conclusion must be based on findings demonstrating its effectiveness. One can distinguish two distinct periods in the training of psychotherapists: the first for training novices, and the other for training practicing professionals. The training needs are different indeed, ranging from basic, general therapeutic abilities to advanced, specific ones. Nonetheless, it is important to underscore that basic abilities are not necessarily easier to acquire and employ and advanced skills are not necessarily more difficult to develop. Moreover, it is important to emphasize the facilitative or challenging role that the personal characteristics of a given psychotherapist-in-training may play in his or her own development, and the optimization of the helping resources available to therapists in their own training programs (Corbella et al., 2009). In fact, a given trainee may experience specific difficulties that are different from his or her colleagues-in-training in the same program to the extent that different trainees have at their disposal a different

range of resources that can be facilitative or impeding factors in the acquisition of psychotherapeutic competencies (Corbella et al., 2009). Therefore, such differences highlight the need to tailor the training to the specific strengths and areas for growth as well as the resources of a given psychotherapist-in-training.

Although many training modalities have been researched over time, perhaps Hill's (2014) helping skills training is the one most studied contemporarily. It has been shown that following an 8-week training on helping skills, undergraduate students were more able to use exploration skills, talked less, were more empathic, and were assessed as more effective than those who did not receive the training. After 15 weeks of training, psychotherapists had higher self-efficacy for using helping skills than on their first day of training (Hill et al., 2008). Some authors have indicated that psychotherapists-in-training need between 2 and 3 years to achieve comfort and confidence in using the helping skills (Ericsson, Charness, Feltovich, & Hoffman, 2006). Although teaching and training on empathy and reflection of feelings have been shown to be efficacious, this is not the case with other skills such as insight and action (Hill & Knox, 2013).

Personal Therapy

Personal therapy among trainees has been an important component in training ever since Freud introduced it as a requirement. Initially, a distinction was made between a regular analytic process and a didactic analysis, with the latter being required of psychoanalytic trainees for the purpose of addressing the unconscious conflicts presented by candidates. Contemporarily, psychoanalytic trainees are expected to undergo personal therapy without distinguishing it from a "didactic analysis." The advent of different psychotherapy schools changed these premises a bit, yet continued to emphasize the importance of a sound personal balance as well as a healthy emotional condition. What has been heatedly debated is making personal therapy a requirement in light of the limited empirical support relating personal therapy to an improved emotional balance. Even though this is the case, it is also the case that a critical personal situation can threaten the sound exercise of the profession. The relationship between therapists' functioning and the benefits that clients may derive from therapy is a complex, multivariate equation that is influenced, to a large extent and among other things, by the functional deterioration of a client, the social support network, and the context in which the professional is immersed. Psychoanalytic training has continued to require personal therapy while cognitive-behavioral approaches have been reluctant to do so (Geller, Norcross, & Orlinsky, 2005). Some authors have decried the requirement as having no bearing on improving the quality of the services provided (c.f., Duncan, 2014), others have expressed concern about the potentially detrimental effects of requiring personal therapy (Malikiosi-Loizos, 2013), while others have argued benefits such as improving emotional and mental functioning, facilitating an understanding of personal and relational dynamics, limiting possible countertransference reactions, alleviating the stress and toxicity associated with professional practice, appreciating the role of the client, and modeling (c.f., Norcross, 2005). Contemporarily, many training programs strongly recommend personal therapy as part of the training, yet most do not require it. More important, the emphasis has been on not just personal therapy but on personal development unless the former was clinically indicated. In affirming the importance of personal development, training programs have emphasized a range of activities that facilitate the development of the person of the therapist as well as his or her overall well-being with the goal of achieving optimal performance.

Orlinsky, Schofield, Schroder, and Kazantzis (2011) studied this matter by surveying several thousands of psychotherapists worldwide and found that 87% of respondents participated in personal therapy. Psychoanalytically oriented participants did so in the greatest numbers (94%), followed by humanistic (91%), and then cognitive-behavioral (73%). It should be noted that some associations (cross-national, as well as national or state) may require personal therapy, whereas others may provide incentives to do so. For example, EFPA requires at least 100 hours of personal therapy (or personal development activities specified by each theoretical orientation), whereas the California Board of Psychology incentivizes licensure candidates to receive personal therapy by allowing them to triple count their therapy hours for up to a maximum of 300 hours out of the 3,000 supervised hours required as part of becoming license eligible.

In short, it is important to "work on oneself" particularly while early in training, and at critical personal

instances such as marked interpersonal difficulties, losses, and relocation. It is also important to do so throughout one's professional life, considering how challenging the work of a psychotherapist is, including exposure to clients' trauma. Working on oneself involves maintaining healthy boundaries, continuing to develop professional competencies, acknowledging personal limitations, recognizing our privileges, and overcoming our prejudices. Psychotherapists are particularly vulnerable to omnipotent attitudes as people consult them repeatedly in search of answers to some of the most vexing human difficulties.

Supervision

Supervision is a central element in psychotherapists' training and development and in the delivery of services. Specifically, supervision facilitates the acquisition of psychotherapeutic knowledge by supervisees, guides their practice, and fine-tunes the quality of services rendered (Bernard & Goodyear, 2013; Neufeldt, Beutler, & Banchero, 1997). Feedback is at the center of supervision, a crucial resource to facilitate learning and skill acquisition.

Initially supervision was provided by experts from a given theoretical orientation to train aspiring practitioners in that specific orientation, yet those experts had no qualifications as supervisors other than their psychotherapy experience and prestige as professionals and academics. Specifically, they had no formal training in supervision. This earlier model was associated with providing a holding environment to the supervisee, yet its direct benefits to service provision were unclear, and, moreover, it was fraught with a vertical, authoritarian style that engendered much anxiety in the supervisees. Much has changed with respect to supervision since its early days. As with psychotherapy, supervision has evolved to emphasize the importance of a working alliance in its success. A strong interpersonal bond and a shared agreement on goals and tasks have become crucial in supervision. Similarly, much change among supervisor behavior has occurred; supervisors' style, power usage, self-disclosure, attachment, emotional intelligence, and ethical conduct have begun to be appreciated as the attributes most linked with successful supervision (Bernard & Goodyear, 2013).

Supervision has gone beyond its therapeutic origins, and it currently emphasizes the professional development and acquisition of competencies by the supervisees (Angus & Kagan, 2007; Falender & Shafranske, 2004). At the heart of contemporary supervision is the person of the supervisee and his or her ability to relate to clients and supervisor rather than his or her detailed usage of a therapeutic approach. Supervisors collaborate systematically with supervisees in facilitating the development of supervisees' therapeutic role, while honoring and respecting supervisees' developmental levels in their professional trajectories. Among contemporary supervision models, one that stands out is the integrated developmental model (Stoltenberg, 2005) that emphasizes three evolutionary stages. In the first stage, supervisees do not have much training yet have much motivation; they are quite anxious, fearful of evaluation, and depend a lot on the supervisor. In the second stage, supervisees experience an increased level of confidence, can focus more on the needs of the client rather than their own, and experience ambivalence between depending on the supervisor and feeling self-sufficient. In the third stage, supervisees' relationships with their supervisors come closer to that of peers, and they are more comfortable with constructive criticism of their own clinical work. It should be noted that supervisors themselves go through developmental processes as well and that optimal supervision takes place when the developmental processes of supervisors and supervisees are matched.

Does supervision improve the quality of psychotherapy training and the services received by clients whose therapists receive supervision? Unfortunately, we do not have conclusive evidence on this, though many of the research findings do support the important role of supervision (Neufeldt et al., 1997; Watkins, 2011). Supervisees acquire better awareness of themselves and others, achieve more independence in their professional development, have higher levels of motivation, and increase their perceived self-efficacy (Hill & Knox, 2013). Nonetheless, much of the research in this area has focused only on traditional, one-on-one supervision, whereas newer models emphasize the strength of group and peer supervision. These newer modalities accentuate interpersonal dynamics, which in turn may increase substantially the power of the supervisory alliance. These modalities require of supervisors a different set of skills. Group supervisors must be skilled in facilitating the evolution of groups and in managing group processes. In peer supervision, which can function with or without

an identified supervisor, the supervisory dynamics are much more horizontal rather than vertical, as in traditional supervision, and provide, through vicarious learning, a powerful tool to facilitate and affirm supervisees' autonomy and initiative.

An important, recent development in supervision has sought to transcend the adherence of supervisors to their school of thought and to emphasize the guidance provided to supervisees in implementing evidence-based principles of therapeutic change as well as in incorporating process and outcome measures (Holt et al., 2015). This intentional supervision approach expects supervisors to center the supervision on competencies and on the regular use of measures that assess not only the therapeutic process but also the supervisory relationship. The competencies concern the systematic selection of interventions based on common treatment moderators and mediators, beyond clients' diagnosis (Beutler, Clarkin, & Bongar, 2000). The measures evaluate clients' impairment and resistance levels, their coping style and readiness to change, and the therapeutic and supervisory relationship. Preliminary results of this supervisory model are extremely promising (Holt et al., 2015).

Another important aspect of supervision and its role in the training of aspiring therapists is related to psychotherapy records, supervisors' access to them, and the level of exposure faced by supervisees depending on the record-keeping mechanism employed. Supervision involves the evaluation of supervisees' actions and the quality of their interventions as well as the assessment of the adequacy of supervisors' performance. The outcome of supervision is mediated by the degree of openness and sincerity of the people involved and the availability of a transparent, honest view of the session being supervised. Therefore, access to a range of records capturing the session can prove crucial: whether it be process notes, audio recordings, video, a one-way mirror, and/or live supervision. All these possible windows into the therapeutic encounter are accountable to ethical considerations and strict professional norms. Much research is needed on these important matters as the role of supervision within evidence-based practice has only recently been a subject of assessment (e.g., Milne, 2009).

A further issue is the markedly limited diversity in the supervisory workforce—a concern that merits redressing. Many agencies rely on diverse trainees to provide services to an increasingly diverse clientele. Investing in supervisors' diversity training and evolving competence is an important strategy to support trainees' development. Needless to say, particularly concerning are circumstances where supervisees are provided with substandard supervision such as when multilingual psychotherapists-in-training deliver services in a language (e.g., Spanish) not spoken by their monolingual (e.g., English only) supervisor. This results in the inappropriate arrangement of their work being supervised in a language other than the one in which services are being rendered.

LICENSING

Licensing Requirements

Professional licenses for the practice of psychotherapy in the United States are regulated by state laws contained within each state's business and professions code. These licenses are typically administered by the Department of Consumer Affairs in each state. State licenses are granted in an effort to protect the public/potential consumer by seeking to assure a minimum level of competence in the licensed professional. To earn a license, candidates must meet several requirements, including the earning of a relevant degree, whether at the master's level (e.g., professional counselors, psychotherapists, clinical social workers, marriage and family therapists[1]) or doctoral level (e.g., psychologists, psychiatrists); the accrual of a minimum number of direct clinical hours that have been supervised by a qualified, licensed professional (depending on the state, the required hours can range from 1,500 to 6,000); the passing of a national, written exam (known as the Examination for Professional Practice in Psychology—EPPP—in the case of professional psychologists), and another, state-specific exam that concerns the ethics and laws related to mental health practice in that state, also known as a jurisprudence exam; and the clearance from the Department of Justice and the Federal Bureau of Investigation with respect to possible criminal background.

In Europe, there are significant differences by country on the requirements to obtain a license for the independent practice of psychotherapy. There are professional organizations such as the European Association for Psychotherapy (EAP) and EFPA that have sought to establish uniform criteria for psychotherapists' certification. EAP is an umbrella

organization that includes 130 organizations from 41 European countries with over 120,000 psychotherapists. The goal of EAP is to promote psychotherapy and its practice throughout Europe, advance relevant and commonly agreed-upon regulation for the practice of psychotherapy, and to protect the consumers. The European Certificate in Psychotherapy warrants that those who obtained it have been trained according to a European criterion (known as EN 45013), and it supports a mutual recognition of the degree and qualifications of those practitioners.

Meanwhile, in Latin America, the license to practice psychotherapy depends on the legal norms of each country. There are no regulations beyond those found in each country. Psychotherapists interested in providing services in another country must have their degrees accepted in the new country and then pursue the pertinent national license. The most common degree has been that of *licenciatura* in psychology, which is a 5-year degree obtained after the completion of high school. Nowadays though there is a marked tendency to require postgraduate education with an emphasis in psychotherapy. A large number of academic programs have been started over the last decade, and they have an increasing presence in the practice of psychotherapy in Latin America.

One of the most challenging aspects in psychotherapy practice concerns license portability and professional mobility. As stated, in the United States licenses are state specific, a fact that creates significant challenges when relocating from one state to another. In the case of US and Canadian psychologists, in order to overcome these challenges, the Association of State and Provincial Psychology Boards (ASPPB) has created a Certificate of Professional Qualification in Psychology (CPQ) that permits a given holder to more easily relocate to another state, as long as the host state accepts or recognizes the CPQ. More recently, some members of ASPPB have established license reciprocity agreements between states or provinces, yet only 10 have done so thus far.

In light of the concerns stated earlier with respect to markedly limited diversity in the educational pipeline and similar concerns with respect to the workforce articulated later led us to seek data with respect to licensees in the United States. Unfortunately, we learn that states do not track the race or ethnicity of its licensees and therefore ASPPB does not have such data.

Continuing Education

Once licensure has been achieved, psychotherapists are expected to maintain their licenses in good standing by keeping their knowledge current. This is facilitated, in part, by requiring a minimum number of continuing education (CE) credits (a credit is approximately equivalent to an hour of training) that licensed practitioners must complete in each renewal cycle. This requirement varies by state. For example, in California, licensed professionals must complete a minimum of 36 CE credits for every 2-year renewal cycle. Many associations, including ACA, APA, and EFPA, offer CE programming.

Above and beyond the standard CE requirement, how do psychotherapists continue to improve their performance (Duncan, 2014)? The vastness and diversity of psychotherapy practice presents an important complexity. While a license to practice psychotherapy is appropriately broad, commonly referred to as scope of practice that is set by laws, the actual practice of a psychotherapist is inevitably much narrower, commonly referred to as scope of competence, which is made of a given practitioner's education, training, and experience. Therefore, in order for psychotherapists to improve their performance, it is important that they focus their work on specific, defined areas of competence and that they do so by incorporating evidence-based practices (Lampropoulos, 2011), practice-based evidence (Miller, Duncan, & Hubble, 2004), and community-defined evidence (Martinez, Callejas, & Hernandez, 2010).

Psychotherapists' simultaneous attention to these tripartite sources is likely to engender an openness of mind that combats dogmatisms associated with the traditional psychotherapy trademark approaches. Although psychotherapy is a nomothetic profession constituted by general principles and a formal structure, its practice must remain highly idiographic, attending to the uniqueness of each psychotherapy encounter with a fresh outlook. Finally, experience in and of itself does not warrant an improvement in performance. In fact, Corbella and Fernández-Álvarez (2006) distinguish a cumulative experience stance from a constructive experiential stance. In the former, practitioners limit themselves to the accumulation of hours without the engagement of a reflective conscience that searches for relationships, distinctions, patterns, and the integration of the diverse elements in experiences. In the latter, practitioners

devote themselves to a reflective engagement that helps them bring order to their emotions, thoughts, and actions, and to ultimately construct meaning from ones' experiences. Such a stance facilitates anticipatory knowledge in future therapeutic situations and supports self-corrective actions on the part of the therapist. In short, for experience to be facilitative of professional development it must be accompanied by a reflective practice that furthers one's skill set. Nonetheless, these two stances are not static and one may find oneself taking different stances at different moments. Furthermore, it would not be fair to conclude that therapists with a preponderant, cumulative experience stance are less efficacious than those with a preponderant, constructive experiential stance. What would be fair to conclude is that the latter have better chances at improving their overall psychotherapeutic efficacy by learning from their mistakes and by optimizing their resources, which in turn underscores the importance of self-observation and self-reflection for transforming experience into learning. Nonetheless, the current arrangements in continuing education have not been demonstrated to empirically improve the quality of the services received by clients (Neimeyer, Taylor, & Philip, 2010).

It should be noted that some professional boards in the United States have sought to be proactive about the cultural competence of licensees. In addition to requiring diversity training as part of the degrees that meet license eligibility requirements, some boards have required that a certain number of continuing education credits in a given renewal cycle be concerned with furthering their cultural knowledge as it applies to psychotherapy practice.

PRACTICE

Practice Areas

The practice of psychotherapy can be conceptualized in terms of the modality in which the services are being rendered as well as in terms of the populations being served (see Part II, this volume). Specifically, besides the traditional, individual modality of the provision of services in psychotherapy where a client meets one-on-one with a therapist, therapy can be conducted with couples (Rohrbaugh & Shoham, Chapter 12, this volume), families (Bernal & Gómez-Arroyo, Chapter 16, this volume), and groups (Rutan & Shay, Chapter 15, this volume). In addition, the electronic delivery of psychotherapy services, be that the main modality of intervention or an adjunct to regular therapy, occupies an important place in the current spectrum of possibilities. Electronic-based therapy delivery may offer users more anonymity and flexibility, possibly increasing access and improving utilization (Barrera, Stanley, & Kelman, Chapter 17, this volume).

Among the populations served through psychotherapy, the following groupings stand out. Based on the age of the population and specific needs that may arise, psychotherapy theory, research, and practice have focused on working with children and adolescents (Hoff et al., Chapter 18, this volume), as well as with older adults (Hyams & Scogin, Chapter 19, this volume). Another set of meaningful dimensions has involved clients' sex and gender, generating an important body of knowledge with respect to psychotherapy with women (Vasquez & Vasquez, Chapter 20, this volume), with men (Liang & Molenaar, Chapter 21, this volume), and with lesbian, gay, and bisexual clients (Goldblum, Pflum, Skinta, Evans, & Balsam, Chapter 22, this volume). Similarly, practitioners and researchers alike have generated an important body of knowledge utilizing psychotherapy with the severely mentally ill (Spaulding & Sullivan, Chapter 25, this volume). Moreover, psychotherapy has been utilized successfully to address the specific needs of racial/ethnic minority groups (Chu, Leino, Pflum, & Sue, Chapter 23, this volume) and immigrants and refugees (Morgan Consoli, Wang, DeLucio, & Yakushko, Chapter 24, this volume), as well as military personnel and Veterans (Kugel et al., Chapter 26, this volume). Finally, an important body of knowledge has been developed in psychotherapy to aid people facing extreme circumstances such as mass casualty events (Brown, Beutler, Patterson, Bongar, & Holleran, Chapter 27, this volume), and clinical emergencies (Spangler, Holleran, & Bongar, Chapter 28, this volume).

A relatively recent development, though by no means new (see Dorken & Whiting, 1974) is the framing of mental health service providers, particularly psychologists, as health service personnel (Health Service Psychology Education Collaborative, 2013). This view makes mental health matters only a portion, albeit still a quite significant one, yet within the larger, more proper umbrella of health. Moreover, psychotherapy is made part of comprehensive health

services, which include prevention, early intervention, treatment, and rehabilitation not only of mental disorders and mental health but also of other difficulties and diseases as well as of health promotion. Nonetheless, psychotherapy practice confronts a difficult workforce problem, centered on unjust current demographics: In the United States, while ethnic minorities make up approximately 38% of the population, it is estimated that they account for less than 13% of the psychology workforce (Michalski & Kohout, 2011).

Competence and Expertise

The practice of psychotherapy, as well as the expected abilities of psychotherapists, has been changing toward centering on the acquisition and demonstration of specific competencies (see Graduate Training section earlier in this chapter). Epstein and Hundert (2002) define competence as the "habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p. 226). As previously noted, competencies consist of discrete knowledge, skills, and attitudes (Kaslow et al., 2004). Competence implies an acceptable level of performance and the integration of multiple competencies. Each competence can be operationalized into indicators that in turn allow us to evaluate their presence and quality. Specifically, the Competency Benchmarks (Fouad et al., 2009) and the Competency Assessment Toolkit (Kaslow et al., 2009) provide important guidance with respect to how to function successfully within the current emphasis on competencies.

Although some differences exist between the US model of competencies compared and contrasted to the one put forward by EuroPsy, the European qualification standard for psychologists (www.europsy-efpa.eu), overall they are quite similar in their emphasis on foundational and functional competencies. And while competencies are particularly emphasized in the context of training for the purpose of standardizing learning outcomes, at the practice level they are stressed for the purpose of demonstrating competence and regulating professional standards of performance.

Orlinsky and Ronnestad (2005) researched the evolution of 5,000 psychotherapists over the course of 15 years. They found three critical dimensions that are involved in professional development. They termed the first one Healing Involvement, which captures the experience of therapists feeling personally committed, involved, and affirming in their relationship with their clients, as well as highly empathic and constructive during sessions. The second one they termed Stressful Involvement, where therapists find themselves feeling unconstructive, avoiding, bored, and anxious during sessions. They termed the third one Controlling Involvement, where therapists exercise an authoritative, commanding presence that balances dominant and reserved relational styles. Although the first two dimensions are experienced by all therapists, those who found themselves more often in Healing Involvement were more likely to grow and evolve as therapists, whereas those experiencing Stressful Involvement found themselves depleted, stressed, and therefore less likely to grow. Controlling Involvement acted as a protective factor in professional growth.

Perhaps even more important within the realm of practice competencies and expertise is the growing recognition of the therapists' individual characteristics that facilitate or impede professional performance, as discussed by Beutler (1997). These characteristics play a role not only in psychotherapists' training but also in the differential performance observed in daily practice and consistently documented in psychotherapy research. Beginning with the work of Ricks (1974), who coined the term "supershrink," to highlight the outstanding performance by a given therapist who did so by devoting more time to clients who were most disturbed, making use of resources outside of therapy, being firm and direct with parents, encouraging and supporting movement toward autonomy, facilitating problem solving in everyday life, and timing interventions based on clients' readiness. Meanwhile, therapists who did not perform as well were dubbed "pseudoshrink" (Bergin & Suinn, 1975), and their actions included withdrawing due to feeling frightened by the degree of pathology, becoming depressed for similar reasons, and ignoring hopeful signs in clients while becoming increasingly hopeless about clients' future. Since then, more sophisticated works have explored these matters more closely, including the writings and research by Duncan, Miller, Wampold, and Hubble (2010; Duncan, 2014; Wampold, 2001; Wampold & Imel, 2015) (see Machado & Beutler, Chapter 29, this volume).

What are those individual characteristics that make a difference, and how can they be systematized? Are psychotherapists born with these characteristics, or do they learn them? If born with them, can those characteristics be improved? If not born with them, can they be learned? Corbella et al. (2009) have resorted to the relational abilities from the theory of mind (Premack & Woodruff, 1978) to emphasize certain characteristics that facilitate the performance of psychotherapists, such as the capacity to interpret and anticipate the mental states (e.g., desires, thoughts, intentions) of oneself and others, as well as the ability to anticipate and modify the comportment of self and others. Corbella et al. (2009) argue that these personal abilities might be precursors to professional abilities such as empathic holding and working alliance. Meanwhile, Fernández-Álvarez (2004) has argued for the importance of psychotherapists' own personal styles and how such styles drive the theoretical and applied choices they make in their practice. Moreover, Hill (2006), from a conceptual perspective, and Wampold and Brown (2005), from an empirical perspective, have demonstrated that therapist variables explain a larger portion of the variance in treatment outcome than the treatments themselves (see Machado & Beutler, Chapter 29, this volume).

What differentiates experienced, competent psychotherapists from expert ones? In other words, how do psychotherapists go from good to great? These are challenging questions to answer, yet there is some evidence to support the following affirmations. Expert therapists organize their knowledge hierarchically, reflecting a deep understanding of a given phenomenon; they focus on what is relevant and develop functional accounts of a problem; they are particularly flexible and are able to reflect deeply on their knowledge and actions vis-à-vis a given situation; they attend simultaneously to both the ends and the means; they embody implicit processing and reasoning that goes beyond deliberative, analytic thinking; and they engage in intuitive decisions (Oddli & Halvorsen, 2014). Nonetheless, psychotherapy experts work harder than competent therapists at improving their performance and engaging in deliberate practice, as well as in challenging their own, current levels of proficiency. This attitude that brings to mind a quote attributed to Thomas Edison, "Genius is 1% inspiration and 99% perspiration," as well as matters of motivation that keep the experts engaged in their practices. Yet such devoted practice is not enough: Experts are particularly attentive to feedback, they seek it systematically, and, above all, they fine-tune their performance through successive follow-ups with their clients (Miller, Hubble, Chow, & Seidel, 2013).

Wellness

The provision of psychotherapy can be, simultaneously, an extremely dangerous as well as rewarding endeavor for the practitioner. As Freud put it, "No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed" (1905/1933, p. 184). On the one hand, psychotherapy practice can be grueling and demanding, plagued by uncertainties and inconsistencies, and likely to take a toll on the therapist's own mental health as expressed through moderate depression and anxiety, emotional exhaustion, and disrupted interpersonal relationships (Brady, Healy, Norcross, & Guy, 1995). On the other, the work of a psychotherapist can generate "relief, joy, meaning, growth, vitality, excitement, and genuine engagement" (Norcross, 2000, p. 712). Psychotherapists attribute to their work an increase in their own capacity to enjoy life, say it makes them better, wiser, more aware people, and describe it as a form of spiritual service (Mahoney & Fernández-Alvarez, 1998; Radeke & Mahoney, 2000).

Nonetheless, the provision of psychotherapy, "the harvest of human misery," according to Kureishi (1998), raises the need for significant steps in self-care on the part of the provider. Norcross and Guy (2007, 2013) recommended the following strategies: (1) recognize the inherent hazards of psychological practice and mind the body; (2) set appropriate boundaries; (3) think of broad strategies, as opposed to techniques and methods; (4) begin with self-monitoring, self-awareness, and self-liberation (choosing and self-realization); (5) embrace multiple strategies traditionally associated with diverse theoretical orientations; (6) employ stimulus control when possible while appreciating the importance of a facilitative environment; (7) use counterconditioning strategies such as relaxation, assertion, cognitive restructuring, exercise, and diversion; (8) emphasize the human element through peer groups, clinical supervision, friendships, and love relationships; (9) seek personal

therapy; (10) avoid wishful thinking and self-blame; (11) diversify professional activities; (12) appreciate the rewards of mental health practice; (13) focus on cultivating spirituality and mission; and (14) foster creativity and growth.

RETIREMENT

The published literature concerning this phase in the professional life of psychotherapists is minimal (Guy, Stark, Poelstra, & Janet, 1987). Rogers (1980) had expressed that aging favored several psychotherapy abilities, specifically, patience, spontaneity, and acceptance. Because the practice of psychotherapy does not require much in terms of physical capacity beyond an adequate cognitive function, a sustained motivation, and a sound emotional disposition, it is possible to continue practicing even at an advanced age.

Nonetheless, much has been written about retirement and its impact in other disciplines. As life expectancy and therefore the size of the retirement-eligible population have increased, several programs have established precautions to prevent possible negative consequences to oneself and one's community (Schlossberg, 2009). Some authors have taken into consideration existential matters and psychological factors associated with the transition (Osborne, 2012), and a special issue of the *American Psychologist* encompassed several articles on the matter, including one on the changes involved in the transition (Schutz & Wang, 2011). The APA's website contains some practical and pertinent recommendations on the matter (McGurk, 2005), including a checklist for closing one's own practice.

Retirement may take place at an earlier age than expected, due to burnout or lack of motivation to continue practicing, or due to some significant life event such as disease, accident, or migration. The grieving process associated with these scenarios will be quite different. The first may require vocational orientation, while the second may call for assistance from another psychotherapist. Retirement may also be due to advanced age, yet two different circumstances should be contemplated. The first one concerns psychotherapists who are retiring from an institutional practice, where the transition involves the separation from an institution. The second one concerns closing one's own independent practice. Regardless, retirement demands that the therapist attend to several clinical, ethical, and legal issues. Retiring therapists should prepare their clients for the transition when feasible, and they may want to resort to consultation or supervision to best navigate the process. Robbins (2006) and Power (2012) offer some personal reflections on this process. Meanwhile, Milne (2013) raised the following factors to consider in facilitating a successful process: Resources (for example, financial), Exercise, Coping Strategies, Intellectual Activity, and Purpose and Engagement (social support) (RECIPE).

CONCLUSIONS/KEY POINTS

Psychotherapy, a social science and practice, is the facilitation of a helping relationship by a trained mental health professional for the purpose of ameliorating suffering as well as enhancing the quality of clients' lives. To be able to accomplish these lofty goals, psychotherapists must receive proper training, including instruction on cultural competence, and commit themselves to a lifelong professional development process characterized by devoted and reflective practice, flexibility and openness to feedback, and much humility. Psychotherapists must be knowledgeable about a large body of strategies, interventions, and techniques supported by research and community standards of practice, and be observant of the ethical principles and codes of professional conduct in their professional judgment and actions, all the while remaining cognizant of psychotherapy as a culturally sanctioned practice.

- Specific admission criteria to a psychotherapy training program vary by world regions, yet candidates can expect an examination of motivation to enter the field; interpersonal abilities, including empathic capacity, flexibility, latitude of acceptance, and conceptual skills; and their career trajectories and professional endorsement via letters of recommendation. Training programs must do more to ensure that the demographic diversity of their graduates and faculty members reflects those of their communities.
- The two most common training models in psychotherapy are the *scientist-practitioner* and the *practitioner-scientist* models. Training curricula within these models typically include

interviewing abilities and helping skills, ethical judgment, and cultural competency, inclusive of cultural humility and advocacy. The educational methods employed involve instruction, modeling, formative feedback, summative evaluation, rehearsal, case notes, case formulation, supervision, and the use of audio and video recordings, one-way mirrors, live supervision, and/or co-therapy.

- Psychotherapy can be practiced at the master's or doctoral level and requires a pertinent professional license preceded by the successful accrual of a specified number of supervised hours of engagement in clinical service delivery.
- The personal well-being of psychotherapists is of significant importance. Facilitation of well-being may include but is not limited to a personal psychotherapy process and often involves a sizable range of proactive self-care activities.
- Foundational competencies in psychotherapy include professionalism, reflective practice, scientific knowledge and methods, relational abilities, individual and cultural diversity, ethical knowledge and comportment, and interdisciplinary abilities.
- Functional competencies in psychotherapy include assessment, intervention, consultation, research, supervision, teaching, management-administration, and advocacy.
- Expert therapists work harder than competent therapists at improving their performance by engaging in deliberate practice, challenging their own current levels of proficiency, seeking feedback systematically, and fine-tuning their performance through successive follow-ups based on that feedback. Moreover, they are particularly flexible and are able to reflect deeply on their knowledge and actions vis-à-vis a given situation; they attend simultaneously to both the ends and the means; they embody implicit processing and reasoning, and they engage in intuitive decisions.
- To the extent that the main requirements to practice psychotherapy involve adequate cognitive functioning, sustained motivation, and a sound emotional disposition, it is possible to continue practicing even at an advanced age. Retiring therapists must attend to several clinical, ethical, and legal aspects, including preparing their clients for the transition when feasible.

REVIEW QUESTIONS

1. What elements should be included in the admission criteria of aspiring psychotherapists?
2. What are the most common training models in psychotherapy?
3. What is the role of supervision in the training of psychotherapists?
4. What are the competencies expected in psychotherapy, and what is their role in the training of psychotherapists?
5. How is expertise achieved in the practice of psychotherapy?

NOTE

1. Some of these professionals, such as clinical social workers and marriage and family therapists, may hold doctoral degrees as well, though some states may only grant them licenses at the master's level in the United States.

RESOURCES

Websites

APA's Division 29: Society for the Advancement of Psychotherapy: http://www.societyforpsychotherapy.org

APA Psychotherapy Video Series: http://www.apa.org/pubs/videos/about-videos.aspx

Association for Counselor Education and Supervision (ACES): http://www.acesonline.net

European Association for Psychotherapy: http://www.europsyche.org

Psychotherapy Networker: http://www.psychotherapynetworker.org

Society for the Exploration of Psychotherapy Integration (SEPI): http://www.sepiweb.org

Society for Psychotherapy Research (SPR): http://www.psychotherapyresearch.org

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31

Ethics and Legal Matters in Psychotherapy

Kasie L. Hummel
Benjamin Bizar-Stanton
Wendy Packman
Gerald P. Koocher

Abstract
This chapter addresses ethical and legal issues in psychotherapy. Customarily considered a subfield of philosophy dealing with moral rights and wrongs, ethics in mental health practice primarily focuses on practitioner behaviors. As the field of psychology evolves, novel situations occur that necessitate thoughtful, well-informed, ethical decision making. Practitioners can help ensure ethical practice by educating themselves on ethical standards and codes, applicable legislation and legal standards, adopting an ethical decision-making framework, and by utilizing consultation in an ongoing fashion. Furthermore, the ethical and legal issues surrounding components of the treatment relationship, therapist obligations, multiple-patient therapies, diversity within treatment, and contemporary ethical issues are presented.

Keywords: ethical issues, legal issues, decision making, psychotherapy, ethical guidelines

Ethical practice in psychotherapy means upholding our duty to our patients. The field of psychology emphasizes that psychologists should conduct themselves in a way that upholds moral principles (Fisher, Fried, & Masty, 2006). To inform and maintain this standard of conduct, the American Psychological Association (APA) developed its Ethical Principles of Psychologists and Code of Conduct (2010a) based on universal ethical principles and practice standards informed by critical incidents submitted by psychologists. However, providing ethical practice depends on psychologists' awareness of ethical standards and actions to address ethical problems as they occur.

APA and all state or provincial licensing boards (by adopting the APA Ethics Code) expect psychologists to demonstrate a commitment to providing services ethically (Fisher et al., 2006). This includes an obligation to maximize benefits and avoid harm to individuals with whom they have professional roles (Jacob, Decker, & Hartshorne, 2011). Ethical standards stand at the core of a psychologist's professional responsibility.

Ethical codes, like the one developed by the APA, aim to establish clear standards and protect society (Jacob et al., 2011). However, becoming a member of a particular professional association does not guarantee that one will behave ethically. No ethics code will address every possible context, and revisions flow from societal change, practice shifts, and in response to extreme cases. Professionalism and the moral character of practitioners develop in part through ethics education at both degree programs and in continuing professional education courses. Because aspects of ethics codes remain open to interpretation and

ethics education varies, different psychologists may behave differently when confronted with challenging ethical decisions.

Customarily considered a subfield of philosophy dealing with moral rights and wrongs, ethics in mental health practice primarily focuses on practitioner behaviors. Often equating ethics with competency, some conceptualize ethics and ethical behavior as learned frameworks (Behnke & Jones, 2012) or aspects that can be taught in a classroom. However, years of education in professional ethics will never completely shield a psychologist from ethical quandaries or an accusation of misconduct (Cottone, 2012). As the field of psychology evolves, novel situations occur that necessitate thoughtful, well-informed, ethical decision making. With no precise standards on how to proceed, new situations can prove problematic. Some argue that personal values and conscience should help guide one's decisions in practice. However, personal values do not always overlap with professional values, and at times they may run counter to professional ethical codes (Kitchener & Kitchener, 2012). As a method of best practice, psychologists should base decisions on a formal decision-making process such as representative models and organizational frameworks (Handelsman, Knapp, & Gottlieb, 2009). This approach provides an educated and theory-driven direction for addressing puzzling ethical circumstances.

ETHICAL DECISION-MAKING MODELS

Various ethical decision-making frameworks have been developed to assist practitioners in answering complex ethical questions that may not be solved by simply reading a code of ethics. Covering all the models of decision making lies beyond the scope of this chapter. However, we will discuss two models that seem particularly relevant to practitioners and can be utilized in conjunction with each other.

Developed by Koocher and Keith-Spiegel (2008), the initial model focuses on three pillars: documentation, reflection, and consultation. First, a practitioner must decide whether the situation indeed involves an ethical dilemma. Dissatisfied patients or colleagues may at times assert claims of unethical behavior by psychologists, when in fact the psychologists acted competently and ethically. A thorough evaluation of the situation will allow the practitioner to determine any need for further steps. Second, practitioners should review existing guidelines (e.g., ethical codes, laws, research) and collect relevant information from all parties involved to contribute to the decision-making process. Third, psychologists should consider all factors that may have an effect on the process. Factors may include demographics, values, personality characteristics, and/or cultural variables. Fourth, discussing the ethical issue with a colleague can provide valuable external input, which may allow the practitioner to view the dilemma from an outside stance. Furthermore, consultation allows for a check and balance system, where one's collegues can offer counsel surrounding conflicts of interest and reassurance regarding one's situation and decision-making process (Behnke & Jones, 2012). Fifth, it is important to evaluate and take into account the rights of the individuals involved (e.g., privacy, informed consent) when formulating solutions (Koocher & Keith-Spiegel, 2008). Sixth, practitioners should develop multiple solutions and consider the pros/cons of each. Seventh, the pros/cons should include the costs (financial, psychological, and social), time and effort, feasibility, available resources, benefits, and risks. Lastly, the practitioner should utilize all the previously collected information in order to take action and all aspects of the process should be delineated thoroughly in the practitioner's documentation process. Moreover, incorporating ongoing consultation in all the stages may also help ensure ethical decision making and reduce the risk of legal liability (Behnke & Jones, 2012).

Developed by Gottlieb, Handelsman, and Knapp (2013), a model for integrated ethics consultation can serve to augment the model established by Koocher and Keith-Speigel, as well as other ethical decision-making frameworks. Prior to developing a consulting relationship, a practitioner should consider the consultant's competence, any boundary-crossing risks or the existence of multiple relationships, relevant confidentiality issues, possible fees, and specific guidelines for recordkeeping (as consultant's records may become part of court proceedings). Because ethical dilemmas differ in regard to complexity, the level of consultation needed will also vary. Gottlieb, Handelsman, and Knapp (2013) describe four categories of consultation complexity to assist

in the process. Level 1 involves the simplest and least laborious consultations. An ethical dilemma that involves explicit questions with precise answers best fits this level of consultation. Level 2 involves ethical dilemmas that may appear forthright, but actually have more complex features. For example, consultees may lack awareness of particular issues, such as reporting mandates that may affect the decision-making process. Level 3 issues do not necessarily increase in complexity; however, the level of the consultee's distress may increase the degree of difficulty and the amount of time required on behalf of the consultant. Prior to focusing on the ethical issue, the consultant should address the consultee's distress by taking on a quasi-therapeutic role. Level 4 is the highest degree of difficulty. It involves consultees who do not recognize that they need assistance and/or resist such help. Lastly, an integral part of the process involves follow-up. Follow-up will help determine whether the issue has resolved, can provide the consultee with closure, and will help solidify what the consultee learned throughout the process (Gottlieb et al., 2013). In addition to the discussed ethical decision-making models, two core principles should guide a practitioner's ethical analysis: *beneficence and nonmaleficence*.

BENEFICENCE AND NONMALEFICENCE

Nonmaleficence, a fundamental of the Hippocratic Oath, involves avoiding intentional harm, as well as activities that have the possible potential to harm (APA, 2010a; Kitchener & Kitchener, 2012). Despite its status as a prima facie duty, minimal harm may be considered justifiable at times, such as the short-term emotional discomfort that often occurs in therapy. *Beneficence*, or providing benefit to others, is the commitment of most psychotherapists and it has two key aspects. First, beneficence dictates that practitioners act in ways that improve the well-being of others. Second, it requires practitioners to conduct a cost-benefit analysis when making decisions that affect patient care and to discontinue care when a patient may no longer benefit (Behnke & Jones, 2012). One key to the treatment relationship and to ensuring that the patient is educated in the practitioner's method for cost-benefit analysis regarding treatment decisions is the informed consent process.

TREATMENT RELATIONSHIP

Informed Consent

From an ethical perspective informed consent becomes important because it protects the legal rights of patients (Cruzan v. Director, 1990). From a clinical perspective, informed consent has value because it can bolster good clinical outcomes by initiating a therapeutic alliance (Pomerantz, 2012). Furthermore, informed consent promotes patient autonomy and self-determination, corrects misconceptions about psychotherapy, encourages clinicians to reflect on clinical practices, and can instill a positive first impression of the clinician in the patient's eyes. Informed consent affords an ideal opportunity to create an atmosphere of empowered collaboration between the clinician and patient, but this also requires understanding that the consent is not a singular event or signed form, but rather an ongoing process (Pomerantz, 2012). Both the APA Ethics Code and the Health Insurance Portability and Accountability Act (HIPAA, 1996) require a psychologist to use understandable language when obtaining informed consent and to seek assent from individuals incapable of providing consent, all while documenting the process (APA, 2010a). It is important to address the "nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the patient to ask questions and receive answers" as early as possible in the professional relationship (APA, 2010a, p. 13). This becomes especially important when working with court-ordered or mandated patients. The APA Ethics Code requires therapists to address any additional limits of confidentiality related to these patients as well as the purpose and course of psychological services (APA, 2010a).

The APA Ethics Code suggests that psychologists use the informed consent process to establish and maintain trust, ensure the patient remains aware of risks and benefits, and respect a patient's autonomy and rights to privacy. Professionals have disagreed about what to include and the extent of the informed consent process (Pomerantz, 2012). Individuals favoring extensive informed consent suggest informing the patient of matters ranging from the potential effects that successful psychotherapy can have to a detailed list of the intricacies of the payment process and potential adverse side effects.

Multiple Roles and Boundary Violations

A trusting psychotherapy relationship between patient and therapist forms the core of a successful treatment process and outcome. Thus, establishing appropriate boundaries and addressing boundary concerns becomes essential to maintaining a high-quality psychotherapy relationship (Sommers-Flanagan, 2012). To maintain this strong and beneficial relationship, Sommers-Flanagan (2012) suggested articulating and explaining the boundaries of the relationship as part of the informed consent process. The process of delineating, establishing, and maintaining boundaries differs depending on therapist orientation, goals of treatment, personal characteristics of the patient and therapist, economic considerations, and the treatment setting. Good practice requires establishing boundaries and methods for handling boundary issues at the outset of therapy and refreshing these discussions as issues arise over the course of treatment. The APA Ethics Code requires psychologists to carefully approach concurrent and successive relationships (in addition to the psychologist–patient relationship), avoid conflicts of interest, inform patients of potential boundary issues, and use caution and fairness when bartering with patients (APA, 2010a).

Boundary issues lend themselves to classification as boundary crossings and boundary violations. A boundary crossing occurs when a boundary is trespassed in order to further therapeutic goals and does not damage the relationship or harm the patient. For example, when a psychologist utilizes self-disclosure in order to achieve a clinical goal, a boundary crossing has occurred for the benefit of the patient. Boundary crossings may occur inevitably, as when the therapist and patient encounter each other in a small community outside of a professional context. A boundary violation occurs when a boundary is broken, causing harm to the patient and damage to the therapeutic relationship, or when the therapist takes advantage of the patient (even if the patient does not experience personal harm). Sexual intimacies provide a ready example of a boundary violation. Good practice holds that psychologists anticipate and discuss how they and their patients will handle boundary issues, especially when they encounter each other outside of therapy, as this can raise issues with confidentiality (Sommers-Flanagan, 2012).

The APA Ethics Code does not expressly forbid multiple concurrent or sequential relationships, and it specifically states that not all such relationships raise ethical issues (APA, 2010a). However, Younggren and Gottlieb (2004) provide a list of questions to consider when contemplating multiple relationships: "Is entering into a relationship in addition to the professional one necessary, or should I avoid it? Can the dual relationship potentially cause harm to the patient? If harm seems unlikely or avoidable, would the additional relationship prove beneficial? Is there a risk that the dual relationship could disrupt the therapeutic relationship? Can I evaluate this matter objectively?" (pp. 256–257). Complementing these considerations, Sommers-Flanagan (2012) suggests assessing four domains in regard to multiple relationships or nonprofessional interactions. These include foreseeable harm to the patient and therapist, and foreseeable beneficial outcomes to the patient and therapist. Additionally, a psychologist should assess the nature, duration, breadth, and extent of the psychologist–patient relationship when considering the potential ethical repercussions of a multiple relationship (Sommers-Flanagan, 2012). The process of evaluating all aspects of a multiple relationship can prove difficult. Thus, therapists should seek advice from trusted and knowledgeable colleagues when uncertainties arise regarding a multiple relationship.

Concerns about therapist self-disclosure have triggered ongoing debate (Sommers-Flanagan, 2012). Self-disclosure can serve a therapeutic function when used in a thoughtful, well-reasoned manner. However, self-disclosure can sometimes harm the therapeutic relationship and affect the perceived role of the professional. Sommers-Flanagan (2012) lists questions to consider when contemplating self-disclosure: "Does it fit with the therapist's theoretical orientation? Is it offered in the best interest of the patient's well-being? Is there a chance it could backfire and cause harm? Have you considered your own attributes and those of your patient? Are there cultural considerations?" (p. 251). Both intentional and inadvertent disclosures can be looked at through the same lens and may require discussion if a therapist finds that the self-disclosure amounts to a boundary violation (Sommers-Flanagan, 2012).

The Beginning and End of a Psychotherapy Relationship

Psychologists' obligations to patients begin at the outset of the professional relationship (Younggren &

Davis, 2012). These duties do not attach instantly, but rather accumulate over the course of treatment. Examples of duties that begin to develop upon initial contact with a potential patient include the informed consent details described earlier. A psychologist has no obligation to provide treatment for a patient he or she has agreed to meet with; however, the psychologist may have a duty to refer the patient for treatment elsewhere or to inform the patient that the therapist cannot provide adequate services. Examples might include patients with needs that lie outside the psychologist's areas of competence, those whose needs exceed the clinician's capacity, or those with whom the psychologist does not feel comfortable for any reason. The psychologist's duties continue to increase as contact between the therapist and patient increase. When a psychologist formally offers psychological services to a potential patient, the traditional treatment duties and responsibilities attach (Younggren & Davis, 2012). The APA Ethics Code states that a psychologist should consider terminating therapy if the services are no longer needed, there is no likely benefit of continued service, there is a potential for harm, or when the therapist is at risk for harm from the patient or someone close to the patient (APA, 2010a). The Ethics Code also requires, in most cases, for a psychologist to "provide pretermination counseling and suggest alternative service providers as appropriate" (APA, 2010a).

The three categories of termination include mutual agreement, patient-initiated termination, and therapist-initiated termination (Younggren & Davis, 2012). Mutually agreed-upon termination may occur when the therapy goals or prior-agreed-upon terms of the treatment contract have been achieved. When the patient initiates termination, the psychologist does not usually have an obligation to follow up with the patient, unless the patient's judgment seems severely impaired or a crisis situation exists. Lastly, therapist-initiated termination may occur because of danger or threat to the therapist (or therapist's family) posed by the patient or someone close to the patient, the therapist sees no reasonable benefit to continuing therapy, or continuing therapy is not in the best interest of the patient. Except in situations involving a direct threat, the process of termination should proceed in a collaborative manner, and by anticipating and addressing such issues at the outset a psychologist can avoid or mitigate many of the problems that may accompany the end of therapy. Specifying the conditions under which termination will occur can promote good therapy outcomes and establish obligations to the patient (Younggren & Davis, 2012). Effectively navigating informed consent, multiple relationships, boundary crossings, and termination of treatment are not the only obligations of therapists.

THERAPIST OBLIGATIONS

Competence

Two broad categories of competence relate to psychologists' ability to provide a high standard of care (Koocher & Keith-Spiegel, 2008). The first involves intellectual and educational competence or the "knowing about and knowing how" to care for one's patients, which includes possessing the needed information, clinical knowledge, and experience (Pope & Vasquez, 2011, p. 61). According to Koocher and Keith-Spiegel (2008), it "may also refer to a general ability to assess, conceptualize, and plan appropriate treatment for a particular patient or problem" (p. 71). Intellectual competence also includes a practitioner's capability to recognize situations in which he or she lacks the requisite skills or competencies and may need help. In new or emerging areas of practice, such as telehealth or prescribing medications, achieving competence may prove difficult (Nagy, 2012). However, professional associations and continuing education organizations provide a ready source of programming to enhance one's development. Increasing and maintaining competence allows practitioners to improve their chances of facilitating positive changes in patients' lives (Nagy, 2012). Illustrating the need to maintain competence, a recent Delphi poll sought opinions on the half-life of knowledge (i.e., how frequently does the knowledge base in a field degrade by 50%) and discovered that the perceived half-life of knowledge varied from a high of 18.37 years (in psychoanalysis) to a low of 7.58 years (in clinical health psychology), with the durability of the knowledge base across all areas of psychology averaging 8.68 years (Neimeyer, Taylor, Rozensky, & Cox, 2014). The survey also estimated that the half-life of knowledge durability will shrink to as little as 5.61 years within a decade.

The second type of competence involves emotional capability or "knowing yourself" and having the ability to function effectively at an emotional level

in the stressful context of psychotherapeutic practice (Pope & Vasquez, 2011, p. 62). According to Tamura (2012), "emotional competence refers to a psychologist's awareness of all of the ways in which their emotional experience and functioning affects, both positively and negatively, their professional judgment and the performance of their job duties" (p. 175). It also refers to a practitioner's ability to manage his or her emotions in order to avoid potential harm to the patient.

Although one might expect intellectual competence to increase over a practitioner's education and career, emotional competence may fluctuate as a function of life events, illness, and countertransference variables. To increase and maintain emotional competence, a psychologist must strive for self-awareness, self-monitoring, and proper self-care to ensure a high level of personal competence. Emotional competence and the ability to connect to patients form the foundation for successful treatment (Tamura, 2012).

Reporting Mandates

Duty to Warn/Protect

Child and Elder Abuse

Due to their increased vulnerability, mandated reporting legislation has been enacted around the world to protect children, dependent adults, and older adults from abuse (Feng, Chen, Fetzer, Feng, & Lin, 2012; Zeranski & Halgin, 2011). Practitioners must become familiar with their specific state's laws about reporting requirements (Zeranski & Halgin, 2011). Although reporting child abuse possibly benefits the child, it may be harmful to the parent. "The justice of reporting opposes child and parental autonomy" (Feng et al., 2012, p. 277). What further complicates this paradox of beneficence and nonmaleficence is that many states' reporting procedures are complex and ambiguous in nature. However, by law, practitioners have a responsibility to intervene regardless of any misunderstanding of the law (Feng et al., 2012). If practitioners are uncertain if a report is warranted, statewide hotlines may help clarify any questions. If utilized, these hotlines have the potential to help reduce the amount of unsubstantiated reports made to Child Protective Services (CPS; Deisz, Doueck, & George, 1996). Furthermore, consultation is another tactic that may be useful in determining whether there is a reasonable suspicion of child abuse or neglect.

As a result of the rapid aging of the baby boomer generation, it is increasingly likely that a practitioner will provide treatment to an older adult. Therefore, it is imperative that psychologists are aware of the reporting laws that apply to older adults and are also familiar with their state's Adult Protective Services procedures (APS; Zeranski & Halgin, 2011). It is estimated that almost 5% of older adults will be affected by elder abuse and neglect (Acierno et al., 2010). Furthermore, older adults with impairments, whether cognitive or psychological, have an increased risk of victimization. The three types of abuse or neglect incorporated into many states' laws include elder abuse, elder neglect, and elder self-neglect. Elder abuse is described as a purposeful act (psychological, emotional, or physical) that harms an older individual, including unsolicited sexual contact and financial abuse (APA, 2010b). Elder neglect defined as the "inability to provide adequate shelter, food, water, clothing, medications, or assistance with daily activities" is considered "unintentional" and at least 36 states include it in their respective laws (APA, 2010b; Zeranski & Halgin, 2011, p. 295). Lastly, self-neglect (i.e., inability to meet fundamental needs) on the part of the older individual may also be present in some states' APS laws. As previously discussed in regard to child abuse, statewide hotlines and consultation should be utilized if a practitioner is uncertain about filing a report with APS.

Homicidal Patients

Numerous court cases have sparked the establishment of mental health statutes aimed at establishing sound public policy to guide psychotherapists whose patients pose a danger to others. Stemming from one of the most infamous cases (*Tarasoff v. Regents of the University of California*), the duty of psychotherapists to warn/protect third parties endangered by one's patients has become an essential part of therapist training (Welfel, & Benjamin, 2012). Moreover, notifying and working with the pertinent authorities, typically law enforcement, has also been incorporated in the training process. Practitioners should only divulge enough information to ensure the safety of the identifiable third party, which is referred to as minimal disclosure.

Although many states do not specifically establish duty to protect standards, most have passed related legislation (Werth et al., 2009). Because these regulations apply at the state level, the requirements can vary substantially across jurisdictions. In a study conducted by Pabian, Welfel, and Beebe (2009), 76.4% of psychologists admitted to being unfamiliar with their state's laws regarding duty to protect. This substantial percentage indicates most practitioners faced with a situation warranting a breach of patient confidentiality would not fully grasp their responsibility (Welfel et al., 2012). Psychotherapists must familiarize themselves with the state laws most applicable to their practice, as failure to follow such laws opens up the possibility for ethical violations or litigation. Werth et al. (2009) outlined five procedures that can help practitioners successfully abide by these varying legal requirements: "(a) disclosure and informed consent before evaluation and treatment begins, (b) therapeutic alliance, (c) assessment of threat, (d) peer consultation, and (e) documentation" (p. 10). Adherence to such criteria can reduce the likelihood of unethical behavior and lawsuits, and, more important, decrease the possibility of harm to patients.

Suicidal Patients

When patients are suicidal, the psychotherapist has a duty to protect the individual from carrying out the self-destructive act (Welfel et al., 2012). There is no "duty to warn" per se because there is no risk to a third party in this situation (Welfel et al., 2012). Potential interventions for suicidal patients are similar to when a patient poses a risk of danger to others (Welfel et al., 2012). Ethically justifiable actions include increasing the frequency of sessions, seeking voluntary hospitalization, and including loved ones in the treatment (with client's consent) (Bongar, 2002). In some instances, the psychotherapist may need to breach confidentiality to attempt involuntary hospitalization or to notify the client's loved ones (Welfel et al., 2012).

Patients Near the End of Life: The Question of Rational Suicide

Physician-assisted suicide (PAS) refers to the deliberate death of an individual with the help of a physician, typically in the form of a lethal dose of prescribed medication (Walker, 2001). It is termed "suicide" because the individual purposefully chooses to end his or her life. Some prefer the term "hastened death" (Werth & Gordon, 2002, p. 161).

Psychotherapists may find themselves in many roles during the end-of-life process. First, a psychologist can serve as an advocate (Werth, Gordon, & Johnson, 2002). During this difficult time, patients may have trouble communicating their wishes to loved ones or a health care team. A psychologist can help facilitate those discussions and help the patient express his or her desires. Second, a practitioner can counsel (Kleespies, 2004); by helping the patient sort out and address the many concerns he or she faces, quality of life can improve. Third, a psychologist can provide education regarding available alternatives to patients and their families (Kleespies, 2004). Lastly, a psychologist may become an evaluator during the process. In states where PAS is legal, a mental health professional must deem the individual seeking this alternative as competent to make such a decision (Werth et al., 2002).

Because practitioners should only provide services within their boundaries of competence (APA, 2010a), psychologists who do not judge themselves as competent in working with terminally ill patients should seek appropriate training and/or consultation (Werth & Blevins, 2006). Furthermore, psychologists should base their work on their knowledge of the discipline (APA, 2010a). When working with terminally ill patients and asked to assess a dying person's preferences, taking physical status into consideration becomes imperative (e.g., ability to concentrate, hearing impairments, pain level) in assessing decisional capacity (Werth & Blevins, 2006). Finally, patients confronting terminal illness present significant emotional challenges to practitioners (Werth & Blevins, 2006). The issue of countertransference, or coping with one's own feelings toward a patient, commonly occurs when working with patients seeking PAS, and it may become an issue when a practitioner's own experiences interfere with his or her ability to provide services (Werth & Blevins, 2006).

A psychologist may need to share pertinent information with the patient's loved ones or other health care providers. Due to the sensitive nature of the end-of-life process, the patient needs to remain aware of two concerns: the terms of confidentiality if he or she becomes incompetent and if he or she dies. If an individual becomes incompetent and unable to make

health care decisions, a proxy is often consulted. Furthermore, depending on the state, once a patient dies the executor of the individual's estate may have access to the patient's medical records (Kleespies, 2004; Werth & Blevins, 2006).

Other Situations in Which Patients Present a Danger

When treating patients with serious contagious diseases (e.g., HIV, hepatitis, or tuberculosis), practitioners need to remain cognizant of their state's reporting mandates (Welfel et al., 2012). Few states have passed legislation that mandates a duty to warn/protect concerning serious contagious diseases; however, many ethical codes allow a breach of confidentiality in order to warn identified third parties of the potential risk (Welfel et al., 2012). Nevertheless, consultation with a knowledgeable colleague, as well as an attorney, prior to taking action will often help reduce the likelihood of malpractice litigation.

According to the National Highway Traffic Safety Administration (2014), in 2012, 9,678 drivers involved in fatal traffic accidents were impaired by alcohol. Practitioners should consider what actions they might take if their patient attended session intoxicated and they are aware that the patient plans to drive after the session, if their patient is cognitively impaired and is having difficulty with his or her eyesight, and if they are mandated to report them to authorities. Although some states do allow practitioners to report impaired drivers (whether by drugs, dementia, or some other medical factor), Pennsylvania is presently the only state requiring such practice (Pennsylvania Vehicle Code, 1977). Nonetheless, psychologists do have an ethical obligation to evaluate their patient's ability to operate a motor vehicle or heavy equipment, and to support the patient in decreasing his or her threat of harm to self or others (Welfel et al., 2012). Several states have enacted statutes that mandate reporting of mentally disordered individuals. For example, medical and mental health care providers in Illinois must report: "adjudicated mentally disabled person"; "voluntarily admitted to a psychiatric unit"; determined to be a "clear and present danger"; and/or determined to be "developmentally disabled/intellectually disabled" to an online registry (Illinois Department of Human Services, 2014). Moreover, psychotherapists must keep themselves up to date on applicable statutes in their jurisdictions.

HIPAA

One of the most important aspects of the patient–therapist relationship involves confidentiality, which the psychologist should uphold unless reporting mandates dictate otherwise (APA, 2010a). With the enactment of HIPAA, ethical codes have become even more important for psychologists because of the increased attention to confidentiality that ensued after its introduction (Koocher & Keith-Spiegel, 2008; Werth & Blevins, 2006). Due to HIPAA, informational releases are often needed in order for the psychologist to provide sufficient care (Kleespies, 2004). HIPAA becomes especially pertinent when working with multiple patients at one time.

MULTIPLE-PATIENT THERAPIES

In marital, family, and group therapy, multiple people simultaneously acquire patient status (Koocher & Keith-Spiegel, 2008). This can pose some ambiguity regarding who (if anyone) constitutes the primary patient and the foci or goals of therapy. Furthermore, not all parties will necessarily want to fully participate in therapy, possibly due to the limited confidentiality that inherently exists in these contexts (Knauss & Knauss, 2012).

Multiperson treatment requires a thorough informed consent process (Knauss & Knauss, 2012). In family therapy, all adult patients should give consent and minors should be invited to assent, although in many contexts parents may legally enroll their minor children in treatment, even if the minor disagrees. As previously stated, informed consent constitutes an ongoing process, rather than a one-time signature on a written form. Updated consent becomes especially important when proposing a shift in the therapeutic context (i.e., from family to couple therapy; Knauss & Knauss, 2012). Discussion of termination should also be included in the informed consent process, as several issues that can occur in marital and family therapy may pose challenges. For example, during couple therapy, one individual may decide to discontinue therapy, whereas the other individual may wish to continue treatment as an individual patient. Although a practitioner can ethically and lawfully continue seeing one member of the couple, some contraindications may exist (e.g., if there is a possibility that couple therapy would resume). In this

situation, the couple may need to see another therapist in order to continue treatment to avoid any concerns of bias (Knauss & Knauss, 2012).

Group therapy also poses a distinct set of challenges. Consider including the following issues as part of the informed consent process: "entrance criteria and procedures, frequency and duration of group sessions, criteria for termination, fees, goals, and methods" (Knauss & Knauss, 2012, p. 33). Risks exclusive to group therapy include issues of privacy and discretion, hostile opposition, peer pressure, censuring, and inappropriate assurance (Knauss & Knauss, 2012). If group leaders lack competence in group therapy, these hazards will occur more often. Furthermore, unlike individual or even couple therapy, the practitioner's ability to control the content and course of treatment is diminished, often by competing individual agendas and varying levels of motivation.

DIVERSITY

Diversity may encompass factors such as age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2010a). Lack of competence with a patient's specific cultural background can lead to incorrect diagnosis, treatment planning, and use of medications (Salter & Salter, 2012). Thus, psychotherapists are expected to obtain and maintain competence in identifying and addressing diversity, and its impact throughout treatment (APA, 2010a). Although no practitioner can achieve total competence in the multiple aspects of diversity that might be helpful with every possible patient, it is necessary that all practitioners recognize the importance of understanding the patient's cultural context by seeking training, consultation, and supervision specific to their patient's cultural background.

The term "microaggression" describes potentially unconscious, subtle, prejudicial behavior that can range from choice of words to body posture (D. W. Sue et al., 2007). When treating diverse populations, psychologists should strive to remain aware of their potential microaggressions and cultural biases, which can lead to pathologizing a particular patient's unique cultural values and communications (D. W. Sue et al., 2007). Ethical practice with diverse populations requires psychologists to develop self-knowledge as cultural beings, to continuously monitor their communication style and behavior, and to be mindful of their impact on patients from different cultural backgrounds.

Throughout their work, psychologists should utilize a culture-focused approach with all patients during the case conceptualization process, which includes assessing and addressing the effects of family, environment, history, process of immigration, acculturation, enculturation, and other cultural factors (APA, 2003; Salter & Salter, 2012). Adherence to a culture-focused approach can promote better treatment outcomes than nonadherence. Competent multicultural practice requires an ongoing effort and includes increasing clinician self-knowledge and monitoring clinician self-awareness, knowledge and skill evaluation, and gathering information and understanding the effects of different contextual variables on the patient (Salter & Salter, 2012). When in doubt about one's own competence, seek advice from trusted, knowledgeable, and unbiased professional associates.

Ethnically Diverse Populations

Some ethnically diverse populations experience impediments to accessing treatment. This may result from economic or geographical factors, language barriers, or biases among providers. When working with patients whose first language is not English, it is important to have accurately translated consent forms and written materials available for patients (Salter & Salter, 2012). Moreover, ethnically diverse individuals' experiences in the United States can vary greatly depending on which point in history they immigrated and in which geographic region they lived (Salter & Salter, 2012). Ethical practice with certain ethnically diverse populations requires a psychologist to obtain a detailed account of the patient's family's acculturation, enculturation, and immigration experiences. In addition, a psychologist should obtain detailed information regarding life before immigration (Salter & Salter, 2012). Lastly, psychotherapists should practice dynamic sizing, the process of determining whether their cultural conceptualization of a patient constitutes an accurate reflection of the individual patient or whether it is founded on group stereotypes (S. Sue, 1998). Utilization of dynamic sizing enables an

appreciation of an individual patient's differences from his or her larger cultural group, and more appropriate intervention and diagnosis.

Sexual Minorities

As with other minority populations, psychologists must assess their attitudes and biases related to lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals (APA, 2000). LGBTQ populations face stigma, violence, and discrimination at interpersonal, community, and societal levels (Salter & Salter, 2012). The age of the patient and the region in which he or she used to live and currently live are important variables for consideration (APA, 2000). The method of disclosing sexual orientation to family and friends is also relevant to a patient's presentation, as disclosure may have been a traumatic event (Salter & Salter, 2012). Conversely, nondisclosure can also lead to negative consequences. Ethical practice with LGBTQ patients requires psychologists to understand how each of these contexts and factors contributes to a patient's issues and may attempt to elicit an understanding in the patient themselves (APA, 2000). Moreover, patients who identify as bisexual may not feel accepted by lesbian, gay, or straight communities. Therefore, ethical practice with bisexual patients requires psychologists to understand this unique position and its effects (Salter & Salter, 2012).

Children and Adolescents

Children and adolescents do not have the same legal rights as adults. In most states, a parent or legal guardian must consent to a child's participation in psychotherapy (Koocher & Daniel, 2012). Obtaining assent from a minor is important to the therapeutic relationship, as it will help the child feel involved in the process and able to express his or her desires to a limited extent. If a child does not want to participate in treatment, he or she generally does not have any legal ability to prevent participation (Koocher & Daniel, 2012). Furthermore, ethical practice requires psychologists to have an in-depth understanding of the developmental process and to involve parents and guardians.

When working with children, psychologists may have ethical duties owed to multiple individuals, including but not limited to parents or guardians and collateral sources. To lessen the likelihood of complications, psychologists should establish, with all individuals involved, the obligations and limits of the obligations owed to each party, and the limits of confidentiality at the outset of therapy. When the parents of a child seeking psychotherapy are divorced, psychologists should try to seek consent for psychological services from both parents. Laws regarding legal standing, authority to make decisions, and the limits of confidentiality when working with children vary across states. Thus, it is important that psychologists apprise themselves of the applicable laws (Koocher & Daniel, 2012).

Older Adults

In addition to being vulnerable to multiple forms of abuse, older adults have many unique developmental aspects not present in younger age groups, such as cognitive and physical decline, medication use, and extensive losses (Bush, 2012). Ethical practice with older adults mandates that each patient be viewed as a unique individual with special attention to developmental factors. Psychologists working extensively with older adults must have knowledge in pharmacology, rehabilitation, life enrichment, common medical problems, and neuropsychology (Bush, 2012).

Psychologists must often make determinations about the competence of older adults to make legal decisions (Bush, 2012). When an older adult's competence in decision making seems questionable, a psychologist may be asked to assess this faculty. If the adult is found incompetent, the practitioner must obtain consent from a guardian with assent from the older adult for decisions (Bush, 2012). When called upon to assess an older adult's capacity to perform activities of daily living, the psychologist should carefully consider the patient's interest in independence and the well-being of the patient and others (APA, 2010b).

Older adults have a legal right to confidentiality unless they waive that right or (if they are found to be incompetent) an authorized legal representative authorizes release (APA, 2004; HIPAA, 1996). When psychologists consider disclosure of confidential information, they should disclose only the information necessary to address the issue raised by the authorizing release form. Moreover, practitioners should

explain the limitations of confidentiality to the patient at the beginning of the therapeutic relationship, as well as when and why the patient is planning on disclosing information (Bush, 2012; HIPAA, 1996).

Religion and Spirituality

Ethical issues surrounding religion and spirituality include incorporating religion and spirituality into treatment and addressing the role of religion and spirituality in a patient's life (Tjeltveit, 2012). Utilization of religious and spiritual concepts in psychological treatment, such as mindfulness and forgiveness, is increasing in the United States. Regardless of religious beliefs or orientation, psychologists have an ethical obligation to avoid stereotyping. Psychotherapists should assess the unique role of religion and spirituality in each patient's life. This process will inform if and how religion and spirituality should be addressed with each patient (Tjeltveit, 2012). Additionally, this inquiry and discussion may help establish trust and enhance the therapeutic alliance, particularly with patients who indicate a strong sense of religious faith.

CONTEMPORARY ETHICAL ISSUES

Telehealth/E-Therapy

Telehealth refers to the provision of health care through telecommunications technology, including telephone, video conferencing, and emails. Using technology can provide a means for mental health professionals to increase their ability to provide effective mental health services to patients (Ragusea, 2012). A few states have adopted telehealth laws that regulate psychologists; however, these regulations vary from state to state. Psychologists living in states with regulations should consult those regulations. Furthermore, various organizations have guidelines for the ethical provision of telehealth services (APA, 2013).

Confidentiality issues with telehealth can arise in multiple contexts, such as a potential for overhearing, interception of transmission, recording of sessions, and unintended disclosure of email communication (Ragusea, 2012). The APA Ethics Code specifies that as part of the informed consent process, a psychologist must explain the confidentiality risks to patients that are associated with the provision of electronic services (APA, 2010a). Psychotherapists providing services via technology fall under HIPAA regulations, and they must take steps to protect against confidentiality breaches associated with the electronic transmission of patient information (HIPAA, 1996). These may include using antivirus software, not opening attachments in unknown emails, using a firewall, installing intrusion-detection software, using passwords for email documents, and encouraging patient use of passwords (Ragusea, 2012). Patients also need to understand that in choosing to use the Internet, cell phones, or other forms of technology, they may put themselves at risk for surreptitious or incidental monitoring. Psychotherapists who agree to provide such services must provide information about these risks, and in some cases they may have additional obligations to provide additional safeguards (e.g., encrypted transmission, secure lines).

The skills required for provision of telehealth services vary depending on the medium of communication. For example, email communication requires competence with typing and providing written contextual cues in the absence of behavioral cues, while videoconferencing requires competence with video cameras and video software (Ragusea, 2012). Technological competence requires psychologists providing telehealth services to acquire training, supervision, and consultation in order to obtain and maintain competence (APA, 2010a). Because technological illiteracy (lack of knowledge, limited exposure to technology or education about the equipment) and a lack of confidence to manage problems involving technology are the main impediments patients describe in using telehealth, patient technological competence should also be assessed before commencing telehealth intervention (Ragusea, 2012).

Handling emergencies with patients presents a unique challenge to telehealth care providers. Some recommendations include having the patient's home address, home phone number, email address, and contact information for the local police, a hospital, or a local psychologist. In some situations, a preferable option might involve identifying a local psychologist as a backup who is willing to meet with the patient personally and assess risk in the case of an emergency (Ragusea, 2012).

A major issue for psychotherapists utilizing telehealth concerns licensure and providing services across state lines. Psychotherapy has been viewed

by many states as occurring in the state in which the patient and the psychotherapist are located. Psychotherapists utilizing telehealth may therefore face situations in which they are practicing in two states simultaneously (Brenes, Ingram, & Danhauer, 2011). Options for psychotherapists engaging in telehealth that crosses state lines include obtaining a temporary license or becoming licensed in a state in which they intend to practice telehealth frequently. The laws of each state vary regarding the provision of telehealth. It is therefore important for psychotherapists to apprise themselves of the applicable laws of each state in which they intend to practice (Brenes et al., 2011).

Prescription Privileges

Psychologists with specialized education and training are currently authorized to prescribe psychotropic medications in the Territory of Guam, Illinois, Louisiana, and New Mexico, while other states are actively pursuing expansion (American Psychological Association Practice Organization, 2014; Shearer, Harmon, Seavey, & Tiu, 2012). Authorizing prescription privileges for psychologists has been a hotly debated topic by psychologists and other health care professionals (McGrath, 2010). APA has published practice guidelines for psychologists involved in pharmacological issues (APA, 2011) and has collaborated in establishing a national examination to assess competence for prescriptive practice.

There are several arguments in favor of prescription privileges for psychologists: the numbers of psychiatrists are shrinking; most prescriptions for psychoactive drugs in the United States are written by nonpsychiatrists (e.g., internists, pediatricians, and nurse practitioners); nonpsychiatric physicians have little to no training in psychosocial interventions; psychologists may prove less likely to resort to medication, which might lessen overmedication and unnecessary polypharmacy problems for some patients; one-stop shopping for comprehensive mental health care is desirable; and it will be more cost-effective to reduce the number of care providers (APA, 2011; McGrath, 2010). A further justification holds that prescription privileges will enhance the role of psychologists within the health care system (McGrath, 2010).

Arguments against prescription privileges for psychologists include the idea that psychologists may increasingly rely on quick-fix medications, which could lead to psychosocial interventions going out of use. Furthermore, pharmacotherapy may prove less safe and effective in the hands of psychologists. With respect to cost, comprehensive training in pharmacotherapy for nonpsychiatrist medical doctors would be more cost-effective for improved interventions than establishing prescription privileges for psychologists (McGrath, 2010). Official APA policy favors prescription privileges for qualified psychologists and has put forth guidelines covering psychologists interested or involved in prescription, collaboration, or provision of information regarding pharmacotherapy (APA, 2011).

Affordable Care Act

The Affordable Care Act (ACA) was enacted into law in March 2010 (US Department of Health and Human Services, 2014). The ACA was established to address two issues in American health care: accessibility and affordability (Hoerger, 2013). Accessibility is addressed by providing insurance to those who lack it, and affordability is addressed through increasing the effectiveness of care delivery and improving outcomes. The Patient-Centered Outcomes Research Institute (PCORI) was formed in order to fund research looking into ways to improve cost-effectiveness and quality of health care (Nordal, 2012). The ACA provides financing from the government in order to enhance patient outcomes by utilizing a pay-for-performance model, in which reimbursement is linked to the outcome of treatment. This emphasis on pay-for-performance may hold medical service providers accountable, and this accountability may require greater adherence to evidence-based practices (Nordal, 2012).

The ACA adopted provisions from the Mental Health Parity and Addiction Equity Act of 2008 ensuring that behavioral health services receive reimbursement rates for evidence-based services at a rate that is on par with that of physical health services (Nordal, 2012). Aspects of the ACA were designed to foster the integration of medical and behavioral health care and to solidify behavioral medicine's place in health care reform. In addition, insurance carriers are now prevented from limiting the annual

or lifetime expenses for mental health treatment to a lower level than that for physical health treatment (Hoerger, 2013). The lasting impact of the ACA is uncertain, as the regulations are far-reaching, but not entirely mandatory. In addition, the extent of implementation of the ACA is likely to be greatly affected by social, economic, jurisdictional, and political factors (Nordal, 2012).

Health Care Setting

Psychologists increasingly practice in integrated care settings in which they have frequent contact with other medical professionals in order to provide coordinated, high-quality services to patients (Hoerger, 2013). Recent trends in health care are moving toward accountable care organizations and patient-centered medical homes. These models are intended to create cost-effective health care systems by integrating mental and physical health services into one location. Providing care in such models creates changes in the delivery, financing, and reimbursement of health care (Kelly & Coons, 2012). Integration has been found to benefit patient care and decision making as well as quality of care, patient experience, and cost-effectiveness (Hoerger, 2013).

Hanson and Kerkhoff (2012) specified a requisite level of minimal competence for a psychologist working in a health care setting. This level includes understanding the practice environment's effect on provision of services, the psychologist's role in the medical team, the limits of confidentiality, the effects of multiple relationships, and the informed consent and reimbursement process. In addition, psychologists should have knowledge of common diseases, disabilities, and medical terminology and the ability to conduct brief assessments and interventions. For more information, The Council of Clinical Health Psychology Training Programs (www.cchptp.org) provides a list of aspirational competencies for doctoral programs and internship curriculums for entry-level practice working in medical settings.

Within an integrated care setting, the patient will interact with many different health care professionals, which can make acquiring informed consent more challenging (Hanson & Kerkhoff, 2012). The consent process should include a disclosure of the limits of confidentiality that may occur from the sharing of patient charts and reimbursement procedures among medical staff. Patients need to be made aware of the open communication between health care providers because this practice benefits the overall treatment of the patient. It is also beneficial for patients to be informed of financial collection practices and other health care setting policies. Again, it is recommended that the informed consent process is ongoing in order to fully integrate patient participation (Hanson & Kerkhoff, 2012).

Research has demonstrated that within a team environment, an individual's influence on other team members is related to that individual's contributions to the team (Hanson & Kerkhoff, 2012). Thus, in an integrated care setting, it can be helpful for psychologists to articulate what they may uniquely provide to the team and how their assessment might contribute to the overall health of patients. In general, psychologists have much to offer in the understanding of human health and behavior because they have been trained and educated in the relationship between biological, psychological, social, and emotional factors. Specific contributions include providing medical professionals with strategies for delivering dismal updates or prognoses, pain management, reducing inappropriate polypharmacy, and monitoring team cohesion, effectiveness, and well-being (Hanson & Kerkhoff, 2012).

CONCLUSION

Practitioners can help ensure ethical practice by educating themselves on ethical standards and codes, applicable legislation and legal standards, adopting an ethical decision-making framework, and by utilizing consultation in an ongoing fashion. Moreover, by maintaining competence in newly developed arenas and employing a culture-focused approach, psychologists can increase their ability to provide individualized, efficacious treatment.

KEY POINTS

- The APA has developed a set of ethical principles, a code of conduct, and many guidelines grounded in moral principles and professional standards that can prevent and help solve ethical dilemmas.
- Ethical codes do not provide a sufficient foundation on which to base decisions regarding

ethical challenges; psychologists should base decisions on a formal decision-making process such as representative models and organizational frameworks, while taking into account clinical data.

- Nonmaleficence, a well-established principle of bioethics, includes avoiding intentional harm, as well as activities that have the potential to harm.
- Beneficence, or providing benefit to others, is the commitment of most psychotherapists and it has two key aspects. It dictates that practitioners act in ways that improve the well-being of others and requires practitioners to conduct a cost-benefit analysis when making decisions that affect patient care, and to discontinue care when the patient does not benefit.
- Informed consent is a legal necessity that also promotes patient autonomy and self-determination, corrects misconceptions about psychotherapy, and encourages clinicians to reflect on clinical practices.
- Two types of competence are needed for a psychologist to provide a high standard of care: intellectual/technical and emotional.
- It is important that psychologists familiarize themselves with the state laws applicable to their practice, as failure to follow such laws opens up the possibility for ethical violations or malpractice litigation.
- Throughout their work, psychologists should utilize a culture-focused approach, which includes assessing and addressing the effects of family, environment, history, process of immigration, acculturation, enculturation, and other cultural factors in case conceptualizations for every patient.
- By maintaining competence in new or emerging arenas of practice, psychologists can increase their ability to provide evidence-based, efficacious treatment.

REVIEW QUESTIONS

1. What type of direction do representative models and organizational frameworks provide?
2. What are the two core principles that should guide a psychologist's ethical analysis?
3. What is the difference between a boundary crossing and a boundary violation?
4. What are the two types of competence and how are they defined?
5. What types of ethical concerns arise with the use of telehealth?

RESOURCES

Websites

APA Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Patients: http://www.apa.org/pi/lgbt/resources/guidelines.aspx

APA Practice Guidelines for Telepsychology: http://www.apapracticecentral.org/ce/guidelines/telepsychology-guidelines.pdf

Informed Consent in Psychotherapy and Counseling (Kenneth S. Pope): http://kspope.com/consent/

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The Modern Psychotherapist and the Future of Psychotherapy

Robert L. Russell
Rainey Temkin

Abstract
Following Mahoney (1995), psychotherapy and psychotherapists are situated within postmodernity. Theoretical orientation by *DSM* diagnosis outcome research has lost its hegemonic grip on the researchers in this new period, even as the research–practice gap and formidable environmental stressors must be addressed, and provider allegiance to the cognitive-behavioral and eclectic/integrative brands of therapies appears to grow. Promising developments in mental health care coverage, workforce composition, and Internet-based service provision are coupled with future challenges—in the politics of health care, recruitment of minority health care providers, and in broadening Internet-based services to the elderly and those residing in rural areas. Provider skill sets will need to broaden in the future, especially to stay abreast of neuroscience, imaging, and genetics, as these come to dictate personalized care, and when responding to crises in the United States and/or abroad.

Keywords: postmodernism, psychotherapy, psychotherapists, Affordable Care Act, workforce

In Mahoney's similarly entitled chapter in the previous edition of this text (Bongar & Beutler, 1995), contemporary psychotherapies and psychotherapists are situated in the era of postmodernism, albeit with an acknowledgment that the term and the era's characteristics are difficult to define and delineate. A not uncommon meaning ascribed to the term "postmodern," however, is that it fits in the sequence of historical eras or ages: Prehistoric, Classical, Medieval, Modern, Postmodern (Brown, 2005). Like the previously used terms, "postmodern" is used to designate cultural, political, aesthetic, and ways of life that have emerged and congealed enough to form distinctive constellations or wholes that seem sufficiently different from, and portend to be as stable as, previous constellations. Demarcations between the ages and each age's defining or most salient characteristics, and their generality across the globe, remain subject to debate and refinement (Habermas, 1981). Several prominent features of postmodernity are nevertheless relevant enough to psychotherapy to characterize briefly.

Similar to Nietzsche's (1882) late 19th-century pronouncement that God is dead, key features of modernism have failed to survive and new forms of knowledge and experience have emerged in postmodernity. Grand theories or metanarratives of human knowledge and history, it is argued, have lost their legitimacy—positivism, hermeneutics, Marxism, existentialism, and so on cannot provide meaningful accounts of human existence in its diverse totality and have thus lost their hegemonic grip as synthetic frameworks of knowledge and privilege standpoint for revealing and describing human existence (see

Lyotard, 1984). More surprising, perhaps, is the related claim that authors of texts, as understood in modernity, are moribund as well; they are useless fictions that had origins in modernity's elevation of the status of the individual (as in Descartes and in Luther, on the one hand, and in free markets and capitalism on the other). The fiction of the author promoted the view that texts, literary texts especially, had one correct univocal meaning for every reader, and this meaning was to be attained if and only if the ingenious intentions of the texts' authors could be deciphered (see Barthes, 1977). As authors' intentions lost status as the key to texts' univocal meanings (e.g., in structuralism, poststructuralism, and deconstructionism) so too eroded the modernist rendition of individualism and the privileged relation between an actor's private intentions and his or her own conduct, even in mainstream philosophies of mind, however different from each other (e.g., Churchland & Churchland, 1999; Dennett, 1981; Ryle, 1949). Lastly, postindustrialism congealed in the globalism of postmodernity as digitalism, commercialism, and consumerism, permeating almost every cranny of everyday life with prescriptive commercials and entertaining spectacles that glamorized a "good" life as one based on the fulfillment of false needs with a plethora of commodities, foodstuffs, and electronic gadgets of all sorts. Any real public discourse, debate, and fraternity between an engaged citizenry was tending toward extinction in postmodernity (Habermas, 1989; Putnam, 2000).

The discourses of postmodernity were neither digested nor accepted by everyone, of course, and were not infrequently characterized as the inconsequential cant of a new scholasticism (e.g., Smith, 1994). But postmodernist themes and their impact and relevance to psychology were widespread enough to warrant inclusion in an edited volume in the popular Sage series (Kvale, 1992), and advocates published thoughtful articles in the *American Psychologist* (e.g., Gergen, 2001). Russell and Gaubatz (1994) also pointed out that the consequences of such epochal changes are not always immediate and concrete and can significantly affect the lives of those least likely to be consciously attuned to them (e.g., as when the discourses of modernist architecture motivated the replacement of sprawling tenements with minimalist high rises, resulting in the disruption of family, community, and long-standing principles of urban development).

Even in clinical psychology's professional journals, attempts were made to explicate postmodernist writings and to indicate how the new world order they described would transform everyday consciousness, modernist experiences of the self, and the types of psychopathology and treatment that might emerge as a consequence. In a comment on Lyddon and Weill's (1997) article on the relevance of postmodernism to cognitive psychotherapy, Russell and Reppman (1997) attempted to contribute to such considerations by providing three representative anecdotes of the experience of persons fully immured in the postmodernity depicted in many of its theoretical characterizations.

Suffice is to say that these anecdotes were provided to underscore new conditions affecting and transforming the experiences and conceptions of the self, in that postmodern (1) interlocutors lose control of their participation in the culture's multiplicity of language games in much the same way as painters or novelists lose control of their paintings or writings in a state akin to Nakamura and Csikszentmihalyi's (2002) episodic "flow," and instead enjoy or suffer an enduring loss of self as the rules of the language games dwarf the potency and relevance of individual intentions; (2) actors must occupy so many roles and don so many masks in such rapid succession in both public and private life that there is no interior "home base" of selfhood to which to retreat in reflection in order to formulate self-possessed action plans and strategies of impression management—instead, there is only relentless improvisation (mask after mask after mask) in a present co-constructed with other actors' seemingly selfless improvisations; and (3) workers, alienated from the process and products of their labor, divorced from traditional sources of meaning, and bombarded for hours by an electronic media replete with commodity advertisements and escapist entertainments, are newly created as insatiable consumers whose work is rewarding only to the extent that it provides the means to fulfill false needs with material goods, sensational spectacles, superficial relationships, and other offerings in "McWorld" (Barber, 1995; Miles, 1998). For these and other reasons, the consciousness and personality of a person in postmodernity are supposedly qualitatively different from that of a person in modernity (Gergen, 1991; 1994). If this is true, at least for those residing in the developed postindustrial nations, would it not be necessary to radically revise our nosology and conceptions of treatment?

Motivation to reconsider and revise *DSM*-type nosologies and conceptions of treatment have not risen only or solely from those embracing postmodernism. From within research on psychotherapy, sophisticated meta-analytic and other studies of psychosocial treatments have suggested that significant and impressive amounts of outcome variance could not be consistently and differentially attributed to either intervention type (e.g., confrontation versus reflection) or a specific therapeutic orientation (e.g., psychodynamic, cognitive-behavioral, interpersonal, etc.; Luborsky, Singer, & Luborsky, 1975) once therapist factors and validity threats were factored into models (e.g., Lambert, 1989; Shapiro et al., 1994), or when only rigorous head-to-head comparisons of treatment types were considered (Wampold, 2010). In fact, the fourth phase of psychotherapy research (1984–present [1994]) was characterized as a period of "consolidation, dissatisfaction, and reformulation" (Orlinsky & Russell, 1994, p. 197). Significantly, a sizeable number of senior psychotherapy researchers voiced dissatisfaction with the positivistic metatheory and drug metaphor under whose influence much of the previous research, including their own, had been undertaken, and offered alternative strategies of research (Russell, 1994). The shift in research emphasis was characterized "as one from a concentration on the context of verification, understood in [modernist] positivistic terms, to a renewed concentration—with new methods, models, and theories—on the context of discovery" understood in postmodernist terms (p. 204). One outcome of this shift in emphasis was, for some researchers, the realization that in fact patients do not respond to their therapists' theoretical orientation any more than therapists respond to their patients' diagnostic label. The favored paradigm of coupling theoretical orientation and patient diagnoses for differential outcome studies had not delivered on its promise (Beutler, 1989, 2009; Howard, Orlinsky, & Lueger, 1994; Shirk & Russell, 1996), even if this coupling still informed practice and was necessitated to a certain degree in satisfying requirements of third-party payers.

An additional segment of the research community, in a period following that described by Orlinsky and Russell (1994) and Russell and Orlinsky (1996), appeared to abandon the old paradigm altogether as well. Alternatives to diagnoses, treatment orientations, and typical research paradigms were devised, many of which varied along dimensions of specificity-generality and whether research inspired by the new developments fell within the traditional efficacy-effectiveness classification or were better described as qualitative discovery-oriented (Elliott, Slatick, & Urman, 2001) or patient-focused—as developed in work conducted by or related to Howard's patient profiling methodology (Beutler & Clarkin, 1990; Beutler & Martin, 2000; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lambert, Hansen, & Finch, 2001; Lutz, 2002). Toward the more general pole fell generic or prototypic conceptualizations of therapy, case formulations, and/or psychopathology (e.g., Barlow, Allen, & Choate, 2004; Kendjelic & Eells, 2007; Shirk & Russell, 1996; Wampold, 2001). Toward the more specific pole fell conceptualizations of therapy, case formulations, and psychopathology tied to empirically derived "integrative" principles of treatment (e.g., Castonguay & Beutler, 2006); specified pathogenic cognitive, emotional, personality, or interpersonal processes (e.g., Amir, Beard, Burns, & Bomyes, 2009); and/or case formulations tied to theories of pathology and/or treatment (e.g., Persons, Roberts, Zalecki, & Brechwald, 2006). Coupled with the NIH rejection of the newest revision of the *DSM* (Insel, 2013) and the growing use of neuroscience and genetics in pinpointing pathology and treatment effects (Fonagy, 2004; Nasrallah, 2009), the theoretical treatment type by *DSM* diagnostic category paradigm for research has been largely transcended. In this sense, the new period of psychotherapy research might best be dubbed the "postparadigmatic period." The traditional comparative outcome studies and the dodo bird metaphor (i.e., all therapy orientations must win a prize for efficacy/effectiveness in treating *DSM* articulated disorders) too must be seen as trending toward obsolescence, as the contestants and the methodology of the competition now appear in hindsight to have been fatally flawed with too many sources (e.g., patient characteristics, therapist effects, variations in fidelity and expertness) and too large amounts of error variance (see DiFilippo et al., 2003; Norcross, Freedheim, & VandenBos, 2011 for further prognostications).

Two formidable obstacles that are immediately apparent in and for this postparadigmatic period of research are (1) how and who in the research community will translate the new findings for front-line practitioners varying widely in the types of training (e.g., counseling, clinical psychology, family and marriage, etc.) they have received and terminal degrees

(e.g., MA, MS, PsyD, PhD, MD) they have earned, and (2) how and even if the "translated" findings produced in this new paradigm will adequately prepare mental health care practitioners to react to and ameliorate predictable mental health crises that are likely to arrive in postmodernity or its epochal successor. In the first instance, *DSM*s and theoretical therapy orientations at least provided a common means of communication for researchers and practitioners alike, even if both were practicably imprecise because of large amounts of variability among patients within the same diagnostic category and among practitioners providing therapy under the same theoretical banner. In other words, the research–practice gap, always an issue, will likely expand rather than contract, as long as there is a lack of at least a modicum of a common terminological core and a valid arsenal of empirically supported best practices. Furthermore, broader and more intense erudition will be required of practitioners to keep abreast of the developments of postparadigmatic concepts and research in genetics, neurosciences, cognitive, affective, behavioral circuits and systems, and so on, however wedded the field remains to its empirical base and however stalwart practitioners' allegiance to eclecticism and integration might remain. Without the erudition and experience, providers may devolve into technicians—"therapetrists" to use a neologism akin to psychometrist—possessing quite narrow scopes of competencies (Russell & Orlinsky, 1996).

In the second instance, the objective conditions of postmodern patients will likely provoke significantly different polytraumas, levels of severity, and types of disorders if the predicted effects of global warming and its concomitant array of new stressors are as widespread and severe as suggested by climatologists. How will research be able to rapidly refocus on the new pathologies (e.g., somaterratic, psychoterratic, and solastalgia; Albrecht, et al., 2007) that practitioners will be asked to respond to, often emerging precipitously in times of crises, and what empirically based treatments will practitioners have ready at hand to confidently deploy? That this must occupy the mental health community of researchers and practitioners alike is strongly suggested by the forecasts being disseminated by the Center for Disease Control (CDC). The CDC's chart on the "Impact of Climate Change on Human Health" (www.cdc.gov/climateandhealth/effects/default.htm) (see Figure 32.1) presages what kinds of stressors may be prevalent in the not too distant future. Note that although mental health

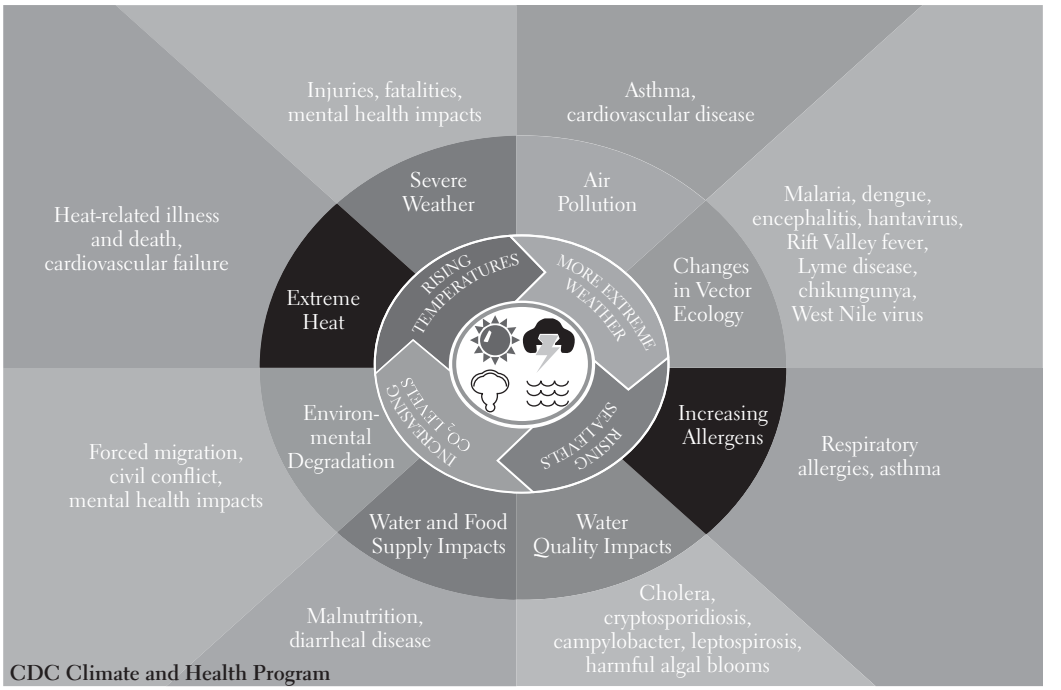

FIGURE 32.1 Impact of climate change on human health.

impacts are only explicitly stated in two of the eight vectors, utilization of mental health care workers' expertise is likely to be relevant in adapting to the direct or indirect impacts of all eight vectors.

It might also be noted that since national security can be compromised in any of these environmental, political, or economic crises, governments across the globe might be expected to be proactive enough to create a workforce whose expertise and response readiness are uniquely suited to help in these projected crises. Because some (sub)populations in the United States and in other countries will see their homelands/habitats and cultural "footprints" entirely disappear (islanders and coastal communities, for example), rapid provision of services to simultaneously aid in enculturation and cultural preservation will need to be devised and then implemented by providers trained in diversity and cultural competence, not to mention a variety of languages (Sue & Zane, 2009; Watters, 2010). Thus, the diversity in competencies and practices of the mental health workforce will continue to grow in complexity, as described by Mahoney (1995) over 20 years ago. Consequently, it would appear that these circumstances will also cause the research–practice gap to persist in the future, but in entirely new, yet equally detrimental ways.

THE FUTURE OF PSYCHOTHERAPY

There are important developments in the politics of health care; in the composition and organization of the mental health care workforce; in the use of "telehealth" and Internet technologies for the provision of information, diagnostics, and services; and in the allegiances espoused by practitioners to theoretical orientations, despite the disfavor such orientations suffer in cutting-edge research contexts. In this section, the politics of health care and practitioner theoretical allegiances will be sketched. In the following section on the future of psychotherapists, workforce composition and telehealth and Internet interventions will be outlined, before providing a concluding summary.

Mental Health as Legitimate Health Care Concern

In the United States, access to covered mental health services and their legitimation in the health care system are fundamental to the future of psychotherapy. Until recently, mental health had been largely excluded from the larger US government and insurance health care operations, with the exception being the Veteran Administration. Mental health professionals and "physical" health providers did not often share spheres of practice, power in health care organizations, and third-party payers and were not systematically yoked in team-based collaborations with other health care disciplines (McDaniel & deGruy, 2014). This separate and unequal organization, first challenged by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, is shifting with the implementation of the Affordable Care Act (ACA) of 2010. The ACA, for example, provides government financing to test newer and more efficient delivery models, redefines payment and reimbursement responsibilities, expands the underutilized system of pay-for-performance, increases wellness and preventive care, and holds providers to stricter levels of transparency and accountability (Nordal, 2012). Moreover, mental health services are likely to fall under the umbrella of primary care, which not only alters psychological practitioners' role in the system but also imposes expectations and consequences that are more explicitly tied to patient outcomes and efficiencies in the delivery systems. In addition, more health care dollars will likely be allocated to substance abuse treatment and prevention, expanding territory for practicing psychologists and other mental health care workers (Silverman, 2013).

Conceptualizations and evidence regarding health and health outcomes have served to narrow and refocus the biomedical model as an appropriate framework for understanding and treating disease and its associated pain but also to establish the biopsychosocial model as the appropriate framework for understanding both wellness and suffering in the context of treating the full scope of patient illnesses (Charon, 2001; Cuff & Vanselow, 2004; Donnelly, 2005). In fact, the humanist medicine movement has gained traction as an organizational prerogative in many prestigious medical schools (e.g., University of Indiana). Moreover, training in ethics, diversity, and humanism are now required of most medical students, as part of or in addition to their training in professionalism. Behavioral medicine, in addition, has made impressive inroads in being integrated into treatment regimens for tobacco and alcohol addiction, pathogenic dietary choices and eating disorders,

and for detailing and changing how sedentary lifestyles can contribute to morbidity and mortality.

As the majority of individuals in the United States begin with their primary care physician to address behavioral health care (e.g., Rushton, Bruckman, & Kelleher, 2002), more mental health care providers will need to be accessible and available at primary care sites, not just to offset the cost of medical utilization, but to facilitate the provision of more holistic and contextualized services and to improve physical and mental well-being. It has been estimated that one third of the patients seen in primary care settings meet criteria for a mental disorder and up to another third, while not diagnosable, are struggling with subthreshold symptoms and behavioral habits that impact their daily functioning (McDaniel & deGruy, 2014). The Affordable Care Act (2010) requires that mental health benefits be covered under insurance plans, dispelling the myth that mental health simply augments and is not integral to patients' physical and mental well-being.

Two delivery systems are poised to emerge as dominant integrative models: accountable care organizations (ACOs) and patient-centered medical homes (PCMHs). The ACO is comprised of a group of providers, including a hospital, primary care physicians, and specialty care providers (which incorporate psychologists and other mental health care providers). The ACO is responsible for the care of its designated population, incentivized by sharing in the calculated cost savings the organization achieves through efficiencies and improved outcomes (Nordal, 2012). The PCMH model, also being supported by the federal government, is similar to ACOs but functions on a smaller scale. Early evidence suggests that these models contribute to improvements in quality of care, patient satisfaction, and reductions in hospital and emergency department visits. This combination of primary care physicians, behavioral health professionals, and care managers will become more prevalent in the future and offer comprehensive and integrated care to a larger proportion of the public.

The commitment to these new service models requires changes in how practice is conceived by participating mental health professionals. For example, "sessions" may be shortened, sometimes to 15 minutes or less, patient treatment contacts may appear more episodic than continuous, and the range of problems that these professionals may address will likely broaden, requiring not only adaptable treatment strategies but knowledge of disease and illness processes and emergency crisis management. In other words, these roles necessitate expansion of the competencies normally needed in private practice settings (McDaniel et al., 2014). Expectations are high that mental health care workers will thrive in this new integrated health care environment and produce demonstrable positive health outcomes that will reduce the nation's overall health care expenditures. Lastly, more and more practitioners are likely to be selling their labor to provider organizations and thus lose the autonomy associated with being an independent practitioner. Such circumstance has led to serious consideration of and support for unionization by other health care workers (e.g., physicians and nurses) as a way to better represent the interests of health care providers in negotiations with owners and their management teams, and mental health care workers will also have to consider this option.

Progress, as depicted earlier, may stall or even regress. For example, one characterization of the history of psychiatry depicts four eras, each defined by its "lexicon" of professional terms, namely, the asylum, psychodynamic, psychopharmacology, and the current molecular neurobiology eras (Nasrallah, 2015). The exclusion of psychosocial aspects of mental illness in the last two eras is as notable as it is worrisome for the future of integrated health teams. Furthermore, as depicted in the Institute for Alternative Futures' "Health and Health Care in 2032" (2012), their "zone of growing desperation"—one of three possible scenarios—projects a less positive view of health and health care. Their scenario reminds us that the ACA can be revoked with significant changes in any of three branches of government and that regional or state-by-state options may then vary widely—from a return to a market-driven fee-for-service system to single-payer options to complicated systems involving capitation and provider incentives for reduced expenditures. Poor health outcomes—increases in the population's disease burden—are predicted, with differential access and service quality varying further across economic, racial/ethnic, and gender statuses. We can further add that integrated health teams will begin to disappear and crises in public health, including mental health, will become the norm. In this projected future, the parity between mental and physical health care ceases, and the future of psychotherapy appears tenuous at best.

Psychotherapy Theory, Strategies, and Technique

Over the past 20 years self-reported allegiance to the cognitive-behavioral theoretical framework has grown among therapy practitioners. Norcross and Karpiak (2012) posit that this expansion of cognitive and cognitive-behavioral orientations will continue to grow into the future. Johnson (2012) notes this "changing landscape" may be occurring as a result of the increasing number of evidence-based treatments that are cognitive-behavioral. Recent trends in orientation continue to see diminished popularity of psychoanalytic and humanistic therapies, while integrative-eclectic and cognitive-behavioral treatments have begun to substantially increase in the field. As mental health care providers continue to be held accountable for securing demonstrable outcomes in shorter time frames and are required to comply with insurance restrictions on services, evidence-based practices and treatments have become the guiding standard. In this context, the intensive research on cognitive-behavioral treatments has demonstrated their efficacy and effectiveness over the broadest range of psychopathology. Not surprisingly, Berke, Rozell, Hogan, Norcross, and Karpaik (2011) found that psychologists endorsing cognitive-behavioral orientations reported the highest overall usage of evidence-based practices. Psychoanalytic and humanistic orientations have declined, replaced by either cognitive-behavioral or integrative-eclectic orientations (Norcross & Karpiak, 2012; Norcross & Rogan, 2013). When not given the eclectic or integrative option, Sayette, Norcross, and Dimoff (2011) found two thirds of the faculty in APA-accredited clinical psychology training programs selected cognitive or cognitive-behavioral orientations over all others.

These trends were notable in the 1990s and clearly have traction across mental health disciplines and patient populations. In a nationwide survey of US psychologists, counselors, and social workers, integrative and cognitive orientations were most frequently endorsed at 24%, followed by psychoanalytic-psychodynamic at 16%, and humanistic at 9% (Bike, Norcross, & Schatz, 2009; Norcross & Rogan, 2013). A recent analysis of pediatric psychologists found a similar trend, with a majority of individual orientations as well as graduate program orientations identified as cognitive-behavioral in nature (Mullins, Hartman, Chaney, Balderson, Benjamin, H. K., & Hoff, 2013). In 2010, Norcross et al. surveyed APA-accredited counseling programs, finding 43% of all core faculty members endorsing cognitive or cognitive-behavioral orientation followed by humanistic (21%) and psychodynamic (19%). In 2009, the APA's Survey of Psychology Health Service Providers found 39% of all providers endorsing a cognitive-behavioral orientation. Just how far this trend has come is illustrated in a 1982 survey of clinical child psychologists: Twenty-five years ago, 28% of child psychologists reported having a psychodynamic orientation followed by 25% as behavioral (Johnson, Janicke, & Reader, 2008). Twenty years later, 52% identified as cognitive-behavioral with an additional 7% as purely behavioral (Johnson et al., 2008). Contrary to these trends, however, is the growth of interest in mindfulness and mindfulness-based practices. Following the lead of Jon Kabat-Zinn, mindfulness interventions have been utilized in a variety of treatments for a variety of psychological disorders, including anxiety reduction, pain management, mood elevation, and reductions in emotional distress. This trend is likely to continue to grow in popularity and become further integrated in established therapies and health care overall.

Some argue, however, that this overall "narrowing" of orientations, especially in clinical training programs, is detrimental to the field (Heatherington et al., 2012). These critics posit certain dangers, including loss of innovation, biases in judgment, overconfidence, and discounting of alternative explanations or case conceptualizations (Levy & Anderson, 2013). The balance of competing ideas and intellectual diversity contributes to, rather than detracts from, rigor and refinement, especially in terms of theoretical orientation. Levy and Anderson (2013) suggest that psychotherapy research, when enriched with diverse conceptual schemes, can result in breakthroughs that might not occur in a more monolithic field. Interestingly, when microanalytic process researchers investigate what goes on within sessions conducted by cognitive-behavioral therapy and behavioral therapy theorists, they find that their work incorporates aspects of dynamic and humanistic approaches, even as all treatments are trending toward shorter durations and episodic administrations.

What do these trends in theoretical orientation mean to the future of psychotherapy, as opposed to the future of providers' and educators' responses to

surveys couched in terms of competing theoretical orientations? As indicated in the introduction, researchers are aggregating treatment elements into unified generic protocols that share common elements for use across types of dysfunction (Barlow, Boswell, & Thompson-Hollands, 2013). Others are using what are called modular therapies, where the therapist can choose from various core modules individualized to patients depending on symptoms, severity, and unique aspects of the patients' presentations. Still others are prescribing empirically derived principles in treating the dysfunction of individuals, without use of diagnostic classification or employing neurobehavioral retraining focused on precisely defined pathogenic processes. Although a sizeable proportion of therapists responding to surveys have endorsed a cognitive-behavioral theoretical orientation, the research and clinical realities are becoming much more nuanced to be adequately covered with a terminology that has trended, and will continue to trend, toward obsolescence. In that future, dysfunction if not disorders will become better described in etiological terms and precise interventions will be trained on underlying pathogenic processes, variously specified in genetic, neuroscience, neurobehavioral, or cognitive, affective, or interpersonal terminology.

If this sounds like old wine in new bottles, it is only because the past and future conceptualizations of psychopathology and psychotherapy share a common root stock. Some might see this common root stock in the etiological speculations contained in the *DSM-I* and *DSM-II*; that is, prior to the 1980 publication of *DSM-III* where neutrality about the etiology of mental disorders was putatively achieved. Others may see it in the traditional emphasis on diagnostics and case formulations that have always been the clinicians' guide in defining targets for intervention. Still others may see new blends from the four root images (i.e., treatment, education, correctional, and moral/spiritual redemption) characterized as the sources from which most conceptualizations of psychotherapy research derive (Orlinsky, 1989). Lastly, given the new emphasis on genes, brain morphology, and neural circuitry (i.e., biomarkers) in diagnostics and treatment, it is difficult not to conclude that "psyche" and "soma" are in the process of seeking a new if uneven balance in this postparadigmatic period. Unfortunately, as indicated earlier, climate change has and will foreground "terre" as the most conspicuous and largest health and mental health determinant in the future, considered on a global basis.

THE FUTURE OF THE PSYCHOTHERAPIST

Mental Health Care Workforce

In 2013, the US Department of Health and Human Services estimated a total of 1,001,599 individuals in the behavioral workforce. Of these individuals, 188,708 identified as psychologists (including master's or doctoral degrees) with 35% working in other health practitioners' offices, 22% in elementary and secondary schools, 10% in outpatient care centers, 9% in hospitals, 5% in individual and family services, and 20% in all other settings. A reported 68% identified as female and 32% as male. Approximately 85% of these psychologists identified as White, 5% as Black/African American, 6% as Hispanic/Latino-a, 3% as Asian/Native Hawaiian/Pacific Islander, 0.3% as American Indian/Alaska Native, and 1.3% as Multiple/Other Race. Given that roughly 50% of the projected 450 million US population will be comprised of minorities by midcentury, the racial/ethnic composition of the mental health care workforce will need to significantly increase its rate of diversification if it is to be representative of the United States' demographics.

According to the US Health Workforce survey, counselors were estimated at 295,263 in the US workforce with 41% in individual and family services, 26% in outpatient care centers, 15% in residential care facilities without nursing, 11% in hospitals, 4% in other health care services, and 4% in all other settings. Similar to psychologists, 68% identified as female and 32% as male. Within this cohort, 63.2% identified as White, 22.3% as Black/African American, 9.5% as Hispanic/Latino-a, 2.1% as Asian/Native Hawaiian/Pacific Islander, 0.8% American Indian/Alaska Native, and 2.1% Multiple/Other Race. The paucity of Hispanic/Latino-a and Asian/Pacific Islander counselors is particularly striking, as the proportion of mental health care services provided by counselor-level clinicians is likely to increase in the future.

Finally, social workers account for an estimated 517,628 individuals in the US workforce with 55.2% in individual and family services, 13.6% in hospitals,

11% in outpatient care centers, 9.4% in residential care facilities without nursing, 4.6% in nursing care facilities, and 6.2% in all other settings. Of these social workers, 81% identified as female and 19% as male. Within this cohort 63% identified as White/Caucasian, 21.1% as Black/African American, 10.5% as Hispanic/Latino-a, 3% as Asian/Native Hawaiian/Pacific Islander, 0.6% as American Indian/Alaska Native, and 1.8% as Multiple/Other Race. As with counselors, recruiting Hispanic/Latino-a and Asian/Native Hawaiian/Pacific Islanders will need to rapidly increase to respond adequately to the changing demographics in the United States. Note too that across all of these different mental health care professions, female professionals predominate and it is likely this trend will continue.

Psychologists continue to be small in numbers compared to the aggregate of other mental health care practitioners. According to the Bureau of Labor Statistics Occupational Handbook (2010–2011), there are currently 50,000 psychiatrists, 4,200 psychiatric nurses, 347,000 licensed clinical social workers, 55,000 licensed marriage and family therapists, and over 120,000 licensed professional counselors in the mental health field. Current estimates of licensed psychologists are approximately 108,000, which comprises about 16% of the entire behavioral health care workforce (Nordal, 2012). Employment of psychologists is estimated to grow 12% from 2008 to 2018.

Other data sources (National Plan and Provider Enumeration System) identified 75,248 psychologists, 283,000 primary care physicians, and 420,000 total behavioral health providers in the United States in 2010. Psychologists comprised under 20% of the total workforce, and for every psychologist there were approximately 4.3 psychiatrists, social workers, and marriage and family therapists. The APA's Center for Workforce Studies estimates 106,500 psychologists possessing current licenses with approximately 34 psychologists per 100,000 population in the United States. The District of Columbia (173.3) and Vermont (100.5) have the highest representation per 100,000 population, while Mississippi (12) and South Carolina (13) have the lowest. Overall, the South (24) has the lowest representation when compared to the Midwest (30.6), West (37.5), and Northeast (54.2) regions.

Employment settings fell into a broad range of categories with primary full-time settings, predominantly in university and business or government environments, at 21% each. Hospital settings (mostly VA medical centers) accounted for 14%, with other human service settings at 11%. These included university/college counseling centers, outpatient clinics, primary care offices, and community health centers. Less than 6% listed independent practice as their primary position. To summarize, 37% of full-time positions were in the human service sector, 32% in academia, 21% in business and government, 8% in schools and other educational settings, and 6% working in managed care mainly in community mental health center settings (Michalski, Kohout, Wicherski, & Hart, 2011).

The Bureau of Labor Statistics predicted that there will be a 12% growth in the number of jobs available for psychologists, a figure that is said to be about average across occupations for the 2012–2022 period. However, growth in available positions for counselor-level jobs and social work jobs was predicted to be almost 2.5 and 0.5 times larger, respectively, than for psychologists over the same period. Mental health outcome researchers will need to determine if the shrinking proportion of psychologists in the mental health care workforce affects rates of positive mental health care outcomes, increases access to needed services for the roughly 20%–25% of US citizens afflicted with a mental health problem, and decreases health disparities. Given that the workforce comprised of counselor-level individuals is more diverse, the mental health care workforce can expect to be more representative of the US population demographics, even if the active strategies to improve diversity in psychology training programs do not meet expectations. One of the areas where significant progress must be made is the availability of mental health care services to Medicaid recipients. In a recent study, over one third of counties in the United States had no outpatient mental health facilities that would accept Medicaid, affecting a disproportionate number of Black, Hispanic/Latina-o, and rural-dwelling individuals (Cummings, Wen, Ko, & Druss, 2013).

Telehealth and Internet Technologies

New digital modalities are influencing how mental health information is acquired, how services are delivered, and how services are assessed, capitalizing on the widespread access to, and competence in, the

use of cell phone technologies and the Internet, by children/adolescents, adults, and, to a lesser extent, seniors. Internet sites concerned with mental health promotion, symptom and syndrome descriptions, and summaries of courses of treatment and prognoses are a click away. Benefits include facilitating social interaction for shy individuals, utilizing video-chatting as a tool for sessions and groups, acquiring psychological screenings and assessments, texting to assist suicidal patients, podcasts for psychoeducational material, and utilizing apps and smartphones to assist with data collection, tracking, and even homework (Silverman, 2013). With respect to psychotherapy, diagnostic procedures, treatments, progress assessments, supervision, and mental health outcome research are all undertaken via the Internet, and its use appears to be growing. Cost-effectiveness and broadened access by patient groups are two features that make the use of e-technologies so attractive as another strategy in mental health education and its prevention and treatment.

Research has also documented the promise of e-mental health care both in the United States and internationally. Some studies have indicated that Internet-based therapies are as effective as office-based therapy (Attridge, 2011) and can provide health interventions to Whites, Blacks, and Latina/o populations equally in times of disaster (Price, Davidson, Andrews, & Ruggiero, 2013). In reviewing over 125 studies using e-technologies of some sort (e.g., videoconferencing, telephone and mobile phone applications, email, etc.) with children and youth, Boydell et al. (2014) concluded that there was a high level of patient satisfaction and noteworthy levels of effectiveness. Likewise, Internet interventions have been shown to improve cancer patients' well-being (Leykin et al., 2012). Liu, Contreras, Munoz, and Leykin (2014) provided evidence that suicide attempts and depression could be assessed online in a Chinese population residing in China. These advances simply illustrate some of the breakthroughs in e-mental health that have occurred over the past decade. The future will reveal many more gains in using e-technology to provide low-cost, highly accessible, and effective mental health services across the globe.

Several challenges will need to be faced, however, for these technologies to revolutionize mental health delivery systems. Obviously, access to the Internet and smartphone technology is required to benefit from e-mental health services. Furthermore, there is significant diversity in familiarity with and comfort and competence in their use. For example, in a recent study of older (50- 93-year-old) rural adults, nearly 75% never heard of Internet mental health services, and intention to use the services was extremely low, under 14% (Handley, Perkins, Kay-Lambkin, Lewin, & Kelly, 2014). Moreover, further comparative research is needed on assessment and intervention protocols to determine relative effectiveness among available options. Last but not least, concerns will persist about data security and user privacy.

DIVERSITY

If the distribution of racial/ethnic minorities in the mental health workforce is not representative of the demographics in the United States, as the summary of data suggests, it is also the case that there are disparities in the provision of mental health care to racial/ethnic minorities, LGBTQ individuals, non-English-language speakers, persons with disabilities, and others; and, correlatively, there is an urgent need for further advances in training providers in multiculturalism and the methods for adapting evidence-based practices to the needs of all classes of mental health care utilizers in the United States. Together, persistent disparities in mental health care and lapses in multicultural training will pose significant challenges for the therapeutic enterprise as well as for treatment providers (Chae, Foley, & Chae, 2006; Chu, Huynh, & Arean, 2011; Sue & Zane, 2009).

For example, Jimenez, Cook, Bartels, and Alegria (2012) studied differences in mental health care episodes and disparities in provided services to a large sample of Black, Latina/o, and White elderly adults. They reported many differences in treatment initiation (40%, 27%, and 24% in Whites, Latinas/os, and Blacks, respectively) and adequacy between the two minority groups and the White group. Low rates of mental health care service utilization are also evident across other ethnic and minority groups (Sue, Ka, Cheng, Saad, & Sue, 2012) and self-identified LGBTQ individuals (Burgess, Lee, Tran, & van Ryan, 2007). Barriers to treatment utilization are numerous, including cost, availability, fear of stigma, disappointing previous personal experiences or those communicated by significant others, language competence, and cultural/ethnic belief systems, to name a few.

Training in the provision of culturally sensitive and/or competent service provision has progressed and is in fact required in accredited programs in clinical, counseling, and school psychology. However, agreed-upon standards for training and education are still wanting, and those even at the forefront of advocacy for multicultural training recognize the complexities involved in increasing the effectiveness of services for racial/ethnic and other minority groups (Sue & Zane, 2009). Similarly, there is no standard procedure for adapting empirically supported treatments to the needs of minority groups, although several methods have been suggested (Chu, Huynh, & Arean, 2011; Sue, Cheng, & Sue, 2011). Furthermore, in a review of adapted treatments, Helms (2015) reports that researchers used standard measures in assessment and outcomes without adapting them for cultural influences and did not use participants' experiences in defining symptoms. Much more effort is needed in the future to adapt the mental health care system, workforce, and mental health treatments to the changing demographics and experiences of all potential clients.

The adverse health consequences of global warming, while affecting everyone, will not affect all equally, resulting in further impetus to improve the mental health care workforces' diverse composition and expertise in diversity and cultural sensitivity. As outlined in the Lancet Commission's report (2015): "The underpinning science shows that impacts are unevenly distributed, with greater risks in less developed countries, and with specific subpopulations such as poor and marginalized groups, people with disabilities, the elderly, women, and young children bearing the greatest burden of risk in all regions" (p. 8). Preparation of an appropriate response in mental health care training programs will need to advance quickly to deal responsively with the most vulnerable groups in the United States and globally.

CONCLUSIONS/KEY POINTS

The future of psychotherapy and psychotherapists is difficult to predict. Psychotherapies are likely to be less defined by closed theoretical systems (psychodynamic, cognitive, behavioral, etc.), shorter in duration, integrated in primary care or other health care organizations, and delivered by a growing proportion of professionals, mostly female, without doctoral training. More therapies will target underlying pathogenic processes and will be coupled with genetic, radiographic, neurobehavioral, and chemical diagnostics and progress indicators, even those that use e-technology as it grows and becomes more prevalent. Personalized mental health treatments, like personalized medicine, will grow at advanced medical centers and cost less as technology innovates.

The need for crisis intervention, posttraumatic stress disorder treatments, and culturally sensitive interventions will continue to grow in response to extreme effects of climate change (Watts, et al. 2015), exposure to violence/war and political events, even as the workforce becomes more racially and ethnically diverse. It is hoped that service organizations will become increasingly sensitive to the self-care and continuing education needs of their mental health care workforce but will tie reimbursement more directly to performance. As access grows, the patients utilizing mental health services will be less well educated and share less of the country's wealth, in addition to exhibiting new and more serious types of postmodern psychopathology. In these contexts, there will be no dearth of challenges—in training, assessment, and intervention. A plethora of opportunities to serve in the betterment of humanity will continue to be available in the short and long term.

REVIEW QUESTIONS

1. Name three characteristics of postmodernism and describe how they differ from their modernist counterparts.
2. Describe characteristics of postmodern interlocutors, actors, and workers and articulate any personal experiences that may give credibility to the descriptions.
3. Describe two alternatives to the use of a psychotherapeutic orientation to guide theory, research, and practice.
4. The CDC describes eight sectors of adverse consequences of global warming. Name the eight sectors and speculate how mental health may be affected in each.
5. Discuss why training in multiculturalism and its implementation in mental health services are challenging and complex.

RESOURCES

Readings

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