is likely to be under the control of a current establishing operation. Although the theoretical explanation just provided is based on operant principles developed from nonverbal organisms, it must be recognized that much of the learning involved in HBR is occurring within a verbal context and with verbal organisms. Thus, it is likely that behavioral processes unique to verbal organisms, such as stimulus equivalence, play perhaps an even greater role in explaining the effectiveness of HBR. Unfortunately, a description of such procedures is outside the scope of this article.

III. EMPIRICAL STUDIES

Home-based reinforcement was first evaluated by Jon Bailey and colleagues in 1970. Because this original study demonstrated the effectiveness of controlling school-based behavior with home-based consequences, a growing volume of research has evaluated various effective forms and uses of HBR. This body of research is briefly reviewed later and includes discussions of behaviors targeted with HBR, methods of implementation, effective consequences, child variables, maintenance programs, and treatment acceptability of HBR.

A. Behaviors Targeted with HBR

Home-based reinforcement has been successfully used to increase academic skills and decrease disruptive behaviors in the classroom. Specifically, HBR has been used to increase motivation, rule following, grades, homework completion, listening, asking and answering questions, staying on-task, and completing class work. It has also been used to successfully decrease aggression, name calling, making noise, talking without permission, physically disturbing other children, and out-of-seat behavior.

The effects of the HBR procedure may also generalize to other nontargeted behaviors, persons, or settings. In 1983 Joseph C. Witt and colleagues found that when HBR was implemented to increase academic behavior, decreases were also seen in disruptive behavior. In addition, it has been found that when a HBR procedure is used on selected target students, the positive effects of the procedure may been seen in nontargeted students. For example, if a teacher targets the classroom behaviors of only half a class, it has been found that the nontargeted half will also show decreases in disruptive behavior. Likewise, data suggest that the positive effects of HBR can generalize from school to home settings.

B. Methods of Implementation

Also of interest is the specific method that should be used when implementing HBR. Issues such as how the plan should be communicated to parents, how often the home notes should be sent home, what information should be included on the home note, and who should be in charge of the home note at school, all must be considered.

In 1972 R. J. Karraker investigated how much effort was needed to instruct parents in the use of HBR. The researchers taught the procedure to three groups of parents during either two, 1-hour conferences, a 15-min. conference, or by mailing the instructions home. It was found that all three methods of implementation were equally effective in increasing academic behavior.

In 1997 Richard W. Saudargas investigated the rate that home notes should be sent home and found that sending notes home daily was more effective in increasing academic behavior than sending the notes home every Friday. In addition, research has shown that parents prefer daily school notes to both weekly and standard report cards.

There is considerable variation in the amount of information that is included on the home notes. Some home notes only have information on performance in a specific area, such as math completion or disruptive behavior whereas others give a global rating of the child's behavior for the whole day. Both methods have been shown to be effective in changing the student's behavior.

Student involvement in HBR has also been successfully varied. In some cases, the teacher has completed the home note without the student's knowledge, and in others, the teacher has instructed the student when to mark the home note and then signed it at the end of the class. To this date no studies have directly compared the effectiveness of the two methods.

C. Effective Consequences in HBR

One issue that is clear is that some type of reinforcing consequence is necessary for HBR to be effective. In 1972 R. J. Karraker investigated whether receiving the home note without reinforcement would be effective in changing the behavior of children and found that improvements in academic behavior were seen

only after the home note was paired with some rewarding consequence.

Although it is clear that a home-based consequence must be delivered, the most effective form of that consequence is less clear. A number of studies demonstrated the effectiveness of praise and tangible reinforcers for bringing home a note with good ratings, but not all researchers have been successful with only praise. In 1977, Jean B. Schumacher found mixed results in student behavior when using only praise but found consistent increases in school conduct, class work, and daily grades when praise and tangibles were contingent on a satisfactory home note. Some research also suggests that using contingencies that affect a group of individuals in the home, rather than just the target child, may also enhance the effectiveness of HBR.

Researchers have also had success by adding response cost to HBR. In 1995, Mary Lou Kelly and colleagues found that inappropriate behavior could be decreased using normal a HBR procedure, giving points exchangeable for rewards contingent on appropriate behavior, but found greater effects by having the children cross a "smiley" face off their home notes for inappropriate behavior. In the response-cost phase of the experiment the children needed to keep certain amount of smiley faces or points to earn reinforcers.

D. Child Variables

The effectiveness of HBR has been demonstrated with children from kindergarten to high school, in both special and regular education classes, and with children who have learning disabilities. HBR has also been shown to be effective in institutional or group home settings.

E. Maintenance Programs

As stated earlier, the goal of HBR is to have the child eventually function independent of the reinforcement program. To do this, fading or other procedures are often utilized. Some research has suggested effective ways to gradually reduce reliance on HBR procedures.

In 1973 Richard Coleman demonstrated that increases produced by HBR could be maintained while gradually altering the procedure to make the child's school environment more natural. Prior to the altering the procedure, points were rewarded contingent on appropriate behavior using a short, variable interval schedule. The teacher gradually made the child's environment more natural by (1) increasing the interval, (2) subtracting points for inappropriate behaviors instead of reinforcing appropriate behaviors, (3) extending the period of time during which points were taken away, (4) and making the child's weekly allowance contingent on an acceptable report from the teacher.

Another successful method for removing HBR is to gradually fade the procedure by increasing the criterion level required to receive reinforcement. For example, going from daily reinforcement, reinforcement could be made contingent on two consecutive days of appropriate behavior, followed by three until the schedule has been thinned to the point where the program can be terminated.

G. Treatment Acceptability of HBR

Clinicians should not only consider treatment effectiveness when choosing a procedure but should also attend to the acceptability of the intervention. An effective, but unacceptable intervention will likely meet with resistance and may produce negative emotional reactions in those involved. Thus, the acceptability of HBR procedures are discussed next.

Research has been conducted to determine the characteristics of acceptable behavioral interventions. Thomas Reimers conducted a review of the acceptability literature of behavioral interventions and found that the most acceptable interventions were those that (1) did not require large amounts of time, (2) were positive, (3) were less costly, and (4) did not produce negative side effects. Given that these are all characteristics of HBR, one could predict that HBR is an acceptable procedure.

In fact, many HBR investigations have assessed parent and teacher acceptability of HBR. In all, results showed that parents and teachers found HBR to be an acceptable way to deal with a student's behavior or academic problems. In 1989 Brian Martens and Paul Meller asked teachers to rate the acceptability of a response-cost procedure and a HBR procedure. The researchers found that the HBR procedure was rated as more acceptable than the response-cost procedure.

IV. SUMMARY

In summary, home-based reinforcement is an efficient, effective, and acceptable behavior modification procedure that is used to improve school-based performance or behavior in children and adolescents. Although there are many minor variations of the HBR procedure, in general it involves the delivery of

home-based consequences by the child's parents, contingent on school-based behavior.

See Also the Following Articles

Backward Chaining ■ Fading ■ Good Behavior Game ■ Homework ■ Minimal Therapist Contact Treatments ■ Parent–Child Interaction Therapy

Further Reading

Atkeson, B. M., & Forehand, R. (1979). Home-based reinforcement programs designed to modify classroom behavior: A review and methodological evaluation. *Psychological Bulletin, 86,* 1298–1308.

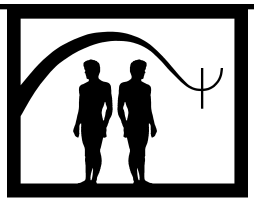
Bailey, J. S., Wolf, M. M., & Phillips, E. L. (1970). Home-based reinforcement and the modification of pre-delinquent classroom behavior. *Journal of Applied Behavior Analysis, 3,* 223–233.

Barth, R. (1979). Home-based reinforcement of school behavior: A review and analysis. *Review of Educational Research, 49,* 436–458.

Kelley, M. L., & McCain, A. P. (1995). Promoting academic performance in inattentive children. *Behavior Modification, 19,* 357–375.

Leach, D. J., & Byrne, M. K. (1986). Some "spill-over" effects of a home-based reinforcement programme in a secondary school. *Educational Psychology, 6,* 265–276.

Witt, J. C., Hannafin, M. J., & Martens, B. K. (1983). Home-based reinforcement: Behavioral covariation between academic performance and inappropriate behavior. *Journal of School Psychology, 21,* 337–348.



Homework

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GLOSSARY

behavior therapy A systematic, direct, educational approach to therapy that uses principles and strategies that have been supported by research to change thoughts, feelings and behaviors to help clients.

cognitive therapy Very similar to behavior therapy but focuses much more exclusively on altering problematic thoughts and beliefs that are perceived as causing problems.

effect size A measure of how well therapy works.

meta-analysis A research methodology and set of statistical techniques that combine the results of several individual studies to get a more reliable answer to questions, such as "Does homework help therapy outcome?"

Homework assigned to be done outside of therapy sessions is believed to add to treatment effectiveness or even to be necessary for treatment effectiveness by therapists of most theoretical orientations. This article describes types of homework, the benefits of homework, the evidence that homework is useful, and some guidelines for increasing homework assignment compliance.

I. DESCRIPTION OF TREATMENT

Homework refers to therapeutic assignments given by a therapist to a client to complete between sessions. The use of such assignments has a number of purposes. First, homework is purported to enhance treatment generalization through *in vivo* practice. Consider the example of a client taught assertiveness skills in session. From a behavioral perspective, practice in a natural environment allows for nascent skills to come under the control of naturally occurring contingencies. Newly learned behaviors reinforced *in vivo* have a higher probability of further generalizing to other real-world settings than skills merely performed in the clinic with a therapist. Even unsuccessful attempts have their uses: they may be discussed with the therapist and used to shape new homework assignments addressing more specific problem areas. Second, homework assignments are meant to optimize treatment in a cost-effective way. Rather than investing in therapy for multiple sessions per week, clients are asked to practice skills on their own, leading to a more comprehensive and seamless therapeutic experience. In fact, many behavior therapy procedures, such as progressive muscle relaxation, depend on in vivo practice to attain meaningful treatment goals. Finally, consistent with Albert Bandura's theory of behavior change, experiences of success in homework assignments should increase clients' self-efficacy and thus improve general motivation for persisting with treatment.

A seminal work describing the importance of homework assignments in cognitive-behavior therapy is the

1979 depression treatment manual, *Cognitive Therapy for Depression* by Aaron T. Beck, A. John Rush Brian F. Shaw, and Gary Emery. These authors posit that homework plays a critical role in the therapeutic process. They conceptualize homework as a sort of trial in which clients strive to gain new insights about their thoughts, emotions, and behaviors that lead to the negative thinking that precipitates and maintains their depression. Assignments develop from collaboration between therapist and client, and their goal is not perfection, but practice. The function of homework assignments is to assist clients to effectively transfer skills learned in session to their home and work environments. With homework, progress made in session may be more likely to be applied throughout a client's life, across both time and situations.

Homework assignments first became incorporated into psychotherapy during the 1950s in G. A. Kelly's fixed role therapy, which encouraged clients to adopt different, more adaptive interpersonal behavior patterns or "roles" and to practice these patterns outside of the therapeutic environment. In recent years, cognitive-behavioral and rational-emotive therapies, as well as some psychodynamic therapies, have integrated systematic homework into their treatment paradigms. Homework assignments have been incorporated into manualized treatments for a wide variety of psychological problems, including depression, anxiety, substance abuse and dependence, personality disorders, posttraumatic stress disorder, sexual dysfunction, and schizophrenia as well as for parent training (child management).

Written assignments, self-monitoring procedures, and skills practice are three broad types of homework assignments. However, the structure, content, and quantity of homework assignments are a function of several factors, including the therapist's theoretical orientation and the client's particular problem and commitment to therapy. For example, in the 1979 Beck, Rush, Shaw, and Emery depression treatment manual, homework assignments are geared toward reducing the incidence of (or eliminating) the negative thinking that plays a role in depressive symptomatology. In this type of homework, a cognitive therapist might ask a client to monitor and write down pessimistic thoughts related to depressed mood, and then to practice replacing such thoughts with more positive thoughts. Similarly, a rational-emotive behavior therapist might direct a client to identify irrational thoughts, and then to produce evidence that both supports and counters their validity. With such evidence in hand, the client is instructed to weigh these pros and cons and then judge the truth value of the cognition. A behavior therapist treating depression, on the other hand, might collaborate with the client to identify maladaptive behavior patterns, such as insufficient exercise or social withdrawal, and design homework assignments to alter these behaviors. It is not uncommon for a depressed client under the treatment of a behavioral therapist to leave a session with instructions to increase the frequency or duration of exercise, to visit at least one friend once per week, or to take time away from serving others to do something for themselves that they would ordinarily never do. Other typical homework assignments include exposure to feared thoughts, images, or situations, practice of social skills, biofeedback techniques, viewing videotapes, and practicing progressive muscle relaxation.

One clear example of the skills approach to homework used in behavior therapy is teaching a client applied muscle relaxation, which is often used for anxiety disorders. Applied muscle relaxation is a treatment in which an individual is taught a behavior that is incompatible with an existing response to specific situations. In the case of inappropriate or excessive anxiety, clients are taught to monitor their anxiety responses to environmental cues, such as increased heart rate and muscle tension, so that they can discriminate when they are becoming anxious. At the same time they are taught progressive muscle relaxation. For progressive muscle relaxation, therapists teach clients in a clinic session to focus sequentially on a number of different muscle groups while they first tense and then relax these muscles. This procedure is repeated until all muscle groups have been addressed, and the client reports lower levels of muscle tension and anxiety. After presenting the progressive muscle relaxation procedure in session, the client is typically provided with either verbal instructions and/or an audiotape of the therapist conducting the procedure along with homework instructions to practice the procedure at home. Initially, practice is done in a quiet, comfortable setting. Once mastery is achieved under those conditions, practice is done in progressively more distracting and less comfortable settings or situations. For example, a cancer patient who becomes anxious before and during chemotherapy sessions might first repeatedly practice relaxation at home, eventually add visualizing receiving cancer treatment while practicing, and then utilize relaxation just before and during the treatment itself.

Another type of homework assignment is *in vivo* exposure. Exposure involves persistently and repeatedly confronting feared objects or situations until feelings of anxiety subside. For example, in a 1993 study by Ruth

Edelman and Dianne Chambless, clients diagnosed with agoraphobia were assigned homework consisting of self-directed exposure between sessions. In comparison with clients who complied less, those who complied more with between-session exposure assignments reported significantly lower fear levels and fewer avoidance behaviors. By incorporating homework practice in treatment, it is believed that both the speed of learning a skill as well as the ease of acquiring that skill are enhanced.

II. THEORETICAL BASES

In general, homework assignments, as utilized in cognitive-behavioral therapies, are believed to improve client outcomes. Specifically, they are believed to increase the effectiveness and generalizability of treatment via between-session practice. This practice should both optimize the intervention and increase cost effectiveness for the consumer: homework, if adhered to, ensures multiple "sessions" per week for the price of one.

The major questions asked about homework deal with compliance with assignments. One question is whether the relationships found between homework compliance and treatment outcome are causal. That is, does increased homework completion lead directly to greater clinical improvement or is this simply a correlational relationship that is actually the result of some other factor or factors. The second question is how can therapists increase homework compliance and, relatedly, what factors are known to predict compliance difficulties. Awareness of the latter can assist therapists to be better prepared and have additional strategies in hand to aid compliance.

Several third-variable factors could account for the relationship between homework compliance and treatment outcome. Clients who are more motivated, either dispositionally or from early therapist interventions, might work harder in all aspects of therapy, including homework, and make more treatment gains. Parallel effects could arise from a more optimistic attitude or more openness to change. In either case, the effect of homework compliance on outcome would be incidental.

Also, the compliance–outcome relationship could work in the reverse direction: severely depressed clients might do little or no homework between sessions. This would imply that homework has no effect on outcome.

The evidence from two recent studies indicates that compliance does have a direct effect on treatment outcome. David Burns and Diane Spangler used structural equation modeling to answer this question in a 2000 paper and found support for a causal effect of homework compliance on outcome. Using a very different research strategy, repeated assessments of homework compliance and of improvement in depression, Michael Addis and Neil Jacobson found that early compliance predicted final outcome. Their results countered the reverse compliance–symptom severity alternative hypothesis and supports a causal relationship. Therefore, except for a very few studies that have found compliance unrelated to outcome, it appears that the more clients follow homework assignments, the more they improve.

Although homework is an integral part of many cognitive-behavioral therapies, it appears that client noncompliance may limit the benefits of assignments to treatment outcome. In a 1999 review paper, Jerusha Detweiler and Mark Whisman discuss failure to comply with homework assignments and possible methods for increasing compliance. Their review lists several factors that contribute to poor compliance: unrealistic goal setting (i.e., therapists making assignments too hard), lack of consideration of a given client's ability to complete a particular assignment, poor client motivation, client expectations that their role in therapy is a passive one, and poorly designed assignments (e.g., those that do not come under the control of naturally occurring reinforcers). Other client-based reasons cited range from client perfectionism and fear of failure to comorbid personality disorders and high initial levels of symptomatology. These authors observe that, for homework to be beneficial, practice, commitment, and just plain hard work are required. This points out the importance of presenting to the client a sound, compelling treatment rationale to motivate this effort.

Detweiler and Whisman identify a number of task, therapist, and client characteristics relevant to increasing compliance. In terms of task characteristics, the more specific and concrete an assignment, the more likely a client will understand and complete it. For example, writing down assignments for the client may elicit more compliance than just verbally describing what they are to do. Providing concrete, specific details of what they are to do and when they are to do it can prevent misunderstandings and frustration for both the client and therapist. Shaping the client's assignments, starting with brief and simple tasks and gradually increasing homework demands should also help by building self efficacy. Client characteristics that bear consideration include initial levels of symptomatology, motivation, or merely contextual barriers to completion. Consider a client who works on an assembly line and has been asked to write down instances of an intrusive

thought. Such an assignment is likely to end up a failure due to its poor feasibility. Using role plays with role-reversal, having the client act as the therapist and explain why homework and its completion are important, may enhance motivation. Therapist characteristics that may affect compliance are more difficult to define, as there are gaps in the empirical literature concerning this variable. Nonetheless, the authors posit that factors such as empathy and therapist behaviors related to recommending assignments may merit exploration.

In other studies done to examine factors associated with better homework outcomes, it has been found that the quality of the homework product is far more predictive of outcome than the quantity of homework produced and that more thorough reviews of one homework assignment will promote better compliance with subsequent homework assignments.

III. EMPIRICAL STUDIES

The primary question for homework is "Do homework assignments improve therapeutic outcome over and above in-session therapy effects alone?" In 2000, Nikolaos Kazantzis, Frank P. Deane, and Kevin R. Ronan conducted a meta-analysis of the literature on this empirical question. Combining 11 prior studies with a total of 375 participants, their analysis found strong effects of homework assignments on therapy outcome. Thus the answer seems to be a clear "yes." These authors' results also showed that the effect of homework was stronger for depression than for anxiety disorders. Homework assignments to practice social skills and watch videotapes had stronger effects on outcome than assignments to self-expose to feared objects or situations and relaxation practice. Finally, studies that used a range of homework assignments appeared to obtain better treatment effects than studies that used only single, specific homework assignments.

How large are the effects of homework on therapy outcome? The meta-analysis above found an effect size of $r = .36$. It is useful to see in more concrete terms how large a change a therapist can expect to see on a common measure of distress. The Burns and Spangler study described earlier separately examined two groups of depressed patients for the effects of homework on change in scores on the Beck Depression Inventory (BDI), a short, reliable questionnaire that is used by both researchers and private practitioners. For each of their groups, they found that homework accounted for a drop in BDI scores of 14 to 16 points. This improvement in BDI scores was comparable to a 1988 study done in a private practice setting by Jacqueline Persons, David Burns and Jeffery Perloff. These authors found a 16.6 point BDI change with homework but noted that the vast majority of improvement occurred in their more depressed clients, those with initial BDI scores over 20. Homework had very little effect for their clients who had lower scores at the beginning of treatment. In general, the degree of BDI change produced by homework alone in these studies would move a client from being classified as "severely depressed" to "moderately depressed" or from "moderately depressed" to "mildly depressed."

Psychodynamic and systemic or family therapies also often require or recommend homework. Although there is no literature to date investigating homework effectiveness within these therapies, there is no reason to think that the cognitive-behavioral research findings that support the use of homework would not generalize to these approaches.

IV. SUMMARY

Most theoretical orientations hold that what a client does in the natural environment outside of therapy sessions is a necessary condition for producing therapeutic change. Typically, clients are seen for about 1 hour each week. To extend what clients are taught in session to the time intervening between sessions and to implement what clients learn in session, therapists give homework assignments. Effective homework assignments can optimize the cost effectiveness of therapy for the consumer.

Homework assignments first became incorporated into psychotherapy during the 1950s, and since then, have become an integral part of both behavioral and cognitive-behavioral treatment paradigms. Other treatment modalities, such as systems therapy or psychodynamic interventions, also utilize homework. Homework is used in the treatment of a wide variety of disorders, which, along with factors such as therapist orientation and client commitment, may dictate the type of homework assigned. Common types of assignments include written assignments, self-monitoring procedures, and skills practice.

Research clearly shows that homework improves treatment outcome.

See Also the Following Articles

Applied Relaxation ■ Behavior Rehearsal ■ Discrimination Training ■ Exposure *in Vivo* Therapy ■ Guided Master Therapy ■ Home-Based Reinforcement ■ Negative Practice ■ Panic Disorder and Agoraphobia ■ Self-Control Therapy

Further Reading

Addis, M. E., & Jacobson, N. S. (2000). A closer look at the treatment rationale and homework compliance in cognitive-behavioral therapy for depression. *Cognitive Therapy and Research, 24,* 313–326.

Beck A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy for depression.* New York: Guilford Press.

Bergin, A. E., & Garfield, S. L. (1994). *Handbook of psychotherapy and behavior change* (4th ed.). New York: John Wiley and Sons.

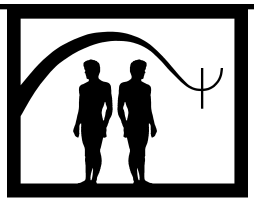
Bryant, M. J., Simons, A. D., & Thase, M. E. (1999). Therapist skill and patient variables in homework compliance: Controlling an uncontrolled variable in cognitive therapy outcome research. *Cognitive Therapy and Research, 23,* 381–399.

Burns, D. D., & Spangler, D. L. (2000). Does psychotherapy homework lead to improvements in depression in cognitive-behavioral therapy or does improvement lead to increased homework compliance? *Journal of Consulting and Clinical Psychology, 68,* 46–56.

Detweiler, J. B., & Whisman, M. A. (1999). The role of homework assignments in cognitive therapy for depression: Potential methods for enhancing adherence. *Clinical Psychology: Science and Practice, 6,* 267–282.

Edelman, R. E., & Chambless, D. L. (1993). Compliance during sessions and homework in exposure-based treatment of agoraphobia. *Behaviour Research and Therapy, 31,* 767–773.

Kazantzis, N., Deane, F. P., & Ronan, K. R. (2000). Homework assignments in cognitive and behavioral therapy: A meta-analysis. *Clinical Psychology: Science and Practice, 7,* 189–202.



Humanistic Psychotherapy

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GLOSSARY

constructivist therapy Humanistic approaches that stress personal and social constructions of psychological growth processes.

existential therapy Humanistic approaches that emphasize freedom, experiential reflection, and responsibility.

humanistic theory Comprises two overarching concerns: What it means to be fully, experientially human, and how that perspective illuminates the vital or fulfilled life.

humanistic therapy Conditions or stances that assist people to grapple with and become more of who they aspire to become.

transpersonal therapy Humanistic approaches that accent spiritual and transcendent dimensions of psychological well-being.

Humanistic psychotherapy is the applied branch of humanistic psychology and philosophy. Humanistic psychology and philosophy are time-honored folk and academic traditions that stress deep personal inquiry into the meaning and purpose of life. In particular, humanistic psychology and philosophy pose two basic questions: What does it mean to be fully, experientially human, and how does that understanding illuminate the vital or fulfilled life? Correspondingly, humanistic psychotherapy comprises the conditions or stances by which people can come to intimately know themselves and, to the extent possible, to fulfill their aspirations. Humanistic psychotherapy is characterized by three major practice philosophies—the existential, the constructivist, and the transpersonal.

I. HUMANISTIC APPROACHES: DESCRIPTION AND OVERVIEW

Humanistic psychotherapy is a broad classification that embraces a diverse ensemble of approaches.[1] Each of these approaches is like a spoke on a wheel, the hub of which is the humanistic theoretical stance. The humanistic theoretical stance derives essentially from ancient Greek, Renaissance, and even Asian sources,

[1] The terms "approach," "stance," and "condition" are used instead of "treatment" in humanistic nomenclature. The reason for this substitution is because "treatment" implies the medical-like application of a technique to a measurable and well-defined symptom; however humanistic psychotherapy emphasizes the significance of a relationship—a condition, atmosphere, or forum—within which not just symptoms but complex life issues can be explored and addressed.

which all uphold the maxim, "know thyself." Although there have been many variations on this theme throughout the development of psychology, let alone humanistic psychology, it has come to acquire a core humanistic meaning. For humanists, to know thyself is far from a simple project with trivial implications; to the contrary, it is an intensive intra- and interpersonal undertaking with world-historical significance. In the parlance of modern humanistic psychology the maxim has come to be understood as a dialectic between profound self-inquiry, and inquiry into the world. Indeed, the self cannot be separated from the world, according to contemporary humanists, and must be understood as a "self-world" process or construct as James Bugental has put it. A corollary to the humanistic stress on inquiry is engagement of potential. It is not enough to ask questions about life's meaning, according to humanists, one must also, at the appropriate time, translate those questions into a meaningful life. In short, humanistic psychology has both an inquiring and moral–ethical component that suffuses through every mode of its application. To learn more about the history and development of humanistic philosophy and psychology, see *The Handbook of Humanistic Psychology: Leading Edges in Theory, Research, and Practice* and *Humanistic and Transpersonal Psychology: A Historical and Biographical Sourcebook*.

Contemporary humanistic psychotherapy is composed of three basic practice traditions: the existential, constructivist, and transpersonal. We will now describe the structure of these traditions, highlight their conceptual underpinnings, and consider the empirical evidence on which they are based.

II. EXISTENTIAL THERAPY

Existential psychotherapy derives from the philosophical and literary writings of such thinkers as Søren Kierkegaard, Friedrich Nietzsche, Martin Heidegger, Jean Paul Sartre, and Maurice Merleau-Ponty; and from the methodological formulations of investigators such as Edmund Husserl, Wilhelm Dilthey, and William James. The basic thrust of existential psychotherapy, as Rollo May, one of the leading contemporary spokespeople for the movement put it, is "to set clients free." Freedom is understood as the cultivation of the capacity for choice within the natural and self-imposed (e.g., cultural) limits of living. Choice is understood further as responsibility; the "ability to respond" to the myriad forces within and about one. Although many forces are recognized as restrictive of the human capacity for choice, for example, influences that May terms "destiny"—genes, biology, culture, circumstance—they are nevertheless highly mutative, according to existentialists, in the light of—and through the tussle with—choice. For existentialists, choice is the key to an engaged and meaningful life.

The second major concern of existential psychotherapy is the cultivation not just of intellectual or calculative decision-making, but decision-making that is felt, sensed, or in short, experienced. The stress on the experiential is one of the primary areas of distinction between existential and other (e.g., cognitive-behavioral, psychoanalytic) modes of practice. The experiential mode is defined by four basic dimensions—immediacy, affectivity, kinesthesia, and profundity. By immediacy, we mean that experience is fresh, living, "here and now", by affectivity, we mean experience is characterized by feeling or passion; by kinesthesia, we mean experience is embodied or intensively sensed; and by profundity, we mean experience has depth, impact, and transcendent significance. Another way to characterize the experiential is through recognition, as Arthur Bohart has put it. To the degree that a thought, feeling, or behavior is recognized, according to Bohart, it is experienced.

Existential therapists have a variety of means by which to facilitate freedom, experiential reflection, and responsibility. Some, such as Irvin Yalom, emphasize the support and challenges of the therapist–client relationship to facilitate liberation. Yalom stresses the building of rapport and repeated challenges to clients to take responsibility for their difficulties. Further, Yalom homes in on the immediate and affective elements of his therapeutic contacts, but he refers little to kinesthetic components. Following the philosopher Martin Buber, Maurice Friedman also homes in on the interpersonal relationship but stresses the dimension of authenticity or the "I-thou" encounter as the key therapeutic element. The I-thou encounter according to Friedman is the dialectical process of being both present to and confirming of oneself, while simultaneously being open to and confirming of another. The result of such an encounter is a "healing through meeting" as Friedman puts it in *The Psychology of Existence*—which is a healing of trust, deep self-searching, and responsibility. Through the therapist's I-thou encounter, in other words, the client is inspired to trust, enhance self-awareness, and take charge of his or her own distinct plight. James Bugental, on the other hand, accents the "intra" personal dimensions of freedom, experiential reflection, and responsibility. For Bugental, choice and responsibility are facilitated, not

merely or mainly through therapist and client encounter, but through concerted invitations (and sometimes challenges) to clients to attend to their subtlest internal processes—flashes of feeling, twinges of sensation, and glimpses of imagination. Via these means, according to Bugental, clients discover their deepest yearnings, their strongest desires, but also, and equally important, their thorniest impediments to these impulses. By grappling with each side, however, Bugental maintains that clients learn to negotiate their conflicts, elucidate their meaning, and rechannel them into living fuller and more empowered lives.

Similarly, Rollo May stresses the cultivation of what he terms "intentionality" in the therapeutic relationship. By intentionality, May refers to the "whole bodied" direction, orientation, or purpose that can result from existential therapy. In his case examples, May shows how intellectualized or behaviorally programmed interventions persistently fall short with respect to the cultivation of intentionality, whereas profound struggle, both between the therapist and client and within the client, can, if appropriately supported, lead to such a quality. For May (as with most of the existential therapists), the struggle for identity is essential—enhancing clarity, agency, and ultimately commitment or intentionality in the engagement of one's life.

The client's internal frame, and his or her own subjective wrestling is also a hallmark of Carl Rogers' client-centered approach. For Rogers, the therapist must create the conditions for client freedom, searching, and responsibility; he or she would not (except in rare instances) attempt to dictate or teach these capacities. The rationale for this stance is foundational—clients must learn for themselves what is meaningful or essential to their growth. In Rogers' view, there are three facilitative conditions necessary for optimal therapy—the therapist's warmth or caring, the degree to which he or she is congruent or genuine, and the degree to which the therapist communicates unconditional positive regard for the client. With the provision of these conditions, according to Rogers, clients are freed to verbalize and embody more of who they experience themselves to be, and by implication, to eradicate the incongruities and pretenses of who they have been. By discovering more of who they are, moreover, clients do not become licentious in Rogers' view; they become responsive, both to themselves and to those around them.

With his Gestalt therapy, Frederick Perls also emphasizes the client's side of the therapeutic encounter, but through a very different means. One might say that whereas Rogers "alerts" clients about their liberating potentials, Perls "alarms" them; and whereas Rogers accents therapeutic receptivity, Perls stresses therapeutic confrontation. For example, whereas Rogers might use active listening or empathic reflection with a given client, Perls might encounter a client directly—"how is it that you continually meet men who are bad for you?" Or Perls might refer to a client's body position or manner of speaking and concertedly encourage the client to amplify and attend to those modalities.

The upshot of this synopsis is that existential therapists use diverse means by which to foster a similar result—client empowerment and consciousness-raising. In recent years, and partly as a response to the ethos of managed care, existential therapists have endeavored to reassess and in some cases streamline their repertoires. Existential oriented investigators are increasingly raising two questions: Which of the various existential practices work best, and under what general conditions? Leslie Greenberg, Laura Rice, and Robert Elliott, for example, have developed what they term "therapeutic markers" to guide their work. Such markers are statements, gestures, or signs that clients are experiencing specific kinds of difficulty, for example, identity conflicts, unfinished business with significant others, loss of meaning. By identifying the markers, therapists are better able to both identify and specify the interventions (e.g., supportiveness, uncovering) that address those markers. Therapists such as those discussed earlier have also found that specific Gestalt techniques, such as "chair work" and "systematically building the scene" can be of particular value in the appropriate circumstances. Chair work entails a role-play between a client and an imagined other who "sits" on an empty chair. The client "works out" or simulates an actual encounter with the imagined other, and with the assistance of the therapist, processes the feelings, thoughts, and implications of that experience. Systematically building the scene entails the use of vivid and concrete language to help clients revive and work through suppressed or traumatizing material.

Eugene Gendlin's "Focusing Therapy" and Alvin Mahrer's "Experiential Therapy" also provide methodical and intensive guidelines to optimize existential practice. Gendlin, for example, homes in on that which he terms the "felt sense," which is a preverbal, bodily experience of a given concern, to facilitate therapeutic change. Very methodically, Gendlin encourages clients to identify their felt sense, explore its nuances as it evolves, and clarify its meaning or implication for their lives. Mahrer has four basic aims in his experiential therapy: assist clients into moments of strong feeling, help them to align with or integrate those moments, encourage them

to enact or embody the inner experiences associated with those moments, and support them to live or translate their discoveries into the present. Mahrer's approach has two overarching goals: (1) to help clients access deeper experiencing potential so that they can become (to the degree possible) "qualitatively new persons," and (2) to help them free themselves from the limiting feelings that have plagued them in the past, and with which they grapple in the present.

Kirk Schneider, with the assistance and inspiration of Rollo May, has synthesized a range of existential approaches with his model "Existential-Integrative Therapy." Existential-integrative therapy draws on a diversity of therapeutic approaches within a unitary existential or experiential framework. The aim of the existential-integrative approach is to address clients at the level at which they chiefly struggle—be that physiological, environmental, cognitive, psychosexual, or interpersonal—but all within an ever-deepening, ever-beckoning experiential context. By "experiential" Schneider refers to four characteristic dimensions—the immediate, the affective, the kinesthetic, and the profound (or cosmic). The degree to which a client can be "met" within the experiential context is a function of his or her desire and capacity for change, but also, according to Schneider, an assortment of therapist offerings. Among these offerings are "presence," "invoking the actual," "vivifying and confronting resistance," and "meaning creation (or cultivation)." Presence, for Schneider, holds and illuminates that which is palpably (immediately, affectively, kinesthetically, and profoundly) relevant, within the client and between client and therapist. Presence holds and illuminates that which is charged in the relationship and implies the question, "What's really going on here, within the client and between me and the client?" Presence is the "soup" or atmosphere within which deep disclosure can occur, and based on this disclosure, the client's core battles become clarified. Invoking the actual refers to the invitation to the client to engage that which is palpably relevant. By invoking the actual, the therapist calls attention to the part of the client that is attempting to emerge, break through, and overcome stultifying defenses. Invoking the actual is characterized by such invitations (and sometimes challenges) as, "What really matters to you right now?", or "I notice that your eye moistened as you made that statement", or "What feelings come up as you speak with me?" At times, invoking the actual calls attention to content/process discrepancies, such as "You say that you are angry but you smile." If invoking the actual calls attention to that which is emerging in the client's experience, vivifying and confronting resistance call attention to that which blocks what is attempting to emerge. These blocks or resistances are seen as life-lines from the existential-integrative point of view, but they are also acknowledged as progressively defunct. Vivifying resistance "alerts" clients to their defensive blocks, while confronting resistance "alarms" or "jars" them about those blocks. Together, vivifying and confronting resistance serve to intensify and eventually mobilize clients' counterresistances (the "counter-will" as Otto Rank has put it); it is these counterresistances that liberate vitality, bolster choice, and incite change. In the final stage of existential-integrative encounter, therapists help clients to consolidate the meanings, values, and directions of their present lives. Although meaning creation evolves naturally and spontaneously following breakthroughs over one's resistance, sometimes it requires a gentle prod. For example, a therapist might challenge a client to translate her newfound boldness into her constricted work relationships.

To sum, existential-integrative therapy, like existential therapy generally, assists clients to grapple with their experiences of life, not just their reports about life, and through this illumination, supports their intentional and embodied engagement with life.

III. CONSTRUCTIVIST THERAPY

"Constructivism"[2] refers to a group of theories holding the philosophical position that "reality" is, in some ways, created by (as opposed to thrust upon) persons. Constructivist therapists are faced with the challenge of understanding the lived reality of each client, not imposing some objective truths on all persons seeking their help. On this basis, constructivists believe that lives can be transformed and horrors transcended when we grasp the unique, personal, and richly powerful "realities" each of us has created. Therapy (and research, for that matter) is a cocreated experience between therapist and client, mutual experts on different aspects of the lived reality being created between them. This egalitarian relationship can be seen as more client empowering than approaches in which the more powerful therapist imposes diagnostic and treatment "realities" on the less powerful client. After briefly describing constructivism, we will discuss

[2] See also postmodernism/postmodern or poststructural philosophy/therapy.

some general aspects of constructivist therapy followed by a brief illustration of a few constructivist approaches.

Although all constructivists agree that reality cannot be known directly, different theoretical groups disagree on the exact nature of the relationship between the person and the world. Radical constructivists argue that it makes no sense to even speak of a reality outside of the meanings the person has created. Because reality cannot exist other than our construing it into existence, radical constructivists would argue that the meanings we create totally determine our experience of the world. Social constructivists would go to the other extreme. We are saturated with meanings created by cultures and imposed on us. Occupying a middle ground between these two extremes, critical constructivists argue that meanings are created in the dynamic interaction between the person and the world. In other words, although we cannot know it directly, the world is real, integral, and unfolding around us.

Constructivist therapies generally share certain attitudes about therapy. For example, most constructivists will listen to clients from the assumption that everything the client says is "true" in the sense of revealing important aspects of the client's experiential meaning system. (This attitude is termed the credulous approach by some constructivists.) Similarly, there is a respect for contrast, oppositionality, or the dialectic as integral to meaning making. Most constructivists also are very attuned to making the therapy room a safe place for clients to experience life, explore, and grow. Without safety, creative encounter with the central meanings of one's life is hampered; without creativity, reconstruing the bases of one's existence is impossible. Finally, there is an emphasis on seeing the client as a process of meaning creation, rather than a static entity composed of specific meanings. This emphasis on seeing persons as processes implies that constructivists are always looking for the ways the client is changing from moment to moment or session to session. Art Bohart has taken this focus on client change and argued that therapy works because the self-healing client uses whatever the therapist does to grow and change.

As might be expected, different constructivist therapists employ these attitudes in different therapeutic approaches. Franz Epting, for example, is a leading proponent of George Kelly's fixed role therapy. In fixed role therapy, the client first writes a character sketch that is open, revealing, yet sympathetic to the client's experience. The therapist and client then cocreate an alternate sketch for the client to enact, typically for a 2-week period. Rather than being a behavioral prescription, the procedure is designed to free the client to experiment with differing ways of experiencing life.

On the other hand, constructivist therapists such as Miller Mair, Robert Neimeyer, and Oscar Goncalves employ narrative approaches to therapy. These therapists believe that narratives give meaning and continuity to the lived experience of clients. Gaps, incompleteness, and incoherence in the client's life story may indicate struggles in creating an integrated experience of self-in-the-world. Goncalves nicely illustrates constructivist narrative therapy with his "moviola" technique. This is a technique in which the therapist's attention scans the settings of a client's life, much like a camera in a movie. The therapist can zoom in on a detail or back off and get a more panoramic view. For example, a therapist might start by having the client describe the entire room in which a traumatic event occurred. Eventually, the therapist might help the client zoom in on the faces in the room, filled with fear and horror, while the abuse occurred. Because people intimately create meanings to understand their experiences, the experience of reviewing the abuse with an empathic therapist allows for new constructions to be created. These newer meanings, in turn, allow for newer experiences as clients' lives move into the future.

Bruce Ecker and Laurel Hulley's depth oriented brief therapy (DOBT) applies constructivist principles to understand and engage clients in radical change in a very short-term treatment. DOBT understands the symptom as painful because of the ways it invalidates important aspects of our experience. At the same time, there are other constructions, often at a lower level of consciousness, which makes the symptom absolutely necessary for the client. DOBT uses specific experiential techniques to help the client gain access to these deeper meanings. The client then can more consciously decide whether to keep or abandon these more unconscious meanings. For example, one client who described himself as a complete failure uncovered the ways in which his failure was rewarding. It served both as punishment for and proof to his parents that they had failed him in many ways.

Larry Leitner's experiential personal construct psychotherapy (EPCP) is based on the relational, experiential, and existential foundations of constructivism. EPCP construes persons as simultaneously needing and being terrified of depths of emotional closeness. On the one hand, such intimate relationships can affirm the meanings that have formed the very foundation of our existence. On the other hand, we can experience devastating disconfirmation in intimate

relationships. Clients then struggle with needing to connect with others, risking terror to gain profound richness, versus retreating from intimacy, buying safety at the cost of the empty objectification of self and others. EPCP engages this struggle in the live relationship in the therapy room. Therapeutic growth can occur as the therapist offers optimal therapeutic distance, a blending of profound connection and separatensess, when the therapist is close enough to feel the client's experience, yet distant enough to recognize those feelings as the client's and not the therapist's own.

Constructivist therapy also has been applied to special populations. For example, EPCP was an approach developed to understand and therapeutically engage the experiences of more severely disturbed clients, often those who have received *DSM* diagnoses such as "schizophrenia," "borderline," and "schizotypal." (Terms most constructivists would not countenance by the way.) Fay Fransella has applied constructivist therapy to stutterers. A central aspect of her therapy involves the creation of meaningful ways of encountering the world as a fluent speaker.

Tom Ravenette, using only blank sheets of paper and pencils, uses constructivist techniques to access the meaning-making system of children. For example, he will draw a bent line in the center of a page and have the child draw a picture incorporating the line. He then has the child draw a second picture, depicting an opposite to the one just drawn. As the child talks about the pictures, Ravenette enlarges the conversation to allow the child to say what she knows (but could not express) about her world. Linda Viney and Sally Robbins, working on the other end of the age spectrum, successfully utilize constructivist principles with elderly clients. Robbins, for example, has poignantly described using a constructivist version of reminiscence to help elderly clients come to terms with their lives and their deaths. Family system constructivists may use systemic bowties to help each client understand how their actions, based on their deepest fears, confirm the deepest fears of other family members. For example, in response to his fears that his wife does not love him, a client may respond vaguely to her when she is angry. She interprets the vagueness as his not respecting her, making her even angrier.

Finally, there is a growing literature empirically supporting the use of constructivist therapies. Linda Viney (in a 1998 issue of the journal *Psychotherapy: Theory, Research, Practice, Training*), for example, reviews 19 different studies exploring the effectiveness of personal construct therapy across different countries, ages, and types of problems. Not only did she find substantial support for the effectiveness of constructivist therapy, she found effect sizes for client change to be at least as large as those reported in the cognitive-behavioral and psychoanalytic literature. In other words, good constructivist therapy respects the lived experiences of persons while being empirically supported using studies that meet the most rigorous of experimental criteria.

IV. TRANSPERSONAL THERAPY

The differences among the major humanistic approaches are certainly more of degree than of kind. There is a very wide overlap among transpersonal, existential, and constructivist modalities. However, whereas existential and constructivist therapies emphasize the interhuman, personal elements of client–therapist interaction, the transpersonal approaches accent the spiritual, religious, or cosmic implications of those dimensions. It is not that an existential- or constructivist-oriented therapist would exclude any such transpersonal theorizing—indeed, a number of them welcome such theorizing—however, on the whole, transpersonal therapists, above and beyond their existential and constructivist counterparts, bring to bear into their practices two basic knowledge domains: (1) religious faith traditions, and (2) mystical healing traditions. Religious faith traditions represent the seven major religious systems of the world—Buddhism, Hinduism, Islam, Judaism, Christianity, Taoism, and Confucianism—as well as the many indigenous lineages, such as Native American, Asiatic, and African traditions. Mystical healing traditions encompass a breathtaking span of indigenous, institutionalized, and individualized elements, but they all converge on one basic pattern—the experience of oneness with creation. While transpersonal therapists tend to be conversant with these transcendental viewpoints, it should be pointed out they do not draw on them to proselytize. Their essential task, by contrast—in accord with transpersonal pioneer C.G. Jung—is to facilitate client self-discovery.

In his essay from the germinal *Paths Beyond Ego,* edited by Roger Walsh and Frances Vaughan, Bryan Wittine sets forth several "postulates" of transpersonal psychotherapy. The first postulate proposes that transpersonal therapy embraces egoic, existential and transpersonal levels of human consciousness. This postulate derives from a "spectrum" model of human consciousness, developed formally by Ken Wilber, and used broadly by transpersonal scholars and practition-

ers. Roughly speaking, the spectrum model proposes a hierarchy of developmental psychospiritual stages, from the infantile "pre-egoic" stage to the culturally competent "egoic" stage to the personally inquiring "existential" stage to the unitive "transpersonal" stage. Although there are many nuances within this model, and diverse interpretations of its accuracy, it is nevertheless a core view for many transpersonalists.

The first postulate of transpersonal therapy then assumes a sweeping scope—all developmental stages of identity from the precultural (infantile) to the transcultural (sagely or saintly) are embraced. Moreover, for some in the transpersonal community, each developmental stage is a prerequisite to the next. One cannot, for example, simply "leap" from stage to stage, for example, from the conventional egoic stage to the transconventional "subtle" or "soul" level, without predictable difficulties and consequences. Among these are various kinds of regression, as manifested, for example, by the accomplished meditator who also semiconsciously indulges in alcohol, or the pious adept who concomitantly exploits others, and so on. Generally speaking, the more that clients can address and work through the stage of their developmental arrest, the greater their ability to advance to an expanded or "higher" developmental level. Put another way, the transpersonal therapist (like most depth therapists) must help clients "get through the night," or manage their dysfunctionality, before he or she can assist them with profound or mystical realizations. Although other transpersonalists, such as Brant Cortright, believe that spiritual and mystical healing can, and often does, occur alongside of the dysfunctional, they do not discount the significance of addressing those dysfunctional states, and of supporting healing processes generally.

Wittine's second postulate is that the therapist's role in transpersonal therapy is critical. The therapist's ability to hold and value psychospiritual healing refers directly back to his or her own psychospiritual work, awareness, and capacity to translate that work and awareness to the therapeutic setting. To the extent that therapists can "see" and acknowledge the unfolding spiritual implications in client's quandaries, they embrace a deeper and broader therapeutic possibility for clients, a deeper and broader language within which to engage that possibility. Consider, for instance, the therapist who works strictly within a psychoanalytic frame and who views clients' conflicts as derivative of circumscribed parental relationships; to what extent would such a therapist be open to implicit spiritual strivings in clients' material—such as urges to wonder, yearnings to transcend, or impulses to meld? The therapist's presence to these spiritual possibilities is crucial—an entire therapeutic direction may hinge on what therapists ask about, how they inquire, and what they imply or suggest when they inquire. If a therapist is not attuned within himself or herself to the longing for or fear of an enlarged sense of spiritual meaning in a client's rage or tearfulness, that client may never broach those motivations, and may feel shortchanged as a result. A conscious transpersonal therapist, on the other hand, can detect and call attention to emerging affects, images, symbolisms, and the like, that are bell-weathers of profound spiritual or religious transformation; to the degree that one has not experienced and dealt with such intensities within oneself, however, it is doubtful that one could facilitate them in others. Great care, finally, needs to be taken in calling attention to emerging spiritual concerns—as with all humanistic therapies, it is the client, not the therapist, who must ultimately decide his or her fate, and the meaning or significance of that fate.

Wittine's third postulate is that transpersonal therapy is "a process of awakening from a lesser to a greater identity." By "awakening," transpersonal therapists mean enlarging or expanding one's identity. The enlargement of one's identity invariably entails disruption, pain, and relinquishment. One cannot simply "leap over" one's former way of living, particularly if it has been familiar and "safe," and fail to experience disturbance. This disturbance becomes particularly acute if one lacks the means and resources to address it. For example, there is a major difference between an identity crisis that evolves gradually within familiar circumstances, and one that "shatters" or overtakes one abruptly. The experience that transpersonal therapists term "spiritual emergency" is an example of the latter variety of crisis. In spiritual emergency (which is to be distinguished from brief psychotic episodes or nonspiritual "breakdowns"), clients experience an acute transpersonal tear or rupture in their conventional experience of the world. This rupture may take the form of psychic openings, for example, visions, voices, telepathic states; or shamanic-like alterations of consciousness, such as channeling experiences, possession states, and UFO encounters.

According to Cortright, who draws on the foundational work of Stanislav and Christina Grof, there are three distinguishing features of those undergoing spiritual emergency: (1) They display changes in consciousness in which there is significant transpersonal consciousness; (2) they have an ability to view the condition as an inner psychological process, amenable to

inner psychological resources; and (3) they have the capacity to form a sufficient working alliance with a therapist. Although these features stand in marked contrast to relatively nontranspersonal, nonintrospective, and oppositional crisis clients, there are many gradations when it comes to spiritual emergency and there is as yet no firm consensus as to which clients fit which criteria. The general consensus for treating spiritual emergency clients, according to Cortright, is to help "ground" or support them, to offer deep and abiding presence to their struggle, and to draw on diet, exercise, massage, proper rest, meditation, and (when necessary) medication, to begin their healing path. Following these initial steps, a more depth-experiential approach can be implemented. The goal of such an approach, as with most transpersonal approaches, is to assist clients to integrate and transform split-off parts of themselves, and to facilitate expanded consciousness.

In general, transpersonal work proceeds through a series of steps that increase clients' awareness. The more that clients can become aware of stifling or debilitating patterns, the more they are in a position to question and reshape those patterns. Although most therapists facilitate expanded awareness, transpersonal therapists create an atmosphere and make available methods that carry clients beyond conventional change parameters. Hence, whereas a cognitive therapist might help clients to deconstruct maladaptive beliefs, a transpersonal therapist would work with clients to deconstruct maladaptive attachments—beliefs, values—any core investitures that warp or curtail consciousness. Among the means that transpersonalists employ to facilitate such emancipations are meditative breathing, mindfulness and concentration exercises, guided visualization, stress reduction techniques, sustained self-observation, experiential reflection, disidentification exercises, demystifying dialogue, and somatic practices.

To sum, transpersonal therapists tend to be integrative therapists. They employ egoic stances (e.g., medical, psychoanalytic, cognitive) when questions of adjustment or personal identity are at stake, and transpersonal modes (e.g., spiritual-existential, contemplative) when issues of emancipation, enlightenment, or transpersonal identity arise. The question as to "who am I" is relentlessly pursued by transpersonal therapists. Although there are many gradations and variations among transpersonal practices, several principles stand out: Transpersonal therapy addresses the entire spectrum of (purported) consciousness; the therapist's personal role is critical; and the enlarging or awakening of identity is the core of transpersonal practice.

V. EMPIRICAL STUDIES OF HUMANISTIC THERAPY

Humanistic therapy occupies a unique position among organized psychological practices. Whereas conventional therapies target overt and measurable symptom change as indicative of "effective" therapeutic outcome, humanistic approaches recognize many alternative criteria. Among these are shifts, not just in symptomatology, but in values, attitudes, and approaches toward life. To the extent that one becomes a "qualitatively new person," as Alvin Mahrer puts it, or develops new talents, capacities, and appreciations for life, as Rollo May has put it, one fulfills humanistic standards. For humanists, it is one thing to "return to a previous level of functioning," or to adjust to one's spouse, or to become more productive at work, and quite another to supersede one's previous level of functioning, to deepen one's connection with one's spouse, and to become passionate about one's vocation. Whereas the latter tend to be overt and quantifiable, the former tend to be tacit, intimate, and qualitative. Given the confines of conventional research methodology (e.g., randomized controlled trials, objectified rating scales), humanistic therapies have become forgotten "stepchildren" in the competitive outcome battles. The empirical challenge of humanistic therapies is formidable: How does one assess the depth and breadth of intimate humanistic change? Or in short, how does one match the methodology with the mission?

Given these thickets of difficulty, humanistic researchers have turned to two basic investigative modalities to study therapeutic outcome—innovative quantitative methodology, and that which humanistic trailblazer Amedeo Giorgi terms "human science research methodology." Although quantitative methodology has been found to be wanting by many in the humanistic community (e.g., because of its restrictive procedural requirements) for others, it has been considered both adaptable and informative. Since the 1950s, for example, Carl Rogers and his successors have undertaken a series of quantitative investigations of client-centered therapies. Among the prominent findings from these studies, and continuing today, are (1) robust support for therapist relationship factors—e.g., empathy, warmth, and genuineness—over therapist technical offerings (e.g., skilled interpretations), and (2) support for client agency, as opposed to therapist directiveness, as central to successful therapeutic outcome (as discussed in Bohart et al.'s 1997 review). Recent meta-analyses (large-scale analyses of aggre-

gated studies) confirm these findings. These have found, for example, that fully 30 to 35% of the variance in general therapeutic outcome is accounted for by therapist and relationship factors whereas only 15% of the variance is accounted for by techniques or therapeutic approaches (as discussed in Bohart and colleagues' 1997 review). Coupled with the research on affective expression and therapeutic outcome (see, for example, the studies in Greenberg et al.'s 1998 work), these quantitative findings provide broad support for humanistic practices.

In addition to these broad findings, there is specific quantitative evidence for the effectiveness of specific humanistic outcome. For example, there is specific evidence for the effectiveness of client-centered therapy for a variety of disorders; there is also evidence for the effectiveness of Gestalt therapy; and there is considerable evidence for the saliency of the underlying principles of meditative, experiential, and existential modalities. (See the Cain & Seeman volume for an elaboration).

There have also been important quantitative investigations of humanistic psychiatric practices. Drawing from the foundational work of R.D. Laing, Loren Mosher and his colleagues have studied numerous psychiatric "safe-houses." These facilities emphasize relational over medical and egalitarian over hierarchical therapeutic environments. Such programs, concluded Mosher after a 25-year review, are as effective or more effective than conventional hospital care, and on average, less expensive.

With regard to human science or qualitative inquiry into humanistic therapies, particularly therapeutic outcome, there have been far fewer rigorous studies. While the reasons for this situation are beyond the scope of this article, suffice it to say that there is a burgeoning new interest in such inquiry. Increasingly, sophisticated qualitative designs are being developed, such as Robert Elliott's Hermeneutic Single Case Efficacy Design, David Rennie's Grounded Theory Method, Arthur Bohart's Adjudication Model, and Kirk Schneider's Multiple Case Depth Research. These innovative formats hold the promise for important new inroads into outcome assessment. In the meantime, humanistic therapies enjoy wide qualitative support in a variety of case, observational, and testimonial modalities; the current emphasis is on formalizing those modalities.

VI. SUMMARY

Humanistic therapy is a multifaceted perspective that emphasizes existential, constructivist, and transpersonal practice philosophies. Varied as they are, these philosophies explore (1) what it means to be fully, experientially human, and (2) how that understanding illuminates the vital or fulfilled life. By assisting people to grapple with these perspectives, humanistic therapies empower people to become more of who they profoundly aspire to be; and in consequencemore of who they are.

See Also the Following Articles

Alternatives to Pyschotherapy ■ Existential Psychotherapy ■ Feminist Psychotherapy ■ Gestalt Therapy ■ Individual Psychotherapy ■ Integrative Approaches to Psychotherapy ■ Interpersonal Psychotherapy

Further Reading

Bohart, A. C., O'Hara, M., Leitner, L. M., Wertz, F. J., Stern, E. M., Schneider, K. J., Serlin, I. A., & Greening, T. C. (1997). Guidelines for the provision of humanistic psychosocial services. *Humanistic Psychologist, 24,* 64–107.

Cain, D. J., & Seman, J. (2002). *Humanistic psychotherapies: Handbook of research and practice.* Washington, DC: American Psychological Association.

Cortright, B. (1997). *Psychotherapy and spirit: Theory and practice in transpersonal psychotherapy.* New York: SUNY Press.

Greenberg, L. S., Watson, J. C., & Lietaer, G. (1998). *Handbook of experiential psychotherapy.* New York: Guilford.

May, R., Ellenberger, H., & Angel, E. (1958). *Existence: A new dimension in psychology and psychiatry.* New York: Basic Books.

Moss, D. (1999). *Humanistic and transpersonal psychology: A historical and biographical sourcebook*. Westport, CT: Greenwood Press.

Neimeyer, R. A., & Raskin, J. R. (Eds.). (2000). *Constructions of disorder: Meaning making frameworks for psychotherapy.* Washington, DC: American Psychological Association Press.

Schneider, K. J. & May, R. (1995). *The psychology of existence: An integrative, clinical perspective.* New York: McGraw-Hill.

Schneider, K. J., Bugental, J. F. T., & Pierson, J. F. (2001). *The handbook of humanistic psychology: Leading edges in theory, research, and practice*. Thousand Oaks, CA: Sage.

Walsh, R., & Vaughan, F. (Eds.). (1993). *Paths beyond ego: The transpersonal vision.* Los Angeles, CA: Tarcher.

Implosive Therapy

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GLOSSARY

implosive therapy A technique that involves use of an *in vivo* or imagery presentation procedure designed to extinguish via repetition those aversive conditioned cues responsible for eliciting and maintaining symptom execution.

neurotic paradox Why neurotic behavior is at one and the same time self-defeating and self-perpetrating.

imagery exposure Imaginal exposure of the feared or anxiety-evoking stimulus, using flooding in implosive therapy.

Implosive (flooding) therapy is a learning-based exposure technique of psychotherapy designed to treat a wide variety of maladaptive behaviors in a relatively short time period. The underlying theoretical model for this behavioral cognitive treatment approach to therapy is based on an extension of two-factor avoidance learning theory.

I. DESCRIPTON OF TREATMENT

A. Introduction

Imagine the suffering of a woman who becomes so panic stricken by the obsession she has cancer that psychiatric hospitalization is required. No matter how much medical assurance she is given that she is in excellent physical health, the nagging doubt somehow persists that she is not. Or consider a man who is forced to relinquish his professional career because he is afraid to leave his home out of fear that dog feces may be in his yard. His day becomes dominated with disturbing thoughts that find relief only in repetitious washing of his hands, clothes, and body. Perhaps it is hard to comprehend how one could become so frightened of bath water that a life preserver must be worn, or that a sound of a locomotive whistle in the distance evokes such terror in an individual that he runs around in a circle screaming at the top of his voice. The range of human fears may be extended almost indefinitely. Some individuals break out in a cold sweat at the sight of a car, an airplane, or a tall building. Others become so afraid of their own sexual feelings that they avoid the opposite sex, having become convinced they will be sent to hell for such feelings. Still others fear failure, loss of control, taking responsibility, being angry, or giving love and expressing compassion.

Committed to the goal of seeking methods to ameliorate such psychological suffering, the mental health

worker is confronted with the difficult task of selecting from hundreds of different treatment techniques. The rather chaotic state of the field today suggests the need to isolate and maximize the central procedural variables that appear to be reliably correlated with behavior change. One factor common to most treatment techniques stems from the observation that behavior change appears to occur following the elicitation from the patient of a strong emotional response to material presented during the therapeutic interaction. Implosive therapy is a treatment technique that is designed to maximize in a systematic manner the last-noted common denominator of therapeutic interaction, that of emotional responding and its resulting effects. Disillusioned with the insight-oriented emphasis of the time period, Thomas G. Stampfl in the late 1950s developed the technique of implosive therapy which some authors today call flooding therapy or response prevention therapy. Each of these terms is frequently used interchangeably in the literature since the goal of therapists is to maximize emotional responding by getting patients to confront their fears directly. Stampfl was the first investigator to extend systematically his learning-based exposure treatment approach to the treatment of a wide variety of clinical nosologies. Borrowing a term from physics he labeled his newly developed cognitive-behavioral approach implosion, to reflect the inwardly bursting (dynamic) energy process inherent in the release of affectively loaded environmental and memorial stimuli encoded in the brain.

Stampfl was initially influenced by the extensive clinical experience he gained from conducting "nondirective" play therapy with emotionally disturbed children. He concluded from this experience that exposure to the emotional stimulus features of the play material could account for virtually all the positive effects of therapy. Consistent with his clinical observations was the insistence by Abraham Maslow and Bela Mittleman in their 1951 abnormal text that the neurotic's symptoms, defense mechanisms, and general maladaptive behavior resulted from a state of anticipation or expectation of an impending catastrophic event, which, in turn, provided the motivating force for symptom development. These authors concluded that, although the catastrophic even usually remained unspecifiable by the patient, it generally involved fears associated with anticipation of abandonment, injury, annihilation, condemnation and disapproval, humiliation, enslavement, loss of love, and utter deprivation. Stampfl reasoned that if therapy was to succeed, these anticipatory fears, as was the case for the children he treated, needed to be confronted directly in order for the unlearning of the emotional response attached to these fears.

B. *In Vivo* Exposure Approach

Stampfl at first adopted an *in vivo* exposure approach in which he instructed patients to confront directly in real life their feared stimulus situation. For example, one of his patients, a college student, reported a compulsive behavior he had engaged in for years. Upon retiring at night, this patient reported an urge to check to see if he had left the radio on. Every night (without exception) he checked the radio up to 50 times. He reported that any time he failed to engage in radio checking he developed much apprehension and anxiety and the feeling that something "terrible" or "catastrophic" might happen. He would fear, for example, that perhaps a short circuit would occur and a fire would result. Stampfl then instructed the patient to confront his fears directly by forcing himself not to check the radio and imagine that his worst fears would happen. He was asked to let himself tolerate as much anxiety as possible. The patient was able to follow the therapist's instruction; he reported seeing the radio burst into flames and hearing his father's voice telling him to "turn off the radio." Following additional repetitions of the therapist's instructions, the patient recalled a number of traumatic memories involving his father. Once the affect associated with these memories was eliminated, his compulsive symptoms disappeared.

C. Imagery Exposure Approach

Thomas Stampfl recognized that although this patient followed his *in vivo* instructions to confront directly the anxiety he experienced, most patients avoid engaging in an *in vivo* task because of the strength of the fear response associated with the task. He also recognized that many of the fears motivating the patient's symptoms did not lend themselves readily to an *in vivo* approach. He then developed his implosive imagery procedure, which was capable of being presented within the context of a therapy session. In an attempt to illustrate the above point, consider the case of an airplane phobic. Although most phobic behavior is clearly amenable to an *in vivo* exposure approach, the use of this procedure with an airplane phobic would entail the therapist's accompanying the patient on repeated airplane trips. Stampfl recognized that his imagery exposure procedure had the advantage of presenting the feared cues in the therapist's office. Furthermore, and

most importantly, the imagery technique has the additional advantage of introducing the more salient and emotionally intense fear cues associated with the phobic reaction that do not lend themselves to direct *in vivo* presentation. Examples of such fear cues include the fear of the plane crashing, the fear of dying, and the fear of being punished for guilt-producing behavior in the after-life. Imagery scenes involving the incorporation of these non *in vivo* presented fears have been clinically shown to produce a powerful emotional reactivity and subsequently a lasting therapeutic effect.

In summary, the fundamental task of the implosive therapist is to repeatedly re-present, reinstate, or symbolically reproduce those stimulus situations to which the anxiety response has been learned or conditioned. By exposing the patient to the stimulus complex of fear cues that are being avoided, the patient will be confronted with the full emotional impact of these cues. As a function of repetition, this emotional exposure weakens and eventually eliminates the connection between the eliciting stimulus and the resulting emotional response. For example, imagine a patient who is terrified of viewing horror films and takes a job as a movie projectionist which requires him to show such a movie. Although terrified during the first showing, by the tenth time he is exposed to watching the film little emotional reactivity is left.

It may at first seem that the goal of specifying the aversive learned events in the patient's life history represents a difficult, if not impossible, task. Stampfl noted that it is feasible for a trained clinician to locate "key" stimuli associated with the patient's problem area following in-depth diagnostic clinical interviews. This information allows a trained clinician to formulate hypotheses as to the type of traumatic events that may have contributed to the client's problems. Of course, these initial hypotheses must be conceived as only first approximations in the quest to determine the aversive cues controlling the patient's maladaptive behavior. As therapy progresses, it is usually possible to obtain additional information as to the validity of these cues and to generate new hypotheses. The elicitation of these hypothesized cues in imagery frequently results in the reactivation of the patient's memory regarding the initial historical events associated with development of the patient's conflict and fears. However, it is not essential to present imagery scenes that are completely accurate since some effects of emotional unlearning or extinction effects will occur through the established learning principle of generalization of extinction. Naturally, the more accurate the hypothesized cues are and the more realistically they are presented by the therapist, the greater will be the emotional arousal obtained and subsequently the greater the emotional unlearning to the cues presented. This process is continued until the patient's symptoms are reducd or eliminated.

D. Procedural Instructions

Following the completion of two to three interview sessions, a treatment plan is developed. Patients are provided the rationale and theory behind the technique. A commonly used approach is to ask patients the following question: if they were learning to ride a horse and fell off the horse, what would the instructor have them do? (The usual answer is to get back on the horse.) The therapist might then comment that failure to get back on the horse might result in an increase in fear and possibly the generalization of that fear to events surrounding riding horses. The point is to illustrate that fears can be overcome by directly confronting them. Patients are told that the procedure being used involves an imagery techneque and they will be asked to imagine various scenes directed by the therapist. Patients are instructed to close their eyes and play the part of themselves. They are asked, much as an actor or actress would be, to portray certain feelings and emotions that represent important parts of the process. They are told that belief or acceptance, in a cognitive sense, of the themes introduced by the therapist is not requested, and little or no attempt is made to secure any admission from patients that the cues or hypotheses actually apply to them. Following the administration of neutral imagery practice sessions, the therapist is ready to start. Once the implosive procedure is started, every effort is made to encourage patients to "lose themselves" in the part that they are playing and "live" or reenact the scenes with genuine emotion and affect. Compliance with the technique is readily obtained and rarely do patients terminate therapy prematurely.

Thomas Stampfl's procedure encompasses an operational feedback approach that is self-correcting. If the hypothesized cues introduced into a given scene presentation elicit emotional affect, support for their continued use is obtained. The greater the emotional arousal elicited by these cues, the greater the support for their use. Cues that do not elicit emotional arousal are abandoned and replaced by new hypothesized cues. This process is continued until the desired emotional affect is obtained and unlearned. Therapy continues until symptom reduction occurs. Significant levels of

symptom reduction usually occur within 1 to 15 hours of treatment.

E. Stimulus Cue Categories

As a guide in using the therapy, Thomas Stampfl has outlined the use of four cue categories that can be conceptualized in terms of progression along a continuum that ranges from extremely concrete to hypothetical. These four cue categories, in order of their presentation, are as follows: (1) Symptom-contingent cues, those cues correlated with the onset of the patient's symptoms; (2) reportable internally elicited cues, those verbally reported thoughts, feelings, and physical sensations elicited by presentation of the symptom correlated cues; (3) unreported cues hypothesized by the therapist to be related to the second cue category; and (4) hypothesized dynamic cues, those fear cues suspected to be associated with an unresolved conflict situation being avoided by the patient.

As an illustration of the application of these cue categories, consider the case of a woman who had to wear a life preserver while taking a bath. The symptom-contingent cues would encompass the presentation in imagery of all those cues surrounding her taking a bath without wearing a life preserver. Upon presentation of these cues, she reported the feeling that the bathtub consisted of a "bottomless pit of water," the second category. This in turn led to the therapist's hypothesis that she was afraid of drowning (third category). Because the patient manifested considerable feelings of guilt, the therapist hypothesized that the patient's fear of drowning related to her fear of being punished in hell (the fourth cue category). The systematic presentation and repetition of all these fear cues led to the elimination of the patient's phobic response and to the recovery of a memory in which she almost drowned in a bath tub when she was a child. Since repetition of the feared stimuli is considered an essential requirement in producing symptom reduction and elimination, patients are expected to conduct homework that involves 20 minutes daily of repeatedly imagining the scenes assigned to them by the therapist.

II. THEORETICAL BASES

Implosive theory is unique in its ability to integrate areas of psychology, in its resolution of the neurotic paradox, and in its ability to define complex behavior according to basic principles of experimental psychology. To explain theoretically the development, maintenance, and unlearning (extinction) of psychopathology, Stampfl adopted and extended O. Hobart Mowrer's 1947 version of two-factor avoidance learning. Mowrer was influenced by Sigmund Freud's conclusion in 1936 that human symptoms reflecting psychopathology resulted from patients' attempts to escape and avoid the anxiety elicited by stimuli ("danger signals") associated with past exposure to traumatic experiences. Mowrer then concluded that the development and maintenance of human and animal avoidance (symptom) behavior involved the learning of two response classes.

A. Emotional Learning

The first response learned is how one becomes afraid of a previously nonaversive stimulus situation. To explain how fear is learned, Mowrer relied on the well-established laws of classical conditioning. Fear and other emotional conditioning result from the simple contiguity of pairing this nonemotional stimulation, in space and time, with an inherent primary (unlearned) aversive event resulting in the production of pain, fear, frustration, or severe deprivation. This biologically reactive, pain-producing stimulus is referred to as the unconditioned stimulus (UCS). Following sufficient repetition of the neutral stimulus with the UCS, the neutral stimulus becomes capable of eliciting the emotional response with which it was paired. Once the process is learned, the neutral stimulus is referred to as a conditioned stimulus (CS) and its elicitation of the emotional response (e.g., fear) as the conditioned response (CR). Stampfl believes the conditioning events of humans to be multiple, involving a complex set of stimuli comprising both external and internal CS patterns. Such conditioning events are believed to be encoded in long-term memory and capable of being reactivated at a later point in time.

B. Avoidance (Symptom) Learning

Mowrer viewed the resulting conditioned emotional response as a secondary or learned source of drive, possessing motivational or energizing properties, as well as reinforcing properties. These motivational properties of the conditioned emotional response set the stage for the learning of the second class of responses, referred to as avoidance or escape behavior. Avoidance or symptom

behavior is believed to be governed by the established laws of instrumental learning. Avoidance behavior is learned because the response results in the termination or reduction of the emotional state elicited by the CS. It is this reduction in aversiveness that serves as the reinforcing mechanism for the learning of the avoidance behavior.

C. Emotional-Avoidance Unlearning

Finally, Mowrer's two-factor theory argues that both emotional responding and subsequent avoidance behavior can be readily unlearned via the well-established principle of Pavlovian extinction. This principle states that the repeated presentation of the classically conditioned CS will weaken and cease to elicit emotional responding via the principle of nonreinforced CS exposure. The extinction of the CS results in the extinction of its drive properties. Without any motivating state to elicit and reinforce the avoidance behavior, it also will undergo an extinction effect. This is the therapeutic premise on which implosive therapy is based.

D. The Neurotic Paradox and Symptom Maintenance

Implosive theory has been instrumental in resolving Freud's expressed concern and puzzlement as to why patient's symptomatology may persist over the course of a lifetime. Mowrer labeled this concern the "neurotic paradox." In Mowrer's words it is a question as to why neurotic behavior is at one and the same time self-defeating and self-perpetuating. In other words, why does the neurotic's neurosis persist to the point of seriously incapacitating the individual when the behavior has long outlived any real justification?

To resolve theoretically the issue of sustained symptom maintenance, Thomas Stampfl developed his serial CS hypothesis. He observed that, although some clinical symptoms do appear to last for lengthy periods, the CSs initially eliciting the symptom frequently undergo a change over time, with the cues originally triggering the symptom failing to serve as an eliciting stimulus to repeated CS exposure. However, as they weaken, these cues are replaced from memory by a new set of previously unexposed fear cues that upon exposure recondition secondarily the first set of cues. When the new set of released cues also undergo an extinction effect from nonreinforced CS exposure, the stage is set for yet another set of new cues to be released. This process continues until all the encoded fear complex of cues undergo an extinction effect. In other words, implosive theory maintains that there is a network of cues representing past conditioning events involving pain which are stored in memory and which, upon reactivation, are capable of motivating a symptom over time. Thomas Stampfl believes these conditioned cues are stored in memory in a serial arrangement along a dimension of stimulus intensity, with the more aversive cues being least accessible to memory reactivation. Repeated symptom execution prevents further CS exposure to these cues and to the elicitation of those cues stored in memory. As a result, the anxiety and fear level attached to these unexposed CSs are conserved or maintained until they are exposed by being released from memory. The presence of these unexposed cues stored in memory, along with the intense emotional reactions conditioned to them, can be observed by preventing symptom occurrence.

III. EMPIRICAL STUDIES

Over the last 50 years, O. Hobart Mowrer's two-factor avoidance theory and related fear theories have generated an abundance of experimental support at both the human and animal level of analysis. It still remains the dominant avoidance theory within the field. Stampfl's extension of the theory to the area of psychopathology has also received strong empirical support at the human, animal, and clinical levels of analysis. This includes his serial CS hypothesis and his extension of the conservation of anxiety hypothesis to explain symptom maintenance and the neurotic paradox. Stampfl's techniques of *in vivo* and imagery implosive therapy and related CS-exposure techniques of treatment have been experimentally supported by a host of controlled clinical outcome studies, including studies involving the treatment of phobias, anxiety reactions, obsessive compulsive behavior, trauma victims, depression, and psychotic behavior. The procedure has also been shown to be nonharmful. Today, CS exposure techniques of treatment are regularly recommended as the treatment of choice for a number of clinical nosologies.

IV. SUMMARY

Implosive (flooding therapy) therapy is a cognitive behavioral treatment approach to psychopathology. It was first developed by Thomas G. Stampfl and extended

to encompass the treatment of a wide variety of clinical nosologies. Treatment effects are regularly reported to occur within 1 to 15 treatment sessions. The technique involves the use of an *in vivo* or imagery presentation procedure designed to extinguish, via repetition, those aversive conditioned cues responsible for eliciting and maintaining symptom execution. The therapist's task is to help the patient confront these cues directly within and outside the therapist's office. The underlying theoretical framework behind this technique is based on two-factor avoidance theory which Stampfl has extended to account for symptom maintenance and symptom extinction. Both the theory and treatment technique has been supported by considerable experimental research over the last 40 years at the human, patient, and animal level of analysis.

See Also the Following Articles

Avoidance Training ■ Classical Conditioning ■ Coverant Control ■ Emotive Imagery ■ Exposure *in Vivo* Therapy

Further Reading

Boudewyns, P. A., & Shipley, R. H. *Flooding and implosive therapy: Direct therapeutic exposure in clinical practice*. New York: Plenum Press.

Levis, D. J. (1985). Implosive theory: A comprehensive extension of conditioning theory of fear/anxiety to psychopathology. In S. Reiss, & R. R. Bootzin (Eds.), *Theoretical issues in behavior therapy* (pp. 49–82). New York: Academic Press.

Levis, D. J. (1989). The case for a return to a two-factor theory of avoidance: The failure of non-fear interpretations. In S. B. Klein, & R. R. Mowrer (Eds.), *Contemporary learning theories pavlovian conditioning and the status of traditional learning theory* (pp. 227–277). Hillsdale, NJ: Erlbaum Associates.

Levis, D. J. (1995). Decoding traumatic memory: implosive theory of psychopathology. In W. O. Donohue, & L. Krasner, (Eds.), *Theories of behavior therapy* (pp. 173–207). American Psychological Press, Washington, DC.

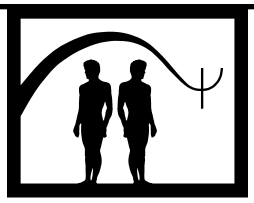
Levis, D. J., & Boyd, T. L. (1985). The CS exposure approach of implosive therapy: In R. Turner, & S. L. M. Ascher (Eds.), *Evaluation of behavior therapy outcome* (pp. 59–94). New York: Springer.

Levis, D. J., & Brewer, K. E. (2000). The neurotic paradox. In R. R. Mowrer, & C. B. Klein (Eds.), *Handbook of ccontemporary learning theories* (pp. 561–597). Hillsdale, NJ: Erlbaum Associates.

Stampfl, T. G. (1970). Implosive therapy: An emphasis on covert stimulation. In D. J. Levis (Ed.), *Learning approaches to therapeutic behavior change* (pp. 182–204). Chicago: Aldine.

Stampfl, T. G. (1991). Analysis of aversive events in human psychopathology, fear and avoidance. In M. R. Denny (Ed.), *Fear, avoidance and phobias: A fundamental analysis* (pp. 363–393). Hillsdale, NJ: Erlbaum Associates.

Stampfl, T. G., & Levis, D. J. (1973). Implosive therapy. In R. M. Jurjevich (Ed.), *The international handbook of direct psychotherapy Vol. 1: Twenty-eight american originals* (pp. 83–105). Coral Gables, FL: University of Miami Press.



Individual Psychotherapy

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GLOSSARY

behavior therapy A theory of psychotherapy in which problems are assumed to have been learned because the consequences of problematic behavior and feelings are rewarding. These treatments attempt to directly alter behavior and feelings by changing the pattern of consequences. The development of these models of treatment is most closely associated with Joseph Wolpe and B. Fred Skinner.

cognitive therapy/cognitive-behavior therapy Models of psychotherapy that attribute problematic feelings and behaviors to one's inappropriate or dysfunctional ways of thinking. The most recognized of these approaches was developed by Aaron T. Beck.

effectiveness studies Research designs that employ representative clinical populations of patients, as well as samples of therapists and psychotherapy. This type of research typically sacrifices some degree of experimental control for procedures that are closer approximations of actual clinical settings, procedures, and populations.

efficacy studies Research designs that employ randomized assignment, closely controlled and monitored treatments, and carefully selected and homogeneous samples of patients. This type of research typically sacrifices some degree of generalizability for experimental control.

experiential therapy Approaches to psychotherapy that emphasize the positive role of feelings and current experience. These approaches assume that efforts to stifle or avoid certain feeling states are at the basis of most human problems. They emphasize the role of the present, of feeling recognition, and of the innate human drive to grow (self-actualization) as processes that produce beneficial change.

exposure therapy Approaches to treatment that emphasize the importance of systematic exposure to situations and objects that evoke avoidance. This is a form of behavior therapy but has been incorporated into many models and approaches to cognitive and cognitive-behavior therapy as well.

integrative/eclectic psychotherapy Methods of intervention that draw from multiple theories. These approaches emphasize that the effectiveness of the procedure rather than its theoretical framework should be the guide to its application. These approaches range from those that blend different theoretical constructs to those that develop a case mix of specific techniques. Newer models are based on the development of cross-cutting principles of change rather than amalgamations of either specific techniques or general theories.

psychoanalysis The method of uncovering unconscious impulses and wishes that was developed by Sigmund Freud.

psychodynamic therapy: Approaches to psychotherapy that generally assume that behavior is caused by inner conflict and by disturbed psychic processes. These models of individual psychotherapy are generally short-term or less intensive variations of psychoanalytic therapies. Some of these variations include those built on object relations theory, ego psychology, and self-psychology.

Individual psychotherapy is the most typical form of psychotherapeutic treatment. It consists of one patient and one therapist. The psychotherapist, assuming the role of healer, authority, facilitator, or guide, employs a variety of theories and procedures to assist the patient or client to modify behaviors and feelings, gain understanding of self and others, change perceptions and beliefs, and reduce fears and anxieties. This entry will describe some of the more dominant methods of psychotherapy and the current status of research on its effects.

I. DEVELOPMENT OF INDIVIDUAL PSYCHOTHERAPY

The field of modern psychotherapy is over 100 years old. Freud is typically credited as the individual most responsible for introducing contemporary psychotherapy, in the form of psychoanalysis, to the Western world at the end of the nineteenth century. Almost from its inception, the developmental history of modern psychotherapy has been one of conflict, controversy, and change. Freud's early views were under attack nearly from the beginning, both from his students and from the established medical system. Conflict continues with the trend of growth and the emergent influence of various groups who present views that contrast with established schools of thought. In this environment, we have seen the emergence of literally hundreds of different theories and approaches to psychotherapy. Presently, psychotherapies differ in their theoretical constructs, their mode of delivery, their techniques, and the processes to which they attribute the patient's problems.

Those who are endowed by society with conducting and overseeing the field are also diverse, ranging from those with medical and psychological degrees to those with degrees in sociology, human development, social work, anthropology, group process, biology, and the like. Opinions about the nature of desirable credentials, advantageous types of experience and training, and the nature of psychotherapy itself are far from uniform. Yet, the prototype of "Individual Psychotherapy," a process that occurs between an individual person who has a problem and an individual practitioner who offers assistance, as originally set by Freud, continues to be the dominant model. Although there has been a good deal of research and writing on group therapy and to a lesser extent on marital and couples therapy, it is individual psychotherapy that has stimulated the most research and to which most conclusions are addressed.

Psychotherapy has increasingly come to be defined as a health-related activity and has thereby come under the purview of third-party payers and political bodies. Cost containment concerns have placed increasing pressures on practitioners to justify their procedures and to demonstrate that they are effective. This, in turn, has led to increasing emphasis being placed on those who conduct psychotherapy research to demonstrate the value of these procedures in ways that have scientific credibility.

II. Theoretical Models of Individual Psychotherapy

It has been estimated that there are over 400 different theories of individual psychotherapy. However, most of these fall within five general classes.

Cognitive psychotherapy models of intervention focus on identifying specific problems and changing the processes and mechanisms by which patients evaluate themselves, others, and their environments. A central assumption of this model is that beliefs rather than facts determine how one will evaluate one's own behavior, remember the past, and anticipate the future. If one's beliefs are distorted and inaccurate, then one's evaluations and memories will be distorted as well. Moreover, one may develop behavioral or emotional disturbances in which the behavior and feelings, too, are inappropriate to one's present situations. Distortions and misperceptions of events are assumed to be at the root of or associated with many problems that impair daily functioning. Cognitive psychotherapy applies methods that encourage re-inspection of these assumptions and the application of rational analysis to correct distortions and cognitive errors. This type of treatment focuses on directly altering one's symptoms through a process that involves the rational and realistic appraisal of situations and the application of thoughtful and systematic problem solving strategies.

Behavior therapy models of individual treatment focus on immediate events and consequences. Symptoms are thought simply to reflect patterns of learning that are cued by the presence of evoking environmental stimuli. That is, behavioral models eschew the use of mental or biological events as explanations for behavior. They look for both causes and consequences within the person's immediate environment or in the concomitant occurrences of sequential cues that progress to more remote consequences. The focus of such treatments is on the development of new skills and on repeated exposure to aversive stimuli leading to extinction of behaviors

that are excessive and repetitive. In this model, the therapist is a guide and instructor rather than a philosopher and healer. Indeed, postulations of illnesses are thought to obfuscate the factors that support and reinforce dysfunctional and disturbed behaviors.

Interpersonal psychotherapy models emphasize that all behavior, whether problematic or adaptive, occurs within a social context. That is, they focus on social and intimate crises such as loss and expected loss, transitions to new social environments, skills to navigate social expectancies and demands, and mediating the competing expectancies and desires that emerge when one enters into relationships with other people. This form of treatment assumes that there are a finite number and type of interpersonal problems that relate to such conditions as anxiety and depression. Interpersonal treatment involves identifying the problematic interpersonal patterns, creating understanding of the interpersonal nature of one's problems, learning to anticipate when problems will emerge, gaining a meaningful understanding of one's own behavior, and developing skills of communication and assertion that can be applied in competitive environments. The therapist assumes an authoritative role in directing the patient through a process of identifying and exploring the nature and causes of one's problems and directs the patient in a process of selecting and using effective procedures for ameliorating these problems and developing improved interactions with others.

Psychodynamic/psychoanalytic psychotherapy models are widely varied but are bound by a common emphasis on the indirect relationship between behavior and environment. That is, disturbed behavior and feelings are thought to reflect internal conflicts rather than current events. The conflicts are symbolized by symptoms and are thought to derive largely from primitive experiences that predispose patients to continue to reenact certain dysfunctional patterns of behavior in a vain effort to obtain a resolution in the present for a conflict whose nature is out of awareness and whose genesis is in the past. Thus, in contrast to other models, neither immediate situations nor dysfunctional thoughts cause disturbance. Indeed, these situations and thoughts are thought to more likely be the consequences of the individual's effort to resolve conflict rather than the causal agents of psychopathology. That is, current behaviors and situations may reflect the disturbance that is caused by the turmoil of inner struggles between contrasting impulses and wishes. Usually, the nucleus of these inner conflicts is kept unconscious by innate efforts to protect one's self from painful awareness. Thus, the patient does not acknowledge, understand, or know the motivation behind behavior. Improvement is thought to relate to the development of insight and awareness, uncovering these unconscious processes, and becoming aware of how past experiences and filial needs, rather than current demands and exigencies, are determining one's current behavior.

Experiential psychotherapy models focus on problems that are associated with the failure to integrate emotional experience with either thoughts or behaviors. They adopt the viewpoint that from traumatic experience and interpersonal crises early in life, individuals learn ways to protect themselves from experiencing strong emotions. These defensive patterns typically involve separating one's self from one's emotional state and learning to be oblivious to personal emotional cues. Overreliance on rationality, on action and "doing," rather than on feeling and awareness is thought to arise when social forces encourage one to lose sight of inner experiences or to distort and suppress emotional drives and experiences. Experiential treatment is based in the here and now of immediate experience. It endeavors to identify current feelings and to bring these into high relief, often magnifying and enhancing these experiences in order to encourage emotional processing. In this process, the therapist attempts to foster the integration of emotional, behavioral, and cognitive life.

Experiential treatments strive to keep patients in the emotional present rather than retreating to thoughts of the past or future. They encourage patients to learn to tolerate strong feelings without withdrawal, attempting to help them remove their internalized, socially imposed sanctions against such feelings.

III. THE EFFECTS OF INDIVIDUAL PSYCHOTHERAPY

A. Models and Theories

Scientific research over the past 40 years confirms that individual psychotherapy is an effective method for initiating personal change and reducing feelings of unhappiness, stress, and conflict. Its effects are substantial and compare well to alternative treatments for emotional problems, such as psychoactive medication. In recent years, considerable attention has turned to efforts to identify which of the many available models and theories of treatment yield positive effects among different patient groups. Research on these various

models or types of psychotherapy indicates that substantial improvements are associated with their use—relief can be reliably achieved in various kinds of symptoms and problems.

Among the most widely accepted methods and models, those based on cognitive-behavioral, behavioral (e.g., exposure therapy), and interpersonal therapy principles have been most consistently identified as being effective. Models that have received some, but less, support from research, include those that are constructed around psychodynamic principles and emotional awareness or emotion-enhancing therapy (e.g., experiential therapy). Cognitive therapies have been identified as especially effective for treating depression, anxiety, general distress, chemical abuse, and specific anxiety disorders (e.g., obsessive-compulsive disorder, agoraphobia, panic disorder). Behavior therapies are identified as effective for treating depression, psychophysiological disorders (e.g., headache, rheumatic disease), and habit control problems (e.g., smoking, drug/alcohol abuse, enuresis, etc.). Experiential therapies are identified as effective for depression and relationship problems. Interpersonal therapy is identified as being effective for treating depression and eating disorders. Psychodynamic therapies are considered useful for depression, chemical abuse, and social distress.

B. Specific versus Common Contributors to Change

In his classic treatise on *Persuasion and Healing,* Jerome Frank defined psychotherapy as a form of interpersonal influence that involves (1) a healing agent in the person of the therapist, (2) a patient who seeks relief of his or her suffering from the healer or healing agent, and (3) a healing relationship comprised of a circumscribed, more or less structured series of contacts between the healer and the sufferer in which the healer attempts to bring about relief.

By restricting his definition of psychotherapy to these three elements and excluding specific mention of any of the myriad procedures and therapeutic models used by therapists to effect recovery or improvement, Frank underscored what has become a major point of controversy in the field. Namely, does the use of particular psychotherapeutic models and procedures add benefit to that which is obtained from a supportive and caring psychotherapeutic relationship alone? The essential controversy embodied in this question can be distilled to a conflict between those who attribute healing to the use of specific techniques and procedures (i.e., specific "antipathogenic" psychotherapeutic interventions) and those who attribute psychotherapeutic healing to the effects of a supportive, caring, and evocative therapeutic relationship in its own right—a medical versus a humanistic view of change.

Adherence to a medical analogy has resulted in the admonition that practice be restricted to the use of interventions that have been supported by scientific research. Scientists who look for the differences among psychotherapeutic treatments have advanced and published lists of effective treatment brands and have identified various diagnostic conditions for which each brand of treatment is considered to be effective. However, this line of investigation may oversimplify the difficulty of garnering evidence of efficacy on the 400+ different models of psychotherapy that are currently practiced in contemporary Western society. Restricting practice even to the 150 or so treatments that have been scientifically supported would mean that much of the service that is currently provided in hospitals and clinics throughout the world would have to be discontinued. Furthermore, even if society were to embrace this view and undertake a systematic study of these various treatments, the results may tell us very little about some of the more important and powerful contributors to treatment gain. Research strictly based on fitting brands of treatment to diagnoses of patients will tell us very little about the various modes and formats through which psychotherapy is applied and virtually nothing about the contributions of important nondiagnostic patient qualities and individual therapist variations.

To those who emphasize the similarities among treatments, rather than the differences, such lists of brand-name models inappropriately imply that there are more differences among the various models than have been consistently demonstrated. The qualities that contribute to the development of a healing relationship and those that dictate the specific use of different treatments may have little to do with the patient's diagnosis or the brand name of the treatment provided. By extension, many authors suggest that focusing on differences among brands and models of psychotherapy discourages research on ways both to enhance the presence of therapeutic relationships and to blend interventions across therapeutic models.

Many of these same authors suggest that the effort to identify certain brands of treatment that fit with patients who are identified only by diagnosis would both require that therapists learn many different and frequently contradictory treatment models and that clinicians could only treat a limited and perhaps insignificant number of patients—those who comply with certain inclusion and exclusion criteria.

The use of a medical analogy and the corollary assertion that practice should be restricted to empirically supported treatments applied within the confines of patient samples on which they have been systematically tested is one way to increase the credibility of mental health treatment in a political world. It reflects an effort to place psychotherapy on a parallel with medical treatments for diseases—effective treatment depends on accurate diagnosis, and once diagnosis is established, one should select and apply a treatment that has been scientifically demonstrated to be safe, practical, and effective in the treatment of that condition. From this perspective, the field would do well to consolidate around a uniform effort to find or develop specific procedures that work with particular kinds of problems and conditions.

Working from this viewpoint, clinicians and researchers alike are continuing to develop new theoretical models and technical methods of intervention, with the implicit assertion that these specific techniques and procedures are responsible for the effects of treatment, either positive or negative. This point of view has generated hundreds of theoretical constructs and causal inferences that describe the nature of effective psychotherapy. Each of the resulting theories and procedures vies for the status of being "most effective."

Controversies between those who attribute change to the elements that are common to all treatments and those who attribute change to specific and unique treatments that derive from certain brands of treatment are not unique to psychotherapy. The past decade has seen the emergence of similar conflicts in the general area of health and medicine as well. Placebo effects, expectancy, hope, and other constructs are implicated in the treatment of a wide array of medical and health conditions and compete for effectiveness with active drugs, surgery, and other interventions that are based on contemporary notions of illness. Clearly, whatever else is working, both physical health and emotional/behavioral well-being rely more than most would acknowledge on the forces of interpersonal persuasion, expectation, faith, and relationship, and less than some would wish on the specifics of pathology-based treatments.

In contrast to the specific treatments approach, the common factors viewpoint focuses on the interpersonal qualities that are correlated with change rather than with the technical ones. Scientists from this camp point out that virtually no direct comparison of one legitimate treatment against another yields any meaningful differences between them. Most who review this latter body of literature conclude that "all have won and all must have prizes." From the bulk of existing data, it is not scientifically sound to conclude that there are any treatments that are uniquely effective. To many of these scholars, it is the ubiquitous qualities of support and caring within the patient–therapist relationship that are seen as signals in evoking change in all of these treatments. Proponents of the common factors model consider these relationship qualities to be relatively independent of the specific procedures and techniques used—they are based largely on the nature of the relationship or the bond that develops between patient and therapist. That is, common factors proponents conceptualize a healing relationship as one that instills hope, facilitates communication, conveys safety, and is imbued with the patient's respect for, and trust of, the therapist.

These two viewpoints color how one perceives the extant research literature. For example, investigators who seek to identify specific treatments that work best with patients who carry different diagnostic labels are gratified by evidence that some treatments may produce substantially better effects among patients with different disorders than various comparison treatments or control groups. However, these same investigators tend to ignore the abundance of evidence indicating that all treatment studies produce essentially equivalent results. At the same time, researchers who believe that all treatments owe their effects to common interpersonal processes find their viewpoint reinforced by evidence that relationships and alliances are consistently related to outcomes but ignore the absence of direct evidence of a causal (rather than simply a correlational) relationship between alliance and outcomes. These investigators see the similarity of outcomes among different psychotherapy models as evidence for the causal nature of common factors, but no studies have been published that clearly demonstrate such a causal chain. For example, alliance may simply be a consequence of change rather than a cause of change.

It is certainly persuasive to look at the consistent correlation that exists between treatment qualities and outcomes, and to conclude that the many diverse therapeutic procedures that are effective all exercise their effects through the medium of improving the patient's sense of safety, comfort, and support. Thus, it is popular to conclude that therapists who provide safety, while being collaborative and supportive, are likely to produce good effects regardless of the specific procedures or theories used. Such a conclusion lacks the necessary scientific support to conclude that the observed correlation is the result of a causal chain of events. It is equally plausible that change itself may cement and

foster warm and caring relationships, for example. It is also scientifically unjustified at present to conclude that some treatments are better than others.

Out of this awareness has emerged a third group of individuals within the individual psychotherapy movement who have attempted to integrate the opposing views of therapeutic specificity and therapeutic commonality. Members of this third group hold that the principal reason treatments don't show significant differences is that they have been tested on groups that are too homogeneous. They observe that within any treatment, there are some patients who get better, some who get worse, and some who fail to change. This pervasive pattern constitutes strong evidence that undisclosed patient factors are interacting with treatments. These scientists also hold that most research fails by attending only to therapy or relationship factors, and they assert that patient qualities themselves as well as the fit between patient qualities, and the procedures used also contribute to outcome. Indeed, they assert that patient qualities, therapy procedures, treatment relationship, and the fit or match between patient and treatment qualities are likely to make independent contributions to treatment benefit and that if relevant patient and matching qualities could be identified, the accuracy of predictions and the power of treatments could be substantially improved.

Contemporary research provides some evidence that while no specific procedure holds a mean or average advantage over others, there are some patient characteristics that mediate or moderate the effects of treatment, moreover, while the therapeutic relationship is very important, it may be more or less important depending on a variety of patient proclivities and the psychotherapeutic techniques utilized. Integrative and eclectic psychotherapy models accept the assumption that at least some interventions from widely different models are equally appropriate for some symptoms, some people, or some occasions. These models also assume that all treatment models are inappropriate for some people and that different people may benefit from different treatments. Some of these models simply blend two or more theories to make one new theory that is compatible with the techniques from more than one theoretical position. Other models attempt to directly identify patient markers that will indicate when to use different procedures and techniques of treatment, each representing different broad-band models.

Relatively new approaches within integrative and eclectic field have directed attention away from deriving finite lists of either theories or techniques, asserting that integration is best achieved by identifying cross-cutting principles that govern behavioral change in any of several different individual therapy formats. These latter approaches attempt to develop prescriptive treatment programs based on trait and statelike characteristics that the patient brings into the treatment relationship. Research is accumulating to support this point of view and to suggest that cross-cutting principles and discriminative use of different treatment procedures tend to enhance treatment outcomes. At present, these three points of view are yet to be reconciled. Moreover, the diversity of viewpoint and of research interpretation embodied in these views underlie the presence of other cardinal issues in the field of individual psychotherapy.

C. Lesser Issues in Individual Psychotherapy

As individual psychotherapy begins its second century as an accepted treatment for emotional, behavioral, and mental disorders, it is faced with a variety of complex and difficult problems. These problems are largely occasioned by threats to the credibility of this form of treatment.

I. The Proliferation of Psychotherapy Models

In the past three decades, the sheer number of available and practiced psychotherapies has grown exponentially, now reaching several hundred. All or at least most of these theories purport to offer both an explanatory model of psychopathology and a model of treatment change. In almost all theories, the model of psychopathology, incorporates an explanation of normal behavior by invoking developmental and situational factors, as well as an explanation of deviance by invoking pathogens and insidious precipitators of disorder and disease. The explanations extend to all disorders and identified conditions, and, if they exclude a causal explanation of any type of psychopathology at all, it is an explanation of those disorders that are judged to be outside the influence of interpersonal persuasion methods. Thus, all theories undertake to explain virtually all behaviors and to develop concepts that can fit all persons. Although psychotherapists may be comfortable with this breadth, it does not instill great faith in the idea that psychotherapists really know what produces change and what is healing in the patient–therapist exchange. Those within the managed health care environment who are in charge of assigning treatments to patients are likely to find the process of distilling the truly effective treatment from among 400 or so theoretical descriptions rather daunting they may

conclude that a theory that explains everything really explains nothing.

Even among clinicians, the proliferation of theories and models may be taken as an indication that none of the models really works well. Clinicians are likely to develop new models when old ones don't work. Certainly, the fact that the highest percentage of clinicians identify themselves as being "eclectic" supports the view that no one theory is satisfactory. It is no wonder that psychotherapy has lost credibility both among patients and among managed health care providers, both of whom seem to believe that the various models and methods are interchangeable—there is no real or meaningful difference among them. Thus, a patient is recommended for or seeks psychotherapy for a condition or symptoms like depression; patients rarely seek a specific type of psychotherapy. In the rare instances in which a patient does seek a particular kind of therapy, typically one in which he or she has become familiar through friends or through reading, these treatments are likely to be rather exotic or unusual therapies. Predominantly, patients seem to view the particular therapist as being more important than the theoretical model from which he or she practices.

2. Criteria of Effectiveness

One of the major controversies in the field is how treatment effectiveness should be judged. Many psychologists believe that the best test of the worth of a psychotherapeutic treatment is in the observations of the clinician who exercises judgement and forms an opinion based on his or her theories of psychological disturbance and the elements that facilitate change. Such opinions, however, are by their nature very subjective; they cannot be reliably replicated, and their validity is highly suspect.

The usual criteria by which a treatment is judged to be effective is based on how persuasive, sincere, and articulate a clinician may be. These factors determine how effective a therapist is in persuading fellow clinicians to adopt his or her philosophy and perspective about psychotherapy. Political and legal criteria of a treatment's value are equally subjective and rarely focus on what the actual impact of the treatment is at the level of the patient's problems. Factors such as treatment cost, number of people accessed, popularity, and acceptance among peers are all considered in these criteria and frequently take precedence over actual effectiveness at altering symptoms and resolving problems.

In North America, as health care companies continue to struggle with the cost containment of mental health services, managed health care has increasingly turned to more objective methods of assessing whether a treatment is appropriate. Some professional groups have emphasized the need for a scientific standard by which to judge a treatments worth and have suggested certain research-informed standards by which to assess effectiveness.

By far the biggest obstacle to developing a uniform, research-based standard of care is that most contemporary approaches to treatment have not been subjected to empirical test. Nonetheless, a number of well-developed efforts have been made to translate the available research into standards of care or guidelines to direct practitioners. These guidelines typically specify the priority of various models and identify which ones among them have achieved empirical support through scientific research. A continuing obstacle to the implementation of these guidelines involves the sheer number of treatment models available.

Recognizing that it is difficult for clinicians to learn several different theoretical models and that often these guidelines are overly rigid, some authors have argued for a set of standards that emphasize empirically derived principles of psychotherapeutic change rather than either techniques or whole theories. This approach identifies various principles of selecting and applying treatments that are sensitive to ways in which patients differ from one another in their receptivity to different techniques, models, or therapeutic styles. It also emphasizes the need to customize the treatment to each patient, usually by mixing and fitting specific interventions or general styles to defined patient characteristics.

3. Integration of the Science and Practice of Psychotherapy

In these several ways, research findings are becoming more central to clinical practice, though this merger is frequently mandated by law and policy rather than being the result of a voluntary effort. Moreover, without a clear standard for assessing the scientific standing of various models of intervention, whatever merging or integration does occur is difficult to evaluate.

One of the most enduring and complex problems facing the practice of individual psychotherapy is the way in which scientific and clinical observers come to integrate their findings. This problem is complicated both because clinicians who practice psychotherapy and scientists who evaluate it have very different belief systems and perspectives. These differences underlie many of the disputes over the criteria by which to evaluate effectiveness and undermine the credibility of the treatment

itself. Some of the differences that exist between scientists and practitioners are embodied in what kind of research methodologies are most valued. Scientists have tended to value studies of efficacy, whereas practitioners tend to value studies of effectiveness.

Efficacy studies are typically characterized by the use of a highly defined sample of patients, a well-trained cadre of clinicians, random assignment to well-structured and specific treatments, and systematic measurement of outcomes. They contrast with effectiveness studies, which are often less controlled, with more typical samples of therapists and patients, clinical assignment procedures, and less systematic treatments and measures. Although these labels represent the end points of control and generalizability in psychotherapy research, there is ample reason to believe that the distinction between them is more arbitrary than real. Efficacy studies frequently use complex, clinically representative samples, real therapists, and clinically meaningful measurements, whereas effectiveness studies often include random assignment and controlled treatments. In the final analysis, the critical question is the clinical utility of research, by whatever method it is conducted.

Perhaps a more important factor in keeping scientists and practitioners apart is that within both the camp of practitioners and the camp of scientists, there are many factions. In this chapter, we have already pointed to the many different clinical theories that guide treatment, but equally problematic is the fact that scientists themselves have disparate interpretations about what contemporary research tells us.

At the present time, there is no well-accepted way to translate research findings directly into practice or for researchers to be very responsive to clinician opinions and needs. Some argue that a new model of research is needed that adequately addresses the problems of practice. This model would systematically include clinical as well as research perspectives in treatment.

IV. SUMMARY

Over the 100 plus years since it emerged as a formal professional activity, psychotherapy has proven itself to be both popular and effective. Individual psychotherapy is by far the most widely researched and practiced, and it sets the general standard of efficacy and effectiveness by which other approaches can be assessed.

With the popularity of individual psychotherapy has come a burgeoning number of practitioners representing various professional backgrounds and types of training. Moreover, there has been an exponential growth in the number of theories used to describe the psychotherapeutic process and to guide one's work. Research has demonstrated that some of these approaches are effective, but most psychotherapeutic practices do not rely on scientific research for justification. Clinician experience and impressions are the most frequently used yardsticks by which to judge when treatment is effective and is working. However, this situation seems to be changing, and contemporary political movements and health care programs are recognizing the need to identify which treatments are effective and which ones are not. This movement has introduced a number of changes in the field of psychology. It has brought increasing pressure on clinicians to justify their practices in terms of research findings, and this development has placed more emphasis on making research that is clinically applicable.

As a result of changes in the health care environment, the disparities within the field of psychotherapy research as well as those between science and practice are becoming more apparent. New models are needed and are developing, both for making research more applicable and for applying research findings to the task of directing the course of treatment.

See Also the Following Articles

Behavior Therapy: Historical Perspective and Overview ■ Cognitive Behavior Therapy ■ Effectiveness of Psychotherapy ■ Efficacy ■ Exposure ■ Group Psychotherapy ■ Integrative Approaches to Psychotherapy ■ Interpersonal Psychotherapy ■ Neuropsychological Assessment ■ Objective Assessment ■ Research in Psychotherapy ■ Single Case Methods and Evaluation

Further Reading

Bergin, A. E., & Garfield, S. L. (Eds.). (1994). *Handbook of psychotherapy and behavior change,* 4th ed. New York: John Wiley & Sons.

Beutler, L. E. (2000). David and Goliath: When empirical and clinical standards of practice meet. *American Psychologist 55,* 997–1007.

Corsini, R. J. (1981). *Handbook of innovative psychotherapies.* New York: John Wiley & Sons.

Frank, J. D. (1973). *Persuasion and healing.* Baltimore, MD: Johns Hopkins University Press.

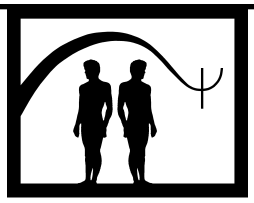
Freedheim, D. K. (Ed.). (1992). *History of psychotherapy: A century of change.* Washington, DC: American Psychological Press.

Nathan, P. E., & Gorman, J. M. (Eds.). (1998). *A guide to treatments that work.* New York: Oxford University Press.

Norcross, J. C., & Goldfried, M. R. (Eds.). (1992). *Handbook of psychotherapy integration*. New York: Basic Books.

Roth, A., & Fonagy, P. (Eds.). (1996). *What works for whom? A critical review of psychotherapy research*. New York: Guilford Press.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes." *Psychological Bulletin, 122,* 203–215.



Informed Consent

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GLOSSARY

confidentiality The ethical (and often legal) requirement to restrict disclosure of client information outside the therapy sessions.

mandated reporting of child abuse The legal requirement in all 50 states that psychologists report to authorities reasonable suspicion of physical, sexual, and/or emotional abuse of a child under the age of 18.

reasonable patient standard The prevailing standard employed when determining the amount of information to provide to clients in order to obtain consent for treatment. Although it is not clearly defined, this standard requires clinicians to provide as much information as a reasonable patient would desire.

Clinicians have an ethical and often legal obligation to obtain consent from clients prior to treating them. In order to obtain valid consent, clients must be fully informed regarding the nature of psychotherapy, including, for example, the potential benefits and risks of treatment, alternative treatments available, and limits of confidentiality. This article provides a description of the components of informed consent and methods of obtaining valid consent. Next, the article discusses the legal and ethical bases of the concept. Finally, a review of the available research on ways of obtaining informed consent and the impact that written forms have on the therapy process is provided.

I. DESCRIPTION OF INFORMED CONSENT

Initially, informed consent was a medical concept applying only to physicians and surgeons. The concept was circumscribed, requiring only that doctors tell patients the type of treatment recommended. Within the medical community, the concept eventually was expanded in scope, requiring physicians to give patients enough information about different available treatments so that patients could make educated decisions as to whether to accept a particular form of treatment. More recently, the concept has been incorporated into other disciplines, such as psychology.

As it applies to psychotherapy, the current doctrine of informed consent requires a client to be informed of the potential benefits and risks of the contemplated treatments, the expected prognosis with and without treatment, and any possible alternative treatments. Barring exceptions such as emergency treatment, a person cannot be given therapy without his or her informed

consent to such procedures. Underlying the concept of informed consent is the principle that allowing a client to make an informed decision respects that person's autonomy and self-determination.

Valid consent implies that the client agrees to treatment intelligently, knowingly, and voluntarily. Intelligence, sometimes referred to as competency, is defined as a client's capacity to comprehend and evaluate the specific information that is offered, whereas knowledge is defined as a client's ability to appreciate how the given treatment information applies to him or her specifically. Finally, the voluntary element suggests that a client's consent may not be coerced or enticed by the treating agent. All three elements must be present in order to consider consent truly informed and valid.

The first element of competency or intelligence is a difficult concept for two reasons. First, there has been considerable debate over how much information should be given to a client to allow him or her to make an informed decision. Second, the concept is often difficult to assess with child clients.

Regarding the debate over the extent of information provided, historically there have been two standards employed to determine whether the client has received adequate information. The first is a professional standard, which requires that the amount of information provided to a client be what other professionals in the community typically provide. The professional standard has been criticized for being somewhat paternalistic, in that clinicians determine the extent of the information that is provided to clients. The second standard is the reasonable patient standard, which requires the professional to give as much information as a reasonable patient would desire to make treatment decisions. The major problem with this standard is the difficulty in quantifying the exact amount of information a reasonable patient would desire. This standard does, in addition, put the onus squarely on clinicians to provide information, even when not requested by a particular client. In recent years, the reasonable patient standard has been the prevailing model.

Regarding child clients, it should be noted that the right to give consent is a legal one that is based on a client's presumed ability to understand the information given. In general, only adults are considered able to understand treatment information and to be legally competent to give consent. In many states, minors are not legally competent to give consent; instead, consent for treatment must be obtained from a legal guardian or parent. However, some state statutes give minors limited rights to consent to treatment. For example, in Oregon, state law allows children 14 years of age and older to give valid consent for outpatient mental health treatment without the consent of parents. Other states' statutes recognize the mature minor exception, granting minors near the age of majority or mature enough to understand and weigh treatment options the right to consent to treatment. Regardless of state law, it is important to involve even young children in the process of obtaining consent. Despite the fact that state laws often do not recognize their capacities, research has found that even young children may be capable of understanding and weighing treatment options. Given these findings, clinicians should endeavor to obtain assent to treatment from children ages 7 and older. The term assent does not imply legal consent; however, it suggests that young children should be given relevant treatment information and asked whether or not they wish to participate in treatment. If a child does not want to participate in treatment, despite parental consent, ethical principles dictate that the clinician should consider the best interests of the child. Such a dilemma would involve considering and respecting the child's autonomy while recognizing the legal authority of the child's parents.

Although providing information about treatment is necessary to ensure a person's consent is done intelligently, it is not sufficient to obtain informed consent from a client. In addition, a client's knowledge or ability to appreciate that the material is relevant to him or her specifically must be assessed. In order to ensure that a client fully appreciates the information provided, a clinician must regularly question the client's comprehension of the material. One way of assessing comprehension is to ask a client to repeat, in his or her own words, treatment information that was presented previously. Only with a reasonable appreciation of the information will consent to treatment be considered valid. By the reasonable patient standard, clinicians bear the responsibility of ensuring that clients understand and appreciate the treatment information given.

Finally, in order to satisfy the requirement that consent be given voluntarily, no undue pressure may be placed on the client by the treating agent. For example, clinicians should avoid promising miraculous and timely cures; they should also avoid offering financial incentives for participating in treatment. To ensure the voluntary element necessary to valid consent, clients must be told that they can withdraw from treatment at any time.

The limits of informed consent should be noted by clinicians. Obtaining informed consent does not provide permission to clinicians to perform illegal or unethical acts. For example, a therapist cannot justify sexual acts with a client by claiming that informed consent for these

acts as part of treatment was obtained from the client. In other words, there clearly are limits on those things to which a client can validly consent.

Given the three elements of valid consent, it should be clear that obtaining informed consent is not a one-time incident but instead is an ongoing process throughout treatment. Several authors have suggested that clinicians adopt a process model rather than an event model of informed consent. Ongoing discussions with clients throughout the treatment process may be necessary to ensure that they have sufficient opportunities to ask questions and have information clarified. At a minimum, there are two discrete times during the therapy process when informed consent should be obtained: at the initiation of therapy and when particular treatments are proposed.

At the initiation of therapy, clinicians should provide general information on the nature and process of therapy to potential clients. Informed consent for treatment generally should be obtained at the beginning of the very first session, prior to obtaining potentially sensitive information, conducting assessments, or implementing any treatment techniques. The following information should be given at the initial session to assure informed consent. First, clients should be told the qualifications of the therapist and any supervision that is required. Second, clients should be told the limits of confidentiality (e.g., mandated reporting of child abuse) and general client rights (e.g., the right to withdraw from therapy at any time). Finally, clients should be told logistical information, such as scheduling practices and fee structures.

In addition to general information on the nature of therapy, the informed consent process should continue when specific treatments are proposed. At this time in the therapy process, clinicians should provide information on the purpose of the proposed treatment, any possible discomforts or harms, and any potential positive benefits. In addition, clients must be told about alternative treatments available and the possible risks and benefits of these treatments. Finally, clients must be told that no treatment is an option and must be informed of the possible consequences of opting out of treatment.

It is imperative that clinicians document this ongoing process of obtaining informed consent. The first major point of documentation is at the first session. At that time, clinicians are advised to employ a written information sheet that is read and signed by the client. Although there are many variations of this form, it should be written in plain language free of jargon or legalistic phrases and should contain the information necessary for the client to make an informed choice regarding whether or not to participate in therapy. However, it should be noted that a signed informed consent form is not enough to demonstrate knowledge, one of the three elements of informed consent. To document client knowledge, clinicians should include in a progress note any client questions or statements that indicate that the client has a full appreciation of the information given. The second major point of documentation is when specific treatment techniques are proposed. At that time, clinicians should carefully document in progress notes the treatment options presented to the client and any questions asked by the client. Standard of care issues now dictate that clinicians should determine which treatment to employ by reading available literature and using empirically supported treatments. If a clinician decides to employ an unusual or experimental treatment, he or she should thoroughly document that the client has been fully informed about the nature of the experimental treatment and the possible risks and benefits. In addition, the clinician should document that the client was given information about standard treatments.

The documentation requirements ensuring valid consent may become more time-consuming when clinicians conduct family or couples sessions. In those instances, informed consent should be obtained from all participating members at the initiation of therapy and throughout the treatment process. In addition, progress notes should document that discussions have been held regarding any issues that are unique to family or couples sessions. For example, clinicians should discuss with all family members how to handle difficult confidentiality issues faced when more than one client is in the room and should document these discussions in the progress notes.

II. LEGAL AND ETHICAL BASES OF INFORMED CONSENT

Several legal cases illustrate the importance of obtaining informed consent. The first major legal statement of the need for consent occurred in the 1905 case of Mohr versus Williams. In this case, the plaintiff used a physician for performing an unauthorized surgical operation. While the plaintiff did consent to an operation on her right ear, the physician instead performed an operation on her left ear, as he had found the left ear to be more in need of treatment once the surgical procedures had commenced. Following the operation, the

plaintiff claimed that she had not previously experienced any difficulty with her left ear but that she currently was having trouble hearing out of that ear. The court found in favor of the plaintiff and stated that a surgical operation by a physician upon the body of his patient is unlawful when performed without either the express or implied consent of the patient.

In 1914, the case of Schloendorff versus the Society of New York Hospital expanded on the requirements for informed consent. The court stated that a patient must be apprised of the potential benefits and major risks of any proposed treatment, as well as the available alternative treatments. However, the court did not give specific guidance on how much information is sufficient. A later case, Canterbury versus Spence (1972), appeared to support the reasonable patient rather than the professional standard of information provision. The court in this case stated that physicians have "a duty to impart information which the patient has every right to expect." Since this 1972 case, physicians have been considered to have an affirmative duty to impart as much information as a reasonable patient would require, regardless of whether a particular patient asks for such information.

It is clear from the above brief review that case law has supported obtaining informed consent for medical procedures. However, courts have not directly addressed whether or not informed consent is applicable to typical psychological or counseling services. Likewise, state statutes that address the concept of informed consent have typically addressed only physician obligations to obtain consent. Currently, all states have statutes mandating some type of informed consent procedures for physicians and psychiatrists. Not every state, however, clearly specifies that psychologists or other mental health providers must obtain informed consent for psychological treatments. For example, Oregon law on informed consent states only that physicians and surgeons must obtain informed consent for treatment, with no mention of any such obligation on the part of psychologists. On the other hand, Colorado and Indiana statutes mandate that psychotherapists obtain informed consent. Other state legislatures currently are considering bills requiring psychologists to obtain informed consent prior to treatment. It appears that the recent increase in legislative activity stems from controversy surrounding therapy techniques designed to activate repressed memories. These techniques supposedly help adults recover or unlock previously repressed or forgotten memories of childhood sexual abuse. Critics claim that these techniques result in false memories rather than true memories of abuse and that the techniques lack a scientific basis. Critics have introduced legislation requiring psychologists to inform clients of the scientific basis of all treatment techniques, as part of their efforts to reduce the use of repressed memory techniques. Clearly, clinicians should be aware of the statutes in the states in which they practice, as laws regarding informed consent for therapy vary across state lines.

Regardless of whether state statutes or case law mandate that clinicians obtain informed consent prior to mental health treatment, ethical codes of conduct typically dictate that clinicians apply the concept of informed consent with all clients. For example, the ethical codes developed by the American Psychological Association (APA) and the American Counseling Association (ACA) contain sections dealing with informed consent. In the APA code, Principle 4.02 states that psychologists must obtain informed consent by using "language that is reasonably understood by participants." If a client is a child or otherwise unable to give consent, psychologists must obtain consent from the legal guardian. In addition, psychologists must provide information to a child or other legally incompetent person and obtain assent from that person. The overarching principle espoused in ethical principles is that clinicians must consider the client's best interests, autonomy, and self-determination.

Clinicians should be aware that not obtaining valid consent prior to treatment places them in a precarious position. Due to ethical principles requiring informed consent, a client may file an ethical complaint with the state licensing board for a clinician's failure to obtain valid consent. Complaints regarding lack of informed consent may be based on the three areas discussed previously: lack of competence to consent to treatment, lack of voluntary consent, or lack of sufficient information. To be found in violation of the ethical code, a psychologist must only be found to have neglected standard and reasonable informed consent procedures. It is not necessary for the client to have been harmed due to the psychologist's negligence for a clinician to be found in violation of the ethics code. In egregious cases, the result may be suspension or loss of the license to practice psychology in that state.

In addition to an ethical complaint, clinicians who neglect to obtain valid consent from clients may find themselves facing a civil lawsuit. Despite a lack of case law directly addressing the concept of informed consent for psychological services, it is only a matter of time until such a suit is filed. In contrast to an ethical complaint, the client in a civil suit must show, among other things, that the client was harmed by the clinician. To win a suit based on a failure to obtain informed

consent, the client must prove all of the following five things: (1) that the risks involved with a therapy should have been disclosed; (2) that the risks were not disclosed; (3) that the risks materialized; (4) that the materialized risks resulted in injury; and (5) that the client would not have accepted the therapy if he or she knew of the risks involved. It is true that such lawsuits are uncommon and difficult to prove currently. However, the rise of empirically supported treatments may increase the frequency of complaints made by clients who did not receive information and full disclosure regarding such treatment options. Injury or harm may be demonstrated by a client who incurred expenses while participating in an ineffectual therapy for a long period of time, when a more time-efficient and empirically supported therapy was available but was not disclosed to the client. In our increasingly litigious society, clinicians should be aware of the growing possibility of legal liability for failure to obtain fully informed consent.

III. RESEARCH ON INFORMED CONSENT PROCEDURES

There has been little research conducted on the process or effects of obtaining informed consent. The limited research that is available has addressed three main areas: prevalence of informed consent procedures, optimal methods of obtaining informed consent, and effects of informed consent procedures on client disclosure or attendance.

First, research has not supported the idea that all clinicians employ some form of consent procedure. As stated previously, consent procedures include utilizing a written informational form and documenting ongoing discussions with the client. As recently as 1993, Daniel Somberg, Gerald Stone, and Charles Claiborn found that only 60% of psychologists reported utilizing any type of consent procedure with all clients. Thirty-seven percent of the remaining psychologists stated that they did not employ informed consent procedures with all clients due to believing that such procedures were irrelevant, while 16% stated that they often simply forgot to obtain informed consent.

As should be clear from previous sections, the use of both written forms and ongoing discussions with clients is encouraged. Research has found that the sole use of written forms to convey information on the therapy process and treatments has increased over the past two decades. However, research does not support the exclusive use of a written informational form as a method of obtaining valid consent. There are two major problems with sole reliance on such forms. First, researchers have found that the average length of consent forms doubled from 1975 to 1982, in order to include more information about client rights and confidentiality. Second, the written forms typically employed generally require that the reader have at least a college education. One study found that the average readability of consent forms was grade 15.7 (third year college level), while some reached grade 17+ (postgraduate level).

Given the increasing length and complexity in such forms, it is important to ask whether the typical client can comprehend such information. It is possible that longer and more detailed forms, while covering all of the required consent elements, are primarily utilized to protect clinicians against ethical complaints or lawsuits rather than as a way to educate and inform clients. Clearly, understanding is an important element in giving informed consent; without it, a signature on an informational form is not valid. Although not directly addressing clinical or treatment forms, a 1994 study by Traci Mann on the understanding of research informed consent forms is relevant. Overall, Mann found that longer consent forms inhibited the amount of information retained by participants. Mann concluded that research participants often agree to engage in studies that they do not understand, which belies the whole idea of informed consent. His findings imply that long, complex consent forms should not be employed with clinical clients.

An alternative to employing detailed informed consent forms is a procedure suggested by Mitchell Handelsman and Michael Galvin in 1988. These authors developed a question sheet that includes a list of commonly asked questions. This sheet also instructs potential clients that they have a right to ask any or all of these questions to their therapist. Handelsman and Galvin directed that some of the questions must be answered by the therapist even if not asked by the client; examples of such questions that therapists are ethically obligated to discuss with clients would be those dealing with confidentiality and the general nature of treatment. However, the remaining questions are left to the discretion of the client, respecting the right of clients to not be given information that is not wanted. It may also encourage the use of a process format of obtaining informed consent, rather than a single event model. To date, no studies have been done investigating the level of client retention of information presented in such a format.

Several studies have examined the effects of informed consent procedures on the therapy process, with most of the research examining the effects of

written informational forms. Clearly, some clinicians have been reluctant to employ informed consent procedures, particularly written forms, on a regular basis. The primary concern may be that the use of legalistic forms and terms is detrimental to the establishment of a therapeutic relationship. In other words, informed consent procedures, particularly written forms, may create a negative impression of therapy in general and the therapist specifically. It is also possible that clinicians are concerned that too much information on the limits of confidentiality may deter clients from revealing important but sensitive information. However, in general, the literature does not support these negative effects of informed consent procedures; instead, research has found primarily positive results from the process of obtaining informed consent.

In regard to the therapeutic relationship, in 1990 Mitchell Handelsman surveyed 129 undergraduate students regarding their impressions of a hypothetical therapist. Holding level of experience of the therapist constant across conditions, Handelsman varied the amount of written information provided to survey participants. In all conditions, participants were provided minimal written information about the therapist, including his educational background and years of experience. In the first condition, participants also were provided the question sheet. In the second condition, participants were given a legal disclosure form, outlining client rights, limits to confidentiality, and other information often considered part of informed consent procedures. Finally, in the third condition, participants were given a brochure that provided general information to commonly asked questions (e.g., What is the difference between a psychologist and a psychiatrist?). Based on the information provided, participants were asked to complete a questionnaire regarding their impressions of the hypothetical psychologist. Overall, Handelsman found that the use of more written information increased participants' positive judgments of therapists' experience, likeability, and trustworthiness, in addition to their likelihood of referring the therapist to others. This study suggested that written information, whether disclosed in a more legalistic document or through a question sheet, may improve therapist ratings. The study was not able to conclude that the question sheet was more beneficial than the legal disclosure form.

In a separate study in 1990, Mitchell Handelsman surveyed 137 undergraduate students to assess whether varying level of therapist experience would affect the previously established positive impact of legal disclosure forms. For this study, half the participants received the legal disclosure form; the other half received both the legal disclosure form and the question sheet. In addition, therapist level of experience varied. In the first condition (the low-experience condition) participants were told that the hypothetical therapist was recently licensed within the past year. In the second condition (the moderate-experience condition), participants were told that the therapist had been practicing for at least 9 years. Finally, in the third condition (the high-experience condition), participants were told that the therapist had been in practice for 19 years. Overall, Handelsman found that participants rated experience highly. However, with more information provided, the less experienced therapist was rated more highly. Handelsman's findings suggest that adding more written information in the informed consent process improves client ratings, particularly with less experienced therapists.

In 1993, Therese Sullivan, William Martin, and Mitchell Handelsman conducted a survey of 124 undergraduate psychology students to further investigate the impact of information on ratings of clinicians. Participants were assigned to one of two conditions. In both conditions, participants were given a hypothetical transcript of a first therapy session. In the first condition (informed consent transcript condition), the transcript was accompanied by a written consent form and included discussion of confidentiality, alternative treatments, and risks and benefits of therapy. In the second condition (control transcript condition), no written form accompanied the transcript and no discussion on informed consent issues was included. Following presentation of materials, all participants were asked to complete a questionnaire regarding impressions of the therapist. The authors found that the combined presentation of oral and written information positively impacted therapist ratings.

To date, only one study has found any negative effects of written forms on client impressions of therapists. In 1992, Mitchell Handelsman and William Martin found that male adult clients reported lower ratings for therapists who provided written informed consent forms than no information at all. However, the forms employed in this study were difficult to read, as they required at least a 10th-grade reading level, had complex sentences, and were single-spaced. As previously reported, less readable forms are likely to be misunderstood by clients. It appears from this study that therapist ratings also suffer from complex information forms.

As the above brief review demonstrates, the limited research that has been done appears to support the idea that informed consent procedures improve client ratings of therapists. Further research has examined

whether informed consent procedures affect client behaviors in therapy, such as termination rates and the frequency of disclosures of sensitive information.

Termination and no-show rates of clients at a counseling center of a state university were examined in 1995 by Patricia Dauser, Suzanne Hedstrom, and James Croteau. In the partial disclosure condition, participants received only the counseling center's standard written information, including the services provided at the clinic, limits of confidentiality, length and frequency of sessions, and the client's right to terminate treatment. In the full disclosure condition, participants received the standard written form as well as written materials containing more detailed information. Specifically, participants were told the name of the assigned therapist, the therapist's experience and typical treatment procedures, anticipated positive results of therapy, possible risks, potential alternatives to therapy, fee structure, the name of the therapist's supervisor (if applicable), and the name and number of the state licensing board. Overall, the authors found no differences between the two conditions in no-show or termination rates during the course of therapy, suggesting that more information does not negatively affect client attendance.

The results of research on the impact of informed consent procedures on client disclosures have been mixed. In recent years, legislation in most states has mandated that certain information revealed by clients (e.g., child abuse, imminent harm to others) be disclosed to authorities. This legislation is based on the idea that society has more of an interest in preventing harm than in protecting client confidentiality. Informing clients of the limits of confidentiality is a standard part of most informed consent procedures. Some studies have found that warning clients of the limits of confidentiality reduces client disclosures, whereas other studies have found that it has no impact. As an example, Daniel Taube and Amiram Elwork examined rates of disclosure of sensitive information in 1990. These authors assessed 42 adult outpatient clients regarding level of self-disclosure following either minimal information on confidentiality limits or full information regarding this topic. The authors found that information on confidentiality limits does reduce self-disclosure for some patients in some circumstances. In particular, more informed clients did not admit to as many child punishment and neglect behaviors, nor did they admit to as many socially unacceptable thoughts and behaviors as the minimally informed group. The authors suggested that legislation on mandated reporting of certain client information may not achieve its intended aim of protecting society and may also hinder the therapy process. Due to conflicting findings in the literature, further research is needed to clarify the impact of informed consent procedures on client disclosures.

IV. SUMMARY

Obtaining informed consent of all clients is an ethical requirement for psychologists. In addition, it is likely that psychologists will increasingly be legally required to obtain informed consent prior to treatment. Informed consent is valid only if given intelligently, knowingly, and voluntarily. The reasonable patient model is now the standard of care, suggesting that clinicians must take the responsibility for initiating dialogues with clients regarding consent issues. An ongoing, process model is advisable, rather than a single event model that relies exclusively on a written informational form. Both written forms and continual discussions are helpful, as long as the client understands these basic areas: nature of therapy in general, limits to confidentiality, treatment techniques available, and the risks and benefits of potential techniques (including the option of no treatment).

Research has found that not all therapists currently utilize informed consent procedures, believing it may be irrelevant or even harmful to the therapeutic relationship. In general, research has supported the positive effects of providing more information to the client prior to treatment. For example, research has found that increased information appears to improve client ratings of clinicians. Although not directly studied, it is possible that providing more information to clients reduces the risk of exploitation of clients by informing them of rights and expectations. In addition, it is possible that utilizing informed consent procedures may align client and clinician expectations of therapy, resulting in a better therapy outcome, as well as fewer lawsuits or ethical complaints for clinicians. Clearly, further research should be conducted on these hypotheses.

It should be noted, however, that research has not been uniformly positive as to the effects of informed consent procedures. When long or complex written materials are utilized, client comprehension suffers. Also, research is mixed on the effects of informed consent procedures on client disclosure of sensitive information. At least one study has found that disclosure of sensitive material may be inhibited when more information on the limits of confidentiality is provided to clients. Further research on this issue is needed to clarify the extent of client censoring of sensitive materials.

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American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 42,* 1597–1611.

Appelbaum, P. S. (1997). Informed consent to psychotherapy: Recent developments. *Psychiatric Services, 48,* 445–446.

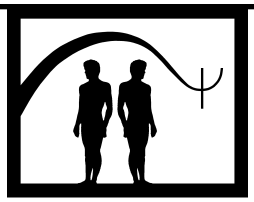
Crowhurst, B., & Dobson, K. S. (1980). Informed consent: Legal issues and applications to clinical practice. *Canadian Psychology, 34,* 329–343.

Gustofson, K. E., & McNamara, J. R. (1987). Confidentiality with minor clients: Issues and guidelines for therapists. *Professional Psychology: Research and Practice, 18,* 503–508.

Koocher, G. P., & Keith-Spiegel, P. (1998). *Ethics in psychology: Professional standards and cases* (2nd ed.). New York: Oxford University Press.

Marczyk, G. R., & Wertheimer, E. (2001). The bitter pill of empiricism: Health maintenance organizations, informed consent, and the reasonable psychotherapist standard of care. *Villanova Law Review, 46,* 33–93.

Zuckerman, E. L. (1997). *The paper office* (2nd ed.). New York: Guilford Press.



Integrative Approaches to Psychotherapy

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GLOSSARY

assimilative integration A system of psychotherapy integration that depends largely on one approach but that incorporates concepts and methods as dictated by clinical necessity. These new elements are transformed to fit into the primary approach.

common factors That group of variables that have been found to be the effective ingredients of most psychotherapies.

common factors integration The combination of therapeutic approaches based on the ability of particular methods to deliver the desired common factor of change.

psychodynamic A synonym for psychoanalytic, it refers to unconscious motivations, perceptions, emotions, and conflicts that determine behavior, and to forms of psychotherapy that emphasize these factors.

psychotherapy integration The combination of techniques and/or concepts from two or more psychotherapeutic approaches into a single method of psychotherapy.

technical eclecticism The most pragmatic and common form of psychotherapy integration, in which interventions are matched to patient characteristics, symptoms, and problems on the basis of research findings and clinical knowledge.

theoretical integration The most conceptually complex form of psychotherapy integration, in which the underlying theories of personality and psychopathology are synthesized and are the foundation of a new therapeutic approach.

This article will introduce the reader to progress in the area of psychotherapy integration. This is a new and exciting subdiscipline in the field of psychotherapy. It is concerned with using and combining the most effective elements of psychotherapy theory and practice in ways that accentuate the power of integrated psychotherapies to help a wider range of patients, with a broader spectrum of problems, to change.

I. DESCRIPTION OF TREATMENT: A HISTORICAL AND CONCEPTUAL OVERVIEW OF PSYCHOTHERAPY INTEGRATION

From the earliest foundations of modern approaches to psychotherapy, practitioners and students of psychotherapy have been extraordinarily unwilling to learn from systems of psychotherapy other than their own. Each school of psychotherapy has developed in a state of isolation from the other schools. This state of segregation within the field of psychotherapy has had dramatic and important effects. It has led to unwanted

hostility between adherents of the various psychotherapeutic schools, and to efforts to dismiss out of hand the ideas and methods of competing approaches without systematic study or intellectual consideration. This self-imposed therapeutic "apartheid" also has prevented psychotherapists and patients from benefiting from clinical and theoretical innovations introduced by colleagues who are loyal to other psychotherapeutic approaches. Michael Mahoney argued in 1985 that these schisms in the field were political in nature and did not reflect clinical reality, which indicated that none of the therapeutic schools could claim to be vastly superior to any other.

This stubborn isolationism in the field of psychotherapy stands in contrast to the fact that psychotherapists have always been interested in, and long have attempted to use, new developments in the natural and social sciences, philosophy, theology, the arts, and literature. A small group of scholars and clinicians have been able to cross sectarian lines and have countered the segregation of the various schools of psychotherapy. These integrationists have aimed at establishing a useful dialogue among members of the various sectarian schools of psychotherapy. Their goal has been the development of the most effective forms of psychotherapy possible. The integration of therapies involves the synthesis of the "best and brightest" concepts and methods into new theories and practical systems of treatment.

Integrative forms of psychotherapy vary greatly depending on the particular version that is being considered, yet all share one common goal and purpose. Integrative psychotherapies are the result of the synthesis of theoretical concepts and clinical techniques from two or more traditional schools of psychotherapy (such as psychoanalysis and behavior therapy) into one therapeutic approach. It is hoped and assumed that this therapeutic synthesis will be more powerful and will be applicable to a wider range of clinical populations and problems than were the individual models of psychotherapy that formed the basis of the integrated model.

Histories of early efforts at integrating compiled by Marvin Goldfried and Cory Newman in 1992, and by Jerold Gold in 1993, identified scattered but important contributions as early as 1933, when Thomas French argued that concepts from Pavlovian models of learning should be integrated with then current psychoanalytic insights. In 1944 Robert Sears offered a synthesis of learning theory and psychoanalysis, as did John Dollard and Neal Miller in 1950, whose translation of psychoanalytic concepts and methods into the language and framework of laboratory-derived learning principles was a watershed event.

Early clinical efforts at integrating behavioral and psychoanalytic interventions in a single case were introduced by Bernard Weitzman in 1967, in 1971 by Judd Marmor, and by Benjamin Feather and John Rhodes in 1973. These clinical efforts demonstrated that unconscious factors in a patient's psychopathology could be ameliorated through the use of behavioral methods, along with traditional psychodynamic exploration and interpretation.

In the past two decades a number of important integrative approaches to psychotherapy have been developed. In 1977 Paul Wachtel published a groundbreaking book that advocated an integration of psychoanalytic theory with social learning theory, and in which he demonstrated ways in which clinicians could effectively use behavioral and psychoanalytic interventions with one patient. This integrative approach received enormous attention within the behavior therapy and psychoanalytic communities, and was followed by other efforts at promoting a dialogue between clinicians of various orientations, as well as a relative torrent of articles and books that focused on integrative topics. In 1984 Hal Arkowitz and Stanley Messer published an edited volume in which prominent behavior therapists and psychoanalytic therapists discussed and debated the possibilities of extensive integration of the two systems.

In 1992 John Norcross and Marvin Goldfried published a handbook that presented a variety of fully developed integrative systems of psychotherapy. This effort was followed in 1993 by a volume edited by George Stricker and Jerold Gold in which an even greater number of integrative models was presented, and the clinical utility of psychotherapy integration was explored with regard to a variety of clinical problems and populations. These volumes illustrated that integrative models were no longer focused exclusively on the synthesis of psychoanalytic and behavioral systems. Newer integrative efforts have combined humanistic, cognitive, experiential, and family systems models with each other and with psychoanalytic and behavioral components in ever more sophisticated combinations and permutations. Process-experiential psychotherapy, an innovation introduced by Leslie Greenberg, Laura Rice, and Robert Elliot in 1993, and acceptance and commitment therapy (ACT), described by Steven Hayes, Kirk Strosahl, and Kelly Wilson in 1999, are important examples of integrative approaches that rely heavily on the integration of humanistic and experiential approaches with cognitive-behavioral therapies. Similarly, an integrative model that blended existential,

humanistic, and narrative therapies was described in 1999 by Alphons Richert.

These psychotherapeutic systems have received increasing attention on the part of clinicians and researchers alike, and have become established and viable alternatives to traditional schools of psychotherapy.

In 1992 John Norcross and Cory Newman identified eight variables that have encouraged this rapid proliferation of integrative psychotherapies after decades during which these efforts were scanty. These included (1) The ever-increasing number of schools of psychotherapy; (2) a lack of clear-cut empirical support for superior efficacy of any school of therapy; (3) the failure of any single theory to adequately explain and predict pathology, or personality and behavioral change; (4) the growth in number and importance of shorter term, focused psychotherapies; (5) greater communication between clinicians and scholars that has resulted in increased willingness to, and opportunity for, experimentation; (6) the intrusion into the consulting room of the realities of limited socioeconomic support by third parties for long-term psychotherapies; (7) the identification of common factors in all psychotherapies that are related to outcome; and (8) the development of professional organizations, conferences, and journals that are dedicated to the discussion and study of psychotherapy integration.

II. THEORETICAL BASES OF PSYCHOTHERAPY INTEGRATION

A. Modes of Psychotherapy Integration

The three most commonly discussed forms of integration are technical eclecticism, the common factors approach, and theoretical integration.

1. Technical Eclecticism

This is the most clinical and technically oriented form of psychotherapy integration. Techniques and interventions drawn from two or more psychotherapeutic systems are applied systematically and sequentially. The series of linked interventions usually follows a comprehensive assessment of the patient. This assessment allows target problems to be identified and identifies the relationships between different problems, strengths, and the cognitive, affective, and interpersonal characteristics of the patient. Techniques are chosen on the basis of the best clinical match to the needs of the patient, as guided by clinical knowledge and by research findings.

a. Multimodal Therapy The most influential and important integrative approach that is representative of technical eclecticism is multimodal therapy, described by Arnold Lazarus in 1992 and studied extensively by him and many others since that time. Multimodal therapy was derived from Lazarus's experiences as a behavior therapist, and particularly from his follow-up studies of patients who relapsed after seemingly successful behavioral treatment. His research and clinical experience indicated that most behavioral problems had more extensive psychological and social causes and correlates than then current behavior therapy had addressed. Seeking to expand the range of his ability to work in a more "broad spectrum" way, Lazarus arrived at a multimodal, or broad-based, eclectic therapy.

Multimodal therapy is organized around an extensive assessment of the patient's strengths, excesses, liabilities, and problem behaviors. Upon completion of this assessment, that patient's clinically significant issues are organized within a framework that follows the acronym of the *BASIC ID:* Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relations, and Drugs (or biology). As the firing order or causal sequence of variables in the BASIC ID is identified, interventions are selected and are implemented. More microscopic BASIC ID profiles of discrete or difficult problems and of components of a firing order can be attempted once the initial, global assessment and interventions are completed.

Lazarus states that he prefers to use methods that have been demonstrated through empirical tests to be effective with specific problems and skills, and his theory and technical strategies are more heavily aligned with social learning theory and with cognitive-behavior therapy than with any other therapeutic school. However, in his broad-spectrum approach, he often includes imagery work, techniques drawn from couples and family therapy, gestalt exercises and some affective and insight oriented interventions.

b. Systematic Eclectic Psychotherapy This system of psychotherapy integration was described by Larry Beutler and Amy Hodgson in 1993. This is an empirically informed system in which a thorough assessment of the patient is followed by the prescription of techniques, if available, that have received the most research validation for efficacy with that specific clinical profile. When such research-based matching is not possible, techniques are selected according to accumulated clinical findings drawn from the literature and from the experience of the individual therapist. Beutler and Hodgson choose therapeutic interventions by considering the

interaction of three variables: the stage of involvement in psychotherapy that the patient has reached; the necessary change experiences for which the patient is prepared; and the dominant aspects of the patient's immediate clinical status. Clinical techniques can be matched with four psychological spheres that are assessed on an ongoing basis: overt dysfunctional behavior, faulty thinking, inhibitions of affective and sensory experience, and repressed unconscious conflict. Therapists who work in this framework are free to draw on interventions from any existing system of psychotherapy ranging from psychoanalytically oriented interpretations, to experiential, emotional work, to efforts at modifying thoughts and overt behaviors.

2. Common Factors Approaches to Integration

Common factors integration starts from the identification of specific effective ingredients of any group of therapies. This way of thinking has its origins in the 1936 paper by Saul Rosenzweig, who argued that all therapies shared certain effective ingredients of change, despite their overt ideologies and technical procedures. Also critically important in this area is the work of Jerome Frank, who in 1961 suggested that all systems of psychological healing share certain common, effective ingredients, such as socially sanctioned rituals, the provision of hope, and the shaping of an outlook on life that offers encouragement to the patient. Integrative therapists who rely on common factors concern themselves with the task of identifying which of the several known common factors will be most important in the treatment of each individual. Once the most salient common factors are selected, the therapist reviews the array of interventions and psychotherapeutic interactions to find those that have been found to promote and contain those ingredients. The integrative therapies that result from this process are structured around the goal of maximizing the patient's exposure to the unique combination of therapeutic factors that will best ameliorate his or her problems.

a. Transtheoretical Psychotherapy The most important and widely accepted integrative psychotherapy that exemplifies the common factors mode is transtheoretical psychotherapy, described by James Prochaska and Carlos DiClemente in 1992. In this system, the therapist selects intervention techniques after three patient characteristics are assessed. These are the change mechanisms or common therapeutic factors that are required, the stage of change at which the patient seeks help, and the level of change that is necessary. Prochaska and DiClemente identified 10 possible change factors that operate in the entire range of the psychotherapies, including consciousness raising, self-liberation, social liberation, counterconditioning, stimulus control, self-reevaluation, environmental reevaluation, contingency management, dramatic relief, and helping relationships. Each of these factors is linked to particular therapeutic interventions, although most therapies contain only 2 or 3 of the 10. The concept stage of change refers to the patient's readiness and motivation to change. Five stages have been identified, including precontemplation (the patient is not actively considering change), contemplation (consideration of change without current readiness), preparation, action, and maintenance. Depth of change refers to the sphere of psychological life in which the targeted problem is located, including situational problems, maladaptive thinking, interpersonal conflicts, family conflicts, and intrapersonal conflicts. The transtheoretical therapist selects interventions that will have maximal impact at the desired level of change, will be consistent with the patient's readiness for change, and will convey the highest level of exposure to the most powerful change factors.

b. Common Factors Eclectic Psychotherapy Sol Garfield described in 2000 another influential integrative model that is grounded in common factors research. Garfield integrates interventions from a variety of psychotherapies, with the aim of providing the patient with a number of positive experiences and skills. The common factors that guide Garfield's selection of therapeutic techniques include an empathic, hope-promoting therapeutic relationship; emotional release or catharsis; explanation and interpretation; desensitization; reinforcement; confrontation of problems; provision of new information and skills; and time as a healing factor.

3. Theoretical Integration

Theoretical integration refers to the most complex and sophisticated mode of psychotherapy integration. Psychotherapies that are theoretically integrated rely on the synthesis of concepts of personality functioning, psychopathology, and psychological change from two or more traditional systems. These integrative theories explain behavior and internal experience in cyclical, interactional terms, by looking for the ways in which environmental, motivational, cognitive, and affective variables influence and are influenced by each other. Perhaps the best known version of theoretical integration is a form of psychotherapy that is so well established that it is recognized only rarely as integrative:

cognitive-behavior therapy. As described by Marvin Goldfried in 1995 in an important work on psychotherapy integration, cognitive-behavior therapy is based on a theory of psychopathology and of personality change that is greater than the sum of its behavioral and cognitive parts. This expanded, integrated theory guides the therapist in the selection and use of interventions that are drawn from each school of therapy.

The systems of psychotherapy that are based on theoretical integration use interventions from each of the component theories, and lead to original techniques that may be added to the technical repertoire of the originating therapeutic schools. At times, the clinical efforts suggested within a theoretically integrated system substantially may resemble the choice of techniques of a technically eclectic model. The essential differences may lie in the belief systems and conceptual explanations that precede the clinical strategies selected by the respective therapists. Theoretical integration goes beyond technical eclecticism in clinical practice by expanding the range of covert and overt factors that can be addressed therapeutically. Subtle interactions between behavioral and interpersonal experiences and internal states and processes can be assessed and targeted for intervention from a number of complementary perspectives. Expected effects of any form of intervention in one or more problem areas can be predicted, tested, and refined as necessary. This conceptual expansion offers a framework in which problems at one level or in one sphere of psychological life can be addressed in formerly incompatible ways. That is, the therapist might target a problem in cognition not only to help the patient to think more adaptively, but to promote change in interpersonal behavior, or to rid the patient of a way of thinking that maintained powerful unconscious feelings.

a. Cyclical Psychodynamics Paul Wachtel introduced the most important and influential integrative approach that exemplifies theoretical integration in 1977. This system is known as cyclical psychodynamics and was the first psychotherapeutic model in which psychodynamic theory and therapy were integrated completely with other systems, including especially behavioral theory and behavior therapy techniques. The integration of psychoanalytic and behavioral theories led to the integrative theory that posited that human beings are influenced by unconscious factors that reflect their ongoing perceptions of significant interpersonal relationships. Further, these unconscious issues were seen as maintained and reinforced by the responses of the persons with whom the patient was interacting.

With this cyclical theory as a foundation, Wachtel pioneered the viewpoint that those clinical issues that were the typical concern of psychodynamic therapists could be addressed in therapy through the use of behavioral techniques such as desensitization and assertiveness training. Wachtel argued convincingly that these active behavioral interventions could reach and change unconscious conflicts, fantasies, and depictions of the self and of other people, and as such were useful within a psychodynamically informed psychotherapy. In an updated work on cyclical psychodynamics that was published in 1997, Wachtel expanded his integrative approach to include concepts and methods that were drawn from family systems therapy and gestalt therapy.

b. Cognitive-Analytic Therapy Cognitive-analytic therapy was developed by Anthony Ryle in his role as a consulting psychiatrist in the British National Health System, and has been described in two books that were published in 1990 and 1997. Cognitive-analytic therapy is a theoretical and technical integration of psychoanalytic object relations theory with schema-based cognitive theory and therapy. Ryle found that it was possible to reconceptualize psychoanalytic concepts as the unconscious images of self and of others in explicit, cognitive terms. This theoretical integration allows the cognitive-analytic therapist to introduce and to emphasize the use of cognitive techniques for the purpose of actively modifying these depictions of the self and of other people that exist outside of the patient's awareness but that exert powerfully negative influence on the patient's behavior, symptoms, and relationships.

c. Assimilative Integration A particular subset of theoretical integration that has been the focus of much recent interest is assimilative integration. This way of thinking about psychotherapy integration was introduced into the literature in 1992 by Stanley Messer. Messer suggested that many integrative approaches could best be termed assimilative due to the impact that new techniques have on the existing conceptual foundation of the therapy. As therapeutic interventions are used in a context other than that in which they originated, the meaning, impact, and utility of those techniques are changed in powerful ways. Essentially, these interventions (such as psychodynamic interpretation used by a behavior therapist) are assimilated into a different model and thus are changed in meaning and in impact. In his discussion of assimilative integration of psychotherapies, Messer pointed out that all actions are defined and contained by the interpersonal, historical,

and physical context in which those acts occur. As any therapeutic intervention is an interpersonal action (and a highly complex one at that) those interventions are defined, and perhaps even re-created, by the larger context of the therapy. Therefore, a behavioral method such as systematic desensitization will mean something entirely different to a patient whose ongoing therapeutic experience has been largely defined by psychodynamically oriented exploration, than that intervention would mean to a patient in traditional behavior therapy.

George Stricker and Jerold Gold introduced an influential version of assimilative integrative psychotherapy into the literature in 1996. This integrative approach is one in which the basis for the therapy is traditional psychodynamic exploration. Most of the therapeutic work is carried out through the usual psychoanalytically oriented techniques of clarification, confrontation of defenses and resistances, and interpretation of unconscious conflict and of transference phenomena. However, there are frequent occasions during which an intervention that originated in cognitive, behavioral, or experiential therapy will be introduced into the treatment. Even though these interventions may seem identical to those used by therapists from those other schools, the assimilative nature of this therapy means that the intention, meaning, and potential impact of these interventions will differ, reflecting the basic psychodynamic foundation of the therapy. As an example, when a common behavioral intervention such as assertiveness training is assimilated, it is chosen as much for its ability to bring unconscious conflicts about anger into awareness for the patient as it is for its behavior benefits. Similarly, the use of a cognitive restructuring technique may help a patient to lessen his or her resistances to therapy by reducing anxiety, as well as helping that person to learn a more adaptive way of thinking.

III. RESEARCH ON INTEGRATIVE APPROACHES TO PSYCHOTHERAPY

Research on systematic eclectic psychotherapy as described by Beutler and Hodgson has yielded promising empirical support for the effectiveness of matching patient characteristics and specific therapeutic interventions. Larry Beutler, Paulo Machado, David Engle, and David Mohr conducted an important study of this approach to integrative psychotherapy in 1993. These authors reported that when depressed patients were assigned randomly to three different forms of psychotherapy, two patient characteristics were crucial in predicting the effectiveness of the different therapies. As predicted, cognitive therapy was most effective for those patients who externalized responsibility for their depressions, while those patients with an internal locus of control showed the greatest improvement in the insight-oriented, focused expressive psychotherapy. Patients with higher levels of defensiveness and with greater resistance to authority were helped most by a self-directed therapy.

In 1999 James Prochaska and John Norcross summarized the research literature concerned with the effectiveness of technically eclectic psychotherapies. Although they were appropriately concerned with the limitations of the methodologies used in many of these studies, Prochaska and Norcross concluded that this approach had, on average, a moderate to large effect size and performed better than control therapies in about 70% of the studies that were located.

The transtheoretical model of psychotherapy and its basis in the stages of change in psychotherapy as described by James Prochaska and Carlos DiClemente in 1992, has been studied extensively. These studies, summarized by Carol Glass, Diane Arnkoff, and Benjamin Rodriguez in 1998, have demonstrated the maximized effectiveness of psychotherapies that include interventions that are drawn from several different dimensions of psychological life, as does our model. These studies impressively support the idea that technique serves the patient best when interventions are matched to the patient's immediate clinical need and psychological state.

Clinical trials of integrative psychotherapies that synthesize psychodynamic formulations and exploration with active interventions have yielded preliminary but positive results. For instance, the integrative, interpersonal psychotherapy for depression developed by Gerald Klerman, Myrna Weissman, Bruce Rounsaville, and Eve Chevron in 1984 has outperformed medication and other psychological interventions in a number of studies. Haim Omer, writing in 1992, offered empirical support for integrative interventions that heighten the patient's awareness of his or her participation in psychotherapy, thus improving the impact of the basic exploratory stance of the psychotherapist. Carol Glass, Brian Victor, and Diane Arnkoff pointed out in a 1993 publication that several systems of integrative psychotherapy, such as the "FIAT" model (Flexible, Interpersonal orientation, Active, and Teleological understanding) have been demonstrated, albeit in limited numbers of studies, to outperform either strictly psychodynamic or cognitive-behavioral interventions.

Anthony Ryle reported in 1995 that short-term and long-term versions of cognitive analytic therapy (CAT) have been found to be more effective than

purely psychodynamic or behaviorally oriented approaches. Perhaps the most impressive and important collection of studies of integrative psychotherapy that compare the synthesis of two or more approaches with traditional therapies have been carried out by David Shapiro and his colleagues at the Sheffield Psychotherapy Project. Shapiro and Jenny Firth-Cozens reported on this work in an important paper published in 1990. These workers studied the impact of two sequences of combined psychodynamic and cognitive-behavioral therapy: dynamic work followed by active intervention or vice versa. They found that the greatest gains were made, and the smoothest experiences of treatment were reported, by those in the dynamic-behavioral sequence. Patients in the behavioral-dynamic sequence more frequently deteriorated in the second part of the therapy, and did not maintain their gains over time as often as did patients in the other group.

An integrative approach to treating agoraphobia that combines behavioral, systemic, and psychodynamic theories and techniques was evaluated by Diane Chambless, Alan Goldstein, Richard Gallagher, and Priscilla Bright in 1986. These authors found that their integrated model led to marked or great improvement for almost 605 of the patients. Specific treatment effects included lessened avoidance, depression, social phobia, and agoraphobic symptoms, and enhanced assertiveness for their subjects. When this treatment was compared to standard drug therapy and to behavior therapy, the patients treated with the integrated therapy had a much lower dropout rate then either of the other therapies.

Another theoretically integrated approach that has been tested empirically is process-experiential therapy, an integration of principles and methods derived from client-centered, gestalt, and cognitive therapies that was described in 1993 by Leslie Greenberg, Laura Rice, and Robert Elliot. This therapy has been found to be more efficacious than control therapies such as standard behavior therapy. The effectiveness of this integrative model has been demonstrated with individuals on a short-term basis for problems such as anxiety and depression. Glass, Arnkoff, and Rodriguez pointed out in 1998 that a version of this approach that had been adapted for use with couples also has been demonstrated to be more effective than standard control measures.

Dialectical behavior therapy (DBT) is an integrative psychotherapy aimed at alleviating borderline personality disorder. Marsha Linehan described this approach to this disorder in 1987. DBT integrates skills training, cognitive restructuring, and collaborative problem-solving from cognitive-behavior therapy, with relationship elements (such as warmth, empathy, and unconditional positive regard) from client-centered therapy, and with aspects of psychoanalytic works as well. Borderline personality disorder is recognized by most clinicians as among the most difficult forms of psychopathology to treat, yet DBT has gained wide acceptance among clinicians in recent years, due in great part to the research support for its effectiveness. Glass, Arnkoff, and Rodriguez reported that patients who received DBT demonstrated better treatment retention, had fewer suicide attempts and episodes of self-injury, fewer hospitalizations, decreased anger, greater social adjustment, and more improved general adjustment when compared with those who received standard therapies. These results were maintained over a 1-year follow-up period, and were replicated in a second study.

The first psychotherapeutic approach that has been demonstrated empirically to be effective for treating chronic depression (dysthymic disorder) is an integrative model developed by James McCullough in 2000. This psychotherapy is known as CBASP, for the systems that it synthesizes: Cognitive, Behavioral, Analytic, and Systems psychotherapies. CBASP has been found to be as or more effective as antidepressant medication and traditional forms of psychotherapy in alleviating the symptoms and interpersonal problems involved in chronic depression. As importantly, its results are more enduring and more resistant to relapse than are other treatments.

IV. RANGE OF PATIENT POPULATIONS AND ISSUE OF DIVERSITY

Marvin Goldfried, an early, influential advocate of psychotherapy integration, summed the dilemma of the psychotherapy patient in a cartoon that he included with an article published in 1999. Goldfried's cartoon shows a therapist and patient shaking hands, with two thought bubbles above the head of each person. The therapist is seen to be thinking, "I hope he has what I treat!" while the patient silently worries, "I wonder if he can treat what I have?"

Integrative approaches to psychotherapy would seem, at least in theory, to be uniquely suited to the needs of patients with diverse backgrounds and problems. The problem highlighted by Goldfried may best be avoided by employing an integrative outlook. The hallmark of effective integration is the flexibility of the therapist and the therapeutic approach, and the overriding concern for the individuality of the patient. Unlike many traditional psychotherapeutic systems and schools, wherein the patient is made to fit into, or to

conform with, the therapist's preconceived notion of what works for whom, the integrative therapist tries to tailor the therapy to meet the needs and characteristics of the patient.

Similarly, it would be difficult to think of a specific psychological disorder or patient population for which integrative approaches could not be considered. Since the cornerstone of psychotherapy integration is using the best of what works, any therapeutic approach to any problem may, at least in theory, be improved by the addition of active ingredients from other models.

Presently there exist a number of important contributions to the literature on psychotherapy that are concerned with improving the lot of patients from diverse backgrounds. Sheila Coonerty demonstrated in 1993 that an integrative model of psychotherapy that combines behavioral and psychodynamic elements could be used successfully in the treatment of school-aged children. Mary Fitzpatrick published in 1993 the application of a similar integrative model to the problems of adolescents. Iris Fodor introduced into the literature in 1993 an integrative therapy that was designed particularly for the needs of female patients. Fodor's model integrated concepts and methods from gestalt therapy and cognitive-behavior therapy with feminist theory and therapy. Many integrative therapists have focused on improving the effectiveness of family therapies by adding elements from other schools of psychotherapy. Among the more influential approaches of this type are William Pinsof's integrative family therapy, published in 1995, which assimilated behavior, cognitive, and psychoanalytic methods into family therapy, and Mary Joan Gerson's 1996 integration of psychoanalytic and family systems therapies.

In 1993 Anderson Franklin, Robert Carter, and Cynthia Grace described an integrative approach to psychotherapy with Black African Americans in which issues of race and culture were synthesized with clinical concepts and methods. These authors illustrated how an understanding of the adverse social and cultural factors in American life that shape African American identity development and family structure can be integrated with a variety of therapeutic approaches within a systems framework. Nicholas Papouchis and Vicky Passman, also writing in 1993, described an integrative model of psychotherapy specifically designed to meet the needs of geriatric patients. These authors described how the cognitive deficits, personal losses, and physical illnesses that often afflict the elderly make the traditional psychodynamic therapist less accessible to many older people. However, Papouchis and Passman pointed out that the judicious integration of structured cognitive-behavioral techniques into a psychodynamically oriented psychotherapy may be used effectively by this population, allowing these patients to benefit from the curative factors contained in both approaches.

A number of integrative psychotherapists have explored the ways in which an integrative perspective can be helpful in extending the reach of Western psychotherapies to other sectors of the world. These contributions collectively demonstrate the cultural sensitivity and respect for indigenous traditions, meanings, and ways of life that must be part and parcel of any effective psychotherapy. Articles by Sylvester Madu and Karl Pelzer, both of which appeared in 1991, described integrative therapeutic systems that synthesized several Western therapies with traditional African modes of healing. Both of these writers noted that the openness and flexibility of integrative therapies made these approaches more likely to be able to accommodate the cultural necessities of African life than were standard forms of treatment. Willi Butollo published in 2000 a report of an integrative therapy that he had developed while working in refugee camps in Bosnia during and after the civil war and ethnically motivated atrocities that occurred in the Balkans. Butollo's approach synthesized elements from humanistic, interpersonal, psychodynamic, and cognitive-behavior therapies, and was found clinically to be extremely effective in helping trauma survivors to recover from posttraumatic syndromes.

Integrative therapists have been concerned with expanding the effectiveness of psychotherapy to include politically and economically disenfranchised individuals. In 1989 Paul Wachtel expanded his pioneering integration of psychoanalysis and behavior therapy by focusing on the economic, political, and societal factors that lead to psychopathology. Wachtel then expanded his clinical methodology to include intervention in these areas.

In 1990 Jerold Gold described an integrative therapy that was aimed at helping institutionalized inner-city children and adolescents recover from the mixed impact of individual psychopathology, family dysfunction, and social problems such as divorce, poverty, drug abuse, malnutrition, and substandard housing. Gold's synthesis of psychodynamic, family systems, and behavioral methods also included a strong emphasis on understanding and utilizing the cultural framework within which each patient lived, and posited for the therapist the role of social and political advocate when appropriate.

Integrative psychotherapies have been applied successfully to a wide range of clinical syndromes and patient

populations. Anxiety disorders and related conditions such as panic disorders and phobias are the focus of at least three integrative models. As noted above, Diane Chambless and her colleagues demonstrated in 1986 that an integrative treatment model for agoraphobia was highly successful in alleviating that difficult condition. Barry Wolfe described an integrative approach to anxiety disorders that has been highly influential since it appeared in print in 1992. Wolfe proposed a developmental model for anxiety disorders in which unconsciously processed experiences of self-endangerment are established and maintained during traumatic interpersonal experiences. Wolfe demonstrated how an integration of imagery, behavioral, experiential, and interpersonal techniques could be used to treat this disorder. Another integrative therapy for anxiety disorders was published in 1993 by Jerold Gold, who based his integrative model on a synthesis of concepts and methods from attachment theory, behavior therapy, and humanistic therapy. Obsessive-compulsive disorder was targeted for treatment by R. Harris McCarter in 1997. This author based his approach on a combination of behaviorally oriented exposure techniques with psychoanalytic interventions that were aimed at enhancing the patient's ability to regulate his or her internal emotional experience.

Depression, in its acute and chronic manifestations, has been the focus of much effort on the part of integrationists. We have already encountered the integrative, interpersonal psychotherapy for depression developed by Gerald Klerman, Myrna Weissman, Bruce Rounsaville, and Eve Chevron in 1984. In 1992 Hal Arkowitz presented an integrative approach to depression that exemplified a common factors model. In 1993 Adele Hayes and Cory Newman wrote about an integrative model for depression that allowed the therapist to intervene with techniques drawn from behavior therapy, cognitive therapy, experiential therapy, interpersonal therapy, psychodynamic therapy, and biological psychiatry. As discussed earlier, the most effective therapy for chronic depression that has been introduced to date is the integrative CBASP model that was described by James McCullough in 2000.

Other integrationists have turned their attention to more severe disorders that often are impervious to the effects of traditional psychotherapies. One of the most important examples of this work was discussed earlier in this article, that being Marsha Linehan's dialectical behavior therapy for borderline personality disorder. Anthony Ryle wrote in 1997 of his successful attempt to treat borderline and narcissistic disorders with cognitive analytic therapy. Other important integrative models that have been applied to severe psychopathology include Mitchell Becker's treatment for organic disorders that he wrote about in 1993; the integrative therapy for bulimia proposed by David Tobin in 1995; Nicholas Cummings' integrative psychotherapy for substances abusers, reported on in 1993; and integrative therapies for schizophrenia discussed by David Hellcamp in 1993 and by Giovanni Zapparoli and Maria Gislon in 1999. Finally, integrative models have made inroads into areas such as health psychology, as discussed by Robert Dworkin and Roy Grzesiak in 1993. These authors described an integrative psychotherapeutic approach to the treatment of chronic pain that combined the behaviorally oriented procedures of biofeedback, hypnosis, and relaxation with psychodynamic exploration and medical interventions.

V. CASE EXAMPLE

This brief case report is drawn from the author's practice and exemplifies aspects of theoretical, assimilative integration and an instance of technical eclecticism. It overlaps to a large degree with other integrative approaches but cannot be assumed to illustrate exactly the many approaches that have been discussed in this article.

Mr. X was a 35-year-old single man who had entered psychotherapy suffering from dysthymic disorder of several years' duration. He was seen in weekly psychodynamic psychotherapy sessions. As the therapy unfolded the unconscious determinants of Mr. X's depression were explored and were interpreted to him. It became clear that Mr. X had never gotten over the dissolution of his relationships with his parents, which had occurred when the patient was in his late twenties. At that time he had abandoned a lucrative career in the financial industry to become a high school teacher. This decision was highly satisfying to him on an emotional and interpersonal level, but was experienced by his parents as a major disappointment and betrayal. After trying to "mend fences" and receiving only continued anger and criticism from his parents, Mr. X had stopped seeing and speaking to them.

As far as the patient was aware, he had gotten over his hurt, anger, and longing for contact with and approval from, his family. However, as his dreams, free associations, and reactions to the therapist were explored, it became apparent that he was stuck in a process of interrupted mourning for his parents. In this state he was beset by helpless rage at his mother and father, guilt and shame at having hurt them, and an unrealistic hope that

they would one day come to love and accept him for his choice. All of these emotions were kept outside of his awareness through active defensive processes, among which was the unwitting decision to turn his anger against himself. The outcome of these unconscious attacks on himself was to feel sad, listless, and depleted, and to be constantly plagued by self-critical thoughts and images.

Interpretation of these unconscious processes and emotions helped to gain some distance and relief from his self-critical, attacking stance, but he was still unable to feel the anger and longing that he agreed intellectually seemed to be at the core of his depression. At this point, a period of cognitive restructuring was begun, with two goals: first, to further alleviate the patient's suffering, and second, because it was assumed that the presence of these thoughts continued to turn Mr. X's anger at his parents back toward himself to externalize his anger. The use of the cognitive intervention to test this was typical of assimilative integration, as it involved using a technique from cognitive therapy in order to promote change at a psychodynamic level.

As Mr. X became increasingly successful at countering his self-critical thinking, his depressive symptoms improved significantly. He began to have longer periods during which his self-esteem was maintained. As importantly, he began to recognize that the internal stimuli for his self-criticism often were dimly perceived reminders of his parents, and he began to fully feel the anger that their rejection still evoked in him. It seemed that the integration of cognitive restructuring had in fact accomplished its assimilative goal of reaching and making more accessible to the patient previously disavowed, unconscious emotional conflicts.

As Mr. X gained more access to his anger and feelings of rejection, his guilt and sense of failure diminished greatly. However, he also experienced a powerful upsurge of longing for his parents and for their love and approval. These feelings led him to contact them, but he was rebuffed in a cold and cruel way when he refused to give into their demands to return to his old job. This experience was, of course, entirely disheartening to the patient, but did help him to recover a series of memories from his childhood, all of which were concerned with his inability to satisfy his parents' demands for academic, social, and athletic success on his part. These memories echoed his present-day experience in their emotional tome of longing for love, and of feeling essentially unlovable because of his inability to attain it from his parents.

Mr. X explored these memories, emotions, and the connected image of himself as unlovable, for a number of weeks without much progress. Remembering the success he had had with the introduction into the therapy of cognitive techniques, Mr. X asked the therapist if there might be another way to approach these issues. The therapist suggested that Mr. X might try using the empty chair technique. This method originated in gestalt therapy and involves speaking to an imaginary person whom the patient imagines is sitting in a chair in the therapist's office. This technique has been found empirically to be highly effective in helping people with "unfinished business" in this case, with Mr. X's incomplete mourning and with his longing for parental approval and love that did not seem possible to obtain. This prescriptive matching of an effective technique with a specified problem is typical of technical eclecticism, but in this case it also has an assimilative purpose. The therapist hoped that any unconscious factors that were maintaining the patient's longing could become more accessible by having Mr. X interact with the images of his parents in the sessions. As Mr. X spoke with the imaginary figures in the empty chair he was able to experience his need for love and approval in an expanded way, and found that this catharsis left him sad but comforted at the same time, with a lessened sense of need. He also became aware that he had always blamed himself for his parents' coldness and criticism. His dialogue with them helped him to become more aware of their intrinsic emotional limitations, and to separate his sense of worth and of being lovable from their inability to love. Again, the integrative technique had been successful at two levels, in this case at the experiential level for which the method had been designed, and at the psychodynamic level for which it had been integrated in an assimilative mode.

After about 11 months of therapy, Mr. X had freed himself of his dysphoric mood, but had begun to experience frequent bouts of anxiety that bordered on panic. It became clear that he also suffered from significant social anxiety that had been disguised and warded off by his depression.

Attempts to explore Mr. X's anxiety symptoms, and to identify the situational precipitants or the psychodynamic meanings of these symptoms, were fruitless and frustrating. Mr. X felt helpless and incompetent during these discussions, and the therapist eventually began to consider these interactions as constituting a transferential repetition of some past relationship in which Mr. X's distress had been responded to with a lack of concern or competence on the part of a significant other. The therapist then suggested a change of tactics: the introduction of cognitive-behavioral techniques that were aimed at relaxation, anxiety management, and self-soothing.

These techniques were employed for a number of simultaneous purposes. The first purpose was to address the clinical situation and to enable Mr. X to master his anxiety and to gain a new level of comfort when faced with anxiety. Second, these active interventions were a way to move the therapy past this stalemate, and thus to resolve the resistances involved in the patient's anxiety symptoms without addressing those resistances directly. Attempts to explore and interpret the unconsciously motivated, resistive nature of the patient's anxiety had led only to Mr. X feeling criticized, ineffective, and "stupid," and to a perception of the therapist as hostile and demeaning. Finally, the therapist hoped that by actively helping Mr. X to lessen his anxiety, the patient would have an immediate (corrective emotional) experience of being valued and cared for that would illuminate and correct the negative enactment in which patient and therapist were caught.

As Mr. X became more capable of managing his anxiety he also became more aware of the interpersonal precipitants of these symptoms, and was better able to explore the warded-off meanings as well. Most important, patient and therapist were able to reestablish a positive working alliance and to explore fruitfully the past relationships, particularly with Mr. X's father, in which Mr. X's pain and fear had been met by indifference and ridicule. As he stated, "By showing that you cared how I felt and that you were willing to help in an accepting way, you proved how different you are from my father. That allowed me to see and feel how hurt and angry I am at him for how he made fun of me when I was scared, and how I expect that, and get it from others now."

This case example demonstrates the ways in which interventions from another therapeutic system can be assimilated into psychodynamic therapy, changing the meaning and impact of that intervention, and eventuating in psychodynamic and interpersonal changes that would not be anticipated in the original (here, cognitive-behavioral and experiential) systems. The active interventions led to the reduction of painful symptoms and the acquisition of new skills, but also to a radical shift in the patient's defenses, transference situation, and his understanding of his psychodynamics. Most important, the active provision of help led to the establishment of new and benign ways of perceiving himself and important people in his life, which became the bases for hopefulness, a sense of self-worth, and a newly independent, grief-free, way of life.

VI. SUMMARY

Integrative approaches to psychotherapy blend together techniques and ideas that are drawn from the widest possible ranges of schools of psychotherapy. The goal inherent in these approaches is maximizing the patient's exposure to those factors that induce change. As such, integrative approaches represent an attempt to develop and apply, custom-fitted, broad-spectrum psychotherapies that will meet the needs of the majority of patients.

Among the many useful integrative approaches there are a number that synthesize psychoanalytic, cognitive, and behavioral features. Others emphasize the integration of humanistic and experiential therapies with more active approaches, while still a third group has focused on the combination of family systems and integrative models. Some integrative therapies are empirically tested and are guided by data, while others reflect clinical wisdom and experience.

See Also the Following Articles

Alternatives to Psychotherapy ■ Existential Psychotherapy ■ History of Psychotherapy ■ Humanistic Psychotherapy ■ Individual Psychotherapy ■ Interpersonal Psychotherapy ■ Multimodal Behavior Therapy ■ Research in Psychotherapy

Further Reading

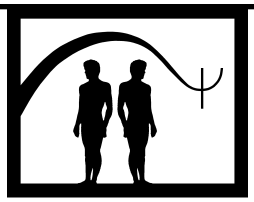
Beier, E. G. (1966). *The silent language of psychotherapy.* Chicago: Aldine.

Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work.* Washington, DC: American Psychological Association.

Cummings, N., & Cummings, J. (2000). *The essence of psychotherapy.* New York: Academic Press.

Gold, J. R. (1996). *Key concepts in psychotherapy integration.* New York: Plenum.

Hubble, M., Duncan, B., & Miller, S. (1998). *The heart and soul of change.* Washington, DC: American Psychological Association.



Interpersonal Psychotherapy

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GLOSSARY

cognitive behavior therapy (CBT) A treatment which focuses on the patient's internally based cognitions in an effort to relieve symptoms, change behavior, and ease suffering.

content affect Refers to the dominant feeling experienced at the time of a significant event.

defense mechanisms Psychological structures that assist in the modulation of internal conflicts in order to achieve harmony, both internally with demands and prohibitions, and externally with social reality and individual desires, needs, and wishes.

ego strength A term broadly referring to the ability to modulate and balance internal needs and wishes with external reality. Sometimes the term is simply used to refer to the ability to withstand threats form the external world and to modify the external world.

here and now A term that refers to present, ongoing active events in interpersonal relationships, in contrast to fantasized future or past presentations.

interpersonal incidents Descriptions by the patient of specific interactions with a significant other.

interpersonal inventory A brief description of important people in a person's life, which include the amount and quality of contact, problems in the relationship, and expectations about the relationship.

interpersonal psychotherapy (IPT) A time-limited treatment that focuses on interpersonal relationships as a means of bringing about symptom relief and improvement in interpersonal functioning.

maintenance treatment The explicit agreement to continue treatment and contact at a "lower dose" than the agreed upon for active treatment.

process affect Refers to the emotion experienced by the patient as he or she is describing to the therapist events surrounding the cause of the affect.

transference The feelings and attitudes brought about towards a person in the present that stem from unconscious feelings and attitudes derived from a relationship with a person in the past.

treatment contract The conscious and explicit understanding between the therapist and the patient, which includes the number, frequency, and duration of sessions, the clinical foci of treatment, the roles of the patient and therapist, and the planning for contingencies such as illness, lateness, missed sessions, and acceptable and unacceptable contact for out of session and off hour emergencies and behavioral expectations, such as substance abuse.

Interpersonal psychotherapy (IPT) is a time-limited treatment that focuses on interpersonal relationships as a means of bringing about symptom relief and improvement in interpersonal functioning. This article will describe the fundamental characteristics of IPT, the

theoretical basis of the treatment, and will detail several of the therapeutic interventions used in IPT.

I. TREATMENT DESCRIPTION

A. Introduction

IPT is a time-limited, dynamically informed psychotherapy that aims to alleviate patients' suffering and improve their interpersonal functioning. IPT focuses specifically on interpersonal relationships as a means of bringing about change, with the goal of helping patients to either improve their interpersonal relationships or change their expectations about them. In addition, IPT also aims to assist patients to improve their social support network so that they can better manage their current interpersonal distress.

IPT was originally developed in a research context as a treatment for major depression, and was codified in a manual developed by Klerman and colleagues in 1984. Since that time, a great deal of empirical evidence supporting its use has accumulated. As clinical experience with IPT has increased, its use has broadened to include both a number of well-specified *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV) diagnoses and the treatment of patients presenting with a variety of interpersonal problems.

IPT is based on both empirical research and clinical experience. Rather than being a static and codified treatment, IPT is designed to incorporate changes that improve the treatment, as additional data and clinical experience accumulate. Instead of being applied in a strict "manualized" form in which the clinician is required to follow precisely a treatment protocol, clinicians using IPT are encouraged to use their clinical judgment to modify the treatment when necessary in order to provide maximum benefit for their patients. The practice of IPT should be based on equal measures of empirical research, clinical experience, and clinical judgment.

B. Characteristics of IPT

IPT is characterized by three primary elements: (1) IPT focuses specifically on interpersonal relationships; (2) IPT is time limited as an acute treatment; and (3) the interventions used in IPT do not directly address the transference relationship.

1. Interpersonal Relationships

Interpersonal psychotherapy is based on the concept that interpersonal distress is linked with psychological symptoms. Thus the foci of treatment are twofold. One focus is the difficulties and changes in relationships that patients are experiencing, with the aim of helping patients to either improve communication within those relationships, or to change their expectations about those relationships. The second focus is helping patients to better utilize their social support network so that they are better able to deal with the crises that precipitated their distress.

Interpersonal psychotherapy therefore stands in contrast to treatments such as cognitive-behavior therapy (CBT) and psychoanalytically oriented psychotherapy. In contrast to CBT, in which the focus of treatment is the patient's internally based cognitions, IPT focuses on the patient's interpersonal communications. In contrast to analytically oriented treatments, in which the focus of treatment is on understanding the contribution of early life experiences to psychological functioning, IPT focuses on helping the patient to improve communication and social support in the present. Past experiences, although clearly influencing current functioning, are not a major focus of intervention.

Interpersonal psychotherapy seeks to resolve psychiatric symptoms rather than to change underlying dynamic structures. Although ego strength, defense mechanisms, and personality characteristics are all important in assessing suitability for treatment, change in these constructs are not presumed to occur in IPT. The question that should drive the therapist's interventions is, "Given this particular patient's personality style, ego strength, defense mechanisms, and early life experiences, how can he or she be helped to improve here-and-now interpersonal relationships and build a more effective social support network?"

2. Time Limit

The acute phase of IPT is time-limited. In general, a course of 12 to 20 sessions is used for the acute treatment of depression and other major psychiatric illnesses, and a contract should be established with the patient to end acute treatment after a specified number of sessions. Clinical experience has shown that having a definitive endpoint for therapy often "pushes" patients to make changes in their relationships more quickly. The time limit also influences both patient and therapist to focus on improving the patient's interpersonal functioning in current relationships.

Although empirical research is limited to controlled treatment studies in which weekly treatment is provided and then abruptly stopped, clinical experience has clearly demonstrated that tapering treatment over time is more effective. In other words, weekly sessions may be used for

6 to 10 weeks, followed by a gradual increase in the time between sessions as the patient improves, such that weekly sessions may be followed by biweekly and monthly meetings. Although acute treatment should be time-limited, both empirical research and clinical experience have clearly demonstrated that maintenance treatment with IPT, particularly for recurrent disorders such as depression, should be provided to reduce relapse risk. Maintenance IPT must be distinguished from the acute phase of treatment in IPT, and a specific contract must be negotiated with the patient for the maintenance phase.

3. The Interventions Used in IPT Do Not Directly Address the Transference Relationship

The third characteristic of IPT is the absence of interventions that address the transference aspects of the therapeutic relationship. It is readily acknowledged in IPT that transference occurs; it is a universal phenomenon in all psychotherapy. However, although in IPT the therapist's experience of transference is used to provide information about the patient and his or her interpersonal relationships, the transference relationship is not addressed directly. To do so detracts from the focus on symptom reduction and rapid improvement in interpersonal functioning that is the aim of IPT, and also typically leads to a longer course of treatment than is required for IPT. The goal in IPT is to work with the patient quickly to solve his or her interpersonal problems before problematic transference develops and becomes the focus of treatment.

Although the transference is not directly addressed, the use of transference in IPT to assess the patient's attachment style and to understand the patient's interpersonal functioning is crucial. The use of transference to formulate questions about the patient's interpersonal relationships outside of therapy is also important. The transferential experience should be used by the therapist to formulate hypotheses about the patient's interpersonal difficulties, and to ask questions about how the patient asks others for help, ends relationships, and reacts when others are not responsive to his or her needs. These questions are directed outside of the therapy relationship, however, to current interpersonal relationships.

As an illustration, consider a patient who forms a dependent relationship with the therapist. The patient may manifest this dependency as difficulty in ending sessions, calls to the therapist between sessions, or in more subtle pleas to the therapist for help or reassurance. This transferential relationship should inform the therapist about several aspects of the patient's functioning: (1) The patient is likely to have similar problems in relating to others; (2) the patient is likely to have difficulty in ending relationships; and (3) the patient has likely exhausted others with the persistent dependency. A hypochondriacal patient would be an excellent example of this kind of behavior, manifested in the ways described.

Further, the transferential experience should be used by the therapist to predict potential problems in treatment, and to modify the therapy accordingly. For instance, the therapist might hypothesize that the patient's dependency may be a problem when concluding treatment, and may begin discussing the ending of therapy much sooner than with less dependent patients. The therapist should also strongly encourage a dependent patient to build a more effective social support network, so that the patient's needs are more fully met outside of therapy rather than fostering a dependent or regressive relationship in the therapy itself. Appropriate modifications would also be made with patients who are avoidant or who manifest other personality characteristics.

C. Treatment Process

IPT can be divided into assessment (described later), initial sessions, intermediate sessions, treatment conclusion, and maintenance treatment phases. During each, the clinician has a well-defined set of tasks to accomplish. Undergirding these therapeutic tasks and techniques is the stance taken by the therapist. Clinicians should be active and maintain the focus of therapy. The therapist should also be supportive, empathic, and strongly encouraging, and should make every effort to convey a sense of hope to the patient and to reinforce his or her gains.

1. Initial Sessions

During the initial sessions of IPT (usually the first one or two meetings following the general assessment) the therapist has three specific tasks. These are (1) to conduct an interpersonal inventory; (2) to work collaboratively with the patient to determine which problem areas will be the focus of treatment; and (3) to develop a treatment contract with the patient.

The interpersonal inventory is a brief description of the important people in the patient's life, and for each includes the amount and quality of contact, problems in the relationship, and the expectations about the relationship. These descriptions need not be exhaustive; those that become treatment foci will be revisited in detail later. The purpose of the inventory is to determine which relationships to work on, and to gather further

information regarding the patient's attachment and communication patterns.

Once the inventory is complete, the patient and clinician should mutually identify one or two problem relationships on which to focus. The therapist should frame the patient's problem as interpersonal, and should give specific examples of the way in which the problem fits into one of the four problem areas: grief and loss, interpersonal disputes, role transitions, or interpersonal sensitivity.

Establishing a treatment contract is an essential part of IPT. In general, the contract should specifically address (1) the number, frequency and duration of sessions, which in general will be about 12 to 20; (2) the clinical foci of treatment; (3) the roles of the patient and therapist, particularly the need for the patient to take responsibility for working on his or her communication between sessions; (4) contingency planning: issues such as missed sessions, lateness or illness; and (5) acceptable conduct: contact out of hours, emergencies, and behavioral expectations such as substance use.

Because of the injunction in IPT to limit discussing the transferential relationship directly, the contract must serve as a rock solid point of reference for both patient and therapist. Thus when contract violations occur, the therapist can remind the patient that both had initially agreed on certain guidelines for therapy, and that the patient, by failing to meet his or her responsibility, is in essence minimizing the benefit of the treatment. The therapist would then proceed to ask questions about similar behavior outside of the therapeutic relationship.

2. Intermediate Sessions

During the intermediate sessions of IPT, the patient and therapist work together to address the interpersonal problems identified during the assessment. In general, work on these issues proceeds in the following order: (1) identification of a specific interpersonal problem; (2) a detailed exploration of the patient's perception of the problem, including communication patterns and expectations about the relationship; (3) collaborative brainstorming to identify possible solutions to the problem; (4) implementation of the proposed solution; and (5) reviewing the patient's attempted solution, with positive reinforcement of the changes made and discussion of refinements to be carried out.

The tasks of the therapist in the intermediate sessions of IPT are to assist the patient in discussing his or her problematic interpersonal relationships, and to attend to the therapeutic relationship. In addition, the therapist must actively work to maintain the focus of therapy, rather than encouraging or allowing the patient to talk about peripheral issues.

Once a specific issue is identified, the therapist should encourage the patient to describe his or her perceptions and expectations about the relationship problem. Whether it is a problem in communication or a matter of unrealistic expectations, the patient and therapist work collaboratively to brainstorm and identify possible solutions. The patient is responsible for attempting to implement the agreed upon solution, and to provide feedback regarding the attempted solution and its results at the next session. The therapist and patient then review these results and make modifications as needed.

A number of solutions can be considered in IPT. For instance, a change in communication to a style that is more direct may be of help with a dispute. A change in circumstances, such as a change in location or in employment, may be of benefit during a role transition. Changes in expectations, with a movement toward other social support, are also viable options. In IPT, however, the endpoint of therapy is not simply insight; it is change in communication, behavior, and social support that leads to symptom resolution.

3. Completing Acute Treatment

Acute treatment with IPT comes to an end as specified by the therapeutic contract. There are both theoretical and practical reasons for keeping acute treatment with IPT time-limited. The time limit is very effective in generating change, as it often compels patients to work more rapidly on improving communication skills and building more effective social networks. In addition, the time limit influences both patient and therapist to focus on acute symptoms rather than on personality change. Moreover, to extend IPT beyond the acute time frame may lead to the development of problematic transference, as the relationship between patient and therapist assumes greater importance.

On the other hand, the success of therapy is also dependent on the patient's belief that the therapist is committed to helping the patient, and that the patient's needs supercede other considerations. The IPT therapist should prioritize helping the patient ahead of satisfying the dictates of a manualized protocol. Consequently, if extending the therapy beyond the number of sessions initially agreed upon is clearly in the patient's best interest, then it should be extended. The apparent conflict between maintaining the therapeutic contract and extending sessions when needed can be resolved by renegotiating a new treatment contract with the patient. Clinical judgment should be used to make such a decision.

Clinical experience with IPT strongly suggests that the best clinical practice is usually to extend the interval between sessions once the patient is in the recovery stage of acute treatment. Rather than continuing to meet weekly, the patient and therapist may choose to meet biweekly or even monthly toward the end of treatment. This gives the patient further opportunities to practice communication skills, to reinforce the changes that have been made, and to develop more self-confidence while remaining in a supportive relationship, all of which facilitate better and more stable functioning.

As the primary goals of IPT are symptom relief and improvement in interpersonal functioning, the specific aims of treatment conclusion are to foster the patient's independent functioning and to enhance his or her sense of competence. The therapist is still available should a future emergency arise, but the expectation is that the patient will quite capably function independently.

4. Maintenance Treatment

Rather than using the traditional psychoanalytic model in which "termination" is a complete severing of the therapeutic relationship, concluding acute treatment with IPT does not signify the end of the therapeutic relationship. In fact, in IPT it is usually agreed that there will be therapeutic contacts in the future, and provision is specifically made for these. Clinical experience, theory, and empirical evidence all make clear that IPT should be conceptualized as a two-phase treatment, in which a more intense acute phase of treatment focuses on resolution of immediate symptoms, and a subsequent maintenance phase follows with the intent of preventing relapse and maintaining productive interpersonal functioning. Therefore, the therapist should specifically discuss future treatment with the patient prior to concluding therapy. A specific contract should be established with the patient for the specific alternative for the provision of maintenance treatment that is chosen. Options include specifically scheduling maintenance sessions at monthly or greater intervals; concluding acute treatment with the understanding that the patient will contact the therapist should problems recur; or planning to have the patient contact another provider in the future. Decisions about how to structure future treatment should rely on clinical judgment.

In essence, IPT follows a "family practice" or "general practitioner" model, in which short-term treatment for an acute problem or stressor is provided until the problem is resolved. Once resolved, however, the therapeutic relationship is not terminated; as with a general practitioner, the therapist makes himself or herself available to the patient should another crisis occur, when another time-limited course of treatment can be undertaken. In the interim, the therapist may choose, like a general practitioner, to provide "health maintenance" sessions periodically. There is no compelling clinical or theoretical reason to come to a complete termination with most patients in IPT, while the data clearly support the benefit of maintenance treatment.

D. Techniques and Therapeutic Process

It is the focus on extra-therapeutic interpersonal relationships rather than any particular intervention which characterizes IPT. Not surprisingly, given its psychodynamic roots, IPT incorporates a number of "traditional" psychotherapeutic methods, such as exploration, clarification, and even some directive techniques. While there are no techniques which are actually forbidden in IPT, all should be used in the service of helping the patient to modify interpersonal relationships.

More important that any techniques, however, is the establishment of a productive therapeutic alliance. Warmth, empathy, genuineness, and conveying unconditional positive regard, though not sufficient for change, are all necessary for change in IPT. Without a productive alliance, the patient will flee therapy, an obstacle which no amount of technical expertise can overcome.

A primary goal of the IPT therapist should be to understand the patient. If the patient does not perceive that the therapist is truly committed to doing this, the patient will not readily disclose information, will not feel valued as an individual, and will not develop a meaningful relationship with the therapist. Working to understand the patient should always take precedence over any technical interventions. Further, all IPT interventions should be therapeutic; the ultimate value of an intervention is the degree to which it helps the patient. Techniques should not be used simply because they are included in a manualized protocol; the benefit to the patient should guide the interventions used in treatment.

1. Nonspecific Techniques

Nonspecific techniques are generally understood as those that are held in common across most psychotherapies. Examples would be the use of open-ended questions, clarifications, and the expression of empathy by the therapist. These techniques play a crucial role in IPT, as they serve to help the therapist understand the patient's experience, convey that understanding to the patient, and to provide information regarding the genesis

of the patient's problems and potential solutions to them. Techniques such as problem solving with the patient, giving directives, and assigning homework can also be used judiciously in the service of facilitating interpersonal change.

2. Communication Analysis and Interpersonal Incidents

The analysis of the patient's communication patterns is one of the primary techniques used in IPT. The therapist's task is to assist the patient to communicate more clearly what he or she wants from significant others. Communication analysis requires that the therapist elicit information from the patient about important interpersonal incidents. Interpersonal incidents are descriptions by the patient of specific interactions with a significant other. If the identified dispute results in a pattern of fighting between spouses, the therapist might ask the patient to "describe the last time you and your spouse got into a fight," or to "describe one of the more recent big fights you had with your spouse." The therapist should direct the patient to describe the communication that occurred in detail, re-creating the dialogue as accurately as possible. The patient should describe his or her affective reactions as well as both verbal and nonverbal responses, and describe observations of his or her spouse's nonverbal behavior.

The purpose of discussing an interpersonal incident is twofold: (1) to provide information regarding the miscommunication that is occurring between the parties; and (2) to provide insight to the patient about the unrealistic view that the problem is intractable. The goal in working through an interpersonal incident is to examine the patient's communication so that maladaptive patterns of communication can be identified. The patient can then begin to modify his or her communication so that his or her attachment needs are better met.

3. Use of Affect

The more the patient is affectively involved in the issues being discussed, the greater the motivation to change behavior or communication style. Consequently, one of the most important tasks for the IPT therapist is to attend to the patient's affective state. Of particular importance are those moments in therapy in which the patient's observed affective state, and his or her subjectively reported affect, are incongruent. Examining this inconsistency in affect can often lead to breakthroughs in therapy.

Affect can be divided into that experienced during therapy (process affect) and that reported by the patient to have occurred in the past (content affect). Content affect refers to the predominant affect experienced at the time of a significant event. For instance, a patient might describe feeling "numb" at the time of the death and funeral of a significant other. Process affect, on the other hand, refers to the affect experienced by the patient as he or she is describing to the therapist the events surrounding the loss. The same patient, for example, might describe a "numb" feeling at the time of the funeral, but when describing the event to the therapist might be in tears, and feeling sadness, or perhaps anger. When met with this incongruence in affect, the therapist can focus directly on the discrepancy between content and process affect. In other words, when the report the patient gives about how he or she felt during an interpersonal event is different from the affect he or she is exhibiting during the session, it should be noted by the therapist and explored further.

4. Use of Transference

Transference is a universal occurrence in all psychotherapies, and plays an extremely important part in IPT. However, in contrast to longer-term psychodynamic therapies, information gleaned from the transference that develops during IPT, although an important source of data, is not typically a point of intervention.

By observing the developing transference, the IPT therapist can begin to draw hypotheses about the way that the patient interacts with others outside of the therapeutic relationship. Sullivan coined the term "parataxic distortion" to describe this phenomena: The way in which a patient relates to the therapist in session is a reflection of the way in which he or she relates to others as well. Attachment theory also supports the idea that individuals tend to relate to others in a manner that is consistent both across relationships and within relationships. Thus the transference or parataxic distortion recognized by the clinician provides a means of understanding all of the other relationships in the patient's interpersonal sphere.

Using these data, the therapist can then begin to draw conclusions about the patient's attachment style and problems in communicating to others. The therapist should ask questions to confirm or disprove these hypotheses. For instance, if the therapist notes that the patient tends to be deferential in therapy, hypothesizing that the patient tends to be the same way in other relationships is reasonable. The therapist may want to ask about the experiences (or difficulties) that the patient has had in confronting others, or in dealing with rejection. Similarly, if the patient behaves in a dependent manner during therapy, the therapist may ask about

how the patient maintains relationships, or about experiences the patient has had in ending relationships.

The key difference between IPT and transference-based therapies is that the IPT therapist should avoid making transference comments, and particularly interpretations, about the therapeutic relationship. As long as a reasonably positive transference is maintained, therapy can proceed without the need to focus on it. The therapist should focus instead on the here-and-now problems in the patient's extratherapy interpersonal relationships. With well-selected patients, keeping the therapy short-term allows the therapist to assist the patient to solve his or her interpersonal problems before the transference becomes intense, and as a result, becomes the new focus of therapy.

E. Interpersonal Model

1. Problem Areas

IPT focuses on four specific interpersonal problem areas: grief and loss, interpersonal disputes, role transitions, and interpersonal sensitivity. Psychosocial stressors from any of the problem areas, when combined with an attachment disruption in the context of poor social support, can lead to interpersonal problems or psychiatric syndromes. Although these categories are useful in focusing the patient on specific interpersonal problems, it is important to be flexible when using them. Rather than "diagnosing" a specific category, the problem areas should be used primarily to maintain focus on one or two interpersonal problems, particularly as the time available in IPT is limited. Because the interpersonal problems experienced by patients are all derived from the combination of an acute interpersonal stressor combined with a social support system that does not sufficiently sustain the patient, effort should always be directed toward improving the patient's social supports as well as addressing the specific problem.

a. Grief and Loss. Grief in IPT can best be conceptualized as a loss experienced by the patient. In addition to the death of a significant other, a loss such as divorce may be seen by the patient as a grief issue. Loss of physical functioning, such as that following a heart attack or traumatic injury, may also appropriately be considered in the grief problem area.

The therapist's tasks are to facilitate the patient's mourning process, and to assist the patient to develop new interpersonal relationships, or to modify existing relationships to increase social support. Although new or existing relationships cannot "replace" the lost relationship, the patient can reallocate his or her energies and interpersonal resources over time.

Several strategies are useful in dealing with grief issues. Primary among these is the elicitation of feelings from the patient, which may be facilitated by discussing the loss and the circumstances surrounding it. The use of process and content affect may be quite useful. Often the patient will initially describe the lost person as "all good" or "all bad," and be unaware that this idealization (or devaluation) covers other contradictory feelings. Grief issues commonly involve layers of conflicted feelings surrounding the lost person, and assisting the patient to develop a "three-dimensional" picture of the lost person, including a realistic assessment of the person's good and bad characteristics, is a helpful process in the resolution of the grief.

This same process can be used for other losses as well, such as the loss of a job, a divorce, or loss of physical functioning. In such instances the patient will also need to grieve the loss, and to move toward establishing new social supports. Encouraging patients to develop a more realistic view of their loss is helpful as well.

b. Interpersonal Disputes. The first step in dealing with interpersonal disputes is to identify the stage of the conflict, and to determine whether both parties are either actively working to solve the problem, have reached an impasse, or have reached a point at which dissolution is inevitable. Successful treatment does not necessarily require that the relationship be repaired. Resolutions to the conflict may be to modify the relationship, to modify expectations about the relationship, or to exit the relationship. The important point is that the patient makes an active and informed decision about the relationship.

A primary goal of treatment is to assist patients with interpersonal disputes to modify their patterns of communication. Patients may become locked in patterns of communication with others that result in misunderstanding, or in cycles of escalating affect. The therapist can assist the patient to communicate his or her needs more clearly and productively, rather than provoking hostile responses. The therapist should model direct communication to the patient, and may engage the patient in role playing to reinforce the new communication. Although IPT is generally an individual therapy, inviting a significant other to therapy for several conjoint sessions can be an invaluable way to observe the communication *in vivo,* and to begin to help the couple to make changes in their interactions.

C. Role Transitions. Role transitions encompass a huge number of possible life changes. Included are life cycle changes such as adolescence, childbirth, and decline in physical functioning, and social transitions such as marriage, divorce, changes in job status, and retirement. Typical problems include sadness at the loss of a familiar role, as well as poor adaptation or rejection of the new role. Role transitions often result in the loss of important social supports and attachments, and may require new social skills.

The therapist should assist the patient in moving from his or her old role, which includes assisting the patient to experience grief over the loss, often using some of the techniques described for dealing with grief issues. It is crucial to help the patient to develop a realistic and "balanced" view of the old role, including both positive and negative aspects. Assisting the patient to develop new social supports is also essential.

d. Interpersonal Sensitivity. There are some patients who either because of personality traits, avoidant attachment styles, or other factors, may have problems with poor interpersonal functioning. "Interpersonal sensitivity" refers specifically to a patient's difficulty in establishing and maintaining interpersonal relationships. Patients with interpersonal sensitivities often require a different approach than is utilized with patients who have better social skills.

Patients with interpersonal sensitivities may have few, if any, interpersonal relationships to discuss in therapy. Relationships with family members, although they may be quite disrupted, may be some of the only relationships the patient has. The therapeutic relationship may also take on greater importance, as it too may be one of the patient's only relationships. The therapist should be prepared to give feedback to the patient regarding the way he or she communicates in therapy, and may utilize role-playing to practice skills with the patient. In addition, the therapist should assist the patient to get involved in appropriate social groups or activities in the community. Above all, the therapist and patient must keep in mind that the therapy is not designed to "correct" the social difficulties, but rather to teach the patient some skills to build new relationships, and to relieve his or her acute distress.

II. THEORETICAL BASIS

IPT is grounded in attachment theory, which as described by Bowlby among others, rests on the premise that people have an instinctual and biological drive to attach to one another. When crises occur, individuals seek reassurance and care from those important to them. Interpersonal communication is intrinsic to this process, and individuals who cannot effectively ask for care, and consequently cannot obtain the physical and psychological care they need, will suffer as a result. When interpersonal support is insufficient or lacking during times of stress, individuals are less able to deal with crises and are more prone to develop psychiatric symptoms.

Bowlby described three different types of attachment styles that drive interpersonal behavior. Secure attachment describes individuals who are able to both give and receive care, and are relatively secure that care will be provided when it is needed. Because securely attached individuals are able to communicate their needs effectively, and because they are able to provide care for others, they typically have good social support networks. Thus they are relatively protected from developing problems when faced with stressors.

Anxious ambivalent attachment, in contrast, is a style in which individuals behave as if they are never sure that their attachment needs will be met. Because of this, such individuals believe that care must be sought constantly. Such individuals often lack the capacity to care for others, since their concern about getting their own attachment needs met outweighs all other concerns. Consequently, they have a relatively poor social support network, which in combination with their difficulties in enlisting help, leave them quite vulnerable to interpersonal stressors.

Individuals with anxious avoidant attachment typically behave as if care will not be provided by others in any circumstances. As a result, they avoid becoming close to others. The paucity of their social connections, along with their tendency to avoid asking for help during times of crises, leaves these individuals quite prone to difficulties.

In essence, attachment theory states that those individuals with less secure attachments are more likely to develop psychiatric symptoms and interpersonal problems during times of stress. A persistent belief that care must be constantly demanded from others, or that care will not be provided by others, typically leads insecurely attached individuals to have more difficulty in asking for and maintaining social support during times of crisis. Severe disruptions of important attachment relationships, such as the death of a significant other, also lead to an increased vulnerability to psychiatric symptoms.

Interpersonal psychotherapy also follows the biopsychosocial model of psychiatric illness, resting on the

premise that psychiatric and interpersonal difficulties result from a combination of interpersonal and biological factors. Individuals with a genetic predisposition are more likely to become ill when stressed interpersonally. On this foundation rests the individual's temperament, personality traits, and early life experiences, which in turn are reflected in a particular attachment style. The attachment style may be more or less adaptive, and has effects on the person's current social support network and his or her ability to enlist the support of significant others. Interpersonal functioning is determined by the severity of current stressors in the context of this social support.

Interpersonal psychotherapy is therefore designed to treat psychiatric symptoms by focusing specifically on patients' primary interpersonal relationships, particularly in the problem areas of grief, interpersonal disputes, role transitions, and interpersonal sensitivity. This is done by helping the individual to recognize and modify his or her communication patterns, which has a threefold effect. First, it leads to more effective problem solving, as conflicts can be more directly addressed. Second, it improves the patient's social support; communicating in a way to which others can more readily respond will more effectively meet the patient's attachment needs. Third, these improvements in communication and in conflictual relationships, and improved social support, help resolve the interpersonal crisis and result in symptom resolution.

III. APPLICATIONS AND EXCLUSIONS

The purpose of conducting an assessment is to determine when IPT should be used, and to whom it should be applied. The assessment may take several sessions to complete. It is only after the assessment, and the determination that the patient is suitable, that IPT should formally begin.

During the assessment, the therapist should evaluate the patient's attachment style, communication patterns, motivation, and insight. Assessment of DSM-IV diagnoses should also occur. IPT should not, however, be restricted only to patients with DSM Axis I diagnoses; it is quite suitable for patients with a variety of interpersonal problems such as work conflicts or marital issues. In fact, because patients without major psychiatric illness often have more secure attachments and better social support networks, they are usually able to utilize IPT very effectively.

Special attention should be paid to patients diagnosed with personality disorders. Those with cluster A disorders including paranoid, schizoid, and schizotypal personality disorders may be unable to form effective alliances with their therapists in short-term therapy, whereas those with severe cluster B disorders such as narcissistic, histrionic, borderline, and antisocial personality disorders may require more intensive therapy than can be provided in an IPT format. However, many patients with depression or anxiety superimposed on a personality disorder may benefit a great deal from short-term therapy with IPT if the focus is on the treatment of the depression or anxiety rather than on personality change.

The assessment should include an evaluation of the patient's attachment style. This should consist of information about the patient's perception of his or her patterns of relating to others, and an evaluation of the patient's past and current relationships. Questions regarding what the patient does when stressed, ill, or otherwise in need of care are particularly helpful. The patient should also be queried about his or her typical responses when asked to assist others.

The patient's attachment style has direct implications regarding his or her ability to develop a therapeutic alliance with the therapist and the likelihood that treatment will be beneficial. Those patients with more secure attachment styles are usually able to form a more productive relationship with the therapist, and because of their relatively healthy relationships outside of therapy, are also more likely to be able to use their social support system effectively. Individuals with more anxious ambivalent attachments can usually quickly form relationships with their clinicians, but often have difficulty with the conclusion of treatment. Those with anxious avoidant attachments may have difficulty trusting the therapist. Consequently, when working with anxious avoidant patients, the therapist may need to spend the initial sessions working on developing a productive therapeutic alliance, waiting until a good alliance is established before moving into more formal IPT work.

The therapist should also use the assessment to forecast and plan for problems that may arise during therapy. For example, because patients with anxious ambivalent attachment styles often have difficulty in ending relationships, the therapist may modify his or her approach by emphasizing the time-limited nature of the treatment, and by discussing the conclusion process earlier. Significant others may also be included in sessions more frequently to ensure that therapeutic dependency does not become a problem. When working with avoidant patients, the therapist should plan to spend several sessions completing an assessment, taking great care to convey a sense of understanding and empathy to the patient.

The therapist should conduct an assessment of the patient's communication style. The way in which the patient communicates his or her needs to others has profound implications for the therapeutic process, as well as for the likelihood that the patient will improve with therapy. The therapist should directly ask the patient for examples or vignettes in which a conflict with a significant other occurred. Patients who are able to relate a coherent and detailed story are likely to be able to provide the narrative information necessary to work productively in IPT. Insight can also be judged by noting the way in which the patient describes an interaction, and the degree to which the other person's point of view is accurately represented.

In general, patients who have characteristics that render them good candidates for all of the time-limited therapies will be good candidates for IPT. These include motivation, good insight, average or better intelligence, and sufficient ego functioning. Other characteristics specific to IPT include (1) a specific interpersonal focus of distress, such as a loss or interpersonal conflict; (2) a relatively secure attachment style; (3) the ability to relate a coherent narrative; and (4) a good social support system.

IV. EMPIRICAL STUDIES

Interpersonal psychotherapy has been demonstrated to be efficacious in a number of research studies; at present, with the exception of cognitive therapy, IPT enjoys more empirical support than any other form of psychotherapy. Since the initial studies of IPT in 1979 by Klerman, Weissman, and colleagues, IPT has been demonstrated to be efficacious with a number of depressed populations, including depressed geriatric patients, depressed adolescents, depressed patients who are HIV-positive, and patients with dysthymic disorder. IPT has also been used for both postpartum and antenatal depression. In addition, it has been tested with patients in the depressed phase of bipolar disorder and with eating disorders.

Largely because of the success of the early efficacy studies, IPT, along with CBT, was chosen as a comparative psychotherapeutic treatment in the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH-TDCRP). Both were compared to treatment with imipramine and with placebo over 16 weeks. IPT was found to be superior to placebo, and was equal to imipramine and CBT for mild to moderate depression. Neither psychosocial treatment was as effective as imipramine for severe depression. The consensus from the NIMH-TDCRP study is that IPT and CBT are effective for mild to moderate depression, but that antidepressant medication should remain the gold standard treatment for severe depression.

Another major study evaluating IPT involved maintenance treatment of patients with recurrent depression. Acutely depressed patients who had suffered at least three prior episodes were treated with a combination of imipramine and IPT over 16 weeks. Patients who recovered were then assigned to one of five maintenance treatments: (1) imipramine alone; (2) imipramine plus monthly IPT; (3) monthly IPT alone; (4) monthly IPT plus placebo; and (5) placebo alone. The patients were then followed for 3 years.

Mean depression-free survival time was significantly longer for those patients who received imipramine alone or imipramine plus IPT. Over 3 years, the mean time before relapse of depression was about 120 to 130 weeks for patients who received imipramine with or without IPT as an adjunct. The patients who received IPT alone or IPT plus placebo had a mean survival time of about 75 to 80 weeks. Although significantly better than the mean survival of patients who received only placebo (roughly 40 weeks), treatment with IPT alone was not as beneficial as treatment with maintenance antidepressant medication. The current consensus is that recurrent depression should be treated with maintenance antidepressant medication, with IPT a viable alternative for patients who do not want or who cannot tolerate medication.

Currently IPT is being investigated for use with social phobia and somatization disorder. The use of IPT has also been described with groups, couples, and in a family practice setting. Excellent reviews of this research can be found elsewhere.

The research on IPT clearly demonstrates its efficacy as a time-limited treatment for acute depression, and as an effective alternative to medication for patients with recurrent depression. Further, there are numerous studies that suggest that IPT may be efficacious for patients with a variety of DSM-IV Axis I disorders.

V. SUMMARY

Interpersonal psychotherapy is characterized by three essential elements: a focus on interpersonal relationships, a contract that specifies a time limit for therapy, and the use of interventions that focus on relationships outside of therapy rather than on the transference relationship. Attachment theory undergirds the approach used in IPT, and the attachment style of the patient

should instruct the therapist about the patient's suitability for treatment, prognosis, and the potential problems that may arise in therapy. Further, the patient's attachment style should inform the therapist about the ways in which the therapy can be modified.

Interpersonal problems and psychiatric symptoms are conceptualized within a biopsychosocial framework. An acute interpersonal crisis, such as a loss, interpersonal dispute, or a difficult life transition, creates problems for patients for two reasons: (1) Their interpersonal communication skills within their significant relationships are not adaptive; and (2) their social support network is not sufficient to sustain them through the interpersonal crisis. IPT proceeds by helping patients to communicate their attachment needs more effectively, to realistically assess their expectations of others, and to improve their social support. This should help resolve interpersonal problems and relieve psychiatric symptoms.

The conduct of IPT is based on a three-point foundation. First, the practice of IPT rests on empirical research. Second, the practice of IPT reflects clinical experience. Finally, and most important, the practice of IPT includes the use of clinical judgment: The therapist must recognize the unique nature of the relationship with the unique individual with whom he or she works, and must always place the needs of the patient above a strict adherence to a manual. Given these foundational supports, IPT is an efficacious, effective, and extremely useful clinical approach to interpersonal problems.

See Also the Following Articles

Grief Therapy ■ Structural Analysis of Social Behavior ■ Sullivan's Interpersonal Psychotherapy ■ Time-Limited Dynamic Psychotherapy

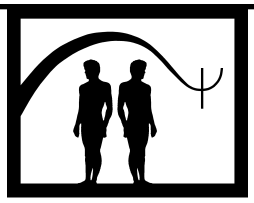
Further Reading

Bowlby, J. (1988). Developmental psychiatry comes of age. *American Journal of Psychiatry, 145,* 1–10.

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression.* New York: Basic Books.

Stuart, S., & Robertson, M. (2002). *Interpersonal psychotherapy: A clinician's guide.* London: Edward Arnold Ltd.

Weissman, M. M., Markowitz, J. W., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy.* New York: Basic Books.



Interpretation

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GLOSSARY

genetic History of the individual encompassing both biological influences, the temperamental givens in birth and development, and the prior influences of environmental nurture and stressors.

internalization Process by which the new knowledge conveyed by the interpretation becomes syncretic with the person's expanded sense of self.

interpretation Technique for reformulating the many competing and conflicting modes of thought from the multiple developmental epochs of the mind.

I. INTERPRETATION: A DEFINITION

Interpretation is a basic process in psychoanalysis and psychotherapy by which old information of the patient is translated into a new syntax of self-understanding by a therapist. It is a fundamental element of the process of psychological healing. The act of interpretation simultaneously promotes psychological repair and is the mode for bringing about psychological change in the individual. It is a technique by which one individual, the psychotherapist or analyst, plumbs the unconscious mind of the analysand or patient with the purpose of bringing to light new cognitive connections, new feeling states, and new perspectives on human relationships. Interpretation involves a reformulation of the affected mind to address the defensive intellectualizations, rationalizations, and denials of fact and outer reality that have been erected by individuals to salvage and preserve their limited and compromised sense of identity and being, such as it is. Interpretation connects the latent and manifest meanings that reside in a person's psyche as they emerge in the context of a special therapeutic relationship. This relationship consists of transference of past history on the part of the patient onto his or her image of the therapist and countertransferential empathic referencing of this transference on the part of the therapist. Interpretation provides a medium and context for further objectification of the individual's subjective experience, leading to an increase in capacities for insight, self-analysis, and self-interpretation. On another level these shifts in reflection are accompanied by new senses of self and identity in relation to others. When it works well interpretation brings about incrementally and occasionally dramatically a new language of self in a new key.

II. WHY INTERPRETATION?

To understand interpretation and its fundamental role in the therapeutic action in dynamic treatments,

psychotherapy, and psychoanalysis it is first necessary to review some central concepts about the growth and functioning of the mind. The brain provides the biological engine of the mind. Dysfunctions of the brain can readily translate into disorders of the mind. The mind is also capable of its own disorders apart from neurophysiology that are related to its often imperfect attempts to synthesize the conflicting types of information that it is presented with and the divergent modes by which it processes that information. For instance, one of the great paradoxes of human existence involves the presence of a sense of both mindedness and mindlessness in our psychology. The evolution of mankind's capacities for consciousness, self-awareness, and self-reflection are central aspects of what separates homosapiens from other organisms. The human capacity for thought that extends beyond the immediate neural responses to stimuli for the purposes of obtaining pleasure, release, or avoiding unpleasure is present and developed in humans as in no other species. The capacity for mental activity that goes beyond the immediate and relatively fixed response to signal forms of activity adds variety to human behavior and to the possibility of thinking about things.

We have a potential and actual psychology that we share, communicate, and talk about in myriad ways. Many organisms may use signs and signals to communicate. These occur without a sense of memory and foreknowledge and the mutually reinforcing transfer of information and intellect that we both observe and infer in humans. In the realm of feelings and affective life, while flight and/or fight provides a foundation of basic organismic and affective responses, the dimension of time adds complexity, depth, and layers of feelings and shared understanding. The apprehension of a dangerous or painful future becomes the foundation for a complex of anxieties and is something that humans share. The memory of a noxious past in the form of depressive dread is part and parcel of human existence in a world of psychological infinitude that continues through and beyond time. We possess minds that meet, diverge, that are lost and found but that are nonetheless capable of thinking about a self or other selves through a unique medium that we call psychological mindedness.

The other part of the paradox of mindedness that I referred to earlier is mindlessness. Mindlessness in psychoanalytic terms represents preconscious and unconscious realms and aspects of our minds that are typically "lost" or unknown. We conceptualize the disavowed "mindless" unconscious as originating in our psychological prehistory. It emerges as part of the earliest psychological stirrings and questings of the infant-organism. As such it contains all the contradictions and conflicts of the organism's attempt to derive a structure and function of thought from rudimentary physical and psychological experience. In Freud's original terms we come to conceptualize this first infant area of psychological strata as primary process thought. Primary process thought is an "unminded" mode of thinking about perceptions that we think are experienced by the infant and are reported by the adult as occurring in a relatively monadic context. There are few social referents in this realm. It is a way of perceiving that will eventually give way through experience, learning, socialization, and neuropsychological maturation to the dyadic mindedness and organized cognition of secondary process thought.

The toll on the developing brain of managing these divergences of mind and consciousness is that certain modes of thought and experience are relegated to unconscious mental functioning. This is the price to be extracted for resolving conflicts between one part of the mind and another. We describe this as intrapsychic conflict resolution. This mode may also be active in resolving conflict between the psyche and forces or beings in the outer world, what we refer to as interpsychic conflict resolution. Both forms may be, and often are, sequestered in the "mindless," disavowed regions of unconscious thought although each area of conflict may also have its derivatives in consciousness.

The result of such syntheses is that we split our consciousness in our waking state and to some lesser extent in our sleeping state. We must think and act as though we know what we are doing and responding to in its entirety even when, in fact, we know only a portion, sometimes only a small portion, of the picture of perception and response. If our responses become stereotypic with fixed outcomes that seem not to benefit from experience and learning, we categorize such responses as "neurotic." Neurosis is a quality of experience that is driven more by the need to appease the internal psychic economy of the individual than it is geared to benefiting from novel experiences and attaining a newer and better adaptation of inner and outer worlds. What in the optimum sense should be a part of mindedness becomes instead coopted by conflict resolution that leads to repetitive behaviors and circular modes of thought. Thus the child who has been severely abused and neglected by a parent may continue to encounter such a parent in his many relationships throughout life as though to work out through repetition the trauma of the early parental catastrophe. Such neurotic modes affirm a mindless frozen psychological state in which

what is unconscious dictates mental outcome rather than facilitating new levels of mentation and psychological organization. In the example just given that would mean having the psychological flexibility to move on to appreciate and appropriate the new opportunities for nurturing and nontraumatic mothering in later life figures or thought.

The therapist is the agent necessary to make interpretations and shed new light on dim repetitions. Such interpretations are delivered in a value-neutral manner except insofar as they carry with them an investment in the patient acquiring increasing self-perspective and making a psychological recovery. To cite another example, the power of an individual's anger may be blocked from perception and expression, or, conversely, it may be expressed in overly strong and inappropriate ways. In either case the person is unable to face the threat that anger poses. They may feel either paralyzed in the first instance or defeated by their own rage in the second. They require interpretation of what they are unaware of through the medium of a significant and trusted other to be able to link up all levels of the neurotic feeling state that has brought with it either such an overabundance or a paucity of action.

We equate "healthy" psychological development with a wholeness of consciousness; one that admits to opposites, similarities, ambiguities, and divergent lines of thought. We look for flexibility, adaptability, and the capacity to ride through life's inevitable conflicts so as to arrive at some sort of stability and interpenetration of conscious thought with unconscious fantasy that enlarges and deepens the individual's engagement with inner and outer worlds. The need for interpretation is always there, but healthy individuals are less blocked and more able to provide meaningful reformulations of everyday events. They are able to learn from their experience and the experience of others without the aid of special pleadings of special agents.

To approach the matter of interpretation from a somewhat different direction, in the ideal, because we are capable of empathy, putting oneself in the mind of another, there exists the possibility of psychological healing. The prototype for this experience is the mother's psychological work in intuiting and inferring the affective and cognitive state of her nonverbal infant and then taking the necessary steps physically or psychologically to remedy its distress. If the child was cold and wet, warmth and dryness would be the soothing response. This response would permit the infant to identify such a state, not from the affective perspective of anxiety and helplessness, but with the anticipation and optimism that the ministrations of another are correct, timely, and will bring relief. Ultimately this would allow for the development of the capacity for self-soothing through the process of internalization. If the infant is fearful of separation from the mother or the presence of strangers, the mother's adoption of a calm stance through verbal tone, words, and actions will eventually increase the child's sense of security in the mother's availability and protectiveness. Such interpretive understanding translates into the child's taking in the mother's loving presence. If things go wrong in such situations the child will end up afraid of anxiety and distrustful of the adult's abilities to understand and remedy their fear of the strange. Over time the infant becomes more able to take in, to internalize, the mother's empathic actions. This eventuates in the ability to consciously and unconsciously soothe and care for themselves in situations of potential estrangement or physical discomfort.

This empathic paradigm is the cornerstone of psychological healing. By means of it, one participant, the therapist, listens and observes another person, the patient, in distress and infers and interprets the hidden and unconscious elements that have led them to repeatedly hit the same mental block as in their love and work lives.

In 1901 Freud originally introduced the technical lynchpin of interpretation in his classic work *The Interpretation of Dreams*. In its initial guise in his attempts to treat hysteria, interpretation involved a "Rumpelstiltskin" sort of technique in which deep understanding by the therapist was converted into memory of genetic events that were expected to magically change the patient's symptomatology. In most versions of the fairy tale "Rumpelstiltskin" if the princess whom Rumpelstiltskin has given a baby can guess his name she may keep the baby and he will vanish. In his treatment of hysterics Freud had started from the notion that as a group hysterics suffer from their reminiscences. His remedy was to go to the heart of their problems and with his profound powers of intuition wrench into consciousness the unconscious amnesic event that was causing the hysteric's symptoms. This would lead to their cure. In this early theory, by finding the "gnome" of their neurosis and labeling it would cause it to vanish.

By 1901 Freud had progressed to the point past labeling the trauma to using the interpretation of dreams as the agent of therapeutic action by which what was unconscious in the manner of unacceptable wishes and impulses was made conscious. Thus he articulated the unconsciously dominated nature of dreams and the light

that their interpretation could shed on the neuroses of everyday life and what had amounted to, heretofore, the individual's mindless domination by their unconscious. The interpretation of a person's dreams was conducted mainly in the context of their own personal meanings and metaphors. The previous historical emphasis had been on dreambook and cookbook kinds of understanding of generic dream symbolism. Inherent in such an approach was a grammar of dream symbolism that attributed meanings to symbols on an abstract basis that was divorced from the possibility that the dreamer might have developed idiosyncratic meanings of their own for the objects and dynamics encountered in their dream life. The analysis of a dream is an example par excellence of the proposition regarding healing that resides in the phenomenon of interpretation. It is the rare individual, and Freud was certainly one, who can interpret the multilayered meaning of one's own dream. To arrive at such meanings usually requires two minds and the convergence of the unconscious "mindlessness" of both parties. The exercise involved in this meeting with another mind may allow the dreamer to eventually carry on the work of dream interpretation independently, just as the exercise of analysis may set the stage for future self-analysis.

In the early era of id psychology, interpretation enjoyed a decade's reign during which it was considered "the royal road to the unconscious" and thus the avenue of therapeutic cure. As the subsequent development of analysis has borne out, innovations expand the range of treatment but they also reveal the shortcomings of the current dominant technique and point toward areas in need of further theoretical clarification. This heyday established the subsequent niche of dream interpretation in analytic technique but it also uncovered its shortcomings. Practitioners began to realize that id psychology with its emphasis on the understanding of forbidden wishes and desires located in the deep unconscious could only bring the treatment dyad so far. There were obvious limitations to its general treatment effectiveness. Other factors of therapeutic significance emerged that came to be categorized in terms of self and object relations. In order to promote the further understanding of symptom and character it became necessary to subject the person's internalized images of others as well as their actual social relations to interpretive attention. Although the initial premise still holds that the work of interpretation is to uncover hidden meanings and occult connections, the potential residence of such meanings took on more global consideration in personality functioning. Areas may be encountered in object relations, ego psychology, and in relation to the defensive activities of the ego, not to mention in relation to the meanings that reside in the unconscious conscience, that are subject to first the therapist's and then the therapist and patient's interpretive scrutiny.

III. WHAT GETS INTERPRETED?

There are now considered to be many dimensions to interpretation. It can be seen as a process that may extend through many aspects of space and time. Freud initially emphasized the temporal and historical aspects of interpretation. The earliest form of interpretation tended to have a genetic emphasis. That is, the ideal interpretation attempted to link up the individual's current difficulties functioning and the many "mindless" factors throughout life that had contributed to the difficulties and were being actively expressed through them. This approach aimed at positing as the nidus for a symptom an event that was either unconscious or not clearly conscious in its recall. "Your arm became paralyzed because you were in conflict about using it to strike your father" would be one such example. If presented in the proper emotional setting, this would expose the noxious forbidden element of trauma. It is brought into consciousness in a more fully and clearly focused manner that allows the individual a better view of the regressed elements of his or her history that his or her mind had hitherto deemed too painful or too awful to acknowledge. This is a technical point that has been emphasized many times by Loewald in his modern reformulation of psychoanalysis.

In an overall sense psychoanalysis is an ally of memory. This is the case to the extent that one of the goals of psychic exploration is to provide the individual with a fuller sense of the historical truth of his or her life as it courses back and forth through memory and time. Ernst Kris conceptualized the therapeutic process as an activity in which the personal myth of the individual is gradually replaced with a sense of conviction about the affective and experiential elements of a life that is both more compelling and more coherent than the one that had been woven into the fabric of their neurosis. Paradoxically adolescence, a period that often holds vivid memories, is also one in which the pressure of interpretation will yield a significantly altered story line through the reconstructions that inevitably accompany a dynamically founded treatment. A not uncommon statement might be "we can now understand your sense of dominance and distance with females during your teenage years as an outgrowth of several early stinging

rejections by girls that became coupled with your own deep anxieties about sexual and emotional intimacy. This seems quite consonant with the manner in which you have kept me (your therapist) at a distance. It has also manifested itself in the conflicts of intimacy that you have attempted to defend yourself against by seeing me as sexually threatening and at the same time emotionally withdrawn." The interpretation presented here *en bloc* would in all likelihood be parceled out over time, eventuating in this summary interpretation. Such ideas when introduced in a timely fashion with a tactful tone of voice should lead over time to a gradual acceptance, acknowledgment, and further elaboration of the interpretive premise. This may lead over time to an equanimity that comes from possessing a sense of an apt and resonant relation to both inner and outer realities. It may be even more enhancing in introducing a larger acceptance of the objective and subjective mix of fantasy and fact that constitutes such "realities." Human experience being what it is, a state of relative equanimity is just that, and although neurotic difficulties may have been fixed, the mind is never fixated in any healthy state. We will always struggle to process our experience in a manner that updates our realities at the expense of our personal myths.

The upshot of any interpretation may be quite varied. The patient may respond with immediate recognition, what Ralph Greenson termed the "aha" phenomenon. Alternatively the reaction may be vague resistance, either in response to the sense of criticism that every interpretation inevitably conveys, or as a function of the partial nature of the interpretation. On the therapist's side of the treatment process or the couch, the reaction may be "oi vay!" The therapist, with or without reaction from his patient, immediately registers the vast error in his interpretation. When errors of interpretation occur, necessarily unavoidable but hopefully rarely, they require acknowledgment on the part of the analyst. Perhaps this would mean an apology, depending on the circumstances and the content of the errant ideas. Following this there should be a moving on to more fully understand how the patient interpreted the misunderstanding on the part of the therapist. For some patients it is the therapist's grace in responding to an incorrect interpretation rather than his or her acumen that saves the day. In addition there is currently developing an added appreciation that such spontaneous moments may reference memory and events that are beyond the usual realm of interpretation in declarative memory. They may bring in elements from the "noninterpretive" realm of nondeclarative memory for attention and objectification.

In addition to the dimension of time there is a metaphorical dimension by which interpretations extend through the layers of mind and consciousness, from surface to depth. In addition to placing the spotlight of interpretation on elements involving group and interpsychic dynamics of social relations and control, the operations of the ego per se need at times to be an object of attention. It is not only the conflicts that the ego works to control but also the workings of the ego as an organ of synthesis and adaptation and as a partner or hostage of conscience that needs to be taken into consideration.

In a stepwise fashion a series of interpretations may lead to a complex revision of the patient's sense of world and self. New and novel choices begin to appear in the mind's eye. Fresh ideas presented in the proper sequence can lead to paranoia evaporating over time, to be replaced by a less anxious, more confident, and less reactive sense of self. "Originally your independence in childhood served you well, given the discontinuities in care that you experienced with your mother and your need to put some space between the two of you. You sensed at several levels of awareness that she could not accept you for who you were. This left you with confusions about dependency and now in your work and in your love life this cloak of alienated independence that you cover yourself with serves to keep you apart from others and unfulfilled in terms of your self-esteem. You end up not safe, as you intended, but anxious and never fully relaxed or satisfied. Yes, your escape is swallowed up by anyone and anything but also you are never able to fully be yourself with another." Such a revisionist approach spans areas of history, defense, self-configuration, and neurotic adaptation while pointing the way toward a potentially less defended and restricted person with a more fulsome nature. Such interpretive syntheses may only be possible toward the end of an analysis when there is a fairly firm sense that all the facts are in and available for tally.

As the previous examples have indicated most interpretations follow from the content of the patient's thoughts, the subject matter of their consciousness. There are exceptions in which the process of associating becomes coopted by predominantly defensive dynamics. We are then confronted with the paradoxical situation that speaking one's mind serves mainly to cloud and obscure one's more cogent thoughts and feelings. This defensive maneuver was initially identified in relation to dreams where the telling of the dream became so elaborated and extended that there was no time or opportunity for its deeper examination and interpretation. The supposedly cooperative and compliant dreamer pro-

duced too much of a good thing and in the process defeated the central purpose of dream analysis. This profusion of information without the opportunity for comment or interpretive scrutiny may occur in the course of any string of associations. At those instances the content of the patient's communication becomes less interesting than the quality and the process of the associations as they exhibit more of the quality of an action. When a torrent of words drowns out the facts contained in the stream of associations, a comment acknowledging the diversion of words from meaning is indicated. "The pressure and volume of your words and speech, while seeming to communicate a great deal, actually confuses me and makes it more difficult to understand what is going on in you. I wonder if there is some anxiety behind your words that we need to examine?" This might be one among many possible comments that the therapist could make in such a situation.

A current associational emphasis that is popular among some therapists is that of "close process monitoring." This technique expands the usual emphasis in any treatment, the ebb and flow of verbal material toward or away from areas of conflict and concern. The defensive nature, particularly with regard to matters of aggression, is given a predominant focus. Comments and questions leading up to interpretive statements are restricted to here and now observations that call patients' attention to shifts in their train of thought away from more affectively loaded material. This often involves bringing to light hostile and aggressive thoughts and feelings about the analyst that the patient is consciously suppressing and unconsciously censoring.

IV. TIMING AND SCOPE OF INTERPRETATIONS

The timing and scope of an interpretation has everything to do with how successful or effective an interpretation is. It is also critical if the therapist's activity at a particular point is gauged toward building to a broader interpretation. Some treatments may hinge upon the proper and timely application of a very limited number of interpretive comments. Selecting the right moment when idea, emotion, and resistance is at a proper pitch is key. The therapist's ease in understanding and delivering a properly timed formulation is also a significant factor in its successful reception by the patient. Much of an interpretation's effectiveness is contingent on how much data, both affective and cognitive, the therapist has at his or her disposal. This may be a factor in setting apart analysis from most psychotherapies. In an analysis, with its greater frequency and often intensity of meetings, we anticipate that there will be less use of guesswork and intuition and a more refined processing of the unconscious into conscious thought. Therapists of different professional persuasions and different temperaments will vary widely in how much they rely on empathy and intuition in their interpretive activity. In Kleinian analyses and in briefer forms of psychotherapy the therapist may rely more heavily on "deep" intuition-rich verbal interventions to shortcut the defensive activities of the ego and get right to the heart of the matter. This is more in accordance with the technique of the early days of id analysis as opposed to current fashion that draws more on a constant assessment of object relations and the quality of the ego's defensive activity to determine how to proceed in a stepwise manner toward id interpretation.

Some versions of interpretation are met with immediate approval or disapproval. Depending on the quality of the therapeutic alliance, positive or negative, collaborative or combative, the degree to which an interpretation will be accepted for further internalization may be immediately apparent. At other times the impact of an interpretation is apparent only over time in the context of the further elaboration and working through of associations and defenses. This may be particularly the case when working with children, whose response to interpretations may appear minutes, hours, or days later. Children's responses may also show up in their play in apparent wide displacement from the therapist's words.

Central to determining what is healthy collaboration and what is neurotic compliance is the degree to which interpretations open up new avenues of information for inquiry and exploration. A premature interpretation may be greeted by a range of responses: incredulity at the therapist's cognitive lapse, confusion and self-blame, or the therapist may find himself the target of a withering attack of invectives and humiliation. Of course, it is impossible to assess the impact on the patient of tactfully delivered words until they are spoken. If the patient's reaction needs to be redressed with regard to the transference or countertransference elements elicited by an interpretive comment, that will require time and an open mind by both parties. Some patients are well-versed in contemporary or past therapeutic techniques and apply them easily and at will. They are also often too smart by half, bending their energies to making interpretive points before the therapist does. The quantity of clarifying comments is also important. Too many interpretations may cause them to fall on deaf ears. At

other points such comments will only be received according to the criticism that is inherent in them. If that is the case the interpretive activity either has no effect or it has a negative countertherapeutic impact. Traumatically sensitized patients are more prone to experience the therapist's words almost literally as being struck by a cudgel or raped. These concrete, physically referenced reactions can be taken up as defensive reactions of one sort or another.

A tilted relationship is one aspect of any therapy in which a psychological "expert" is helping a psychologically in need "patient." There is always the risk and danger that the interpretations will be perceived as a manifestation of the analyst's legitimate or illegitimate authority. Likewise they may be taken as evidence by the patient of the therapist's investment in the power politics of the situation. If that happens, boredom and impatience on the part of either member of the therapeutic dyad may come to supplant the fervor of self–other exploration. If the patient is mainly reacting to suggestion and is in the process of succumbing to the analyst's need to be the authority, the treatment process will come to feel more and more predictable, stereotyped, and static. If there are narcissistic issues on the part of the analyst or analysand that are not accessible to insight and clarification then stalemate, breakdown, or a compromised therapeutic process is inevitable. In these occasional situations unanalyzed rage in the patient or therapist may lead to stultification or truncation of the treatment.

The scope of interpretations has become much more varied and vast as the varied and vast capacities of the human mind have become more accessible to understanding. It ranges from interpretations of content, process, and defense to the sorts of overarching historical and genetic interpretations on which this aspect of technique was founded. In the case of defense analysis, attention is drawn to largely unconscious mechanisms that restrain the patient in speaking his or her mind. These may be in place to avoid coming across to the therapist as too active, too passive, too involved or needy, or too affect ridden, to mention a few of the conditions of defense. Interpretation of the mythic history of the individual may possess a particular power if used sparingly and precisely, identifying and appreciating the compulsive and repetitive aspects of historical experience without taking up camp in the past at the expense of existential frame in the here and now. Care should be taken not to develop a historical mantra that becomes yet another version of the personal myth or that distracts or displaces in an exaggerated and unwarranted fashion from pressing dynamic issues in current-day experience.

There is as yet no agreed on objective standard for interpretation in the field. We are left with an activity that is still more art than science. The crucial element in interpreting is that it should always contain a question mark and rarely an exclamation point. It should indicate both what the analyst knows or thinks he or she may know as well as extending an invitation to the patient to provide further data from all levels of the mind to extend the interpretive moment to a clearer conclusion. As is continually emphasized, the overall treatment alliance is an essential part of therapeutic efficacy. In some instances the process of collaboration is as much or more important than the self-knowledge that emerges from it. At times it is not what is said that is most pertinent. At its core, self knowledge, including the growing ability to auto-interpret, should cause the distinction between what the therapist perceives and anticipates of the patient and what the patient's understanding of themself is, to be subject to more and more overlap. The other's understanding of one's self should become ever more one's self-awareness and self-acceptance.

At the point in a treatment where there are no new issues left to interpret and explore there should be an emerging sense of completion and wholeness to complement the feeling that what has been available for resolution and reformulation has, by and large, been apprehended. To put it another way, in the ideal therapy, a time of mourning, celebration, and parting emerges that signifies that a maximum (for the moment) of self-understanding and self-acceptance has been achieved. It is not the completion of a life's story but rather the end of a chapter in the life of an individual when the need for another to understand one's self has reached a developmental conclusion. This is much as the need for a child to have understanding and defining parents wanes with the ending of adolescence. The self-understanding that comes from interpretation has been internalized and "knowing thyself" in the universal (and idealized) dimensions of love and work has been optimized. For many this will include knowing that at some future time they may come again to be beyond their psychological depth. In addition to having a better sense of when they have reached the limits of self-help, they will be able to interpret their own need to once again rely on the help and interpretive powers of a therapist. Ultimately an open mind with better access to, and reciprocity with, conscious and unconscious mindedness should be the endpoint of interpretation.

See Also the Following Articles

Applied Behavior Analysis ■ Behavioral Assessment ■ Behavioral Case Formulation ■ Countertransference ■ Functional Analysis of Behavior ■ Psychoanalysis and Psychoanalytic Psychotherapy: Technique ■ Transference

Further Reading

Busch, F. (2000). What is a deep interpretation? *Journal of the American Psychoanalytical Association, 48,* 237–254.

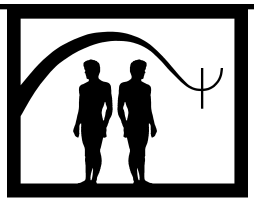
Davis, J. (2001). Revising psychoanalytic interpretations of the past: An examination of declarative and non-declarative memory processes. *International Journal of Psychoanalysis, 82,* 449–462.

Freud, S. (1901). *The interpretation of dreams,* Standard Edition, V. IV. London: The Hogarth Press.

Greenson, R. (1967). *The technique and practice of psychoanalysis.* New York: International Universities Press.

Kris, E. (1975). *Selected papers.* New Haven, CT: Yale University Press.

Loewald, H. (2000). *The essential Loewald.* Hagerstown, MD: University Publishing Group.



Intrapsychic Conflict

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GLOSSARY

abreaction A cathartic release of pent-up affect usually associated with trauma.

censor Synonymous with the term of repressive barrier anthropomorphosized in order to dramatically make the point of the fact of repression.

compromise formation The synthesis created by conflicting mental components.

defense The counterforce opposing the expression and emergence into consciousness of socially unacceptable or otherwise problematic biological and somatic urges.

instinctual drives Mental/somatic entities which are the mental representation of somatic stimuli.

intrapsychic conflict The basic psychoanalytic idea that almost all mental phenomenon and psychologically mediated behavior are the product of opposing mental forces or structures.

latent content An aspect of the dream that deals with underlying or repressed thoughts stimulated by the day's activity and seeking expression.

libidinal drive The tendency of the psychological structure seeking the satiation of biological needs, as well as psychological needs, for affiliation and merger.

manifest content Refers to the aspect of dreams that are expressed clearly and directly within the dream.

multiple functions The almost universal tendency of certain defenses to serve multiple functions at the time of their use.

primary process A mode of thinking in which logical and formal relations between mental contents are absent and there is a press for immediate gratification of pleasurable needs. Contraindications exist without difficulty. Temporal considerations are irrelevant.

psychic energy An imprecise term referring to the economic work or resource required on the part of the individual to accomplish a certain act or invest a psychological structure with capacity.

reality principle The tendency for an organism to orient itself to practical social dictates and requirements.

repression A form of defense in which unacceptable urges and materials are kept outside the realm of consciousness.

repression barrier The psychological structure that separates the contents of the system unconscious from the preconscious system by a defense and the function of the censor.

resistance A form of defense specifically oriented towards keeping certain thoughts and ideas out of the talk between analysis and anlysand.

secondary process functioning Refers to a mode of functioning in which logic, temporal relationships, and social and physical reality predominate as principles.

sexual drives Refers to drives emanating from specific bodily areas and following a development timetable, which have a pressure, an aim, an object, and a source.

structural model The psychoanalytic model developed by Freud that hypothesized the existence of three basic psychological structures that embody and mediate between

the demands of external social reality and internal, biologically based, instinctual needs.

structures Psychological constructs of drive, representation, motivation, and function that exist to carry out psychological work and integrate various domains of mental functioning.

superego The agency within the structure model that is responsible for determining ideal social reality and measuring various aspects of the individual's function in relationship to this reality.

system conscious (CS) A set of structures oriented towards conscious and explicit experience.

system preconscious (PCS) Refers to the existence of psychological material that can be made conscious and has not attracted enough repression to render it incapable of being known consciously.

system unconscious (UCS) Refers to the psychological and biological structures that press for expression and satiation and are not capable of consciousness.

topographical model The model of the mind developed by Freud that postulates the existence of conscious and unconscious mental processes separated by repressive barrier.

transference The tendency for all people to "transfer" feelings, attitudes, and relationships more appropriate to a specific person in the past of the individual to some other analogous, present, and active social relationship.

The concept of intrapsychic conflict, also called internal conflict, psychic conflict, or neurotic conflict, is central both to the psychoanalytic theory of mind and the application of that theory to differential treatment strategies. This concept refers to the basic psychoanalytic thesis that almost all mental phenomena and psychologically mediated behavior are the result of opposing mental forces or structures. Thus, symptoms, personality structure, fantasies, emotions, and so on reflect the synthesis of more basic mental components. This synthesis of these conflicting mental components is referred to as a compromise formation. Psychoanalysts assume that virtually all complex mental acts are compromise formations designed to allow the maximum possible gratification of the conflicting components with the least possible mental pain. Intrapsychic conflict and its subsequent compromise formations are ubiquitous and not inherently pathological. Rather they are understood as essential aspects of the human condition. Thus, psychoanalysis has traditionally been viewed as a psychology of intrapsychic conflict. Conflict and compromise formations are pathological only when they lead to excessive inhibition of key human urges, when they give rise to excessive anxiety and/or depression, when they cause excessive inhibition of important psychological functions, when they lead to excessive self-destructiveness, or when they bring the individual into excessive conflict with his or her environment. Mental health occurs along a continuum in terms of intrapsychic conflict. Conflict and compromise formation move from the healthy to the unhealthy parts of the continuum as they interfere in one's life in the previously listed ways.

I. AFFECT—TRAUMA MODEL

Psychoanalysis' theory of mental functioning, and the technical implications drawn from it, has evolved over the past 100 years. Each phase in that evolution has defined the conflicting elements of the mind differently and derived different technical precepts from those definitions. Freud's first stage of thinking occurred between the mid-1880s and 1897. The psychological model that he developed during those years is commonly referred to as the affect-trauma model. While trying to understand the etiology and treatment of neurotic symptoms, Freud emphasized the role of environmental trauma and subsequently pent-up charges of affect. Essentially Freud said that neurotic symptoms derived from internal conflict between the individual's conscious moral standards and distressing affects or ideas that were incompatible with these percepts. In general, trauma, usually of a sexual nature, was understood to overstimulate the individual to a degree that an intense charge of affective energy developed. This affective charge was defended from consciousness to avoid the unpleasant feelings generated by it running counter to conscious moral standards. Damming up of affect occurred and became expressed in disguised ways through neurotic symptoms. Oftentimes symptoms would develop years later when a current event stimulated memory traces of early events that had not been experienced consciously as fully traumatic at the time they occurred. In these situations a conflict was postulated to arise between what was repressed as a child and the adult's current moral standards. During this earliest stage of psychoanalytic theorizing, the strategy of treatment revolved around helping the patient to remember the traumatic event and to cathartically release the pent-up affect associated with it. Freud called this cathartic release abreaction. In this way the pathological impact of intrapsychic conflict was thought to be overcome.

II. TOPOGRAPHIC STAGE

By 1897, however, Freud was finding this understanding of psychic conflict unsatisfactory and the

treatment results from it disappointing. Thus, his topographic stage of theorizing was developed over the next 26 years as his understanding of intrapsychic conflict underwent radical revision. Perhaps most importantly, several events, including Freud's own self-analysis, led him to shift his focus away from memories of actual childhood sexual traumas and their related affects as a significant component of intrapsychic conflict. Instead Freud came to the conclusion that most of his patients' memories of childhood sexual seductions were, in fact, disguised unconscious wishes. These wishes had to be disavowed because they conflicted with other components of the mind, resulting in a false belief that an actual sexual trauma had occurred during childhood. The recent furor over the false-memory syndrome speaks to how slow nonanalysts have been to realize the intensity and ubiquitousness of childhood sexual wishes and the defenses against them.

During this second phase in the development of his thinking, Freud defined and elaborated his concept of libidinal drive as a key component of intrapsychic conflict. He introduced the concept of instinctual drive as a mental–somatic construct, defining it as a mental representation of somatic stimuli. The sexual drives had a pressure, an aim, an object, and a source. The source referred to a part of the body imbued with sexual energy, following a developmental timetable. These sources became synonymous with the stage of development at which they were primary—hence, the oral, anal, phallic, and genital stages of development. Inherent in this idea of a sexual drive following a developmental timetable was Freud's notion of libido or psychic energy. That is, this energy was postulated to arise in the somatic sources of the sexual drive and to provide the impetus for the mind to work. Freud maintained his belief in the importance of the sexual drive and its underlying energy, even when he ultimately rejected the topographic model in 1923.

Freud's topographic stage of thinking involved far more than the realization that childhood sexual wishes and fantasies exerted a profound impact on mental functioning into and through adulthood, however. That is, he had to explain the reason that patients experienced and reported such wishes as memories of actual occurrences. Furthermore, he needed to explain why such memories (in reality, fantasies) emerged only during treatment. These issues required the introduction of a counter force to becoming aware of such wishes or fantasies—that is, defense. During this stage in his model building, Freud used the term "repression" synonymously with defense. Repression did not refer to any particular type of defense mechanism but to the gamut of ways in which the mind could render a wish, thought, fantasy, or memory unconscious. It represented the work of the ego or self-preservative instincts that had as their aim the preservation of the individual.

Freud's topographic model did far more than redefine the conflicting elements of the mind. It also attempted to chart out the organization of the mind and to map the main components through which internal conflict was actualized. Thus, three systems or layers of the mind were described: (1) the system Unconscious (UCS); (2) the system Preconscious (PCS); and (3) the system Conscious (CS). These three systems were structures, each with its own type of mental contents, and each characterized by qualitatively different modes of functioning. Essentially these structures or stratas of the mind were viewed as the mind's attempt to harness the instinctual drives so that the individual could adapt to reality. Were the instinctual drives and wishes to succeed in their push for conscious awareness and discharge, the individual would experience unpleasant feelings as well as potential danger. During this era of Freud's thinking all sorts of mental phenomena including jokes, slips of the tongue, dreams, as well as neurotic symptoms were understood to involve a conflict between instinctual wishes and the mind's counter forces occurring within and between these mental strata.

The UCS was viewed as the deepest strata of the mind and the repository of instinctual drives and wishes, always pushing for conscious expression. This system is characterized by a very primitive mode of functioning or thinking that Freud called the primary process. In this mode of functioning, logical and formal relations between mental contents are absent. Contradictions exist without difficulty, temporal considerations are irrelevant, and so on. What Freud called the pleasure principle dominates. Drives and wishes push for discharge, gratification, and relief of tension without consideration for anything but pleasure. It is important to distinguish this system UCS from the descriptive term unconscious. Contents of the system UCS are kept unconscious through a repression barrier; that is, active amounts of psychic energy are used to keep the contents dynamically unconscious. In contrast, descriptively unconscious mental contents might be outside of conscious awareness only because attention is not directed at them. Were attention to be focused on them, they would become conscious. No defensive force is exerted against this possible occurrence.

This distinction becomes relevant when defining the system PCS. The contents of this system are also unconscious but only descriptively so. They are capable of becoming conscious once attention is focused on them.

Thus, Freud initially located the active censor or repressive barrier that kept dynamically unconscious content out of consciousness at the boundary between the system UCS and PCS. Intrapsychic conflict occurred first at this juncture. This barrier allowed the system PCS to function according to what he called the secondary process in which logical reason and moral concerns characterize the relationship between its mental contents. The reality principle predominates so that any discharge of instinctual drives or wishes has to be filtered, altered, and/or disguised to make it compatible to reality logic and the individual's moral standards. Freud eventually explained that the system PCS modified drive impulses at all levels on their way through the system to the system CS. Thus, repression or defense no longer became conceptualized as a static barrier occurring between the systems UCS and PCS. Instead unconscious wishes are continually transformed during their traversal of the system PCS and had to pass by a second censor at the boundary between the systems PCS and CS. Intrapsychic conflict could occur at any step along the way. To pass muster and get past the censor unconscious drive laden wishes have to be disguised—what psychoanalysts labeled drive derivatives. Only such derivatives can be allowed into the system CS to be discharged.

The system CS was described by Freud as on the mind's surface. All its mental contents are conscious, although only a limited range of contents can be attended to at any moment. Perception occurs in this system as does attention. Thus, the system CS receives input from both the deeper recesses of the mind as well as from the external environment. To become aware either of mental contents from inside or perceptual stimuli from without, the system CS has to invest what was called attention cathexis, that is, to invest content or stimuli with psychic energy that has become neutralized of its sexual and/or aggressive drive qualities. As with the system PCS, the contents of the system CS follow the reality principle and are characterized by secondary process functioning.

This stage of Freud's thinking in which internal conflict was viewed as occurring between the instinctual drives of the system UCS and the censorship and defenses of the system PCS continues to be important because all of Freud's papers on clinical technique were written during this era. For example, he formulated the important clinical concept of transference during this era and emphasized the importance of analyzing dreams. Dream analysis became synonymous with psychoanalytic technique during this stage as Freud described dreams to be the royal road to the Unconscious. Vestiges of this theoretical understanding of internal conflict continue to appear in modern day clinical literature because Freud never reformulated his theory of technique when he gave up this model in 1923. This failure to recast his theory of technique has impeded the development of modern-day thinking about technical matters as many analysts and nonanalysts alike seem to operate therapeutically out of an outdated understanding of mental functioning and conflict.

For example, the clinical dictum that psychoanalytic technique should aim to raise unconscious mental content to consciousness is still regarded by many as the means by which psychoanalysis cures despite it being overly simplistic and at odds with how most contemporary psychoanalysts understand the mind to work. But during the topographic era, Freud believed that one only had to make the patient aware of his or her unconscious sexual and, later, aggressive wishes derived from childhood in order to overcome the symptoms and/or character traits for which treatment was being sought. Resistance to analytic treatment at this stage was thought to reflect solely the operation of the defense mechanisms in the clinical encounter. That is, resistance was the patient's defensive attempt to protect against the analyst's attempts to make the analysand aware of unconscious wishes. Resistance analysis meant that one had to overcome the resistance so as to allow the patient to gain access to the recesses of the Unconscious. This formulation led to didactic if not coercive practices such as telling the patient that he or she was in a state of resistance with the implicit, if not explicit, idea that he or she should stop doing so. Such an approach has led many nonanalysts as well as analysts of more modern schools to criticize classical analysis as coercive and controlling.

III. TRANSFERENCE

In this theoretical vein, Freud introduced the concept of transference as a clinical phenomenon arising within the analytic situation. Originally Freud viewed transference as the displacement of unconscious wishes and fantasies about past individuals in the patient's life onto the person of the analyst. He first viewed such transference as an obstacle to making the unconscious conscious, but later came to view it as an ally in the work. That is, transference allowed the analyst to see the unconscious wishes, feelings, thoughts, and so on, and to bring them to the patient's conscious awareness.

But during this stage of thinking, too often, the emphasis was placed on demonstrating to the patient the unconscious wishes or fantasies about historical objects rather than on understanding the reasons that such contents had to be disguised or on the analyst's actual contributions to the patient's transference perceptions.

IV. DREAM ANALYSIS

Dream analysis also took priority during this era of psychoanalytic theorizing. Given the dream's latent content about unconscious wishes, the analysis of dreams took high priority in guiding the analyst's decisions about where to intervene. The prevailing theory of analytic cure, making what was unconscious conscious, led the analyst to interpret the unconscious or latent content of the dream to the patient. In particular, this approach to dream analysis focused on remembering or reconstructing the experiences and fantasies of childhood. At the same time, the defensive use of dreams to avoid other less comfortable mental contents received short shrift. So did the attempt to understand why a childhood drive-laden experience or fantasy had to be expressed through dreaming rather than remembered and experienced more directly. Such distinctions about whether to give dream analysis particular priority in determining analytic interventions or whether to regard the dream as just one of many types of mental content that can serve multiple purposes continues to be debated in the literature and serves, in part, to distinguish those analysts who continue to practice from a primarily topographic perspective from those who have integrated Freud's structural model and more recent advances in psychoanalytic thinking into their theory of technique.

V. STRUCTURAL THEORY

By 1923, Freud felt obliged to change his model again, first through his important book, *The Ego and the Id,* and then with *Inhibitions, Symptoms, and Anxiety,* published in 1926. These two volumes are considered to define the structural theory of psychoanalysis, a model which once again shifted the conceptualization of intrapsychic conflict. Essentially, theoretical inconsistencies in the topographic model along with the problem of how to formulate the newfound clinical phenomenon of unconscious guilt led Freud to revise his understanding about what sort of conflicts gave rise to mental phenomena. The terms conscious, preconscious, and unconscious remained in psychoanalytic theory but only as adjectives describing the nature of mental contents or processes. They no longer referred to strata or organizations of the mind.

Instead an explicitly tripartite model with the mind composed of three separate structures—id, ego, and superego—was described. The use of the term structure is a metaphor that refers to enduring patterns and configurations of mental processes that show a slow rate of change. That is, they are theoretical abstractions that have proven valuable clinically and can be inferred from behavior or mental content. The id is the structure that most closely approximates Freud's early concept of the system Unconscious. It involves mental representations of the twin instinctual drives of libido and aggression, operates according to the pleasure principle, and is organized according to the rules of the primary process. Freud conceived of the ego as developing out of and retaining roots in the id while the later ego psychologists such as Heinz Hartmann described the id and ego as differentiating out of an originally undifferentiated matrix. Regardless of its origins the ego is described as the mental structure that balances and mediates the pressure of the id drives and superego and integrates them with the need to adapt to the demands or pressures of the external world. As such it operates toward the goal of preservation of the individual. Thus, it involves multiple functions, the most important of which, in regard to intrapsychic conflict, is defensive functioning. At times it helps the id to gratify its drive impulses and, at other times, it exerts defense against them in order to adapt to the external world. Intrapsychic conflict occurs at such times. Because successful defenses must always allow some drive discharge, the ego facilitates the development of compromise formations.

The third structure, the superego, was added by Freud to help explain unconscious guilt. It is the internalized representation of parental values and prohibitions—in essence a conscience as well as an ego ideal. Conflict among these structures—structural conflict—was seen by Freud as the genesis of all subsequent mental phenomena. In this model, still used by many if not most American psychoanalysts, the genesis of symptoms or character traits is as follows. An id wish or impulse runs into conflict with an internal or external prohibition, which threatens the ego with a variety of unpleasurable situations causing signal anxiety or depression. This signal affect stimulates defensive functioning, which leads the ego to find a compromise formation that allows for some id gratification while also

preventing the impulse from becoming manifestly conscious; the compromise formation also assuages the prohibitions of the superego. Symptoms and character traits are examples of such compromise formations as are other mental phenomena. Besides the intersystemic conflicts that can develop between these structures, intrasystemic conflicts also occur. These conflicts involve clashes between mental contents of the same structure, for example, between incompatible ideals in the superego or between opposing drive wishes in the id.

VI. TECHNICAL IMPLICATIONS

Only in the past 20 years have psychoanalysts begun to systematically revise their theory of technique to implement the implications of this new understanding of mental functioning and intrapsychic conflict. Expanding the ego's unconscious awareness of intrapsychic conflict has become the focus of clinical technique based on the assumption that such ego expansion will bring mastery. No longer are resistances viewed as obstacles to making the unconscious conscious. Instead the importance of understanding the reasons for resistance is emphasized as is an awareness that the occurrence of resistance can be used as an opportunity to teach the patient how to observe the manifestations of unconscious conflict as they occur in his or her free associations.

Increasingly the importance of addressing the conscious ego and intervening at the surface in a way that the patient's ego can grasp and observe is seen as more important than deep interpretations of id content. Psychoanalysts now assume that unconscious id content will emerge into consciousness under its own impetus as the anxieties and threats that motivate the ego to defend against them are understood. Self-analysis—the ability to continue to observe and analyze such resistances to full consciousness—is now a goal of technique and a definition of a successful analysis, as we accept that intrapsychic conflict never disappears. Instead psychoanalysis aims to increase ego mastery over such conflicts with the assumption that conscious awareness and understanding of such conflicts will lead to compromise formations that are more adaptive and less restrictive. Thus, contemporary structural theory promulgates an approach to analytic technique that studies all facets of intrapsychic conflict rather than giving therapeutic priority to one of them. As such it can be viewed as a comprehensive approach to analysis.

See Also the Following Articles

Oedipus Complex ■ Resistance ■ Structural Theory ■ Topographic Theory ■ Transference Neurosis ■ Unconscious, The

Further Reading

Brenner, C. (1982). *The mind in conflict.* New York: International Universities Press.

Dowling, S. (1991). *Conflict and compromise: Therapeutic implications.* Madison, CT: International Universities Press.

Nagera, H. (1966). *Early childhood disturbances, the infantile neurosis and the adult disturbances.* New York: International Universities Press.

Sandler, J., Holder, A., Dare, C., & Dreher, A. U. (1997). *Freud's models of the mind. An introduction.* Madison, CT: International Universities Press.

Sugarman, A. (1995). Psychoanalysis: Treatment of conflict or deficit. *Psychoanalytic Psychology, 12,* 55–70.

Job Club Method

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GLOSSARY

job-finding Viewed as a chain of responses from the initial step of identifying a job lead, each of the steps being taught and supervised in the Job Club session, rehearsed, and actually put into practice under the supervision of the Job Club instructor.

I. THEORETICAL BASIS

The Job Club method is based on established principles of learning similar to those used in behavior therapy and by applied behavior analysis for treating psychological problems. The process of job-finding is viewed as a chain of responses from the initial step of identifying a possible job lead, each of the steps being taught and supervised in the Job Club session, rehearsed, and actually put into practice under the supervision of the Job Club instructor. Also included are modeling (imitation), self-recording of each of the job-seeking behaviors, progress charting, and "homework" assignments for out-of-session behaviors. The same rationale governs the conduct of the Job Club instructor analogous to that of the therapist in behavior therapy; specifically, the Job Club instructor constantly reinforces the job seeker using descriptive praise that designates the specific behavior being praised. The instructor is always positive, praises any action in the direction of the final goal of obtaining a job, never criticizes, and directs attention to future constructive actions rather than past difficulties.

The program takes place in a group for reasons of cost/benefit but also to obtain group support including finding job leads for each other, transportation assistance (car pools), and assigning each job seeker a partner such that they work in pairs with the partner providing a role model, reminders, and assistance, thereby having each person receiving continuous individual assistance while still functioning in a group.

Also similar to behavior therapy, the Job Club program is highly structured with standardized forms and scripts that are individualized for each person.

II. EMPIRICAL STUDIES

Prior to 1975, many types of job-finding programs were being promoted and used, such as those relying on "Job Development," or subsidized priming (such as the G.I. bills), or motivational seminars, interview rehearsal, and public employment agency listings of openings by employers. Controlled evaluation of all of these programs using the accepted scientific require-

ment of a randomly assigned control group was absent, similar to the situation that had existed previously in medicine and clinical psychology.

In 1975 my colleagues and I, as part of an Illinois research group (see Further Reading) conducted the first controlled evaluation using the Job Club method to help normal job seekers to obtain jobs. The result was that in 3 months 92% of the Job Club members had obtained jobs compared with 60% of those in the comparable wait-listed control group.

In 1979, the Job Club program was evaluated with job seekers who had severe job-finding handicaps: former mental patients, retardation, prison records, physically handicapped, and other such difficulties. As compared to a control group of similar job seekers who were given a motivational and information counseling program, 95% of the Job Club members obtained jobs versus 28% of the information counseling members. In 1980, the Job Club method was evaluated in a controlled study with chronic welfare recipients by the U.S. Department of Labor. The results were that twice as many job seekers enrolled in the Job Club obtained jobs than did those counseled by the agency's existing program.

Since that time the Job Club has been evaluated by many different controlled studies, all of which have found the method to be more effective than any of the alternatives with which it has been compared. More specifically, the Job Club has been found effective in different studies with high school students, the elderly, the visually impaired, the intellectually handicapped, the chronically mentally ill, unemployed professionals, deaf people, workforce programs, physically handicapped, state hospital patients, halfway house and outpatient mental patients, alcoholics, drug addicts, those with psychiatric disorders, criminal offenders, and in several foreign countries.

The Job Club method also has been found empirically to decrease depression and to increase feelings of self-efficacy, indicating its value in improving one's psychological state as well as in obtaining employment.

III. DESCRIPTION

A. Setting

The job seekers meet as a group—preferably 8 to 12 persons in a room equipped with a large table for ease of writing. These should be several telephone lines and a extension phone for each primary phone such that the assigned "buddy" and instructor can listen to all calls made. The facility also provides a copy machine for résumé copies, secretarial assistance for typing résumés, daily copies of the help wanted advertisements in the local newspapers, and several copies of the Yellow Pages telephone directory. The room also contains a file of job openings uncovered by previous and current club members. A bulletin board displays for each member a visually conspicuous record in histogram form of the (1) number of telephone calls, (2) number of letters written, and (3) number of interviews obtained; these serve as a progress chart.

B. Schedule

The members attend each day for 2 weeks, arranging interviews during half of each day and attending the interviews during the other half of the day. The second half of the day after the first 2 weeks is attended by all those members who have not yet obtained a job during the first 2 weeks. The local telephone calls, photocopying, postage, stationery, and secretarial assistance are provided without cost to the job seekers. A new group can start every 2 weeks.

C. Initial Session

During the initial session, the members briefly introduce themselves to the group and identify what type of work they have had and hope to obtain. A written form is circulated on which members list their telephone number, address, and any transportation needs. This list is photocopied and distributed to all and arrangements are made to assist those with transportation needs. Each person is paired off with a "buddy" to work together. An explanation of the program and its record of successes is provided. The members are instructed to attend any interviews arranged in the sessions that day and all future days.

D. Specific Procedures

1. Job finding is treated as a full-time job; as stated, half of each day is spent in the Job Club office, and the remainder of the day is spent attending interviews.

2. Personal sources of job leads. Because surveys have consistently shown that the initial job leads for two-thirds of jobs obtained were first identified by a friend, relative, or acquaintance, the Job Club makes a systematic effort to contact those persons and not to rely primarily on published job listings.

3. Supplies and services. As noted above, the program provides all supplies and services necessary for the job seeker without cost. The actual cost to the agency has been found to be very slight relative to the usual cost of a job-finding person.

4. Group support. Members are instructed and prompted to assist each other with transportation, obtaining job leads for others and providing mutual encouragement and advice.

5. Buddy. Each member is paired with a "buddy" to provide each other with assistance. The buddy is given a checklist to record the other buddy's phone contacts with potential employers; they review the checklist recordings together.

6. Positive personal and social attributes. In addition to work skills, the Job Club approach stresses the communication of positive personal and social attributes. The job seeker is shown how to identify these attributes and how to stress these attributes during an interview, in the job resume, and when first contacting a potential employer to arrange an interview.

7. Open letters of recommendation. The job seekers are taught to obtain open letters of recommendation that can be given to interviewers and possible employers at the time of initial contact to maximize the initial positive impression.

8. Interview rehearsal. The program has each jobseeker rehearse being interviewed using common questions asked by job interviewers and is given written material describing how such questions might best be answered for maximum benefit.

9. Interview behavior reminder checklist. The program provides instruction and a checklist of behaviors to be considered in interviews, such as proper posture, eye contact, arranging a call-back date, handshake at start and end, describing positive personal attributes, and so on. The completed checklist is reviewed the next day with the Job Club instructor.

10. Assistance by family. The program sends a letter to the family (spouse, parent, or significant other) providing suggestions as to how they can assist the job seeker, such as by actively seeking job leads, providing needed transportation, relieving the job seeker of household activities that would interfere with Job Club attendance, providing encouragement, assistance in typing or letter writing, and so on. Surveys have shown that family members are typically a source of productive job leads.

11. Counselor individual attention. In order to provide the job seeker with continuing feedback, advice, and support in spite of the group setting, the counselor follows a "continuous rotation" rule in which the counselor observes each club member in systematic rotation, spending no more than about 1 minute per club member. The counselor examines the forms being filled out, listens briefly if needed on the extension phone to job seeker calls, praises for efforts made (e.g., number of leads collected), and gives brief instruction as to what to do until the next counselor contact. This procedure plus the "Buddy" procedure described earlier provides continuous feedback and support.

12. Telephone book. The "Yellow Pages" of the local telephone book is used as a major source of job leads in the session. Because companies are conveniently listed by the type of business, the job seeker contacting those businesses will know if they are likely to utilize the job seeker's skills. As noted above, surveys have consistently shown that jobs were obtained from contact with nonpublicized sources.

13. Current job leads leading to new leads. Because personal contacts have been found to be the most frequent source of productive job leads, job seekers are taught (and supervised in session) to request additional leads from any contact person who has no positions immediately available; this situation occurs often in the telephone book contact, with friends, or at the termination of unsuccessful interviews.

14. Auto transportation is often a problem for job seekers possibly because of insufficient funds, or relative lack of public transportation in rural areas. As noted in "Group support" earlier, the club members are encouraged to assist these members with this need. Also as noted previously in "Assistance by family," family members are sent a letter urging them to supply auto transport to interviews and indeed to the Job Club location as well as to the job site when a job is obtained.

15. Telephone as initial contact. Rather than using actual "drop-ins" as a method of contacting potential employers, which usually allows 2 to 4 contacts per day, the Job Club arranges for the telephone to be used as the initial contact to arrange an interview. The telephone contacts can be made under supervision in the Job Club session and in great number.

16. Number of sessions. The goal of the Job Club is to obtain employment for all (100%) of the job seekers. If a fixed number of sessions are allowed, the most needy or job handicapped are likely to remain unemployed. Therefore, the Job Club program allows and encourages continued attendance until a job is obtained. Even after a job is obtained, the members are encouraged to return if they again become unemployed. This continual access

is logistically made possible by having the continued access members meet in the afternoon each day, while new members meet in the morning hours, with a new group starting in the morning every 2 weeks. After the 2 weeks, the members attend in the afternoon. In practice, past club members attend only occasionally, usually to use the copy machine, or telephone, or to obtain postage or typing assistance, but this continued availability appears very important in assuring the most difficult-to-place persons that they will not be abandoned.

17. Multiple sources of job leads. Surveys reveal that productive job leads result from many sources, primarily from personal contacts, but also about a third from various public announcements. The Job Club accordingly emphasizes primarily the personal sources (see "Personal Sources of Job Leads" earlier), but also common public announcements that are obtained by visits to a local public service employment agency, and announcements in newspapers' help wanted advertisements and professional and trade newsletters.

18. Personal orientation of résumé. In recognition of the great role played by personal attributes, the résumé does not only chronicle the Job Club members' job-relevant experience but also positive personal attributes of the job seeker, such as being "a team player," a "leader," "dedication to one's employer," "motivates the employees reporting to him," "needs no supervision," "well-liked by customers and fellow employees," and so on, whichever attributes honestly apply to the specific job seekers. These personal attributes are noted and emphasized in the interview as well.

19. Type of job applied for. In recognition of the diversity of skills of a given job seeker, they are encouraged to apply for more than one type of position (grant writer as well as English teacher, for example) and also to list the diversity of their experiences that may not be evident from the listing of their work history, such as being multilingual, computer proficient, organizing groups for community service, or club projects leader.

20. Structured job-seeking schedule. The job seeker is given preprinted forms and taught by the counselor to use them to arrange each day's activities with regard to interviews (date, time, name of interviewer, address, telephone number, etc.), call-backs after an initial inquiry or after each interview, persons to contact for possible leads, and so on. By structuring each day's activities the jobseeker's job search is focused, organized, and full-time.

21. Job Seeker Progress Feedback. A major problem in the job search is the discouragement and loss of motivation that results when no job placement has resulted from one's initial efforts. To help overcome this problem, the program provides feedback to the job seeker via a visual display on the wall of the room depicting separately how many interviews, telephone calls, and letters were completed by the job seeker since the start of the research. Also on the wall is a chart showing how the probability of success increases as the number of interviews increases, as determined by the results of all previous Job Club members. A job seeker's attention is directed to this chart as feedback on how his or her efforts are increasing the probability of success even though no placement has yet been obtained.

22. Counselor's style. The counselor's style is consistently positive, never criticizing or pointing out shortcomings or errors in carrying out the specific steps of the search. Rather, the counselor praises all progress and all efforts, even the fact of attendance. To address any omissions or errors, the counselor follows a "future-oriented" style, describing to the client what changes or additions might be made in future efforts to improve the chances of success.

IV. SUMMARY

The Job Club method is a program for assisting job seekers to obtain employment that has been found effective in several controlled outcome studies. It requires an experienced counselor as the leader and functions in a group format. The members do not passively listen to suggestions, but rather are actively engaged and supervised in the job search during each session by obtaining job leads and arranging interviews. The sessions continue for each job seeker until he or she obtains a job or discontinues attendance. The results of this intensive program has been that more than 90% of the attendees obtain employment. The program is based on the principles of learning and motivation embodied in the psychological body of knowledge known as behavioral psychology, which emphasizes rehearsal and functional improvement.

See Also the Following Articles

Behavioral Contracting ■ Contingency Management ■ Good Behavior Game ■ Homework ■ Token Economy ■ Vocational Rehabilitation

Further Reading

Amvine, C., & Bullis, M. (1985). The Job-Club approach to job placement: A valuable tool. *Journal of Rehabilitation of the Deaf, 19,* 18–23.

Azrin, N. H., & Besalel, V. A. (1980). *A Job Club counselor's manual: A behavioral approach to vocational counseling.* Austin, TX: Pro-Ed Publisher.

Azrin, N. H., Flores, T., & Kaplan, S. J. (1975). Job-Finding Club: A group assisted program for obtaining employment. *Behavior Research and Therapy, 13,* 17–27.

Azrin, N. H., & Philip, R. A. (1979). The Job-Club method for the job-handicapped: A comparative outcome study. *Rehabilitation Counselors Bulletin, 25,* 144–155.

Azrin, N. H., Philips, R. A., Thienes-Hontos, P., & Besalel, V. A. (1980). A comparative evaluation of the Job Club program with welfare recipients. *Journal of Vocational Behavior, 16,* 133–145.

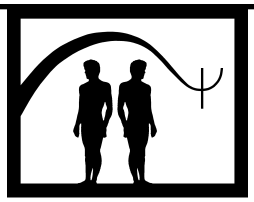
Elksnin, L. K., & Elksnin, N. (1991). The school counselor as job search facilitator: Increasing employment of handicapped students through job clubs. *School Counselor, 38,* 215–220.

Jacobs, E. (1984). A skills oriented model facilitating employment among psychiatrically disabled persons. *Rehabilitation Counseling Bulletin, 28,* 87–96.

McGurvin, M. C. (1994). An overview of the effectiveness of traditional vocational rehabilitation services in the treatment of long-term mental illness. *Psychosocial Rehabilitation Journal, 17,* 37–54.

Murphy, G. C., & Athanson, J. A. (1987). School to work transition: Behavioral counseling approaches to the problems of finding jobs for unemployed adolescents. *Behavior Change, 4,* 41–44.

Stilham, H. H., & Remley, T. P. (1992). The Job Club methodology applied in a workforce setting. *Journal of Employment Counseling, 29,* 69–76.



Jungian Psychotherapy

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GLOSSARY

(Archetypes are preceded by asterisks. Some are also correlated [*in brackets*] to characters in the popular film series "Star Wars," as these were deliberately designed by George Lucas to represent Jungian archetypes.)

active imagination A practice whereby imagery is deliberately engaged as though one were participating in one's dreams while awake. [*As when Luke "feels the Force."*]

amplification Used chiefly as a method of dream interpretation, whereby the therapist explicates a patient's dream by relating those myths, legends, fairy tales or otherwise archived symbol, images, and stories that seem most pertinent to the dream.

analysis (Jungian) The formal designation given Jungian psychotherapy within the Jungian world, reflecting Jung's early role in the development of (Freudian) psychoanalysis. However, the practice of Jungian therapy is very unlike that of classical psychoanalysis.

* ***anima*** A personified representation (imago) of the undeveloped feminine potential in a man. [*Princess Leia*]

* ***animus*** A personified representation (imago) of the undeveloped masculine potential in a woman. [*Han Solo*]

archetypal (Jungian school) Followers of James Hillman. Hillman considers there to be no "Self"—and no "self" either. His school focuses on literary elaborations of archetypal motifs rather in the spirit of Lacan and of deconstructionist literary criticism. He terms his approach "archetypal psychology." While much admired throughout the Jungian world, it has no formal structure (e.g., training methods, programs, or institutes). It may be thought of as being focused on the technique of amplification, narrowly and for its own sake.

archetype An innate, latent nucleus of personality predispositions conforming to a consistent set of attitudes, ideas, emotions, and behaviors. Symbolically represented as the stereotyped characters of myth, fable, and literature.

classical (Jungian school) Followers of Jung's original formulations. The classical school is emphasized in this article and relates Jungian analysis as less a form of therapy than a modernized Gnostic spiritual discipline: a sacred journey or quest to achieve full realization of the Self. [*Luke Skywalker is the hero of the quest*]

* ***collective unconscious*** The various archetypes; the innate preformed structure of the psyche.

developmental (Jungian school) Followers of Jung whose primary interest is in practical therapeutics. Formerly termed the "clinical" school, which is more accurate. However, it is also true that this school assumes that adult personality develops largely on the basis of childhood developmental process. The classical school is more interested in adult developmental changes while the archetypal school considers development a "fantasy."

extraversion One of two fundamental orientations of a person. The extravert directs interest and adaptive effort chiefly toward the outer world and other people.

Gnosticism A perennial religious philosophy that identifies God (or a god) with an interior state of "illumination" available only to initiates. Gnostic strains accompany the

mystical practices of most religions. Gnostic variants of Christianity have always been the chief source of heresy in the Church's view. [*The Jedi Knights*]

* ***Great Mother*** A personified representation (imago) of on the one hand the experience of being comforted and nurtured, and on the other, of being terrifyingly vulnerable to the withdrawal of same.

individuation process The process of achieving "wholeness," wherein all competing aspects of the personality are accepted, integrated and harmonized. Marked by the appearance of the Self, and by subjective states of a religious or spiritual character.

inflation Hypomania.

introversion One of two fundamental orientations of a person. The introvert directs his interest and adaptive efforts chiefly toward the inner world and himself.

mandala A term from Buddhist iconography, these are complex images whose basic structure consists of a circle subdivided into four major quadrants, and further subdivided or inscribed with complex, highly symmetrical, often recursive designs. Mandala-like imagery represents the Self and is expected to emerge spontaneously in dreams and visions as the sign of a successful individuation process.

personal unconscious Jung's term for what Freud called the unconscious (i.e., repressed material) in contrast to archetypes, that are presumed never previously to have been conscious.

psychoid A necessarily ill-defined term that refers to the puzzling mind-brain interface.

* ***Self*** The entirety of the personality encompassing both consciousness and the unconscious; an experienced unity of all archetypes; the endpoint of the individuation process. Often felt subjectively as the presence of God and so symbolized in dreams, visions, and in cultural products. [**The Force*]

* ***shadow*** A personified representation (imago) of the personal unconscious. [*Darth Vader*. But the "dark *father*" is not typical.]

synchronicity The relatedness of two events solely on the basis of their meaning to an individual, in the absence of any possible direct or indirect causal relation. This relatedness was held by Jung to be in some sense objective, however, and not merely in the mind of the individual(s) perceiving the meaning. Pathologically: ideas of reference.

* ***trickster*** A personified representation (imago) of a capacity for paradox, and concealed wisdom, messenger to the gods. [*C3PO and R2D2*]

types A set of innate personality predispositions on three orthogonal axes.

* ***wise old man*** A personified representation (imago) of a capacity for spiritual insight and experience. Leads to the Self [*apart from their ears, Joda looks exactly like Jung.*]

I. INTRODUCTION

Jungian therapy ("J_analysis") is a face-to-face psychoanalytic psychotherapy based on psychodynamic principles elaborated by the Swiss psychiatrist Carl Gustav Jung (b. July 26, 1875, Kesswil, Switzerland; d. June 6, 1961, Küsnacht) after his break with Freud and classical psychoanalysis around 1912. In sharp contrast to the early psychoanalytic model of the mind restricted to instinct, drive, and defense, Jung postulated an innate, irreducible, and thus additional psychic need to apprehend meaning and to express it symbolically. This need most commonly generates a religious impulse that cannot in every case be derived from (nor need always be a defense against conflict with) the biological drives. When ignored or blocked, this need can produce not only unhappiness, but psychological distress and eventually overt symptoms. Jung considered the now-widespread dismissal of religion as driven less by rational disillusionment than by hubris.

Classical Jungian therapy therefore aims at promoting an "individuation process," marked by an individually determined interior experience of a markedly mystical character. Jungian scholarship incorporates and interprets a vast, world-spanning body of mythological, religious, mystical, and occult references. Jungian ideas are widely embraced within artistic, literary, religious, and pastoral circles, but remain largely peripheral to academic psychology and psychiatry.

Jung anticipated many later trends: "ego-psychology," which defines, and focuses treatment toward expanding a defense-free domain of the ego; the ideas of Otto Rank, who similarly focused on free will; Heinz Kohut with his emphasis on a "self" developed out of "normal narcissism"; Hans Loewald's re-evaluation of regression as not merely restorative but creative; and Abraham Maslow's notion of "self-realization." Todays easy blending of "new age" psychotherapy and spirituality likewise parallels Jung's approach—and was in large part fostered by it.

II. DESCRIPTION OF TREATMENT(S)

A. Historical Backdrop

It took about 1000 years for European culture to consolidate around a relatively uniform body of Christian, creedal beliefs. That this would happen was by no means a foregone conclusion. The main competitors to early and medieval Christianity formed a group of philosophies and theologies loosely called "Gnostic." They shared with each other, and with many Eastern religions, the view that the goal of spirituality was a

form of personal "illumination," a specific state of mind, if you will.

Jung considered his "analytic psychology" to be a modern reformulation of these same ancient Gnostic principles. The mass return to these ancient mysticisms that marked the 1960s was therefore unsurprisingly characterized as well by a sudden upsurge of interest in Jung. (Timothy Leary applied to the C. G. Jung Institute of Zürich in 1971 but was rejected.)

Jungian psychology arose within an unusually gifted, accomplished, and eclectic circle of continental scientists, artists, poets, writers, and theologians who gathered around the person of Jung (see, for example, the proceedings of the Eranos Conferences of the 1930s and 1940s). Most shared with Jung a deep hunger for the mysterious and a visceral dislike of the rationalism and materialism that they considered Freudian psychoanalysis to embody—indeed, modernism altogether. But they were also too sophisticated for the fading religiosity of pre–World War I Europe.

They were seekers, an intellectual elite that heralded the new-age spirituality that would explode in populist form worldwide two decades later. As Jung conceived it, "analysis" should stimulate the "Self" to emerge, heralded by imagery associated with God (dreams; induced visions called "active imaginations") and accompanied by the unique emotions attending divine revelation. This "individuation process," hence classical Jungian therapy itself, therefore has a markedly spiritual—specifically Gnostic—cast.

Nonetheless, Jung had a strikingly open mind toward what we now call "biological psychiatry." In the mid-1950s he chaired the First International Congress on Chemical Concepts of Psychosis, having formulated a prescient biochemical theory of schizophrenia—in the same book in which he first outlined his *religiously* based objections to Freudian psychoanalysis. Freud had specifically appointed Jung his "prince and heir," and as Jung was a rising young psychiatrist assigned him the task of "conquering for psychoanalysis the psychoses," as Freud himself had the neuroses, by showing that psychotic imagery, like dreams, consisted of the same infantile conflicts, in disguised form, as in neurotic fantasy. But Jung concluded otherwise: Psychotic imagery was a rigidified self-portrait of innate, biologically foundational brain processes. They were on this genetic basis universal, and did not arise from the idiosyncratic conflicts of an individual mind. Such imagery was accessible in normal states as well, mystical and creative ones in particular; their emergence and fixedness in psychosis was due neither to spiritual development nor creative genius but rather, he guessed, to a destructive toxin. To treat all such imagery as born of neurotic conflict at once grossly underestimated both art and religion and grossly overestimated both the neurological integrity of a brain affected by psychosis and the power of psychoanalysis as a treatment method. Empirically, if not strictly speaking scientifically, Jung was well ahead of his time on both points.

Jungians after Jung have been keen students of other schools of psychotherapy—object relations theory, the ideas of Heinz Kohut, Gestalt therapy, for example, even classical psychoanalysis—as much as they have been keen students of religion, both new and old. However, those Jungians most interested in other schools of therapy tend not to be the ones most interested in religion. This difference in "culture," as it were, underlies the major divisions in the Jungian world, markedly enough so that conferences in the 1970s and 1980s explicitly addressed the conflict between a second-generation "clinical" camp and Jung's first generation of followers. The clinical practices of the former are scarcely distinguishable from the clinical practices of any well-trained, psychodynamic psychotherapist, even if the language they use is different.

By the 1980s, yet a third strand in Jungian thought and therapy had developed, largely under the influence of James Hillman, whose talents and approach to treatment are chiefly literary, with a strong "deconstructionist" cast. Whereas Jung and his early followers sought a form of enlightenment as symbolized by the emergence of a unitary "Self," Hillman and his followers pursue rather a never-ending process of poetic interpretation and story-telling whereby any (and every) firm belief save one can ultimately be "seen through," as they put it: deconstructed not into a set of socially inculcated self-serving biases, but into a set of transcendental self-serving illusions ("gods"). Whereas Jung made an explicit analogy between the "Self" and God (or to a Gnostic Christ), Hillman makes an explicit analogy between his "archetypal psychology," and the god Hermes, messenger among all the gods—and trickster to their self-importance.

The sole firm belief opaque to Hillman's archetypal psychology is, of course, the firm belief that any and every firm belief can ultimately be "seen through," the belief on which depends the trickster's own self-importance.

These three Jungian camps have now acquired more or less formal names: the "classical," "developmental," and "archetypal" schools, respectively. (No school wants not to be called "clinical.") A brief analysis of the same case as approached by representatives of each of the schools may be found in *The Cambridge Companion to Jung,* and

an excerpted web version at http://www.iaap.org/articles/ccj3approaches.html. What follows is a synopsis of classical, hence distinctively Jungian, psychotherapy.

B. Classical Jungian Therapy

1. Format

Jungian therapy ("Jungian analysis") is conducted face-to-face. Jung believed that the "neutrality" of the classical psychoanalyst was undesirable—because largely illusory. He was the first to argue for a more "personal" form of psychotherapy in which the mixing of the patient's problems and biases with those of the therapist would be accepted as a virtue. Treatment sessions last about an hour and take place no more than three times weekly, more typically once or twice.

2. Process

Classical Jungian therapy has two chief components: dream interpretation and "active imagination." Dream interpretation begins immediately; active imagination is a method usually employed later.

a. Dream Interpretation The Jungian approach to dream interpretation uses two main techniques: association and amplification. To associate to his dream, the patient freely expresses, without censorship, any thoughts that the imagery brings to mind. In contrast to classical psychoanalytic technique, however, Jungian-style association is interrupted, not free. It is akin to the limited association Jung asked of his subjects in his early word-association studies: Once a link is established by the patient between an element of the dream and some aspect of the patient's life —past or present— the therapist encourages him or her to set that element aside and associate to other aspects of the dream. Jung insisted that while associations eventually lead toward a patient's familiar conflicts (which he called "complexes") they wandered away from the specific meaning of the dream to which they were tethered. Inevitably, the lack of new information will lead both therapist and patient to devalue dream interpretation. Over the years, this is exactly what has happened in most schools of psychoanalytic psychotherapy. On the other hand, those classically trained Freudians in whose hands dream-interpretation remains a vital art (and those patients who have likewise learned its vitality) invariably interrupt free associations in precisely the way Jung argued they should—a matter more of common sense than of deep theoretical distinction. Jung's rather overly sharp argument with free association also reflects the relatively limited role played by conflict, repression, and compromise in the (early) Jungian psychodynamic theory of symbol and symptom formation, hence in the classical Jungian approach.

For both practical and theoretical reasons, in the early stages of a classical Jungian treatment, dream interpretation consists in teaching the patient (by commentary, not directive) how to make plausible links between the elements of the dreams and their personal concerns. Early on, the dreams are expected to be of the kind familiar to most psychotherapists: fleeting, fragmentary, often confusing.

Patients are encouraged to keep careful records of their dreams, and to note their responses both to the dream imagery itself and to any of the personal material evoked by the dreams. They are likewise encouraged to express both the dreams and their responses in plastic form: drawing, painting, poetry, story-telling, music, even dance, as the patient is inclined. For perhaps two years, a classical Jungian analysis may consist of little else but attention to dreams.

Over time, it is anticipated that the character of the dreams will subtly change. From reflecting a more or less self-evident preponderance of personal problems and concerns expressed in idiosyncratic images composed largely of memory traces, the dreams will begin to become more mysterious—harder to link to personal experiences—and will take on a more general character. More fable-like, such "big dreams" employ the universal characters of myth and legend: heroes, villains, monsters, kings, queens, princes and princesses, fantastic landscapes. They are also more likely to unfold as full-scale dramas, with a coherent structure. This kind of imagery is termed "archetypal," by which Jung meant to indicate at once their common and their fundamental nature. He considered these figures, and the dramas they engaged in, to be the intrapsychic representation of the innate structure and dynamic of the human psyche, the "images of the instincts." Out of the inherent repertoire of such dramas (aspects of brain function that presumably evolved as discrete patterns of adaptive response to being a human being in a typical human setting), the ones that are individually emphasized in each person reflect the psyche's deepest response to particular challenges constructed from the common, evolved responses of the human species to like challenges. Variations in this response unique to each individual's specific genetic background may be evident as well, especially if these reflect relatively long-term adaptational pressures that affected many ancestral generations.

Once criticized as dangerously racialist, such notions tend nowadays to be taken for granted in evolutionary

medicine—as for example in the strong genetic pigment correlations and statistically near-perfect north–south geographic gradient in the distribution of seasonal affective disorder. Group differences in innate brain-based response patterns attenuate, naturally, as the human gene pool becomes increasingly mobile and admixed. It should be said, however, that the classical Jungian therapist attributes to these patterns a transcendent meaning that goes beyond purely biological explanations.

b. Active Imagination Once a patient has begun to experience "big dreams," they are encouraged to take their expressive engagement with the material a step further. The patient will be guided to converse with the dream figures in imagination. The goal is to achieve a state of mind akin to certain forms of meditation that utilize explicit visualization. These meditative practices can be found worldwide and are detailed, for instance, in Jewish Kabbalistic, medieval Christian-contemplative, Tibetan Buddhist, and Chinese Taoist texts, inter alia. When successful, the visualized dream characters are experienced as holding up their end of the conversation, as it were, on their own, not as being invented by the patient in the way that an author invents dialogue.

On the other hand, it is not uncommon for authors (indeed, anyone experiencing creative inspiration) to feel that certain ideas appear spontaneously. But the purpose of "active imagination" is not artistic but rather to learn from whatever the "characters" themselves have to say. "Active imagination" is a state of dissociation, cultivated for constructive purposes rather than for defense. Arguably, it has much in common with classical free association. The major difference between active imagination and free association—and between individuals drawn to the one and those drawn to the other—may precisely be the well-known individual differences in dissociability. The temperament of Jungians, both patients and professionals, may therefore tend on average to be more expressive, sentimental, and "hysteroid"; of Freudians, more restrained, intellectual, and "obsessive." An older parallel distinction is that between the romantic and the classical types. In sum: That which Freudians dichotomize by the abstractions "hysteria" and "obsessionality," Jungians poeticize as the enmity of Apollo and Dionysus.

3. Individuation

In any event, not everyone has a knack for active imagination. Those who do are considered to have the essential skill for the "individuation process." Utilizing active imagination as its chief vehicle, the Jungian analysand may now undergo a lengthy series of imaginative encounters with the major "archetypes." These appear as larger-than-life beings of mythic proportion and (in the meditative state) so real as to engender intense emotional response. The therapist's role at this stage is two-fold: First, to ensure that the emergence of this archetypal material is paced so as to minimize the risk of "inflation" (hypomania); and second, to guide the analysand toward literature that "amplifies" the meaning of the emerging themes.

Jung's own autobiography remains the best example in the literature of such a state, and of the difficulty of discriminating among deliberate active imagination, psychotic hallucination, and extreme dissociation. There are some individuals who are able to engage in active imagination but who should not, because of its potentially destabilizing effects.

In a successful individuation process, the encounter with the archetypes greatly expands the individual's sense of meaning and purpose in life, and their flexibility in adaptation. Potentials previously unrecognized and untapped may be awakened, and aspects of the personality that had lain fallow may now be cultivated and incorporated, yielding greater "wholeness."

Jung believed that such an expansion of the personality was marked in dreams and active imagination by the spontaneous appearance of symbols of the "Self." These are images whose basic geometric format is the quartered circle ("mandala"). They are strikingly similar to symbols utilized worldwide to represent God; in polytheistic cultures, the highest god; in Gnostic religions, the union of all gods.

The symbol system Jung considered closest to that which emerges in modern patients was that of the alchemists. Their journey to all the planets, their "sublimation" of lead through various metals to gold, their quest to unite ever higher-level opposite elements to form the Philosopher's Stone: All symbolized the transformation of personality by the progressive encounter with and integration of the "lesser" gods within to form the "Self"—hence the capitalization.

The ideal classical Jungian individuation process is expected to traverse the following stages: (1) Integration of the "personal unconscious," or "shadow," loosely equated with the unconscious as defined in psychoanalysis; this prepares the individual for integration of the "collective unconscious," that is, the archetypes; to wit (2) the "anima"—unrealized feminine aspects of a man, or "animus"—unrealized masculine aspects of a woman; (3) the "Great Mother," the embodiment of everything maternal, both nurturing and engulfing, as nature herself can be; (4) the "Wise Old Man," the embodiment of "spirit"; (5) the "Self," an overarching union of all of

these, that is at once the superordinate representation of God and the foundation of individual identity (as in the equation of Atman and Brahman in Hindu mysticism; or of Christ and the person in orthodox Christian theology).

Individuation itself is a never-ending process. Jung considered the ignition of the process in therapy, and at least some substantial experience of the "Self," to be the goal of therapy. With the acquisition of a sense of meaning and higher purpose in life, symptoms may be expected either to disappear or, if not, to have taken on the kind of meaning that allows them to be accepted as a gift rather than a hindrance.

III. THEORETICAL BASES

In classical Jungian therapy, practice and theory are intimately intertwined. A common criticism of Jungian therapy is that it amounts to the indoctrination of the patient in a specific quasimystical worldview. The classical Jungian would sharply deny that this is criticism; Jung and many of his followers explicitly consider the individuation process to be a modern equivalent to antique rites of initiation into the cult and doctrine of certain gods and/or goddesses. But he would balk at "indoctrination." A central tenet of Jungian theory is that the "initiatory" sequence of archetypes emerges spontaneously from within the patient, rather than being overtly or covertly taught. Similarities to any external sequences arise because of innate predispositions that underlie the symbol-making potential of the human brain.

Evolution suggests that the brain should develop predispositions to apperceive experience according to common if flexible categories and patterns (like the newborn whose mouth conforms, without instruction, to the negative space of a human nipple). Fully formed "images" per se need not be embedded innately for common forms to emerge widely. Nor can simple commonality of experience account for all the overlap in imagery: Even motherless infants hunger for her expected presence. (This particular line of reasoning led to a rapprochement in the United Kingdom between followers of Jung and of Melanie Klein.)

A. Biology versus Spirit in Jungian Therapy

Against this one may argue that Jung developed Jungian therapy not empirically but much as did Freud: out of a lengthy attempt to define himself, free from serious outside accountability, with patients turning into followers, and with data from all. The importance and plausibility of the archetypal hypothesis notwithstanding, the vast body of Jungian writing detailing "archetypal imagery" in case studies can provide no compelling supportive evidence for it. Today's Jungian therapists are therefore far less likely to assume that something is archetypal just because it looks like it.

What exactly is an innate structure of the psyche? Jung's revolt against Freudian reductionism led to Jung's claim that there is a "level" of the psyche deemed "psychoid," that is at once both instinctive and transcendent. Critics argue that this is a mere assertion and that the concept "psychoid" is ill-defined. In effect, Freud argued that society strikes a never-wholly successful compromise between animal desires and a wholly pragmatic civility, religion of any kind serving to enforce the precarious dominance of the latter. Jung argued that society need strike no such balance, since in the form of spirituality he advocates desire and civility become one; only organized religion is a problem in stifling both spirituality and instinctive gratification.

The religious instinct, Jung thus argues, is real, not a defensive pose taken up by one of the animal instincts to help us avert our gaze from its true intent. Like any instinct, it has an underlying nervous system physiology that is relatively invariant among all human beings. Hence, its patterns of expression, and the sequence of maturational steps it follows, are similarly invariant. It may be ignored, as may any other instinctive drive, but only at significant cost: a sense that life is ultimately meaningless. On the other hand, Jung argued, spirituality that defines itself as unconnected to instinct tends to become sterile and unfulfilling, a criticism he leveled without cease at Christianity.

A dominant Eastern model for the individuation process in early Jungian circles (in the 1930s) was therefore Kundalini Yoga, a form of mystical practice in whose original (Tantric) form enlightenment could be achieved via the sacred sexual union of the male and female practitioners. The corresponding Western model was, again, alchemy, the symbolic content of which was explicitly sacred-sexual, the "union of opposites" depicted as the explicit sexual conjugation of a naked king and queen; and the practice of which involved a male alchemist and his "mystical sister" *(soror mystica)* working together in sacred precincts of the "laboratory."

In the classical Jungian model of therapy as individuation, an intense mutual emotional entanglement of analyst and analysand was anticipated and cultivated. As in psychoanalysis, these emotions are termed "transference"

and "countertransference," but they are not interpreted as the emergence of long-repressed infantile longings whose original objects are found in the family. Rather, they are understood as the awakening of never-before experienced longings whose proper objects are divine.

To penetrate into the depths of the psyche in a classical Jungian analysis is therefore meant to be a profoundly spiritual journey whereby the tension between material drives and spiritual longings are resolved by their union. Such a journey has importance beyond the resolution of an individual's personal conflicts: To achieve in any significant measure a "union of matter and spirit" is to contribute to the building of a new explicitly post-Christian spiritual epoch. In light of modern culture-wide sentiments it is remarkable that Jung and his followers elaborated all these ideas well before World War II.

B. The Structure of the Psyche

1. Conscious versus Unconscious

For Freud the unconscious is primarily a set of primitive, unacknowledged desires that to remain out of sight require an ever-expanding construction of mutually reinforcing false ideas, self-serving attitudes, and conveniently filtered, distorted and, as needed, invented, memories. But such freedom from self-knowledge demands an exhausting vigilance. Psychoanalytic treatment therefore consists largely of a tactful undermining of this vast defensive fortress. Treatment releases the energy invested in defense for other "constructive" purposes.

To that aspect of the unconscious that is more than what has been repressed psychoanalytic theory did once accord a place—Freud recognized that some dream images, for example, represented "vestiges" of an early stage in the (biological) evolution of brain function. But as the term "vestige" suggests, he considered this material of little practical significance. It is rarely even mentioned anymore.

Jung's dislike of psychoanalytic theory, and of Freud's worldview, follows rather directly. Freud's insistence that all human activities are but distorted variations of material, instinctive drives—that "higher meaning" is therefore nothing but cheesecloth veiling the bleak truth of reality—seemed to Jung much like what the alchemists called "the universal solvent." In its attack, it excepts nothing: not even the beaker supposed to contain the solvent; not even, therefore, psychoanalysis itself. In such a bleak view, there are no "constructive" purposes in whose service all that freed energy can be placed without some new illusion to sustain it. "Sublimation" therefore is not sublime, it is merely the "highest' form of defense against reality.

For Jung, by contrast, the structure created by repression is the trivial and uninteresting aspect of the unconscious (the "personal unconscious"). What Freud considered a mere vestige, Jungians view as the essential, inherited anatomy of the psyche, and by virtue of its link to spirit, the pathway toward higher meaning. Jungians argue that meaninglessness is a priori pathogenic, and to train people to accept it is to induce, not alleviate, both psychological and societal disorder. The Nazis succeeded, Jung argued, because they offered Germans meaning, whereas Weimar deprived them of it. The power of his simple insight—that no one accepts meaninglessness—was severely compromised by Jung's own early flirtation with Nazi ideology.

The repressed material of the personal unconscious may need to be dealt with first, but the individuation process proper will only begin when material from the deeper levels of the collective unconscious begins to emerge. This deeper material is not considered to be a disguise for otherwise unacceptable but perfectly expressible thoughts and feelings. The mythic imagery is treated rather as genuine metaphor—that is, the best possible representation of profound states of mind otherwise inexpressible. The repressed material of the personal unconscious and the innate archetypes of the collective unconscious are related in that personal conflict, hence repression, develops only around matters that are of inherently profound import.

2. Archetypes

The infant is born hard-wired to form an attachment to a specific kind of external object. Later, to this latent expectation there becomes associated a specific set of sensory impressions. But the innate representation can never adequately be embodied by any real experience or memory. Instead, the mind, when released from the criticisms of rationality, will creatively weave together—from memory and from imagination—whatever fragments it needs to paint a portrait of the hidden, never before "seen," yet more "real," more deeply longed-for and feared "Great Mother," the "archetype" against which all human mothers—indeed, all women—are subtly going to be judged; and against which they subtly judge themselves.

Religion and therapy come together in this model when the compulsive philanderer, say, realizes that not only is he pursuing his mother in the guise of other

women (the personal unconscious at work), but that his disappointment in his mother arises less from her flaws as a person than from his previously unacknowledged longing for a Mother of the sort not ever available in earthly form (an element of the collective unconscious). The latent, preformed imago of "mother" Jung called the "Great Mother" archetype. A family of archetypes constitutes the basic structure of the human psyche. Such a viewpoint has much in common with later "object relations" psychoanalytic theory except that for Jungians, "introjects" do not come from the outside—they begin within, are projected outward onto more or less suitable objects, and only then reintrojected.

Many Jungian archetypes have obvious parallels in typical human experience and so lend themselves to a more standard psychoanalytic or object-relations reinterpretation: Perhaps images of the "Great Mother" are energized not by innate, universally human expectations but by experiences that are universal, or nearly so, subjectively processed. (The Jungian model is closest to an interactionist model.) But other archetypes are not so easy to reinterpret this way. For example, the so-called trickster figure, common to many folk religions, and especially to shamanism, was the veritable patron god of alchemy in the form of Hermes (Mercurius). Why jokes, trickery, adolescent mischief-making, chicanery, and even outright duplicity should have so honored a place in certain forms of spirituality is hardly self-evident—unless one starts with the assumption that all such "higher" pursuits are cons.

3. The "Self"

The hermetic mysticisms of antiquity guided the seeker along a more-or-less well-known path toward a distinct state of illumination. The state is represented by a plethora of metaphors; the path likewise. But a common feature of most metaphors for the path is that of a synthesis of some sort: Initiation consists of the controlled identification with, incorporation of, and disidentification from a sequence of gods ("metabolized introjects"). The journey to each of the planets (named after the gods) is one such metaphor; the progressive transformation of base metals (lead) to noble ones (gold) is another (with each metal associated with a planet and a god). Hermes guides the soul on its planetary peregrination; Mercurius guides the alchemist in the progressive "sublimation" of the metals. As each "god" is encountered, identified with, and disidentified from, it is integrated to form a larger nucleus of personality that Jung called the "Self." Although experienced within, it is experienced as larger and other than one's personal identity.

4. Personality Types

Jung also authored the widely accepted distinction between "introversion" and "extraversion." He considered these traits as defining an important and universal dimension of human personality—an axis along which everyone tends toward a characteristic position that forms their most comfortable way of relating to the world. Jung extracted two other independent such axes as well: one defined by a polar contrast between "thinking" and "feeling"; the other by a polar contrast between "sensation" and "intuition." The eight types thus defined seem at first glance to have a rather forced symmetry. But of all of Jung's theoretical constructs, his typology has earned the most research-based confirmation.

A careful study of Jung's ideas about the archetypes and the collective unconscious on the one hand, and of his typology on the other, reveals very little compelling connection between them—they could easily be developed as two entirely different models of the psyche.

There is one critical point of contact, however, with respect to the concept of introversion. When he at first accepted Freud's plan that he should conquer the psychoses for psychoanalysis, Jung spoke of the essential problem in psychosis as being that of "narcissism"—the turning away from relationships to a solipsistic world of inner gratification. Freud's understanding was that this turning away was regressive and defensive—that the healthy capacity to spurn narcissism had been acquired by the psychotic and then split off (a defensive "vertical split in the psyche," as Freud would later characterize it when indirectly responding to Jung's abandonment of psychoanalytic theory), a variant of repression.

But eventually, Jung came to two very different conclusions: First, as noted before, that however it may first have been initiated, the profound entrenchment of psychosis was due not to psychological defense and resistance, but by a serious biochemical defect. The second conclusion was that narcissism per se was more than an early stage in psychic development and more than a defensive regression to that stage: It was a normal, natural, and absolutely critical component of the psyche at all stages of life, and perhaps especially necessary in later maturity in particular. That is why when he broke from Freud over just this issue, Jung ceased using the word narcissism and replaced it with "introversion."

When Jung rejected/was ejected from the psychoanalytic movement, a nascent psychodynamic understanding of healthy narcissism was ejected as well. The mutual bitterness of this parting ensured that it would take Jung's followers a good 50 years to accept the importance of the "personal unconscious," and that it

would take Freud's followers the same 50 years to produce and accept the ideas of a Heinz Kohut and of related forms of self psychology.

C. Science or Religion?

Most people are unaware of this, but many major mainstream American churches have tacitly but extensively made of Jungian theory a new theological foundation. (This is especially true, for example, of the Episcopal church in general and of the female religious orders of the American Catholic church.) In many cases the incorporation of Gnostic and pagan themes is remarkably explicit given the flat contradiction between the Hebrew and Christian scriptures, on the one hand, and the Gnostic heretics to whom Jung explicitly relates his own ideas. To the extent that religions have felt that they need to justify themselves on psychological grounds—theology proper apparently being passé—they have frequently therefore become agents for the widespread social acceptance of Jungian psychotheological ideas, although these are rarely recognized for what they are. Jungian theory and therapy thus exerts an extraordinary cultural influence both via formal religion and informal post-sixties' spirituality.

Yet Jung also exerted an important influence—one that continues to grow—on arguably the most fundamental of the hard sciences, namely physics. Mathematical physicists with a keen interest in quantum mechanics cite certain Jungian ideas regularly in their writings. A few of the more prominent names include Christopher Isham, professor of theoretical physics at Imperial College, London, and Henry Stapp of the Theoretical Physics Group at Berkeley, Harald Atmanspacher of the Max Planck Institut and Kalervo Laurikainen at CERN. On the brief back flap biography of his *Lectures on Quantum Theory: Mathematical and Structural Foundations* Isham specifically mentions his interest in "the work of C. G. Jung," and on the cover, the letter "o" in "theory" is replaced by a snake biting its tail—the "ouroborous"—a favorite symbol of Jung's that he often interpreted as referring to a mysterious wholeness of everything that evades causality. This is no accident.

In the late 1920s and early 1930s Jung developed a theory of "synchronicity," the idea that events unrelated by any causal chain were nonetheless related via meaning, not merely as an invention of imagination, but objectively. Astrology, for example, claims that stellar arrangements as happen to be seen on earth, and perceived as forming images drawn from earthly experience (e.g., Scorpio the scorpion), influence both behavioral tendencies and chance events in the life of selected individuals, and that this influence is uniquely symbolized by the constellation's image.

The kernel of astrology is not the idea that stars influence people—one could contrive some chain of physical events, however farfetched, that might effect such an influence; perhaps some as-yet-to-be-discovered radiation, for example. What is nutty is rather the claim that the nature of the effect is reliably characterized by the earthly image to which in two dimensions an impossibly widely separated three-dimensional array of stars happen to conform—only for the moment!—and merely in someone's imagination.

Ideas of this sort strike most scientists as absurd beyond mention, but they have formed an important part of classical Jungian practice: Jung's daughter provided astrological charts for many new students at the C. G. Jung Institute in Zürich—not officially, to be sure, but wholly accepted; lectures on tarot and palm reading are unexceptional; divination via the I Ching has long held an especially esteemed place in classical Jungian practice. In his autobiography, Jung provides a number of examples where he would interpret an incidental event that occurred during a treatment session just as he would a dream reported by the patient—as when once a bird flew into the room. Synchronicity, in short, has never been a mere cognitive foible of classical Jungian therapy; it has been central to it.

But physicists (a minority, to be sure) of varying rank, from modest to the very best, find in "synchronicity" a rather startling analogy to certain bizarre features of quantum mechanics (e.g., "entanglement"), wherein two particles appear to function as though they were one, with an instantaneous orchestration of behavior between them, no matter how widely separated, and even backward in time: Neither causality nor physical interaction (e.g., forces) is involved. Out of early quantum hypotheses Einstein brilliantly drew such behavior as an inevitable consequence, hoping thereby to demonstrate their absurdity. But all subsequent experiments, over 80 years, have instead validated their reality. Physical reality as understood by the very foundations of physical science is exactly as Einstein said quantum mechanics describes it, a description he considered so absurd as to be its own self-evident impossibility proof. Yet so it is.

Marcus Fierz, an eminent Swiss physicist whose brother became a Jungian analyst and founder of the Jungian inpatient psychiatric facility Klinik am Zürichberg, assisted Jung with later corrections to the statistics

in Jung's astrology paper. The corrections erased any statistical significance in the supposed correlations between constellations and psychology. Between hard modern science that does indeed unveil a mysterious universal correlation among subatomic particles everywhere, and Jung's unsuccessful attempt to statistically correlate astronomical orbits with human fantasy, there is a huge gulf—which Jung dismissed.

Having found that a better statistical analysis nullified his hypothesis, he changed his hypothesis. Synchronistic relations occur within statistical fluctuations, he then claimed, not in excess of them as do causal associations. By contrast, the physical relations created by entanglement are detected precisely in their violation of classically expected statistical results. It may be plausibly argued, therefore, that however poetic the analogy between modern physics and a Jungian model of psyche, there is no real connection whatsoever. How is it then that so many eminently qualified scientists have taken Jung's ideas, amateur statistics and all, so seriously? Is there something about the Jungian theory of synchronicity that should perhaps not be dismissed out of hand?

The answer is a qualified "yes," and arises out of an aspect of Jungian theory and history that is often alluded to but has yet to be fully clarified: The personal relationship and collegial interchange between Jung and one of the very greatest of the founders of quantum mechanics—Wolfgang Pauli. Within their relationship Jungian theory, practice, and history unite.

In 1904, Einstein had been Jung's dinner guest: "These were very early days when Einstein was developing his first [i.e., special] theory of relativity…," Jung recalled. "I pumped him about his relativity theory. I am not gifted in mathematics. I went fourteen feet deep into the floor and felt quite small." Nonetheless, says Jung, "…it was he who first started me off thinking about a possible relativity of time as well as space, and their psychic conditionality."[1]

Fifteen years later, in the early 1920s, Wolfgang Pauli was at work on the mathematics of "spin," a quantum phenomenon whose utter mysteriousness even today remains to be fully fathomed. Among other things, spin ensures that two identical particles with the same (half-integer) spin will tend to avoid each other—not via any force propagating at the speed of light, but by fiat, instantaneously, everywhere in the universe and probabilistically, as though orchestrated by some gentle omnipotent conductor who merely urges—and who leaves no physical trace of his existence.

For electrons—the foundational instance of such a spin-bearing particle—these probabilities conform to the mathematical relations of three intersecting rings, rotating about three perpendicular axes with a common center, but with some twists: Each ring may rotate simultaneously in both possible (opposite) directions. By the laws of classical physics (including those in which Einstein firmly believed) such "superpositions" are completely impossible—like one object being in two places at the same time; and to return to its original position, a ring must complete two identical rotations (a fact that is beyond human visualization). But superpositions do, in fact, exist. Recently, objects large enough to be seen by the naked eye have been made to exist simultaneously in two places at once. And on the fact that two-rotations-equals-one depends every diagnostic MRI scan ever taken. Furthermore, the speed of rotation for each ring, in either direction, was quantized—it could assume only discrete values, like pulses or rhythms, giving spin values what we might call "clock-speeds," that in multielectron systems are determined by certain special powers and inverse powers of 2.

Pauli's initial success in 1924 delineating these relations would win him standing as one of the very greatest of the founders of quantum mechanics, the 1945 Nobel prize, and on that occasion an unsurpassed accolade by Einstein, who designated Pauli his "spiritual son" and successor as director of the Institute for Advanced Studies at Princeton.[2] The strange relations of spin—now termed the Pauli Exclusion Principle—are directly responsible for the current explosion of quantum technology, including such astounding feats as quantum teleportation, quantum computation, and the emerging field of "spintronics."

But even this understates the matter: "There is no one fact in the physical world which has a greater impact on the way things *are* than the Pauli Exclusion Principle. To this great Principle we credit the very existence of the hierarchy of matter … which makes possible all of nuclear and atomic physics, chemistry, biology and the macroscopic world that we see" (theoretical particle physicists Ian Duck and E.C.G. Sudarshan).

[1] Jung, C. G.: *Letters,* Vol. 2. p. 108.

[2] Before their estrangement, Freud had publicly deemed Jung his "spiritual son *and heir.*" The infinitely nuanced, unfailingly courteous Einstein, friend to Freud, and knowing of the true relationship between Pauli and Jung, gave Pauli his love with no strings attached. Quantum theory was Einstein's permanent *bête noir.*

But Pauli had also been wrestling with a profound twofold despair. In 1927 his mother poisoned herself after discovering that Pauli's father's was having an affair with a much younger sculptress whom he later married; and his scientific genius had early on led him to a deep estrangement from Catholicism. "I am baptized 'antimetaphysical,'" he wrote, "instead of Catholic." (To safeguard his rise in the professoriate at the University of Vienna in the 1890s, Pauli's Jewish father converted to Catholicism—much as today a conversion to leftism is *de rigeur;* near the end of his life Pauli seems to have made something of a return to his father's abandoned faith.) In May 1929 Pauli formally left the Catholic church and in December 1929 a beautiful and seductive cabaret performer married the lovesick physicist, even though he was her second choice. In 1930 she abruptly abandoned him and quickly married her first choice.

Pauli had by no means been happy with his 1924 formulation of spin, whatever his colleagues thought. "My nonsense is conjugate to the nonsense which has been customary so far," he wrote. Yet in 1927, the year that his mother killed herself, he fully satisfied himself with respect to spin, inventing the three famous "Pauli matrices," mathematical representations of the doubly valued quantum spin, one for each spatial axis. In anguish, regardless, Pauli drank heavily and provoked humiliating public quarrels until, at his father's urging, he consulted Jung.

Jung repeatedly claimed that he never "formally analyzed" Pauli because he found Pauli's natural psychological capacity so great ("He even invented active imagination for himself…") and because Jung was intent on studying and presenting Pauli's dreams as objective evidence for his theory of the collective unconscious, archetypes, individuation, the Self and the relationship of these to alchemy: "Now I am going to make an interesting experiment to get that material absolutely pure, without any influence from myself, and therefore I won't touch it," Jung stated. Instead, "[a]t the end of the year I am going to publish a selection from his first four hundred dreams, where I show the development of one motif only." Pauli was officially treated by Dr. Erna Rosenbaum who, since she was "a beginner," Jung "was absolutely sure she would not tamper."

Nonetheless, Jung supervised Rosenbaum's work and met weekly at noon with Pauli to discuss and interpret Pauli's dreams: "[H]e was doing the work all by himself," for 3 months, Jung says, but "for about 2 months, he had a number of interviews with me. … I did not have to explain much."

In 1935, Jung discussed 400 of these dreams as the 1937 Terry Lectures in Psychology and Religion at Yale. They form the evidentiary backbone for all his volumes on alchemy. At Yale, Jung asserted that "the dreams I am going to relate … represent an entirely uninfluenced natural sequence of events" and that in these dreams, his "well-educated intellectual" (and at the time anonymous) subject "worked out (among other matters) the problem of perpetual motion, not in a crazy way but in a symbolic way. He worked on all the problems which medieval philosophy was so keen on."

The climax of the series was not a dream, however, but a "visual impression" that "sums up all the allusions in the previous dreams." Jung called it "a turning point in the patient's psychological development … in the language of religion—a conversion." The visual impression was (in Pauli's words, as quoted by Jung):

> There is a vertical and a horizontal circle having a common center. This is the world clock. It is supported by the black bird. The vertical circle is a blue disc with a white border divided into 4 × 8 = 32 partitions. A pointer rotates upon it. The horizontal circle consists of 4 colors. On it stand 4 little men with pendulums, and round about it is laid the ring that was once dark and is now golden formerly carried by 40 children. The world clock has three rhythms or pulses. (1) The small pulse—the pointer on the blue vertical disc advances by 1/32. (2) The middle pulse—one complete rotation of the pointer. At the same time the horizontal circle advances by 1/32. (3) The great pulse—32 middle pulses are equal to one complete rotation of the golden ring.

Jung refers to this vision as the "perpetuum mobile," and provides 64 pages of world religious commentary on it, representing it as the spontaneous emergence of the Self. Thereafter, Jung says, Pauli "became a perfectly normal and reasonable person. He did not drink any more, he became completely adapted and in every respect normal. … He had a new center of interest." In 1934, Pauli discontinued his sessions with Rosenbaum and married that same year, for life.

Never in his many discussions of this prototypical vision does Jung mention Pauli's successful matrix model of three quantized spin axes, which this visual impression obviously reproduces; nor the admix of feelings over his personal losses (the black ring turning golden once again; the blue and white motif that Jung related to Mary, the Mother of God in Catholicism, but not to Pauli's own lost mother). Indeed, the particular problem that the Pauli Exclusion Principle solved was how and why the first four "magic" numbers of the periodic

table arise: 2, 8, 18, and 32. Pauli was widely known to have continued his problematic drinking long after.

However weakened Jungian theory may be by the lack of evidence from one of its chief sources, and in spite of the fact that throughout their ensuing friendship Pauli made his own doubts clear about many of Jung's scientific claims, Pauli made no bones about his personal debt to Jung. He had wanted Jung to test "synchronicity" against the rigors of statistical evidence; Jung refused. When urged by colleagues not to damage his reputation by later copublishing a book with Jung, Pauli nonetheless insisted: "For there comes the time when I must give documentary evidence of what I owe this man."

IV. EMPIRICAL STUDIES

Only very recently has any attempt been made to assess the value of Jungian treatment with due consideration to the fundaments of experimental design. Numerous presentations on outcome have been delivered at Jungian conferences by Dr. Seth Rubin of the Society for Psychotherapy Research, and the first peer-reviewed article was published in 2002 in the *Journal of Analytical Psychology.*

However, a German Jungian society has published on the web and in print an extensive, lengthy, and independently funded study with attempt at controls and a clear delineation of its own limitations and weaknesses. This study found that "Even after 5 years, … improvement in the patients' state of health and attitude … resulted in a measurable reduction of health insurance claims (work days lost due to sickness, hospitalisation days, doctor's visits and psychotropic drug intake) in a significant number of the patients treated … [with] long-lasting effects on the patients' psychological well-being. [However], there are numerous major methodological problems with these data including the lack of comparison sample, the non-representativeness of the sample, the unreliability of pre-treatment data, the high rate of attrition, the need for multi-variate statistics, and uncertainty about the actual treatments offered."

V. SUMMARY

C. G. Jung has exerted an enormous and steadily growing influence on modern culture, especially as the "search for meaning" has taken on special urgency in light of the triumphs of scientific materialism. Transplanted via analogy from physics to psychology, the seminal ideas of the theoretical physicist Wolfgang Pauli profoundly influenced Jung's theory of the psyche. Although greatly helped by Jung the person, and deeply grateful to him, Pauli predicted what has in fact happened: That for an era bereft by science of religion, Jungian theory would ultimately prove more worthy as a philosophy than as a strictly scientific model of psychology.

Jungian therapy is therefore most distinct when aiming its therapeutics primarily at the development of a spiritual life. Its practitioners root themselves theoretically in a model they find personally congenial and that provides for them, as it were, a larger myth within which to lead a meaning-infused life. In practice, the evidence for and against the comparative efficacy of a specifically Jungian treatment method is no better than for any other method—or worse. Given the many different approaches that have arisen among the various Jungian schools—and within them—a good argument can be made that the parameters defining Jungian therapy will surely evade adequate denotation, but that individuals who identify themselves as Jungian therapists do as good a job on the whole as do those who do not. There is no doubt that many individuals deliberately seek Jungian therapy for what the term "Jungian" connotes and that Jungian therapists favor a style of communication that is comfortable for such individuals.

See Also the Following Articles

Adlerian Psychotherapy ■ Beck Therapy Approach ■ Behavior Therapy: Historical Perspective ■ Dreams, Use in Psychotherapy ■ Existential Psychotherapy ■ History of Psychotherapy ■ Gestalt Psychotherapy ■ Oedipus Complex ■ Psychoanalysis and Psychoanalytic Psychotherapy: Technique ■ Self-Psychology ■ Sullivan's Interpersonal Psychotherapy ■ Unconscious, The

Further Reading

Archive for Research in Archetypal Symbolism. (1991). *An encyclopedia of archetypal symbolism.* Boston: Shambhala.

Cook, D. A. G. (1987). Jung, Carl Gustav. In *The Oxford companion to the mind* pp. 403–405. Oxford: Oxford University Press.

Edinger, E. F. (1973). *Ego and archetype; individuation and the religious function of the psyche.* Baltimore, MD: Penguin Books.

Jacobi, J. S. (1984). *The psychology of C. G. Jung: An introduction with Jungian analysis.* Edited by M. Stein (Eds.); Introduction by J. Singer. Boulder, CL: Shambhala.

Jung, C. G. (1989). *Memories, dreams, reflections.* Recorded and edited by A. Jaffé; translated from the German by R. and C. Winston. New York: Vintage Books.

Jung, C. G. (1970). *Collected works. 1953–1961.* Princeton, NJ: Princeton University Press.

Jung, C. G. (1973). *Letters.* (Selected and edited by G. Adler, in collaboration with A. Jaffe. Translations from the German by R. F. C. Hull.) Princeton, NJ: Princeton University Press.

Jung, C. G. (1984). *Dream analysis: Notes of the seminar given in 1928–1930.* Princeton, NJ: Princeton University Press.

Jung, C. G. (1996). *The psychology of Kundalini yoga: Notes of the seminar given in 1932 by C. G. Jung* Edited by S. Shamdasani. (Bollingen series; 99) Princeton, NJ: Princeton University Press.

Meier, C. A. (1959). *Jung and analytical psychology.* Newton Centre, MA: Dept. of Psychology, Andover Newton Theological School.

Meier, C. A. (1987). *The meaning and significance of dreams.* Boston: Sigo Press.

Meier, C. A. (Carl Alfred). (1989). *Consciousness.* Boston: Sigo Press.

Nagy, M. (1991). *Philosophical issues in the psychology of C. G. Jung.* Albany, NY: State University of New York Press.

Neumann, E. (1972). *The great mother; an analysis of the archetype.* Translated from the German by R. Manheim. Princeton, NJ: Princeton University Press.

Satinover, J. (1980). *Puer aeternus:* The narcissistic relation to the self. *Quadrant 13,* 2.

Satinover, J. (1984). Jungian Psychotherapy. In M. Sacks, P. Rubinton, & W. Sledge (Eds.), *Core readings in psychiatry: An annotated guide to the literature* pp. 306–308. New York: Praeger.

Satinover, J. (1986). Jung's lost contribution to the dilemma of narcissism. *Journal of the American Psychoanalytic Association, 34,* 401–438.

Satinover, J. (1995). Psychopharmacology and Jungian analysis. In M. Stein (ed.), *Jungian analysis* (2nd ed.). Chicago: Open Court Press.

Shelburne, W. A. (1988). *Mythos and logos in the thought of Carl Jung: The theory of the collective unconscious in scientific perspective.* Albany, NY: State University of New York Press.

Smith, R. C. (1996). *The wounded Jung: Effects of Jung's relationships on his life and work.* Evanston, IL: Northwestern University Press.

Steele, R. S. (1982). *Freud and Jung, conflicts of interpretation.* London; Boston: Routledge & K. Paul.

Storr, A. (1981). Jung, Carl Gustav 1875–1961. In J. Wintle (Ed), *Makers of modern culture* pp. 258–260. New York: Facts on File.

Ulanov, A. B. (1971). *The feminine in Jungian psychology and in Christian theology.* Evanston, IL: Northwestern University Press.

Vincie, J. F. (1977). *C. G. Jung and analytical psychology: A comprehensive bibliography.* New York: Garland.

The wisdom of the dream [videorecording]: Carl Gustav Jung [Wilmette, IL]: Public Media Video, c1989. v. 1. A Life of dreams (53 min.); v. 2. Inheritance of dreams (53 min.); v. 3. A world of dreams (53 min.)

Language in Psychotherapy

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GLOSSARY

bridging Language that associates current thoughts and feelings with historical events or previous experiences. For example, "Is this a familiar feeling?" and "You said when she yelled at you the thought 'I am such a loser' popped into your head. Is that a new thought or is it a familiar one?"

clarification Clarifications are questions (or statements with the inflection of a question) that serve to confirm the perspective of the client. During instances when the client is vague, clarifications are used to encourage more description or explanation in order to bring clarity to the session. Importantly, a clarification can also be a way to convey an understanding of the client's situation or perspective.

confrontation Noticing, and bringing the client's attention to, events, behaviors, or content that are inconsistent with the goal of progress or change. Mixed messages, aloof behavior, and inconsistent remarks are examples of content that are typically confronted.

counterassumptive A counterassumptive statement is used to manage the working distance between the client and therapist. It targets the assumption of the client and counters it without arguing with the client. For example, when the client says "tell me what I should do" the therapist can respond with a counterassumptive instead of arguing or refusing the client's request ("It isn't obvious to me either … I wish I knew").

description There is an important distinction between inference and description. Describing behavior is generally less threatening than inferring something from the client's behavior. "It doesn't look like you like your kids" is an inference and "when you talk about your kids your face becomes more constricted and strained" is a description.

dichotomous questions Presenting a choice between two statements is a dichotomous question. "What feels more true to you … that you are angry or that you are afraid?"

edification Educating the client is an essential variable in the change process. Explanations regarding the etiology and causes of various problems, imparting treatment options, developing new skills, and Socratic discussions, are all examples of edification in counseling.

exclamations Exclamations are used to convey an active empathic stance. "Wow!," "How awful!," and "Outstanding!" are expressions that either convey an understanding regarding the intensity of a given situation, or welcome clients to experience something they are currently holding at an emotional distance.

extensions When clients constrict content and have difficulty acknowledging what might be obvious emotional dimensions of their life experience, the therapist can take an active empathic stance and state it for the client. This very delicate and advanced skill is used as an invitation to delve further into emotional content. For example, the client says "I am lonely" and when there is a reasonable amount of certainty, the therapist can use an extension "and it has been this way for a long time."

horizontal questions Horizontal questions are used when the therapist wants the focus to stay on the emotional and

relational aspects of a client's experience. When the client makes a sensitive and personal self-disclosure, the therapist can respond either vertically (which focuses on the informational level of content) or can respond horizontally. "Now that you have told me this, what are you thinking?" or "What was happening right before you told me this?" are examples of horizontal questions.

imperatives A statement that elicits a specified action. "Tell me what you're thinking" or "Say the first thing that comes to mind when I say 'airplane'."

interpretations An interpretation is a well-timed and carefully constructed explanation of the client's experience, disorder, or interpersonal context. In most instances, this is where the theory of the therapist emerges. The primary difference between an interpretation and a clarification is that the interpretation introduces a new perspective to the client (it is the therapist's perspective).

minimal encourager These are sounds and statements that encourage the client to continue in a monologue. "Mmm," "uh huh," and "oooh" are examples of minimal encouragers designed to keep the process going without undue interference.

open-ended question A question that cannot be answered with a "yes or no" or single word response. "What did you do on your vacation?" as opposed to "Did you have a nice vacation?"

paraphrasing Putting the client's description into different words as a means of conveying an understanding of the client's thoughts and experiences.

performatives Statements that are also actions. "I do" in a wedding binds the individual in a commitment, a compliment like "That looks nice" has the effect of making the recipient feel good, or the therapist saying "I have confidence in your ability to handle this" is intended to instill a sense of self-efficacy.

probes These are statements and questions designed to elicit more information regarding a specific area of content. "I'm thinking you must have had a good reason to start drinking again after all the things you have been through" is a probing statement and "Why did you start drinking again?" is a probing question.

reflection Rephrasing or restating the emotional or affective part of the client's statement. Many therapists rely on reflections as a way of expressing empathy and acceptance of the client.

reflexive questions Posing questions that put the client in a position to consider new perspectives or alternatives. Reflexive questions start off with statements like "What would happen if…" and "Let's say you were assertive with your boss, what would you expect to happen?"

strategic questions Tactful use of strategic questions is an option when the therapist observes the need for more direct challenges. Strategic questions are often corrective and imply a desired outcome. "What keeps you from doing your own grocery shopping at this point?" and "Something stops you from speaking out about this to your boss (with the inflection of a question)" are examples of strategic questions.

summarizing Rephrasing the client's utterance as a means of clarifying and conveying an understanding of the client's disclosure.

verdictives These are performative statements that serve as verdict or implicit declaration. "I think you can handle this" or "It is necessary to deal with this" are verdictives.

vertical questions Interviewing often requires a number of questions regarding the client's history, family structure, educational background, and other facets of the individual's personal life. Vertical questions are designed to elicit information and logical details. When a client discloses something very personal, the therapist can either address the informational aspects of the disclosure (via vertical questions like "How long?" and "When?") or can focus on the emotional and personal aspects of the revelation (see horizontal questions).

I. INTRODUCTION

Throughout this encyclopedia, there are descriptions of specific psychological theories and novel techniques of therapy that set various orientations apart. In spite of numerous differences expressed by the respective denominations in psychotherapy, there is one common element that very few would dispute; the essential use of language as a mechanism of change. In the short time psychotherapy has existed, the field has evolved into a craft with its own language, conversational rules, and social structure. Although the process of therapy is more than word selection and phrasing, there is a growing accumulation of verbal strategies designed to assist the therapist through a number of situations and contexts. This article is a review of the actual verbal "tools of the trade" that serve as the staple of most therapeutic approaches.

II. EVOLUTION OF THERAPEUTIC LANGUAGE

The systematic use of conversation for therapeutic purposes is not a new concept. As far back as Hellenic Greece, rhetoricians were employed to challenge the logical errors of melancholic "patients" in order to effect a more positive outlook on life and to find solutions to problems. The Greek formulation of mental processes paved the way for the use of persuasion, motivational conversations, and encouragement, as a healing form.

In spite of the historical dominance of mystical and spiritual formulations of human suffering, it is clear that very few "lost faith" in the use of a confidential and abiding relationship to produce behavioral changes or to render assistance to those who needed it. Even the priests of the middle ages were purveyors of a healing conversation in the form of confession. This sacramental ritual included many facets of modern psychotherapy. A confidential setting, self-disclosure, focus on behavior change, and a redemptive relationship are all elements in common with the secular practice of psychotherapy. It was not until the "age of enlightenment" that the intellectual formulations of mental illness and human suffering returned to mainstream Western thought. As the ideas and attitudes shifted away from the more mystical views of mental disturbance, the medical field advanced concepts that served as the precursors to psychotherapy as we know it today. Importantly, the more humane and optimistic views posited by Tuke, in Great Britain, and Rush, in the United States, encouraged treatments based on rational and scientific formulations of mental illness and set the tone for the next century.

A culmination of theoretical contributions led to the ultimate invention of psychotherapy; however, psychoanalysis was the first type of therapeutic conversation to emerge as a discipline. By the time of Freud's death in 1939, psychoanalysis had developed an assortment of well-defined pragmatic verbal strategies. The verbal activity of the contemporary analyst is largely centered around the sequence of free associating, confronting, clarifying, interpreting, and "working through" material as it emerges in the session. In essence, the psychoanalyst's artful use of language creates a process of unencumbered exploration while striking a delicate balance between defensive self-preservation and a desire to access the troubling source of the individual's problem or neurosis. With a strict sense of restraint and economy, the analyst uses a series of prompts and other linguistic devices of language to accumulate enough data or material to form an interpretation. In many ways, it is initially a process of collecting pieces to a puzzle and then it proceeds to an interpretation, at which point the therapist actually attempts to put the pieces together. The interpretation brings to light connections that were, at one time, outside of the individual's awareness. With each insight, the individual is equipped to reallocate psychological resources previously dedicated to the unresolved intrapsychic conflict. Freud described the process as two travelers on a train with one looking out the window and describing what is on the landscape and providing details about the scenery. The other traveler is blindfolded, but is able to explain details and impart meaningful information regarding the countryside as they pass through. This one-sided and slow deliberation was unprecedented in terms of a social structure and seminal with regard to the development of therapeutic language.

The psychoanalytic approach to treating psychological and emotional problems was a dramatic departure from the "bootstrapping" and "advice giving" mores of the time. Society began to accept the notion that emotional suffering and mental illness was often too complex to resolve with simplistic solutions. Along with the changes in attitude came a rapid succession of new therapies, as well as more lively debates about what "active ingredients" of therapy make it effective.

Although psychoanalysis solidified the presence of the "talking cure" in the twentieth century, a proliferation of therapeutic approaches would lead to an expansion of ideas regarding therapeutic language. There was a notable transition from the "free floating" and noninstrusive stance of the psychoanalyst to a more active and broadly applied use of the therapeutic relationship. A new taxonomy of language developed around a number of core concepts in psychotherapy that included a collection of therapist behaviors and types of utterances. Therapeutic orientations began to offer ideas regarding language usage and presented techniques that were based on their respective theories of change. Whether it be insight, a corrective emotional experience, or an in-depth exploration of an important aspect of the client's life experience, clinicians and theorists were discovering how to make these types of conversations occur.

The new faces of therapy expanded well beyond the original constraints imposed by "psychodynamic" theory. Albert Ellis broke through the vales of neutral distance with his often blunt and usually directive approach to dialogue in his rational emotive therapy (now rational emotive behavior therapy). Conversely, Carl Rogers placed considerable importance on a nonjudgmental and supportive collaboration in his person-centered therapy. Mirroring techniques, passive empathic statements, and an emphasis on genuine dialogue, are all activities advanced by Rogers as "facilitative" therapist behaviors. Fritz Perls demonstrated a number of creative strategies that intensified the emotional experience in therapy, including cathartic techniques such as the "empty chair" where the client engages in a role-played conversation with an imagined person. Aaron T. Beck and his colleagues established a

method of "collaborative empiricism" in his cognitive therapy approach. His method included the use of the Socratic method, engaging the client in a scientific inquiry using questions, and persuasive challenges to problematic thought processes and perceptions. The interpersonal theorist Harry Stack Sullivan attended scrupulously to the impact of his wording and phrasing on his patients and lectured extensively on the importance of deliberate syntax. His well-regarded work on interviewing and therapeutic processes articulated minute differences between well-constructed therapist statements and poorly constructed ones. Milton Erickson was widely known for his creative use of language and his effective use of metaphors. The full spectrum of contributions to therapeutic language is a vast and voluminous subject; however, it is clear that developments in therapeutic language have come from a multitude of sources. Close examination of the various techniques and approaches reveal a field that is willing to integrate new ideas and to learn from one another. The rapid growth of "integrative" and "eclectic" therapeutic movements is testimony to the widespread recognition of the need for the creative application of a variety of tools, rather than strict adherence to a narrow and dogmatic view of change.

III. THERAPEUTIC COMMUNICATION

The cornerstone of most therapeutic approaches centers on the mutual participation in a special type of conversation, a conversation that is implicitly different from everyday discourse and that is unique in terms of structure and content. The "way" the therapist phrases something, the timing of a given response, even the selection of words, have become a recognizable form of social interaction. The cliché "How does that make you feel?" may be the best known of the therapist's staples; however, the skilled therapist is capable of applying many more proprietary tools of the trade to help the client. Historically, it is clear that the development of therapeutic approaches was largely dependent on recognizing what worked in different situations. The remainder of this article focuses on the actual verbal behavior of the therapist, how language changes within different contexts of the process, and what the therapist hopes to achieve with different types of verbal responses.

Much of what we know about language in psychotherapy comes from the field of "process research." Studies of the actual behavior as well as *in vivo* observations of different forms of therapeutic communication have resulted in a reliable taxonomy of words and behavior that are unique to psychotherapy relative to everyday conversation. The seminal research of Clara Hill, William Stiles, Sol Garfield, Kenneth Howard, Carl Rogers, Larry Beutler, Leslie Greenberg, Michael Patton, Robert Russell, Hans Strupp, David Orlinsky, and numerous others, elevated the level of description from vague and theoretically laden inferences, to measurable entities. The content and scope of process research attends to complex variables within the session such as therapist intentions, types of utterances or "verbal response modes," probabilities of therapist responses within different contexts, conversation analysis, semantics, "good moments," and other interpersonal variables related to positive outcomes. The collective findings of this type of research have had a direct influence on the therapeutic terminology, the validity of outcome studies that use process measures to assess treatment integrity, and training. The glossary provides an overview of therapist statements, as well as the typical contexts in which they are used. Ultimately, these tools make it possible to engage the client in a conversation that is markedly different from other forms of social support, help, or advisement.

The fields of anthropology and "conversation analysis" observe that in most interpersonal contexts and cultures, verbal interactions fall into fixed patterns that are predictable and orderly. When people abide by these social tenets, it contributes to a sense of cooperation, safety, and compatibility. Even minor infractions of these rules can lead to anxiety, perceived disturbance, interpersonal distance, conflict, or the interpretation of rudeness. For example, a self-disclosure of emotional pain or suffering will typically lead to consolation, commiseration, or supportive comments. Beyond that point, however, intuitive signals cause one or both speakers to change the topic away from the delicate subject matter and on to a subject that is not so sensitive. Subsequently, a concern about intrusiveness or a fear of intensifying the person's emotional pain can effectively thwart a therapeutic conversation. Conversely, it is understood, even expected, that the collaborative relationship between the client and the therapist is in effect to talk about things that are difficult to share and to address issues beyond the normal scope of everyday conversation. Therapists develop the ability to depart from the social restrictions that limit the course and depth of everyday conversation with implicit permission to abandon conventional patterns of conversation in order to engage the client in a

unique and constructive process. Probing questions, long silences, interpretations, *in vivo* descriptions of behavior, and clarifications, are but a few verbal events that are rarely observed in most other interpersonal contexts. This relatively new type of dialogue employs a variety of illocutionary strategies in order to promote positive movement in the therapy process. Therapists-in-training learn to use a variety of verbal strategies that have known effects on the direction of the session and that are introduced as a means of meeting identified therapeutic goals. Specific roles are adopted (e.g., teacher, redemptive listener, a guide through the healing process, motivational speaker, and persuader) to engage the client in different types of therapeutic interactions. In whatever the context, the skilled therapist relies on the systematic use of language to ensure the best chance of a positive outcome.

The appropriateness and quality of any therapeutic response is dependent on the situation at hand. Although there are over 400 identified "orientations" of psychotherapy, the conversation of therapy is fairly uniform when considering context. There is an initial greeting, then a brief gathering of information, a subsequent exploration or delving into more detail, and then a "winding down" period. Each session follows a general trend and provides a "frame" that guides the therapist's responses. Take, for instance, the statement "I feel bad." Again, the type of therapist response will depend significantly on when or in what context the statement was made. If it occurs early in the session, the therapist may ask questions, or direct the client to elaborate, as a means of establishing a focus, or to determine the context of the client's reported experience (e.g., "Tell me what has been happening" or "What has happened since our last session?"). The same statement, "I feel bad", elicits a different set of therapeutic responses when it occurs further into the therapeutic hour. It is notable that most of the "treatment"-oriented techniques occur during this part of the therapy session. It is not unusual for the therapist to use techniques to intensify the client's emotional experience or engage the client into a deeper exploration of content. Therapist empathy becomes more finely tuned and is accompanied by a due amount of encouragement, even pressure, to work through difficult material. Clients are sometimes guided through a courageous process of facing dreaded material, conquering personal demons, and are systematically exposed to fears and stimuli that provoke escape and avoidance. When the client says, "I feel bad" toward the end of the session, the constraints of time affect the therapist's response. The same disclosure might require attention to coping strategies that the client can use between sessions (e.g., "What do you expect to happen to this feeling later today? or "Do you think it would be helpful to go over some of the coping strategies we have discussed previously to get us through the week?"). The therapist will also summarize the session with relevant information, new insights, or present an objective view of the possibilities in the future. It follows then, that the quality of any given response depends significantly on the context in which it occurs.

The therapist is also mindful of "timing" a statement or question appropriately and is poised to respond to opportunities for positive movement. When to exert pressure and when to back off, is an hourly challenge that is largely determined by the readiness and competence of the client. Premature exploration often leads to flight responses or other types of resistance such as restricting content, dominating the session, attempts to change the therapeutic arrangement, and emotional withdrawal. An absence of exertion or movement can lead to meandering and even apathy. In both cases, there is a risk of a negative effect. One poignant example of this comes from an intake conducted by a seasoned psychologist working with a woman struggling to bond with her adopted child. She reported feeling repulsed by her new son's attempts to be close to her. At one point during a description of her son, she displayed a look of disgust and made a gesture that signified "go away." After observing the intensity of her emotion, the psychologist asked, "Is this a familiar feeling?" It did not take long to realize that the question thrust her into a dissociative state. Her history of abuse had yet to be disclosed to anyone and they scrambled for 2 hours using standard grounding techniques to get back to the "here and now." Although this kind of "bridging" question was not a bad one, the timing was clearly premature. If the same question occurred several sessions later, it may have resulted in a more fruitful outcome. Thus, it is not simply what the therapist says that makes a difference, it is also what the therapist chooses not to say. At any given moment, the therapist is considering options, restraining his or her own impulses, and choosing one response over another, based on what has the best chance of leading the conversation in a direction that will help the client.

For better or worse, each utterance has the potential of affecting the course and experience of the conversation. The study of pragmatics examines the interpersonal effect of phrasing and syntax. Each statement has a probability of influencing the direction and nature of

the subsequent utterance. When the therapist makes a statement or asks a question, it is often "goal-directed" and made with specific intentions. For instance, if therapists believe that creating a "here-and-now" experience is important to therapeutic success, then they will ask questions differently than if they are interested in gathering basic information. Instead of the therapist asking "So what was it like in your house growing up?" the therapist might set up the question with a present tense like "It is 6 o'clock in the evening at your house when you were growing up … what is happening around you?" This type of phrasing is more likely to be "experienced" than the past tense questioning.

Depending on the goal of a given session, the therapist will pose questions and initiate dialogue with a fair amount of attention to probability. Starting the session with "O.K., where is a good place to start today?" produces a different direction or set of responses than "So tell me about your week." An even more predictable outcome can be generated with a statement like "Last time we were talking about your relationship with your brother and how he was the prized son." In each case, the therapist uses language to shape the course and emotional depth of the session.

Mindful of the multiple layers of therapeutic communication and the known effects of certain types of statements, the therapist mentally juggles a variety of options and then selects a response according to the immediate goals of the session. An example of how the therapist considers the probable effect of one type of utterance versus another is observable in instances when the client discloses a closely guarded secret. After the disclosure, the therapist can ask "vertical" questions designed to generate information about the historical and factual aspects of the secret. "How long ago did this happen?" or "What makes you think that?" are examples of vertical questions. However, the skilled therapist might decide to prioritize strengthening the therapeutic relationship over gathering information. In this event, the therapist could ask a "horizontal" question such as "What was it like to say that?" or "Tell me what you were thinking before you told me this." Horizontal dialogue changes the focus from the content of the disclosure to the client's experience of therapeutic relationship. When a delusional patient discloses a fear of an "FBI plot" to assassinate him, the therapist can respond with at least two routes of exploration. It is tempting to assess and treat the delusion or psychosis; however, the seasoned therapist recognizes the tenuous nature of the therapeutic relationship with this type of problem. Subsequently, since the notion of an FBI plot is frightening to the patient, empathic language and supportive comments are appropriate responses. "Approximating" statements make it possible to express an understanding of the fear without endorsing the belief. "If I were convinced the FBI intended to kill me it would be very frightening and I wouldn't know who to trust" is different than "If I were in your shoes I would be very frightened." The therapist will attempt to side with the fear and express an understanding of the experience before attempting to confront the delusion. When it is time to confront the delusion directly, it is prudent to phrase the probe in a manner that elicits a description, rather than a belief. "What are you seeing that convinces you that this is happening?" leads to a description of external events and "Why do you think this is happening" generates a response depicting thought processes and theories. Therefore, the therapist can minimize problematic exchanges and lower the chances of exacerbating the patient's delusion with carefully crafted phrasing.

Countless situations are navigated and managed with the deliberate use of language. Although there is not a "right way" to respond to every situation, there are responses that have better probabilities of success than others.

IV. LANGUAGE AND THE THERAPEUTIC RELATIONSHIP

The therapist is also monitoring the quality and strength of the therapeutic relationship. Freud was the first to recognize the intense bond that forms when two individuals embark on the therapeutic journey and others have concluded that this is one of the most critical dimensions to successful therapy. It is necessary to establish intimacy and trust before the therapist employs any deep probes or challenges. In order to keep the focus on the client it is necessary to discard the most common means of achieving interpersonal intimacy, namely two-sided self-disclosure. When people pursue personal relationships, they willingly collaborate in a "do as I do" process that is proportional and rhythmic. When we meet someone for the first time, we often attempt to achieve a level of intimacy and comfort by beginning a search for things in common. "Where are you from?" "Where did you attend college?" and "What do you do for fun?" are questions that lead to a point of excitement when people find a mutual domain of experience or interest (i.e., "Me too!" or "Oh really, I have a friend at that university. Perhaps you know her…").

With emotionally and deeply personal information the implications of disclosure are more threatening. As the layers of self-protection peel away, there is a lingering state of vulnerability until the other responds with either an affirmation or a similar unveiling of personal content. Intimacy in psychotherapy is different. Client disclosures are met with expressions of understanding, empathy, and prompts to continue rather than reciprocal self-disclosures. Empathic sounds (e.g., "uh huh," "hmmm," and "oh") and positive nonverbal gestures serve to encourage, even invite the client to discuss sensitive material if it is needed.

The seminal work of Carl Rogers emphasized the importance of creating a strong alliance between the therapist and client. To be in "sync" with clients and to reflect an understanding of their experience is a necessary condition of therapy. Conveying a genuine interest in the individual, as well as making an effort to understand the client's emotional experience, or empathy, is the cornerstone of a functional therapeutic relationship. Upon disclosing the horror of a traumatic event, the client sees and hears indications of empathy and a human response. A grimace or the sound of a quiet gasp serves to encourage, even prompt the client into further exploration. Rogers emphasized the nonintrusive and tentative stance of "passive empathy" as a means of establishing a safe and "facilitative" environment. Although the therapist is encouraged to monitor (and even express) his or her own personal reactions within the therapeutic process, there is a clear separation between the therapist's experience and the client's reported experience. Instead of "me too" statements, the therapist attempts to acknowledge and validate the client's view of the world. Once the therapist is confident about the level of "intersubjectivity" or degree of shared knowledge, the therapist can tread carefully into the client's space. Sometimes it is a matter of expressing or conveying an "experience of the client's experience," but also verbalizing thoughts and feelings that the client is reluctant to admit. Therapy is brimming with opportunities for this type of connection. For example, as an exhausted and anxious single mother describes all of the activities and obligations that she encounters on a daily basis, the therapist can use a passive empathic statement such as, "That must be overwhelming" or he or she can choose an active empathic statement such as, "Wow, when I think of doing all of that I feel overwhelmed." In either case, the therapist uses empathy to fortify the therapeutic alliance and create a safe place for therapy to occur.

The therapeutic relationship is also subject to periods when it shifts into altered states. During the course of therapy, Freud noted that patients would develop a distorted view of the patient–analyst relationship. Frequently, the patient would transfer thoughts and feelings associated with parental figures to the analyst. It became evident to Freud that this phenomenon, which he labeled "transference," was an opportunity to work through unresolved conflicts of the patient's childhood. Harry Stack Sullivan expanded on the notion of transference with his concept of "parataxis," which included feelings about people in general rather than just parental figures. Nonetheless, when these feelings emerge in the therapy session it presents some opportunities for positive movement. The therapeutic dyad can serve as a microcosm of other relationships and facilitate an opportunity to work through pervasive issues that exist in the individual's social milieu.

Hostility, seductiveness, submissiveness, and dominance are all examples of behavior addressed in the safety of the therapeutic environment. In these cases, the therapist must establish and manage a "working distance." In his book *Making Contact,* Harvard psychiatrist Lesten Havens describes working distance as "being alone together" in a state of "noninvasive closeness." The instincts of the client might compel him or her to submit too readily to the will of the therapist, rebel against the therapeutic process, or to take over the process with his or her own preferred form of dominance. Language moderates imbalances created by these polar movements and prevents the therapist from colluding with the client's attempt to derail threatening but constructive movement. The seductive client may attempt to draw the therapist out of a neutral stance by appealing to the personal needs of the therapist. After disclosing in provocative detail, a sexual dream about the therapist and then conveying current sexual feelings, the therapist is saddled with the task of redirecting the focus without rejecting the client. When the client moves toward the therapist in this way, the use of horizontal questions such as "What is it like to tell me about these feelings?" can create an objective moment. A statement such as "It says a lot about the trust we have established that you are able to talk about this with me. You can speak openly about these feelings and know, with confidence that I will not betray you by changing our relationship in that way" is a "performative" (see glossary) statement that declares the status of the relationship. If the client exhibits embarrassment or regret, a counterassumptive statement such as "One thing I will ask is that the next time you have a dream like that about me could you give me a full head of hair and rippling stomach muscles?" This statement counters the assumption that

the client did something wrong by disclosing the dream, but also reaffirms the safety of the therapeutic setting.

Managing the working distance involves keeping a perspective and thinking of these events in terms of data instead of personal dilemmas. Harry Stack Sullivan referred to a state of mind called "participant observer." Like the ethnographic researcher, the therapist is both experiencing and studying the situation. Instead of treating challenging situations as a problem, the therapist observes the behavior and assesses the degree to which the behavior is likely to be a problem in the individual's daily life. Using the example of the seductive client, rather than thinking about how appealing the therapist must be to elicit such feelings, the therapist considers the possibility that this behavior is a maladaptive response to psychological intimacy. The socially anxious client sometimes projects hostility or aloofness as a way of creating a safe distance from people whom they perceive as a threat. The therapist subdues the initial experience of rejection and, again observes the behavior as important data. By use of description, as well as carefully constructed questions, it is possible to capitalize on the emergence of the behavior and offer an opportunity that literally does not exist in any other setting. The therapist can offer "objective" feedback about potentially problematic behavior without an obligation to apologize or repair the relationship.

In addition to dealing with the challenges of direct "focal messages" or the literal content of any given utterance, there are "metamessages" that are equally important. Metamessages are the implicit messages that are not typically acknowledged as a message, but have a profound impact on the conversation nonetheless. If, for instance, a client pleas to the therapist "Just tell me what to do" the therapist has a few options. One common response to this type of plea is to refuse the request with an explanation. "It wouldn't be appropriate for me to tell you what to do in this case" or "This is your life and I think you are in the best position to make a decision of this importance." The focal messages in this case are "no" and "It isn't a good idea to tell you what to do." However, one of the metamessages might be perceived as "I am withholding my advice" and "I probably do have the answers but it is against the rules to tell you." In spite of the reasonable focal content, these metamessages could result in resistance, problems in the therapeutic alliance, and unnecessary arguments. One way to counter this metamessage would be to use a statement such as "I wish I knew what the right way to handle this would be … it is not obvious to me either" (which is a "counterassumptive" statement). This response counters the assumption that the therapist knows what is best for the client and, for whatever reason, chooses to keep from the client, and sends another message acknowledging the complexity and difficulty of the client's situation.

V. SUMMARY

Psychotherapy resides in our culture as a widely accepted and specialized form of communication. The psychotherapist shapes the process by using a unique combination of verbal tools and well-placed responses to the client. Importantly, statements are selected on the basis of the known effects of specific devices or techniques, and are utilized as a means of meeting an identified therapeutic goal. The therapist adopts specific roles such as teacher, redemptive listener, a guide through the healing process, motivational speaker, and persuader, and engages the client in different types of therapeutic interactions. In whatever the context, the skilled therapist relies on a deliberate use of language to ensure the best chance of a positive outcome.

See Also the Following Articles

Acceptance and Commitment Therapy ■ Communication Skills Training ■ Confrontation ■ Functional Communication Training ■ History of Psychotherapy ■ Interpersonal Psychotherapy ■ Rational Emotive Behavior Therapy ■ Sullivan's Interpersonal Psychotherapy ■ Working Alliance

Further Reading

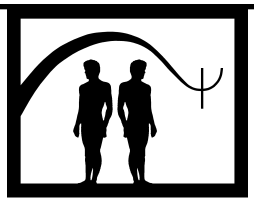
Havens, L. (1986). *Making contact: Uses of language in psychotherapy.* Cambridge, MA: Harvard University Press.

Nofsinger, R. E. (1991). *Everyday conversation.* Newbury Park, CA: Sage.

Schegloff, E. A. (1984). On some questions and ambiguities in conversation. In J. M. Atkinson & J. Heritage (Eds.), *Structure of social action: Studies in conversation analysis* (pp. 28–52). Cambridge, MA: Cambridge University Press.

Stiles, W. B. (1992). *Describing talk.* Newbury Park, CA: Sage.

Wachtel, P. L. (1993). *Therapeutic communication: Principles and effective practice.* New York: Guilford Press.



Legal Dimensions of Psychotherapy

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GLOSSARY

adjudicate Refers to the process whereby differences and conflicts within the justice system are heard and settled.

confidentiality The right of a patient to have any information or communications made during the course of treatment and evaluation to be held in strict confidence unless authorized to be divulged.

due process The process whereby the rights of parties in a conflict are assiduously protected in the settlement of that conflict. Due process generally entails the opportunity to know and examine one's accusers and the chance to present one's own case in defense of an accusation.

HIPAA Health Insurance Portability and Accountability Act of 1996, which is federal law intended to rectify a variety of conflicting state laws concerning health related issues. It has stringent confidentiality protections.

privilege Refers to disclosures made in court or for legal reasons and is an exception to the general rule of evidence of the justice system, in which every member or party to a conflict has a right to every other person's evidence.

There are both ethical and legal underpinnings to the confidential relationship between a psychotherapist and a patient. Confidentiality here refers to the right of a patient to have communications, made during the course of evaluation or treatment, held confidential absent express or implied authorization. Although confidentiality is not absolute, and may vary with the professional qualifications of the therapist, it remains a core value for mental health professionals and patients.

A variety of professionals may fulfill the role of psychotherapist. Physicians specializing in psychiatry and psychoanalysis have the ability to prescribe medication for their patients in addition to performing psychotherapy in its varied forms. Clinical psychologists with master's or doctorate degrees have special training in administering and interpreting psychological testing as well as clinical training in psychotherapy. Other licensed professionals who conduct psychotherapy are social workers and nurses with master's or doctorate degrees. In addition there are marital and family counselors and the clergy.

Psychotherapy involves disclosures of the most personal nature, including wishes, fears, dreams, fantasies as well as detailed disclosures regarding one's personal, educational, legal, employment, social, sexual, and family history. This information is important, not just for the isolated facts and psychological symptoms, but also to learn how the person deals with stress and conducts personal and intimate relationships. This data is needed for accurate assessment and diagnosis, as well

as treatment. The style and process by which the information is disclosed by the patient/client is also revealing of personality traits and cognitive styles of dealing with the inevitable stresses of daily life. It is not uncommon for a psychotherapist to be the recipient of information that has never been shared by the patient with anyone else. Unless there is some assurance of confidentiality, it is unlikely that individuals would be as open or free about making disclosures, especially as there remains a significant stigma associated with mental disorders and their treatment.

I. CONFIDENTIALITY AND PRIVILEGE

Confidentiality protections are derived from a variety of sources. The oldest derives from professional and ethical codes. Since the fourth century BCE, the Hippocratic Oath has required that physicians respect the confidentiality of patient communications:

> And whatsoever I shall see or hear in the course of my profession, as well as outside my profession, in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secret.

Professional organizations, such as the American Medical Association (AMA), since early in its history, have been concerned with the importance of confidentiality. The current code of medical ethics has a section on confidentiality:

> The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of that communication. The physician should not reveal confidential communications or information without the express consent of the patient unless required to do so by law.

The American Psychiatric Association (APA) publishes for its members *The Principles of Medical Ethics* with special "Annotations Especially Applicable to Psychiatry." Members are required to follow the basic AMA principles as well as the APA Annotations. The APA principles state that psychiatrists must "respect the rights of patients, colleagues, and other health professionals, and that they must safeguard patient confidences within the constraints of the law." The guidelines on confidentiality also tell psychiatrists that they "may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy." Other therapists are also bound by ethical codes to keep information within the therapeutic relationship confidential. The American Psychological Association, in its *Ethical Principles of Psychologists and Code of Conduct,* informs therapists that "safeguarding information about an individual that has been obtained by the psychologists in the course of his teaching, practice, or investigation is a primary obligation of the psychologist." The National Association of Social Workers (NASW) also has a code of ethics with an elaborate confidentiality section. Section 1.07c states in part

> Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person.

All clients must be informed by the social worker of the limits of confidentiality in a given situation. The American Counseling Association requires its members to adhere to a code of ethics that has a full section on confidentiality. Counselors must respect their clients right to privacy and avoid illegal and unwarranted disclosures of confidential information.

The concepts of confidentiality and privilege are related but separate. Privilege laws, strictly speaking, only relate to disclosures made in court whereas confidentiality statutes govern therapist's obligations outside the courtroom. Privilege is an exception to the general rule that the justice system has a right to every person's evidence. Confidentiality is both an ethical and legal duty that protects a patient from unauthorized disclosures of protected information. At this point all states and the federal courts recognize important confidentiality and privilege protections in the psychotherapist–patient relationship. At the same time statutes and courts have created numerous exceptions to the confidentiality/privilege rights.

By far the most influential rationale for recent privilege law is the traditional justification enunciated by Dean Wigmore. Essentially utilitarian in nature, this justification asserts that communications should be privileged only if the benefit derived from protecting the relationship is important enough to society that it outweighs the detrimental effect on the search for truth. In particular, Wigmore set out four conditions for the establishment of a privilege:

1. The communications must originate in a confidence that they will not be disclosed.
2. This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
3. The relation must be one which in the opinion of the community ought to the sedulously fostered.
4. The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

The evolution of the privilege concept in law is helpful in understanding its current role for psychotherapists. The rule that an advocate could not be called as a witness against his client existed in Roman times. It is unclear whether the Roman tradition influenced the Anglo-Saxon attorney–client privilege, but English recognition of the privilege goes back at least to the reign of Elizabeth I. The purpose of the privilege was to prevent the attorney from being required to take an oath and testify against his client. Later, it was also considered that such testimony against one to whom loyalty was owed would violate the attorney's honor as a gentleman. Thus, the original justification for the privilege was nonutilitarian. Accordingly, the attorney, rather than the client, held and asserted the privilege. Today the privilege is the prerogative of the client. The client, not the lawyer, holds the privilege. The client has the ultimate authority to raise or to waive the privilege. In addition to the attorney–client privilege under English common law there was also a spousal privilege and, until the Reformation, a clergy–communicant privilege.

The physician–patient privilege did not exist under the English common law, and physicians were expected to testify as any other witnesses in court proceedings. In the United States, a New York court first recognized the clergy–communicant privilege in 1813. In 1828, New York also became the first state to grant a testimonial privilege to communications between a doctor and patient. This permitted a patient to prevent a physician from testifying about information relevant to the patient's treatment that was divulged to the physician in his professional capacity. The psychological counseling privilege has gained recognition since the 1950s, and more recently the privilege has been extended to cover other therapists and sexual assault counselors. Around 1970 there were some efforts by psychiatrists to assert the privilege in their own right. Psychiatrists argued that the patient could not fully understand what they were agreeing to when they signed a release of information. Only the analyst could understand the full implications of the disclosures made in therapy. Courts were by and large not sympathetic with this argument and have clearly held that it is the patient's privilege and is not the prerogative of the therapist.

By 1996 all 50 states and the District of Columbia had enacted some form of psychotherapist privilege. Federal courts, however, did not accept the privilege. In 1972 the Chief Justice of the Supreme Court transmitted to the Congress proposed rules of evidence for the federal courts that had been formulated by the Judicial Conference Advisory Committee and approved by the Judicial Conference of the United States. The proposed rules defined nine specific testimonial privileges, including a psychotherapist–patient privilege. Congress rejected this recommendation in favor of Rule 501, which was more general and authorized federal courts to define new privileges by interpreting "common law principles … in the light of reason and experience."

Until 1996 only a few federal jurisdictions adopted a limited form of a psychotherapist privilege. Others rejected it entirely. Because of these conflicts in the federal courts the U.S. Supreme Court agreed to hear the case of *Jaffee v. Redmond.* Mary Lu Redmond was the first police officer to respond to a "fight in progress" call at an apartment complex in Illinois. As she arrived two women ran toward the squad car saying there had been a stabbing in one of the apartments. Officer Redmond relayed the information and requested an ambulance. As she was walking to the entrance of the building several men ran out, one waving a pipe. Two other men then burst out of the building, one chasing the other and brandishing a butcher knife. He disregarded her repeated commands to drop the weapon, and Redmond shot him when she believed he was about to stab the man. He died at the scene, and people came pouring out of the building, and a threatening confrontation followed before other officers arrived. A suit was filed against the officer claiming excessive force. There was conflicting testimony from the victim's relatives claiming that he was unarmed and that she drew her gun immediately on exiting the squad

car. After the shooting Redmond saw a clinical social worker for 50 sessions. The plaintiff sought access to the therapy notes concerning the sessions in their cross-examination of Officer Redmond. The district judge rejected Redmond's assertion that the contents of the therapy notes were protected under the psychotherapist–patient privilege. Neither the therapist nor Redmond complied with the order to release the notes. The judge instructed the jury that they could presume the notes would have been unfavorable to Redmond, and the jury awarded approximately $550,000 in state and federal claims.

The U.S. Supreme Court majority opinion concerning this case held that confidential communications between a licensed psychotherapist and her patients in the course of diagnosis and treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence. They explicitly recognized and extended the privilege for psychiatrists and psychologists to licensed social workers. They noted that there would be situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others could be averted only by means of the disclosure by the therapist.

In spite of the importance of the recognition of a psychotherapist–patient privilege, it is important to be aware that the patient's privilege is not absolute. There are several exceptions to both the psychotherapist–patient privilege and confidentiality statutes. The patient waives the right to confidentiality when he or she places his or her mental condition into issue in civil litigation, the so-called patient-litigant exception. This is permitted to allow the defendants to explore a patient's prior history to confirm that the current mental condition was related to the claimed injury and had not been present before. Since *Jaffee,* courts continue to differ about the breadth of this exception. The most frequent examples are plaintiff's claims in civil cases for emotional distress damages or in suits under the Americans with Disabilities Act in which a party's mental condition may be part of the case. Some courts have held that where a patient merely alleges "garden variety" emotional distress following an injury and not a specific psychiatric disability or unusually severe distress, this has not been deemed sufficient to waive the psychotherapist–patient privilege. However, there is wide variation in individual rulings. A waiver is frequently deemed to apply when parents cannot agree in custody disputes regarding who is best able to care for the child. In many jurisdictions, statutes also exclude the use of the privilege in involuntary civil commitment proceedings.

The dangerous patient exception to the privilege was explored in a case where a man was indicted for threatening to kill the president. The defendant moved to exclude from evidence his prior statement to a psychiatrist that he "wanted to shoot Bill Clinton." The government argued that under the *Jaffee* exception the privilege was not available, and the trial court agreed. On appeal the Tenth Circuit rejected the broad claim that the privilege does not apply in the criminal setting but remanded the case for an evidentiary hearing "to determine whether … the threat was serious when it was uttered and whether its disclosure was the only means of averting harm to the president when the disclosure was made." If serious and the only means for averting harm then the privilege would not be available. On remand, the District Court heard from the psychiatrist that the man had been discharged to his father's care after his hallucinations of killing the president had stopped and he was stabilized on antipsychotic medication. Three days later the psychiatrist learned that the man had left the father's home, and his whereabouts were unknown. Concerned that he would again stop his medication without supervision, the psychiatrist now concluded that he posed a "serious threat" but commitment was not an option because he had disappeared. The Secret Service was concerned that he had money to travel and had once before been investigated for similar threats. Based on this evidence the court denied the defendant's motion to exclude the disclosure to his psychiatrist. Neither the trial court nor the appellate court considered whether the disclosure, designed to prevent a future harm, should be admissible in a subsequent criminal prosecution.

California has an evidentiary rule permitting this type of disclosure, which has led to psychiatrists and psychologists being called to give evidence of aggravation in capital sentencing hearings after making a *Tarasoff* warning that ultimately failed to protect a victim. The prosecutor was interested in showing long-standing hostility and premeditation by use of this testimony. Other state courts, without this rule of evidence, have refused to let such testimony into evidence.

Other exceptions to confidentiality include reporting laws, such as those relating to communicable diseases; child abuse and neglect; chronic health problems affecting safety to drive; disabled physicians; elderly abuse; and mentally retarded abuse. Most states also permit disclosures, without patient consent, when therapists wish to consult with other professionals for the purpose of diagnosis and treatment, when decisions need to be made regarding hospitalization of the patient, or when the patient poses a risk of harm to self or others.

There are also special rules that come into effect when the work setting or facility has developed specific guidelines. For example, correctional institutions, employee assistance programs, and the military all have additional exceptions to confidentiality. Prison wardens generally require, as a work rule, that any information regarding escapes or escape plans are not confidential and require disclosure to security staff. In employee assistance programs, some information concerning work performance issues may be available to the employer. Commanding officers in the military frequently must be told certain information that would be confidential in other settings. Such special settings frequently require a therapist to learn about and then inform the patient of any limitations on confidentiality that may be applicable.

There have not been many cases brought against psychotherapists for inappropriate breaches of confidentiality reaching appellate levels of review. Many explanations have been offered to account for this small number. The standard of care is not as clearly defined as in other areas of medicine, and causation and damages are hard to prove. There is rarely a physical injury, and courts have been reluctant to make awards for purely emotional damages. Patients may also be reluctant to file cases and expose their mental history in public. It is also possible that many cases settle before reaching open court. Nonetheless a small number of cases have reached public attention, and some are instructive.

In 1986 Diane Wood Middlebrook was writing an authorized biography of Anne Sexton, an American poet. Although Sexton had left detailed instructions regarding most of her papers including some therapy notebooks and a few tapes, her psychiatrist, Dr. Martin Orne, released 300 tapes after obtaining the permission of Sexton's daughter and literary executor, Linda Gray Sexton, to allow the biographer to review the tapes. The release of the tapes evoked great consternation from both literary and psychiatric circles. One professional called his actions a "betrayal of his patient and profession." Others felt the family's wishes did not matter and that confidentiality should survive a patient's death. Dr. Orne believed that the patient would have been eager to have the material reviewed. Eventually charges of an ethics violation were brought against Dr. Orne and adjudicated by the American Psychiatric Association. Ultimately a decision was reached that no ethical violation occurred. Although no lawsuit was filed, the situation illustrates the high sensitivity to these issues as well as the vulnerability of psychotherapists to ethical complaints.

Some liability for disclosures has been founded upon "breach of contract." In *Doe v. Roe* a psychiatrist and her psychologist husband wrote and published a book about a wife and her late husband eight years after the couple terminated psychotherapeutic treatment with the psychiatrist. The book reported extensive details of their lives with verbatim quotations on the feelings, fantasies, and thoughts of both husband and wife concerning the marriage that was breaking up. The therapist claimed that she had obtained verbal consent during the course of therapy. The suit was brought for breach of contract and in tort, for a violation of the confidentiality statute between physician and patient and for invasion of privacy. The court held that the defendant psychiatrist had entered into an agreement with her patients to provide medical care, and although not an express contract, the court stated that the physician impliedly covenants to keep in confidence all disclosures made by the patient concerning the patient's physical and mental condition "as well as all matters discovered by the physician in the course of examination or treatment." The court noted that patients would bring out "all manner of socially unacceptable instincts and urges, immature wishes, perverse sexual thoughts—in short the unspeakable, the unthinkable, the repressed." The psychologist husband who was a co-author was not in a contractual or physician–patient relationship with the plaintiff but the court held him equally liable as a co-violator.

The courts have used a similar means to hold nonphysician therapists to a standard of care encompassing confidentiality. In *Mississippi State Board of Psychological Examiners vs. Hosford,* a psychologist was suspended from practice by the state board for revealing confidential information about his patient. The patient and her husband had sought a treatment for marital difficulties. The psychologist voluntarily and unilaterally revealed information about the wife in a subsequent divorce and custody action to the husband's attorney and signed an affidavit attesting that the wife was not a competent parent. This disclosure was made without a court order requiring disclosure. The Mississippi Supreme Court reviewed the American Psychological Association's Ethical Principles, the psychologist patient privilege, and a "public imperative that the psychology profession as a whole enjoy a impeccable reputation for respecting patient confidences" when the psychologist appealed the decision of the licensure board. The suspension was upheld.

The complexity of the psychotherapist–patient privilege and the Fifth Amendment were illustrated in a case

that arose on an Indian reservation and thus was heard in federal court. D. F. was a troubled 13-year-old adolescent who was admitted to a residential treatment program at a county mental health center. Over the course of 6 months she received very conflicting messages about the confidentiality of her statements made to center staff. She was suspected of harming two infant cousins who had died within a short time of each other. While at the center she was repeatedly encouraged by staff to write and discuss her abuse of young children to gain better ward privileges. At the same time some of the staff were in close communication with Protective Services and the FBI. The staff could never reach consensus about their role and responsibilities. Finally, after more than 6 months on the unit, she confessed. She was arrested and charged with second-degree murder. When the government attempted to introduce her confession, the defense argued that it was not voluntary. The admission into evidence of a confession that was not voluntary, within the legal meaning of the word, violates due process. The court found that the therapists were acting more like "state actors" (police) than they were therapists as they were directly communicating with law enforcement, and thus the confession was determined to be coerced and inadmissible. The staff never clearly defined their role as caregivers with a duty to look after the patient's best interests. Had they done so they would have thought of suggesting that she have a lawyer appointed to attend to her legal problems as well as obtaining legal guidance for the staff.

II. ACCESS TO ONE'S OWN MEDICAL RECORDS

Traditionally, medical records were considered the property of the physician or therapist and thus were under his or her full control. As recently as 1975 a woman, who had signed a contract to write a book about her own experiences as a patient, wished to read her psychiatric records. The New York court, at that time, had no difficulty in upholding the hospital's right to refuse such access. This rule has been altered as the vast majority of states have passed right-of-access laws permitting patient access to their own medical records. Generally, however, these laws allow therapists a limited ability to restrict access where there are reasonable grounds for a judgment that access would be harmful to the patient.

III. "DUTIES TO THIRD PARTIES" OR WHEN CAN VICTIMS OF A PATIENT'S VIOLENT BEHAVIOR HOLD THE PSYCHOTHERAPIST ACCOUNTABLE?

Prior to the mid-1970s psychotherapists had little exposure to lawsuits from individuals who were injured by their patients. This generally was limited to cases of (a) harm by a patient to other patients on an inpatient unit, or (b) negligent discharge from inpatient facilities that resulted in harm to families or strangers within a short period of time from the discharge. This was based on a common-law principal that imposed a duty on the person having custody of another to control the conduct of that person. This common law principle is stated in Restatement of the Law, Second, Torts § 320

> one who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal power of self-protection or is subject him to association with persons likely to harm him, is under a duty to exercise reasonable care so to control the conduct of third persons as to prevent them from intentionally harming the other or so conducting themselves as to create an unreasonable risk of harm to him, if the actor

1. Knows or has reason to know that he has the ability to control the conduct of the third persons, and
2. Knows or should know of the necessity and opportunity for exercising such control.

As written this would not seem to apply to outpatients in psychotherapy.

A. The Tarasoff Case

In 1969 a case arose in California that substantially expanded the duty of care for psychotherapists. The facts are interesting, and although a jury (because of a settlement prior to trial) never heard the case, it has become a landmark case for psychotherapists. Prosenit Poddar was a 25-year-old Bengalese Indian student at the University of California in Berkeley when he murdered another student, 19-year-old Tatiana Tarasoff. Why he killed this young woman he "loved," but barely knew, gradually emerged. Poddar had risen with amazing success through the Indian educational system. In the 1960s he was one of a small number of

Indian students chosen because of his intellectual abilities to pursue graduate-level study in United States in the field of electronics and naval architecture. He grew up in a tiny village in a remote area of India. His upbrining was so the distant from that of Western society that when he first attended the University in India, his friend Farrokgh Mistree had to teach him how to eat with a knife, fork, and spoon and had to explain plates to him. He was a member of the lowest caste in India, the so-called untouchables. During his first year in the United States he did quite well academically. His friend Mistree then joined him in the states but was able to adapt much more quickly to U.S. culture. In the fall of 1968, during his second year, Poddar met Tatiana Tarasoff at an International Students' Organization folk dance. She talked, danced, and flirted with him. She told him of her background, being born in Shanghai of Russian parents, moving to Brazil and then the United States. She was studying languages at a local college and liked to practice at the International House where Poddar was living. She was outgoing and friendly with many of the foreign students but gradually Poddar's interest in her increased, and he told his friend Mistree of his powerful attraction. He did not understand how her behavior, that seemed more than friendly to him, was compatible with spending time with other male students. His friend explained that he thought her interest was genuine but probably only casual.

At a New Years Eve party, he was alone with her in an elevator. It was a festive occasion, and people had been drinking. Impulsively she kissed him for the New Year. He was stunned, as he had never had physical contact with a woman other than his relatives. He almost immediately fled to tell his friend of the new development. In the months that followed he became increasingly upset by her inconsistent behavior. He installed microphones in his room to record their conversations both on the phone and in person. His friend suggested that he end the relationship because it was interfering with his work. He did so, but a month later she called and said she missed him. Within a month he was again uncertain, and in an effort to clarify the situation, he proposed marriage. She did not accept but also did not clearly refuse. Shortly afterward he again confided to his friend that Tatiana's friends were now laughing at him. "Even you, Mistree," he said, "laugh at my state. But I am like an animal, I could do anything, I could kill her. If I killed her, what would you do?" He began to stay in his room for days. He told fellow students that he would like to blow up the house where she lived with her brother and parents. They persuaded him that it was not possible but did not say anything to warn anyone or call the police.

In June, Tatiana returned to Brazil for the summer, but nothing changed for Poddar. His friend suggested that he see a doctor, set up the appointment, and accompanied him. After the initial interview the psychiatrist placed him on antipsychotic medication and set up weekly appointments with a psychologist. During the summer months Poddar became friendly with Tatiana's brother, Alex, spent time with him, and planned to share an apartment with him in the fall. He began to fantasize about rescuing Tatiana from a contrived situation so she would understand the depth of his affection for her. When he told his friend Mistree that he planned to buy a gun to effect this plan, Mistree called the therapist and told him that Poddar planned to stop therapy and buy a gun. The psychologist consulted with the psychiatrist, and they decided that Poddar needed to be hospitalized. Because of peculiarities in California commitment law the psychologist wrote a letter to the University police requesting their assistance in hospitalizing Poddar. Shortly thereafter the Berkeley campus police found Poddar in his new apartment with Alex and interviewed him there. Poddar denied he had a weapon and denied any specific threats although he acknowledged that there had been a difficult relationship between him and the young woman. The police warned him to stay away from her and left without taking any other action. Tatiana's brother Alex was present during interview and knew that the threats were related to his sister but he did not take them seriously and did not report them to his family. When the head of the clinic reviewed the case, he ordered the therapist to destroy the letter to the campus police requesting hospitalization.

Tatiana returned in September, and Poddar overheard her recounting a summer affair to her friends. He began to follow her around. He then purchased a gun, perhaps to carry out his plan of rescuing her from a disaster situation. He consulted with Alex about what would be the best way to approach his sister but Alex recommended that he stay away from her and that it was all over and best forgotten. Poddar insisted that he must talk with her, but Alex told him not to go over to his parent's house, as his father was quite hot tempered. Poddar then made several efforts to see Tatiana at the house. After her mother turned him away, he returned in midafternoon before anyone else came home. As he left his apartment, he slipped a kitchen knife as well as the gun into his pocket as protection against her angry

father. When she answered the door he tried to explain his need to talk with her and forced his way past the closing door. Tatiana screamed, pushed him away, and started to run away. He fired at her scream and followed her. He took the knife from his pocket as they plunged together through the kitchen door. Within minutes he dialed the phone number of the Berkeley City Police stating that he thought he had killed someone. Poddar was charged with first-degree murder. He pled insanity and diminished capacity. Although all experts agreed with the diagnosis of paranoid schizophrenia, the jury found Poddar guilty of second-degree murder. He was sent to California state prison. Five years after he had begun serving a sentence, the California Supreme Court issued its decision; overturning the jury verdict on the grounds the trial judge had given inadequate instructions on diminished capacity to the jury. Rather than retry him, a deal was struck. Because he had already served 5 years, if the state would agree to release Poddar from prison; his attorney personally guaranteed that Poddar would return immediately to India and would never come back to the United States.

Alongside the criminal case, *Tarasoff v. Regents of the University of California* also ended with a settlement. Tatiana's parents sued the University of California and the therapists for the wrongful death of Tatiana. They included a complaint that the psychiatrist's failure to warn them or Tatiana of the danger that Poddar posed to the family was a legal cause of action. Because the trial court dismissed the causes of action as groundless it was appealed to the California Supreme Court on their legal adequacy. After the Court rendered its first decision holding that psychotherapists had a duty to warn potential victims of their patient's threats and that the campus police could be found liable for a failure to warn Tanya, a rehearing was requested although such requests are almost never granted, it was in this case. The second decision reaffirmed but modified the original decision. It required therapists to "protect" intended victims, rather than just "warn" them and absolved the police from any liability. Although the Court expressed concern about the confidentially issues raised by psychiatrists and other mental health professionals, they concluded in both decisions "The protective privilege ends when the public peril begins." The major holding of the case was that the therapists could not escape liability on the grounds that Tatiana was not their patient. The Court held:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

Justice Mosk, in a concurring opinion (meaning that he agreed with the holding but not the legal reasoning), agreed that under the limited circumstances of this particular case, Poddar's therapists had a duty to warn Tatiana. Although Mosk believed the therapists' duty had been satisfied by warning the campus police, he considered this a factual matter to be raised by the defense on remand and did not dissent on this basis. He dissented from the majority's use of the term "standards of the profession." What standards? Psychiatric opinions of future violence were inherently unreliable. "The majority's expansion of that rule will take us from the world of reality into the wonderland of clairvoyance."

Justice Clark, in dissent, was concerned about the pressure on psychiatrists to protect themselves.

> Now, confronted by the majority's new duty, the psychiatrist must instantaneously calculate potential violence from each patient on each visit. The difficulties researchers have encountered in accurately predicting violence will be heightened for the practicing psychiatrist dealing for brief periods in his office with heretofore nonviolent patients. And, given the decision not to warn or commit must always be made at the psychiatrist's civil peril, one can expect most doubts will be resolved in favor of the psychiatrist protecting himself."

Because the case settled prior to trial, there was no discussion or expert opinion of what warnings or protective action were possible or appropriate in the above circumstances.

Although California went on to clarify the meaning of the principle in later decisions to cover only identifiable victims, other jurisdictions disagreed and expanded the scope of the decision. The broadest interpretation occurred in 1980 in the case of *Lipari v. Sears Roebuck & Co.* There, a patient fired a shotgun in a crowded nightclub, blinding a woman and killing her husband. There were no advance warnings to his therapists, and he never threatened any specific person. He did make clear that he was unhappy with his treatment. While still in treatment at the V.A. day care center he purchased a shotgun at Sears, but told no one on his treatment team. He terminated treatment 3 weeks later. One month after the

termination he entered the nightclub. The Nebraska District Court allowed the plaintiffs to proceed in their lawsuit against the hospital. The court held it was for the jury to decide whether the therapist knew or should have known of the patient's dangerous propensity. It did not matter that the victims were not identifiable. The Court rejected the limitation to identifiable victims and focused on the foreseeability of the act.

A Vermont case extended the liability to situations where only damage to property was involved. In that case a patient informed his master's-level counselor that he intended to burn down another person's barn.

The duty has also expanded in some jurisdictions to the area of a patient's erratic driving. In one case a man diagnosed with paranoid schizophrenia, and with an extensive history of depression, self-mutilation, and noncompliance with neuroleptic regimens, was confined following his excision of his left testicle. One day prior to the expiration of his commitment he was observed driving dangerously on the hospital grounds. His commitment was not renewed, and he was released to outpatient follow-up. He promptly threw away his medication and resumed use of street drugs. Five days later he ran a red light at excessive speed and hit a vehicle, injuring the driver. She filed a suit, charging the state with negligent treatment by failing to recommit him or releasing information, regarding his violation of probation conditions. The court adopted the foreseeability standard from *Lipari* to hold that a psychiatrist has a duty to take reasonable precautions to protect anyone who might foreseeably be injured by the patient's drug-related problems. This line of cases requires therapists to protect victims from their patients' negligent behavior rather than just intentional harmful acts.

An interesting variant occurred in another California case where the question arose as to whether a therapist has to make a warning if the potential victim is already aware of the danger. In *Jablonski v. U.S.* the victim was the defendant's common-law wife, Melissa Kimball. Ms. Kimball was fully aware of her husband's violent tendencies in view of his prior beatings of her and his attempted rape of her mother. His more recent behavior included threatening the mother-in-law again. His psychiatrist recommended a voluntary hospitalization, which he refused. Prior psychiatric records from the V.A. were not obtained that would have revealed homicidal ideations toward his former wife. His wife brought him back for a second visit but the physicians felt that although he was potentially dangerous due to his antisocial personality he was not presently committable. Two days later he attacked and murdered his common-law wife. The victim's daughter claimed the psychiatrists were negligent by failing to warn her mother of her husband's foreseeable danger. The court agreed. "Warning Kimball would have posed no difficulty for the doctors, especially since she twice expressed her fear of Jablonski directly to them. Neither can it be said … that direct and precise warnings would have had little effect." The reasoning of the Court seemed to be that, even though others had suggested she stay away from him, a warning from a doctor carries greater weight and might have influenced the victim.

Almost all jurisdictions have adopted some form of the *Tarasoff* duty, either through case law or by statute. Some courts have reasoned that this duty to protect third parties should be imposed because of the therapist's control over the patient, while others have taken a modified approach by broadening the therapist's duty to warn all foreseeable victims. Some have limited liability to specific identifiable victims or to a class of identifiable victims (e.g., children). A minority of jurisdictions has declined to recognize the obligation altogether, especially for outpatient therapists (Florida, Virginia, and Texas). The American Psychiatric Association has proposed model legislation to better define the nature of the liability as well as what actions are sufficient to fulfill the duty. They suggest language to include "actual" or "real" threats as well as identifiable victims. They also suggest that hospitalizing the patient or making reasonable attempts to notify the victim and calling the police is sufficient to satisfy the duty. This model statute was adopted in some 22 states with variations in wording.

There were many concerns that this decision would have dire effects on the psychotherapeutic relationship. Some felt that psychotherapists would be deterred from treating potentially violent patients or that patients would be deterred from seeking therapy. Others thought that patients would be less likely to share violent fantasies or that once a warning was issued the therapy would end as in the *Tarasoff* case. Subsequent studies and experience, however, have failed to confirm these fears. Psychotherapists have and should increase their use of consultation in potential *Tarasoff* cases, which is a useful step in planning carefully as well as averting liability.

Tarasoff and subsequent cases have defined and expanded the psychotherapist's obligations to victims of their patient's actions if they are deemed foreseeable. The challenge is how to maintain trust with patients while carefully assessing and evaluating risk of violence

to third parties. Therapists must then consider how best to protect potential victims as well as their patients by considering increased contact, medication, hospitalization, warnings, or other protective actions. Problems have arisen when past medical records have not been reviewed or past therapists have not been contacted.

By contrast when patients reveal information about past crimes most confidentiality statutes (except for child abuse reporting) do not permit disclosure by the therapist. Yet therapists, unlike attorneys who hear such information are generally more uncomfortable keeping such information confidential, especially if the crime is serious, and often wish to call law enforcement authorities. They are concerned that patients are using psychotherapy to "get away with a crime." But for an expectation of confidentiality, patients would not disclose such information to therapists. In such circumstances a consultation with an attorney or knowledgeable colleague may be useful in reviewing duties and obligations.

IV. FEDERAL LAW AND REGULATIONS REGARDING CONFIDENTIALITY

Aside from comprehensive regulations regarding treatment of substance abusers in facilities receiving federal funding, the federal government has generally left confidentiality protections of medical information to the states. In 1996, however, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). Concerns about the fact that more and more health care providers and plans are using electronic means of storing and transmitting health information caused Congress to attempt to develop privacy rules and to ask the Department of Health and Human Services (HHS) to provide regulations if there was no congressional action by August 1999. Congress did not act, and regulations were developed by HHS and went into effect in April 2001. Compliance is required by 2003. This Act covers all health care providers who have engaged in at least one standard electronic transaction or providers that use billing services that utilize electronic transactions as well as health plans. The Act distinguishes between consent and authorization. Consent must be obtained to release information for "treatment, payment, and health care operations" (TPO). Consent, in this context, is a general document that gives health care providers, who have a direct treatment relationship with a patient, permission to use and disclose all health information for TPO. Authorization is required for more specific releases of information. An authorization is a more customized document that gives providers permission to use specified protected health information (PHI) for specified purposes, which are generally other than TPO, or to disclose PHI to a third party specified by the individual. Psychotherapy notes have received some special protections if they are kept separate from the rest of the medical record and are for the use of the therapist only. In general, disclosures of information will be limited to the "minimum necessary" for the purpose of the disclosure. This provision does not apply to the disclosure of medical records for treatment purposes because physicians, specialists, and other providers need access to the full record to provide quality care.

States that have more stringent confidentiality protections under local state laws (like those covering mental health, HIV infection, and AIDS information) are not preempted by HIPAA. These confidentiality protections are seen as setting a national "floor" of privacy standards. This law was not designed to resolve disputes between insurers and providers nor prevent subpoenas of records for court-related issues. HHS is beginning to issue "guidances" so that practitioners will be able to understand the regulations and their requirements.

V. BOUNDARY VIOLATIONS: PSYCHOTHERAPIST–PATIENT SEXUAL CONTACT

The boundaries of any relationship define how the parties ought to behave toward each other in their respective roles. In the psychotherapist–patient relationship, these boundaries are derived from professional ethical guidelines, cultural morality, and jurisprudence. Generally, boundaries include agreements relating to scheduled sessions; fee agreements; establishing "treatment goals" that are modified through negotiation; therapy sessions focused entirely on the client; an understanding regarding confidentiality and any limitations; and finally, no sexual contact or even social contact with patients, except when "overlapping [social] circles" render such contact unavoidable. The purpose of these limits is to create an atmosphere of safety and predictability within which the treatment can proceed. These guidelines have evolved from the psychoanalytic method of treatment. They have not been codified or updated to include current modes of treatment especially involving treatment of the seriously and chronically mentally ill in the public sector. This work does involve professionals in their clients' lives especially when they live in supervised housing or are being delivered and administered medications in their homes or apartments.

Many of these patients or clients are also supervised and at times accompanied by staff to aid in shopping for food or clothes as well as helping with money management programs. Many of these behaviors have been deemed unethical when they have occurred in psychoanalytic-type treatment settings. Even within psychotherapeutic approaches, it has not been possible to articulate definitive guidelines, as most clinicians would agree that guidelines should be tailored to the particular requirements of the individual patient.

The fiduciary nature of the physician–patient relationship is fundamental to boundary setting and creates a covenant that controls the imbalance of power to ensure a safe and trusting relationship based on the patient's needs. In essence, the physician guarantees that, within the therapeutic relationship, the patient can feel comfortable revealing intimate personal information without fear of exploitation.

Not all boundary crossings are equivalent to malpractice or substandard care. Many do not harm the patient or threaten the treatment. Helping a patient who has fallen or consoling a patient who has just been informed that a close relative has died are humane responses that should not be discouraged. There are situations where some behaviors may be inappropriate in some contexts but not in others, for example some touching of terminally ill, geriatric patients or HIV-infected patients. Both culture and context are important factors to consider in reviewing behavior.

Any sexual contact, however, has been increasingly viewed as an egregious violation of patient trust. Here, psychotherapists are seen as allowing personal interests to supercede those of the patient in a manner that may cause significant harm.

In cases involving breaches of confidentiality courts have been more willing to look at physicians' ethical guidelines and fiduciary duties, than they have in cases involving physician–patient sexual contact. The courts' inconsistency in applying the ethical standards and fiduciary aspects of the psychotherapist–patient relationship to sexual conduct remains unclear. Judicial unfamiliarity with the medical professions standards may reflect the inconsistent statements made by different professional organizations and the relatively late response of the American Medical Association to develop specific standards.

Like confidentiality standards, the ethical proscriptions against sexual contact between physicians and patients are long standing and were emphasized in the Hippocratic Oath that was codified around 460 BCE: "In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men."

Prior to 1990, the AMA recognized the potential for power abuse in the physician–patient relationships and declared "sexual misconduct" in the practice of medicine to be unethical. However, the code did not define "misconduct" and thus did not clarify what type of sexual conduct was proscribed. Today the code expressly provides that sexual contact that occurs concurrently with the physician–patient relationship constitutes sexual misconduct. Sexual relationships that predate the physician–patient relationship, such as sexual contact with a spouse, are an exception to this general rule. In most other cases the AMA has explained that sexual contact between a physician and patient is almost always detrimental to the patient and is unethical because the physician's self-interest inappropriately becomes part of the professional relationship. Because a fiduciary relationship exists between a patient and a physician, physicians have obligations to act solely for the welfare of patients and refrain from engaging in sexual activity.

The American Psychiatric Association, in its annotations to the AMA Code for psychiatrists much earlier specified the possibility for exploitation of patients (1973–first edition of the Principles of Medical Ethics with "Annotations Especially Applicable to Psychiatry"): "The necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Sexual activity with a patient is unethical." This policy was promulgated in the 1970s along with the suggestion that if therapy was ended but the subsequent relationship was exploiting the patient it too was unethical.

Other psychotherapeutic disciplines have similar codes. The ethical code for psychologists states that "Sexual intimacies with clients are unethical." Likewise for social workers, "The social worker should under no circumstances engage in sexual activities with clients." Similarly the ethical code for marriage and family therapists maintains, "Sexual intimacy with clients is prohibited."

In one survey of psychiatrists in the 1980s, 7.1% of male and 3.1% of female psychiatrists admitted sexual contact with patients. In three surveys of psychologists, between 1977 and 1986, 12.1% of male psychologists and 2.6% of female psychologists reported sexual contact with patients. There are several indications that the incidence of sexual contact may be higher than admitted by therapists. For example, there were low return rates in some of the surveys, and some states have felony criminal penalties for such behavior. In one study, 63% of psychiatrists surveyed reported treating

at least one patient who had experienced sexual contact with another physician. In another study, 50% of psychologists reported treating at least one patient who had been sexually involved with a previous therapist.

Indeed, between 1976 and 1986, sexual misconduct was the most frequent cause of lawsuits against psychologists insured under American Psychological Association policies, accounting for 44.8% of all moneys ($7,019,165.00) paid in claims. There is nothing to suggest that the incidence among the different mental health professionals differs greatly. In response to similar concerns, the American Psychiatric Association extended the prohibition from current patients to both current and former patients in 1993.

Problems abound in the implementation of remedies for victims of such misconduct and unethical behavior. There are now generally four avenues of redress and complaints can be filed simultaneously:

1. Traditional malpractice claim
2. Complaint to the state medical or professional licensing board
3. Criminal complaint
4. Ethical complaint to the professional association

A. Traditional Malpractice Claim

Health care professionals—including dentists, gynecologists, physicians, psychiatrists, psychologists, therapists, and medical technicians—spend millions of dollars purchasing medical-malpractice insurance from state, regional, and national liability insurers. For example, the St. Paul Fire & Marine Insurance Company, the largest medical-liability company in the nation, sells and renews thousands of medical-malpractice policies each year. The language appearing in St. Paul's medical-liability contracts is very similar to that appearing in legal-malpractice policies. Typically, the coverage provision states: "This agreement provides protection against professional liability claims which might be brought against you in your practice as a physician or surgeon. … Your professional liability protection covers you for damages resulting from … your providing or withholding of professional services."

For at least 30 years, St. Paul—as well as those professionals who were insured—has asked state and federal courts to decide whether St. Paul must defend professionals who allegedly seduced, battered, sexually assaulted, or molested their patients. As expected, St. Paul's defense has been consistent: These intentional injuries do not "arise out of" or "result from rendering professional services." The medical-liability carrier, however, has not prevailed in every case, even though the third-party patients' allegations involved allegedly intentional acts excluded by St. Paul's insurance contracts. State courts have either refused, or failed to employ, various legal doctrines to help determine whether "deviant" physicians and medical technicians are "rendering professional services." Instead, these tribunals have permitted some generalized notion of public policy to influence whether some insurers must defend their insureds in cases involving sexual assault.

In one early case in 1977, *Hartogs v. Employer Mutual Liability Insurance Company,* Dr. Hartogs was a practicing psychiatrist. Under the guise of medical treatment, Dr. Hartogs administered "fornication therapy" to cure his patient's lesbianism. The patient received judgment for $15,000.00 and Dr. Hartogs's insurer refused to pay the judgment on the grounds that the treatment did not constitute medical malpractice. They argued that sexual relations could not be considered a medical treatment. Dr. Hartogs brought an action against the insurer to recover his costs and expenses in defending the action, as well as the expenses incurred by him when he filed for bankruptcy to protect his property. As part of his argument for compensation, Dr. Hartogs noted that the jury had specifically found medical malpractice.

The court ruled that the insurer was not obligated to indemnify Dr. Hartogs for two reasons. First, the court held that a distinction should be drawn between medical malpractice in the mind of the patient, and medical malpractice in the mind of the doctor. The patient believed at the time that appropriate medical therapy was being administered. On the other hand, the doctor administering this treatment knew at all times that what he was doing was in no way pursuant to the doctor–patient relationship. As such, as between Dr. Hartogs and his insurer, his actions could not constitute medical malpractice.

Second, as a matter of public policy, the court would not allow itself to be used to enforce illicit or immoral or unconscionable purposes. The court held that to allow judgment in this type of case would be to indemnify immorality and pay the expenses of prurience. The Court did not deal with the question of how the plaintiff would collect judgment given that Dr. Hartogs had filed for bankruptcy.

On the other side of the same question, the issue of protecting the victim was focused on by the 1982 Michigan decision, *Vigilant Insurance Company v. Kambly.* In that case, Vigilant Insurance Company filed an action for relief, absolving it from liability under a professional insurance policy issued to a psychiatrist. The court's decision denied relief. In that case, Dr. Kambly

had induced his patient to engage in sexual intercourse under the guise of treatment. In its judgment, the court stated that there was no reason for distinguishing between this type of malpractice and others. The court noted that in each situation, the essence of the claim is the doctor's departure from proper standards of medical practice. In addition, the court found that allowing insurance coverage would benefit the patient, not the physician. Therefore, Dr. Kambly would not unjustly benefit from the determination that coverage existed.

The court further held that it was unlikely that the insured was induced to engage in unlawful conduct by relying on the insurability of any claims. Therefore, allowing insurance coverage would not induce future similar unlawful conduct by practitioners. In addition, the policy was not obtained in contemplation of a violation of the law. Finally, the court noted that there was a great public interest in protecting the interests of the injured party.

A number of insurers in the United States provide funding for a defense in sexual abuse cases but do not pay a judgment on a finding of liability. There is a problem throughout the lawsuit, however, that any settlement negotiations are complicated and restricted by the fact that the organization providing the defense is not ultimately responsible for paying the judgment. Many policies now either exclude or place liability limits (e.g., $25,000) on policies for behavior or malpractice that stems from sexual interest or contacts.

The ethical guidelines in this area have also become the legal standard of care. Nonetheless, posttermination contacts continue to evoke much discussion in the clinical literature. Many allegations of abuse are based on allegations that transference continues after therapy ends. Transference, however, remains a complicated construct with multiple definitions. Freud initially used the concept to explain some of the irrational behavior of patients in treatment by the idea that feelings and other aspects of earlier relationships were "transferred" to the analyst who came to represent, often unconsciously, figures from the patient's past. Some therapists and treatment modalities do not accept or use the concept, while others believe that it exists in all therapies. Some psychoanalysts believe transference never ends and therefore taints any consent for posttermination relationships. This has led to conclusions that both former patients and patients are not capable of providing legally informed consent, even in the absence of a specific evaluation. A popular view of transference is that it refers to all feelings that arise between a patient and therapist. Others extend the concept to include all relationships, for example, a young woman falling in love with an older man. Given this uncertainty, it is not surprising that courts have frequently misunderstood the concept. Even for those adopting a transference paradigm, there is a need to assess what role it may be playing. Patients continue to make many decisions while in treatment and posttreatment, and there is no literature to support global incapacity to do so just as a result of being in treatment.

B. Complaint to State Licensing Board

Another option available to victims is to file a complaint with the state licensing board regulating the offending therapist. Virtually all jurisdictions have licensure laws and codes of ethics that prohibit therapist–patient sexual contact and specify that such contact is grounds for discipline. The primary purpose of licensure laws is to protect the public from incompetent and unscrupulous therapists. As a general rule, state licensing boards are responsible for establishing and enforcing codes of ethics for the professions they regulate. In addition, most licensing statutes give the boards authority to refuse to grant a license to a therapist who has committed sexual misconduct or been found guilty of a felony involving moral turpitude. Furthermore, licensing boards also have authority to investigate ethical complaints and impose disciplinary sanctions.

Therapists accused of sexual misconduct are entitled to a hearing before disciplinary action is taken. Most complaints, however, are resolved without hearings through the use of negotiated settlements. If the complaint is not settled informally, and an administrative hearing becomes necessary, the burden of proof is low, a preponderance of the evidence (the standard of proof required in civil cases), and the rules of evidence are relaxed. In addition, although licensing board hearings are not as private and confidential as those of professional associations, they do provide less public exposure than civil trials.

From the victim's perspective, licensing board regulation has several positive aspects. First, most licensing boards do not impose a statute of limitations on the filing of complaints. In many cases, the statute of limitations is 2 to 3 years for a civil malpractice action. Therefore, disciplinary action by the licensing board may be the victim's only available remedy. Second, state licensing boards have a range of sanctions available to them. Most boards are authorized to discipline by warning, reprimand, censure, or probation. They may also suspend or revoke a license to practice.

C. Criminal Complaints

Several factors have led to the enactment of specific statutes criminalizing psychotherapist sexual misconduct. First, although some mental health professionals feel that the intensity of the therapist–patient relationship impairs the patient's ability to consent to a sexual relationship with the therapist, courts have been reluctant to recognize this in criminal cases making it impossible to prosecute offending therapists under traditional sexual assault statutes. The second and more significant factor has been the public outcry and demand for specific legislation. In 1984, Wisconsin became the first state to enact a specific statute criminalizing psychotherapist sexual misconduct. At least 15 states have enacted some form of criminal penalty for psychotherapist or physician sexual misconduct, and most of these statutes have withstood constitutional challenges. The majority of these statutes impose criminal sanctions on therapists engaging in sexual contact while performing psychotherapy, defining those terms broadly enough to bring physicians within the scope of the statutes. Ten of the 15 statutes cover sexual contact both within and outside actual treatment sessions during an ongoing professional relationship. Two statutes apply to sexual contact outside the treatment setting only if the patient is emotionally dependent on the therapist, and two apply only to contact during therapy sessions or medical treatment or examination. All but one of the statutes applies a strict liability standard, expressly excluding consent as an affirmative defense.

Some private interest groups have argued that consent should not be eliminated as a defense in such cases because to do so "treats any person who consults a mental health professional as a child." Eliminating consent as a defense, however, does not treat the patient as a child but merely recognizes that "competent individuals may be unduly influenced in special relationships." Furthermore, as one commentator indicates, "patient consent to sex … is not the issue." Rather, "it is the breach of fiduciary trust by the therapist who engages the patient in sex that is the appropriate focus of wrongdoing."

Proponents of criminalization point to its deterrent and retributive value, its function as an alternative form of redress for patients inadequately served by civil or disciplinary avenues, and its potential for raising money via fines for both victim treatment and prevention programs. In reality, however, very few people file charges under these criminal statutes, suggesting that the disadvantages of criminal controls far outweigh the advantages.

Furthermore, prosecution is completely dependent on the victim's willingness to come forward, and victims of physician sexual misconduct will be hesitant given the fact that a criminal conviction generally yields no monetary award, and the prosecutor, rather than the victim's own legal advocate, maintains control over the case. In addition, the threat of criminal sanctions may have a chilling effect on both colleague reports and patient complaints, masking the significance of the problem and limiting the effectiveness of other controls. Moreover most malpractice insurance coverage excludes coverage for criminal acts, eliminating access to civil damages to cover the costs of necessary subsequent treatment.

Criminalization may, indeed, make it more difficult for the victim to prevail or negotiate settlements in civil suits, in that admissions will be less likely, and therapist assertions of Fifth Amendment rights may delay discovery in civil and administrative actions, pending completion of the criminal trial. In addition, criminal conviction offers little or no opportunity for rehabilitation. Finally, prosecutors face the higher reasonable doubt burden of proof and the limitations of strict rules of evidence. Given these barriers to prosecution, it is clear that criminal statutes, like civil actions, are inadequate in and of themselves to deal effectively with the problem of physician sexual misconduct.

D. Ethics Complaints to the Professional Association

Although many professional groups use professional licensing boards to adjudicate ethical violations, some professional organizations like the American Psychiatric Association (and the American Psychological Association and National Association of Social Workers) have procedures to adjudicate ethical complaints directly. If a complaint of unethical conduct against a member is sustained, that person can receive sanctions ranging from reprimand to expulsion from the association. A formal complaint has to be made in writing, and the ethics committee of the local district branch has the ability to appoint an ad hoc investigating committee to conduct an investigation and to render a decision. Due process requires that the accused member will be notified of a hearing by certified mail at least 30 days in advance. The notice includes the day, time, and place of the hearing. In addition, it includes a list of witnesses expected to testify, notification of the member's right to representation by legal counsel (or another individual of the member's choice), as well as notification of the member's right to appeal any adverse decision to the ABA Ethics Appeals Board. In addition to sanctions the

district branch may also, but is not required to, impose certain conditions such as educational or supervisory requirements on a suspended member.

Patients are sometimes reluctant to file complaints, because they do not want any publicity of the details of their lives to become fodder for the press. But after years of what was termed a "conspiracy of silence," several factors have changed the dynamics of reporting. First, as a result of both patient and women's rights movements, patients feel less protective of and less intimidated by physicians and other professionals and are more willing to speak out. Increased awareness of sexual abuse, child abuse, date rape, clergy abuse, and therapist–patient exploitation has resulted in an increased focus on the healing professions. Professional organizations have also spoken out against these transgressions, developed training programs, and treatment programs for impaired professionals.

This section highlights a few of the major themes that have come under scrutiny over the past few decades. The factors that influence the practice of mental health professionals are an algorithm of a professional's ethical, moral, and legal duties to provide competent care to patients. These duties are modified over time to reflect changing science, practice, and legal regulations as promulgated by courts, legislatures, professional organizations, and agencies that regulate professional practice. The mental health professional must learn to analyze clinical situations so as to know how to balance sometimes conflicting values and rules so that proper care can be rendered to a patient.

See Also the Following Articles

Bioethics ■ Confidentiality ■ Documentation ■ Economic and Policy Issues ■ Education: Curriculum for Psychotherapy ■ History of Psychotherapy ■ Informed Consent ■ Multicultural Therapy ■ Supervision in Psychotherapy ■ Working Alliance

Further Reading

Developments in the law – Privileged Communications. (1985). *Harvard Law Review, 98,* 1450–1454.

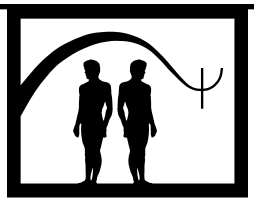
45 CFR Parts 160 and 164, Federal Register: December 28, 2000, volume 65, Number 250, pp. 82461–82829, RIN: 0991-AB08.

Jaffee v. Redmond, 518 U.S. 1, 135 L. Ed. 2d 337, 116 S. Ct. 1923 (1996).

Gutheil, T. G. & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry, 150,* 188.

Jorgenson, L., Randles, R., & Strasberger, L. (1991). The furor over psychotherapist-patient sexual contact: New solutions to an old problem. *William & Mary Law Review, 32,* 645.

Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 442, 131 Cal. Rptr. 14, 551 P.2d 334 (1976).



Logotherapy

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GLOSSARY

dereflection A logotherapeutic technique to redirect clients' attention away from their problems to more positive aspects of their lives. It is built on the human capacity for self-distancing and self-transcendence.

existential analysis Developed by Viktor Frankl, it refers to therapeutic techniques that bring the hidden meaning of existence into consciousness.

logotherapy Developed by Viktor Frankl, it refers to a spiritually, existentially oriented therapy that seeks to achieve healing and health through meaning.

meaning-centered counseling and therapy Developed by Paul T. P. Wong, it focuses on the transformation of cognitive meanings as well as life's purposes. It integrates both cognitive-behavioral and narrative processes.

paradoxical intention A logotherapeutic technique to encourage the patient to do or wish to happen what the patient fears. It is built on the human capacity for self-detachment.

I. INTRODUCTION

This article will present an overview of Viktor Frankl's (1905–1997) logotherapy and existential analysis. Known as the "Third Viennese School of Psychotherapy," logotherapy was developed in the 1930s because of Frankl's dissatisfaction with both Freud and Adler.

Frankl accepts Sigmund Freud's concept of unconsciousness but considers the will to meaning as more fundamental than the will to pleasure. Existential analysis is designed to bring to consciousness the "hidden" meaning or spiritual dimension of the client.

Frankl received training in individual psychology from Adler. He differs from Adler because he focuses on the will to meaning, while Adler emphasizes social interest and the will to power. However, some of the basic concepts of logotherapy, such as freedom and responsibility, bear the imprint of Adler's influence.

A major difference between logotherapy and psychoanalysis is that both Freud and Adler focus on the past, while logotherapy focuses rather on the future—on the meanings to be fulfilled.

Although logotherapy and existential analysis tend to be used interchangeably or together as a single label, it may be helpful to recognize the following difference between these two terms:

Logotherapy means therapy through meaning, and it refers to Frankl's spiritually oriented approach to psychotherapy. *Existential analysis,* on the other hand, refers to the analytical therapeutic process involved in addressing the patient's spiritual, existential needs. To the extent that logotherapy makes the patient aware of the hidden meaning of existence, it is an analytical process.

Logotherapy is a distinct branch of existential–humanistic school psychotherapy, because of its focus on

the human spirit and "the meaning of human existence as well as on man's search for such a meaning." What sets Frankl apart from North America's existential psychotherapy is his unconditional affirmation of life's meaning. The main objective of logotherapy was to facilitate clients' quest for meaning and empower them to live meaningfully, responsibly, regardless of their life circumstances.

Logotherapy was put to severe test in a very personal way between 1942 and 1945, when Frankl was committed to Nazi concentration camps. His experience in these camps was recorded in his best-selling book *Man's Search for Meaning*. His personal triumph over unimaginable trauma has been the most compelling testimony to logotherapy. There are no other psychotherapists whose life and work are as inseperable as Frankl's. He is logotherapy, and vice versa.

II. THE SPIRITUAL DIMENSION

It is not possible to practice logotherapy without understanding the human spirit or the spiritual dimension of human existence. According to Frankl's dimensional ontology, human beings exist in three dimensions—somatic, mental, and spiritual. Spirituality is the uniquely human dimension. However, these different dimensions must be understood in their totality because a person is a unity in complexity.

A. The Defiant Power of the Human Spirit

One of the prepositions of logotherapy is that the human spirit is our healthy core. The human spirit may be blocked by biological or psychological sickness, but it will remain intact. The human spirit does not get sick, even when the psychobiological organism is injured.

According to Frankl, part of the human spirit is unconscious. When the human spirit is blocked or repressed, one experiences existential vacuum or neurosis. Existential analysis seeks to remove the block and brings to consciousness the will to meaning.

According to Joseph Fabry, the noetic dimension of the human spirit is the "medicine chest" of logotherapy; it contains love, the will to meaning, purpose, creativity, conscience, the capacity for choice, responsibility, sense of humor, and so forth.

The defiant power of the human spirit refers to people's capacity to tap into the spiritual part of the self and rise about the negative effects of situations, illness or the past. Paul T. P. Wong proposes that it may be more helpful for scientific and therapeutic purposes to conceptualize the human spirit as inner resources, which can come to one's aid in coping with life stress.

B. Logotherapy and Religion

Frankl differentiates between spirit, spirituality, and religion. Spirit refers to one of the dimensions of humanity. Spirituality is manifest in a person's quest for meaning. Religion encompasses the ultimate meaning, super meaning, as well as God. He clearly recognizes the importance of religion but is reluctant to be considered religious. He equates authentic religion with deep spirituality.

In an interview with Matthew Scully in 1995, when Frankl was already 90, he seemed to be more explicit about the important role of religion and faith in logotherapy. Frankl said:

> I have come to define religion as an expression, a manifestation, of not only man's will to meaning, but of man's longing for ultimate meaning, that is to say a meaning that is so comprehensive that it is no longer comprehensible … But it becomes a matter of believing rather than thinking, of faith rather than intellect. The positing of a super-meaning that evades mere rational grasp is one of the main tenets of logotherapy, after all. And a religious person may identify Supermeaning as something paralleling a Superbeing, and this Superbeing we would call God.

III. THE MEANING OF MEANING

The Greek word *logos* represents the word, the will of God, the controlling principles of the universe, or meaning. Dr. Frankl translates logos as meaning. Therefore, logotherapy means healing and health through meaning. But what is meaning?

A. Specific versus Ultimate Meaning

According to Frankl, there are two levels of meaning: (a) the present meaning, or meaning of the moment, and (b) the ultimate meaning or super-meaning. Dr. Frankl believes that it is more productive to address specific meaning of the moment, of the situation, rather than talking about meaning of life in general, because ultimate meanings exist in the supra-human dimension, which is "hidden" from us. He cautions

against addressing ultimate meanings in therapy, unless the client is openly religious.

Each individual must discover the specific meanings of the moment. Only the individual knows the right meaning specific to the moment. The therapist can also facilitate the quest and guide the client to those areas in which meanings can be found.

B. Meaning versus Value

In his earlier writings, Frankl often used meaning and value interchangeable. Fabry has clarified the difference between meaning and value:

> We create unique relationships and accept unique tasks, face unique sufferings, experience unique guilt feelings and die a unique death. The search for meaning is highly personal and distinct. But millions of people have gone through situations that were similar enough so they could react in a similar way. They found what was meaningful in standard situations. They found universal meanings, which is the way Frankl defines values: "meaning universals."

Therefore, values are abstract meanings based on the meaning experiences of many, many individuals. Frankl believes that these values can guide our search for meaning and simplify decision making. For example, life can be made meaningful if we realize three categories of values—experiential, creative and attitudinal.

Traditional values are the examples of the accumulation of meaning experiences of many individuals over a long period of time. However, these values are threatened by modernization. Frankl believes that "Even if all universal values disappeared, life would remain meaningful, since the unique meanings remain untouched by the loss of traditions."

Implicit in all his writings, Frankl gives the impression that values, like Kant's categorical imperatives, are somehow universal, from which specific meanings flow. Thus, every experience of meaning involves the realization of some values. But these values may lie latent and need to be awakened or cultivated through existential analysis. This kind of reasoning may explain why Frankl insists: "The meaning of our existence is not invented by ourselves, but rather detected."

IV. BASIC TENETS

The logotherapeutic credo consists of freedom of will, will to meaning, and the meaning of life. These are the cornerstones of logotherapy and existential analysis.

A. Freedom of Will

Frankl realizes that "Human freedom is finite freedom. Man is not free from conditions. But he is free to take a stand in regard to them. The conditions do not completely condition him." Although our existence is influenced by instincts, inherited disposition, and environment, an area of freedom is always available to us. "Everything can be taken from a man, but … the last of the human freedoms—to choose one's attitude in any a given set of circumstances, to choose one's own way." Therefore, we always have the freedom to take a stand toward the restrictive conditions and transcend our fate.

Freedom of will is possible because of the human capacity for self-distancing or self-detachment: "By virtue of this capacity man is capable of detaching himself not only from a situation, but also from himself. He is capable of choosing his attitude toward himself."

B. Responsibility and Responsibleness

With freedom comes responsibility. Joseph Fabry once said responsibility without freedom is tyranny, and freedom without responsibility leads to anarchy, which can lead to "boredom, anxiety, and neurosis." Frankl points out that we are responsible not only to something but also to Someone, not only to the task, but to the Taskmaster.

Frankl differentiatess between responsibility and responsibleness. The former comes from possessing the freedom of will. The later refers to exercising our freedom to make the right decisions in meeting the demands of each situation. "Existential analysis aims at nothing more and nothing less than leading men to consciousness of their responsibility."

C. Will to Meaning

Frankl considers the will to meaning as "the basic striving of man to find and meaning and purpose." The will to meaning is possible because of the human capacity to transcend immediate circumstances. "Being human is being always directed, and pointing to, something or someone other than oneself: to a meaning to fulfil or another human being to encounter, a cause to serve or a person to love."

Self-transcendence often makes use of the power of imagination and optimism. Self-transcendence is essential for finding happiness, which is not the end, but the by-product of trying to forget oneself. "Only to the

extent to which man fulfils a meaning out there in the world, does he fulfil himself."

D. Meaning of Life

Every meaning is unique to each person, and each one has to individually discover the meaning of each particular situation. The therapist can only challenge and guide the patient to potential areas of meaning: creative, experiential, and attitudinal values.

According to logotherapy, we can discover this meaning in life in three different ways: (1) by creating a work or doing a deed; (2) by experiencing something or encountering someone; and (3) by the attitude we take toward unavoidable suffering.

Attitudinal values are especially important in situations of unavoidable suffering. Frankl claims: "This is why life never ceases to hold meaning, for even a person who is deprived of both creative and experiential values is still challenged by a meaning to fulfil, that is, by the meaning inherent in the right, in an upright way of suffering."

V. EXISTENTIAL FRUSTRATION AND NOOGENIC NEUROSIS

Existential frustration is a universal human experience because the will to meaning can be blocked by external circumstances and internal hindrances. Existential frustration leads to noogenic neurosis or existential vacuum. According to Frankl, "Noogenic neuroses have their origin not in the psychological but rather in the 'noological' (from the Greek noos meaning mind) dimension of human existence." Therefore, logotherapy is uniquely appropriate in dealing with existential neuroses.

Existential vacuum refers to general sense of meaninglessness or emptiness, as evidenced by a state of boredom. It is a widespread phenomenon of the twentieth century, as a result of industrialization, the loss of traditional values, and dehumanization of individuals. People may experience existential vacuum without developing existential neurosis. Many feel that life has no purpose, no challenge, no obligation, and they try to fill their existential vacuum with materials things, pleasure, sex, or power, busy work, but they are misguided. Frankl believes that "The feeling of meaninglessness not only underlies the mass neurotic triad of today, i.e., depression-addiction-aggression, but also may eventuate in what we logotherapists call a 'noogenic neurosis.'"

Suffering is not a necessary condition for meaning, but it tends to trigger the quest for meaning. Frankl has observed that people are willing to endure any suffering, if they are convinced that this suffering has meaning. However, suffering without meaning leads to despair.

Logotherapists do not ask for the reason for suffering, but guide their clients toward the realization of concrete meanings, and choose the right attitudes. Often, logotherapists appeal to their clients to take a heroic stand toward suffering, by suggesting that unavoidable suffering gives them the opportunity to bear witness to the human potential and dignity.

Search for meaning is more likely to be occasioned by three negative facets of human existence: pain, guilt, and death. Pain refers to human suffering, guilt to the awareness of our fallibility, and death to our awareness of the transitoriness of life. These negative experiences make us more aware of our needs for meaning and spiritual aspiration. Neuroses are more likely to originate from our attempt to obscure the reality of pain, guilt, and death as existential facts. Logotherapy provides an answer to the tragic triad through attitudinal values and tragic optimism.

VI. LOGOTHERAPEUTIC TECHNIQUES AND APPLICATIONS

Frankl considers noogenic neurosis as the collective neurosis of contemporary Western society. The goal of logotherapy is to enable patients to discover their unique meanings and consider their own areas of freedom. In cases of psychogenic or individual neurosis, which may be treated by traditional psychotherapy or medication, logotherapy serves as a supplement and helps break the vicious cycles of neurosis.

According to E. Lukas, the four main logotherapeutic techniques are paradoxical intention, dereflection, modification of attitudes, and appealing techniques.

A. Paradoxical Intention

Frankl defines paradoxical intention as follows: "The patient is encouraged to do, or to wish to happen, the very things he fears (the former applying to the phobic patient, the latter to the obsessive-compulsive)."

This technique builds on the human capacity for self-detachment to break the vicious cycle, which traps people in psychogenic neuroses, such as phobia, anxiety, and obsessive—compulsive behaviour. Self-attachment enables to patient to adopt a new attitude, to stand back or laugh at the situation or self. In applying paradoxical intention, the therapist tries "to mobilize and utilize exclusive human capacity for humor."

For the phobic patient, he has a "fearful expectation" that a particular symptom might occur, and his fear creates "anticipatory anxiety, which in turn brings about what the patient fears to happen. Thus "fear of fear" creates a "vicious cycle." The most common reaction to "fear of fear" is "flight from fear," and the phobic pattern is maintained by excessive avoidance. This vicious cycle is broken when "the pathogenic fear is replaced by a paradoxical wish." As a result, the patient no longer avoids situations that create anxiety.

With phobic patient, paradoxical intention typically begins with self-detachment (often after invitation and persuasion). The second step is to ask the patient to develop a new attitude of not fearing but welcoming the symptoms. This typically results in a reduction of symptom, which allows therapist to work toward enhancing meaningful living.

In the case of obsessive–compulsive disorder, the patient fights against the obsessions or compulsions. However, the more he fights against these symptoms, the stronger they become. Again, a vicious cycle is created. To break this vicious cycle, the patient with compulsive hand washing because of fear of infection would be told to tell himself "I can't get enough bacteria, I want to become as dirty as possible."

According to D. Guttmann, paradoxical intention has been used with increasing frequency with good results especially in treating clients who suffer from phobias and obsessive–compulsive disorder.

B. Dereflection

Frankl developed dereflection to counteract hyperintention (trying too hard) and hyperreflection (thinking too hard). Examples of hyperintention include trying very hard to fall asleep, excessively pursuing pleasure, happiness, or power. Addiction is a form of hyperintention.

Hyperreflection involves excessively monitoring one's performance, and becoming very anxious about failure. Hyperreflection may turn everyday minor problem into catastrophes, and small obstacles into insurmountable hurdles.

This technique is built on the human capacity of self-distancing and self-transcendence. The clients are asked to redirect their attention away from their problems to more positive aspects of their lives. For example, instead of worrying about not being able to fall asleep, the client is asked to use the time to read a book or watch TV. Typically, the first step is to help clients to put some distance between themselves and their symptoms. Then, they are invited to use their defiant power of the human spirit to transcend their present conditions and move toward positive activities. This will result in a reduction of symptom.

Joseph Fabry points out that by immersing ourselves in work or by choosing the right attitude, we can transcend not only external conditions but also ourselves. The goal of dereflection is to help clients transcend themselves and move toward creative and experiential values.

C. Modification of Attitudes

It is used for noogenic neuroses, depression, and addiction by promoting the will to meaning. It can also be used in coping with suffering related to circumstances, fate or illness. Generally, the emphasis is on reframing attitudes from negative to positive. For example, the client may be asked: "Is there anything positive about the situation?" or "What freedom is still available to you in this situation?"

D. The Appealing Technique

These three logotherapeutic techniques are more likely to be effective, when the therapist appeals to the client's defiant power of the human spirit. The therapist makes use of the power of suggestion and directly appeals to the client to change for the better, regardless of the client's current circumstances, and physical–emotional condition. The therapist expresses trust in the client's dignity, freedom, responsibility, meaning orientation, and potential for positive change.

Frankl claims that "Logotherapy is neither teaching nor preaching. It is far removed from logical reasoning as it is from moral exhortation." However, appealing often involves exhortation on the value of taking a heroic stand against suffering. For example, a nurse suffered from an inoperable tumor and experienced despair because of her incapacity to work. Frankl tried to appeal to her sense of pride and moral obligation to her patients:

> I tried to explain to her that to work eight or ten hours per day is no great thing—many people can do that But to be as eager to work as, and so incapable of work, and yet not be despair—that would be as achievement few could attain. And then I asked her: "Are you not being unfair to all those sick people to whom you have dedicated your life; are you not being unfair to act now as if the life of an invalid were without meaning? If you behave as if the meaning of our life consisted in being able to work so many hours a day, you take away from all sick people the right to live and the justification for their existence.

E. The Socratic Dialogue

In Socratic dialogue, the therapist facilitates the client's discovery of meaning, freedom, and responsibility by challenging and questioning. The dialogue may begin with a struggle between client and therapist but should never become negative.

According to Paul Welter: "Socratic questions need to be asked that stretch the thinking of the client. This requires careful listening to find the circumference of the client's thought." Another consideration is that counsellors need to know the moment when silence is more curative. Often silence occurs when the clients reflect on the deeper meanings of words from the counsellors.

F. Family Logotherapy

J. Lantz has applied logotherapy to help the client family discover the meaning of opportunities within the family through social skills training, Socratic questioning, and existential reflection. According to E. Lukas, meaning-centered family therapy helps the family focus on meaningful goals rather than the obstacles; consequently, family members learn to overcome the obstacles to pursue meaningful goals.

G. The Therapist–Client Relationship in Logotherapy

Frankl tends to emphasize partnership between therapist and client in the quest for meaning. According to Lantz, logotherapeutic practice is based on the following assumptions: (a) commitment to authentic communication by the therapist, (b) the therapists' communication of essential humanness, and c) the therapist's ultimate concern being similar to that of the clients.

VII. RECENT DEVELOPMENTS

In the past 15 years, Dr. Frankl's classic logotherapy has been elaborated and extended by Alfried Langle and the International Association of Logotherapy and Existential Analysis *(Gesellschaft fur Logotherapie und Existenzanalyse)*. This Viennese society (GLE-Wien) is parallel to Viktor-Frankl-Institut–Scientific Society for Logothrapy and Existential Analysis *(Wissenschaftliche fur Logotherapie und Existenzanalyse),* also in Vienna.

According to A. Langle, existential analysis is now a full-fledged psychotherapeutic method, of which Dr. Frankl's logotherapy is considered its subsidiary branch. Langle has applied existential analysis to cases of psychosocial, psychosomatic, and psychogenic disturbances.

Langle recognizes four fundamental preconditions for meaningful existence: (a) accept the situation, (b) find some positive value in the situation, (c) respond according to one's own conscience, and (d) recognize the specific demands of the situation.

He also postulates four types of fundamental human motivations:

1. The question of existence: I am, but can I become a "whole" person? Do I have the necessary space, support, and protection?
2. The question of life: I am alive, but do I enjoy it? Do I find it fulfilling? Do I experience a sense of abundance, love, and realization of values?
3. The question of the person: I am myself, but am I free to be myself? Do I experience validation, respect, and recognization of my own worth?
4. The question of existential meaning: I am here, but for what purpose, for what good?

Langle has developed additional methods, such as the biographical method of using phenomenological analysis to overcome unresolved past issues and the project analysis to elucidate areas that have proved to be a hindrance to one's life.

Joseph Fabry was largely responsible for introducing logotherapy to North America. Under his guidance and encouragement, Paul T. P. Wong has developed the integrative meaning-centred conselling and therapy (MCCT). It focuses on both the transformation of cognitive meanings as well as the discovery of new purposes in life. As an integrative existential therapy, it incorporates cognitive-behavioral interventions and narrative therapy with logotherapy.

See Also the Following Articles

Alderian Psychotherapy ■ Biblical Behavior Modification ■ Existential Psychotherapy ■ Humanistic Psychotherapy ■ Paradoxical Intention

Further Reading

Fabry, J. (1994). *The pursuit of meaning* (new rev. ed.). Abilene, TX: Institute of Logotherapy Press.

Frankl, V. E. (1984). *Man's search for meaning* (rev. and updated). New York: Washington Square Press/Pocket Books.

Frankl, V. E. (1986). *The doctor and the soul: From psychotherapy to logotherapy* (Rev. and expanded). New York: Vintage Books.

Guttmann, D. (1996). *Logotherapy for the helping professional: Meaningful social work*. New York: Springer.

Langle, A. (2000). Existential analysis. Ubersetzung von 1999 Fundamenta Psychiatrica: EA – die Zustimmung zum Leben finden.

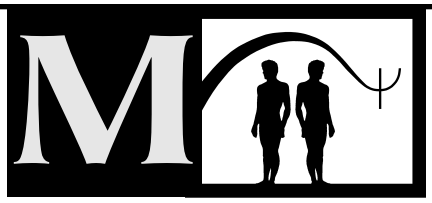
Lantz, J. (1996). Stages and treatment activities in family logotherapy. *The International Forum for Logotherapy, 19,* 20–22.

Lukas, E. (1984). *Meaningful living.* New York: Grove Press.

Lukas, E. (1991). Meaning-centered family therapy. *The International Forum for Logotherapy, 14,* 67–74.

Welter, P. (1987). *Counseling and the search for meaning.* Waco, TX: Word Books.

Wong, P. T. P. (1999). Towards an integrative model of meaning-centered counselling and therapy. *The International Forum for Logotherapy, 22,* 47–55.



Manualized Behavior Therapy

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GLOSSARY

behavior therapy Application of interventions based on an understanding of learning principles.

effectiveness The degree to which a treatment produces positive outcomes in the context in which treatment most often is sought (i.e., "real world").

efficacy Demonstrations that an intervention improves psychological status in well-controlled, experimental studies.

functional analysis of behavior Isolation of proximate, contextual causes of problematic behavior and the tailoring of therapy protocols to reverse these causes once identified.

multicomponent treatment strategies Therapies that contain treatment elements that are based on behavioral and cognitive-affective processes.

treatment integrity Degree to which the implementation of a specific treatment matches the way it was conceptualized and intended to be employed.

treatment manuals Written materials that identify key concepts, procedures, and tactics for the delivery of a clinical intervention.

I. DESCRIPTION OF MANUALIZED BEHAVIOR THERAPY

A. Treatment Manual Description

In general, treatment manuals for psychological disorders are written materials that identify key concepts, procedures, and tactics for the delivery of a clinical intervention. Accordingly, treatment manuals are designed to help modify the variables and processes believed to produce, maintain, or increase the magnitude or frequency of problematic behavior. As is typical of treatment methods in general, there is considerable diversity in regard to the level of specification in a particular manualized therapy, which is contingent, at least in part, on the treatment strategy being employed. Despite this diversity, all manualized therapies provide rules and statements pertaining to how therapists are to prepare for treatment, describe what they should do during the session itself, and characterize how the process of therapy is to proceed over time. In the case of behavior therapy, which reflects the application of interventions largely based on an understanding of psychological learning principles, manuals serve to characterize the treatment process for persons with an identified psychological disorder.

At least initially, the primary aim of developing and implementing manualized behavior therapies was to improve the evaluation of particular treatment strategies and entire treatment programs. Within this context,

manuals served to specify (in abbreviated form) the nature of the treatment, and articulate (in detail) how it was to be delivered. In this way, researchers would have available a precise and standardized clinical methodology that could easily be used in the evaluation of a particular treatment's efficacy. In addition, manuals provided researchers with the opportunity to standardize training in a specific treatment to increase the chance that the therapy would be delivered in the manner designated by and consistent with the theoretical underpinnings of the approach. Today, the development and utilization of manualized behavior therapies reflect an important breakthrough in the larger history of developing and evaluating psychosocial treatments for behavior disorders.

B. Reasons for Treatment Manuals in Mental Health Work

With the advantage of hindsight, it is quite easy to identify a number of key reasons why manualized therapies originally emerged in the mid to late 1970s. Prior to having standardized treatment methods and procedures, researchers often were left "in the dark" in regard to how a particular treatment was delivered. In the best-case scenario, questions about the effects of a clinical trial could be directed at how well a particular treatment was delivered. In the worst-case scenario, it was possible to question whether a particular treatment was really delivered at all, or at least whether the key components of that therapy were implemented. Other types of common concerns were aimed at such issues as whether the therapy under investigation was delivered in a consistent fashion across study participants. Still other concerns were aimed at how well the results could be replicated across independent research sites. All the questions, and others similar to them, essentially reflect questions of treatment integrity. A prerequisite for adequately addressing questions of treatment integrity from a scientific standpoint is to have a methodology that identifies the treatment of interest, and guides one in a step-by-step manner in regard to how it should be delivered.

In more recent years, the development and utilization of manualized behavior therapies have exceeded the boundaries of research circles. Indeed, the use of manuals in clinical contexts with no clear research objectives has been spurred on by health care policy changes demanding that psychological services follow guidelines for relatively brief treatments that have an empirical basis for outcome. Thus, despite the fact that manuals have helped to improve the quality of large-scale clinical trials in accordance with their original intended purpose, it is perhaps not surprising that they increasingly have been the subject of controversy and intense debate. In fact, the use of treatment manuals has called attention to clinical issues that strike at the very heart of what treatment should be considered clinically useful and in what contexts it should be implemented (e.g., controlled or real world settings).

II. THEORETICAL BASES OF MANUALIZED BEHAVIOR THERAPY

A. General History

At the time of inception of behavior therapy, the prevailing paradigm in clinical psychology was psychodynamic. Since that time there has arguably been a major paradigmatic shift from psychoanalytic approaches to behavioral approaches. This transition was based, at least in part, on the observation that psychoanalytic methods for treating behavioral disorders have not been consistently demonstrated to be superior to no treatment, placebo, or other treatment conditions. In contrast, investigations of behavior therapy have emphasized empirical scrutiny and quantifiable behavior change. As a consequence, behavior therapy applications have been widely recognized as being very successful for treating a wide variety of behavioral problems, ranging from anxiety disorders to developmental disabilities.

B. Function Oriented

Behavior therapy differs from other forms of psychological therapies in regard to its commitment to basic research and link with behavior theory. Specifically, behavior therapy is aimed at determining environment–behavior relations that either can explain the cause or maintenance of maladaptive behaviors individuals typically seek treatment for in clinical settings. Elucidation of these environment–behavior relations has emerged from behavioral research, most notably operant and classical conditioning. Congruent with the laboratory research on which it is based, behavior therapy focuses on the function rather than the structure of behavior. In the most general sense, structural analyses focus on how people behave (e.g., form of a

particular response), whereas functional analyses focus on why people behave (e.g., purpose of a particular response).

In a functional approach, behavior therapists attempt to explicate the relation between observable behavior and the contextual variables of the environment, particularly focusing on observable antecedents and consequences of behavioral responses. For example, if a child's recurrent tantruming in a school classroom is routinely followed by attention from the teacher, a behavior therapist might encourage the teacher to praise the child when the child is not tantruming and ignore the child when a tantrum occurs. Thus, tantruming behavior aimed at receiving attention is not reinforced, thereby changing the function of such responding. This process of assessment, called a functional analysis of behavior, is the core of behavior therapy approaches.

C. Idiographic Oriented

The other major theoretical component of behavior therapies is that they have historically been idiographic (i.e., individual) rather than nomothetic (i.e., group) approaches to assessing and changing behavior. Nomothetic approaches, by definition, focus on the identification of the commonalities and differences among traits and dispositions that occur within and between groups of people. Idiographic approaches, on the other hand, focus on variability in the behavior of a person over time and across situations. As such, a second aim of the functional analysis is to identify consistent sources of variance for a particular person presenting to the clinic with a specific behavioral problem.

Despite the uniformity among behavior therapists commonly perceived by the public, it is important to note that not all behavior therapists are alike. Indeed, there are different behavioral approaches, differing in specific aspects of their clinical approach and the focus of treatment. This diversity is reflected in the numerous terms that have been employed to describe this general therapeutic approach (e.g., applied behavior analysis, behavior modification, cognitive-behavior therapy). Although these various terminologies capture relative differences in one's specific approach, behaviorally oriented therapists are all committed to changing maladaptive behavior through a functional, idiographic-based assessment of specified target behaviors. Thus, even in the case of standardized treatment manuals that identify the major processes functionally related to a particular disorder, treatments are tailored to the individual—at least at the level of practical implementation. Through this identification of the controlling variables, it has been possible to develop standardized treatment strategies that are based on behavior principles to alter problematic behavior. To achieve these goals, behavior therapists attempt to provide their patients with a new set of learning experiences that are in accord with positive behavior change within the patients' value system.

III. APPLICATIONS AND EXCLUSIONS

A. Empirically Supported Therapies and the Use of Treatment Manuals

There have a number of important developments within the behavioral health care that have come to shape the application of manualized behavior therapies. Perhaps most influential has been the push to establish empirically supported therapies for a variety of recognized psychological disorders. This movement has been at least partially in response to cost-containment efforts in the health care system in general and funding-related restrictions for behavioral health services specifically. For example, health care policy changes have strongly recommended, and in certain cases demanded, that psychological services follow guidelines for relatively brief treatments that have an empirical basis for positive outcome.

The movement to develop lists of empirically supported therapies for target populations defined by diagnostic categories has been pioneered by the Division 12 Task Force on Promotion and Dissemination of Psychological Procedures. The function of the task force has been to critically review the existing empirical psychological treatment literature in an effort to identify those psychosocial interventions that have shown promise in alleviating specific types of psychological distress. Once potential treatments are identified and agreed on, the task force communicates this information to the behavioral health community. The task of charting efficacious treatments is an ongoing process, as researchers are continuously examining therapies, refining their components, and assessing their utility across different populations, sites, and time periods (see Section IV). In all cases, the therapies that are evaluated by the task force have been manualized to facilitate the understanding and evaluation of the treatment's key concepts, procedures, and delivery tactics.

B. Behavior Therapy's Contributions to Standardization of Psychosocial Treatments

As behavior therapy always has been committed to empirical evaluation and time-efficient strategies, it is not surprising behavior therapists have been at the forefront of the major developments in the movement toward empirically supported treatments. In fact, behavioral and cognitive-behavioral therapies overwhelmingly top the list of empirically supported therapeutic interventions for a wide variety of disorders. In an illustrative example, the majority of empirically supported treatments can be considered behavioral in their theoretical foundations, content, and implementation procedures. For example, of the "well-established treatments," 93% are considered "behavioral" in content and procedures.

Whereas behavioral interventions were largely based on operant and classical conditioning principles through the late 1970s, cognitive treatment strategies have been increasingly added to these therapies from the 1970s through the 1990s. This evolution of behavior therapy reflects the growing recognition that internal processes such as thoughts and language characterize many important aspects of psychological dysfunctions. As an extension, many clinicians believe that by directly targeting cognitive-affective processes, they can facilitate positive behavior change along a greater number of different response domains. Thus, it is not surprising contemporary behavioral interventions can be best described as multicomponent strategies that contain treatment elements that are based on both basic learning principles and more recent developments in experimental cognitive psychology (e.g., research on memory biases). Hence, most behavior therapies are now described as cognitive-behavioral treatments and compiled in multiple component treatment manuals. Although it is not entirely clear at this juncture to what extent specific therapy components contribute to treatment outcome and maintenance, available evidence suggests that both cognitive and behavioral components contribute to the overall positive outcome achieved by cognitive-behavioral treatment protocols.

C. Contemporary Issues Related to the Potential Limitations of Manuals

There have been a number of controversies surrounding the use of manualized treatments (e.g., flexibility of therapist in treatment delivery, creativity of therapist, reification of treatment to a fixed manner). All these intensely debated topics differ in content but essentially rest on questions concerning the relative utility of manualized treatments as applied to "real-world" behavior problems. For the purposes of this article, only two of the most common concerns will be described.

1. Manuals as Standardized Treatment Strategies

Some scholars have suggested that manualized behavior therapy undermines and restricts clinical judgment of individual therapists in the practice setting. Manualizing treatments could be problematic because most clinicians are highly sensitive to the individual needs and characteristics of their patients. Furthermore, greater degrees of flexibility often are need to deliver treatment in the "real world" relative to when the treatments are developed and initially tested in clinical trials conducted in research settings.

Yet, these concerns must be weighed against the background of a large body of evidence that suggests personal biases typically are worse or at the very least not better than statistical prediction based on scientific analyses of persons with the same or similar type of problem. Thus, manualized treatments, which generally are based on scientific testing of groups of people, guide therapists in implementing what research rather than clinical judgment suggests is the most clinically appropriate thing to do. It is becoming increasingly evident that the "truth" lies somewhere between a strict individually tailored relative to a strict manualized approach. Indeed, insofar as a clinician can modify a manualized treatment to help identify and target aspects of an individual's behavior that might interfere with the successful implementation of a proven manual, success rates should continue to improve.

2. Manuals as Treatment Strategies for Comorbidity

Another concern raised about manualized therapies is that they often are developed from studies involving patients with a homogenous diagnostic profile yet are implemented clinically on patients with multiple behavior problems (i.e., diagnostic heterogeneity). Recent research in such areas as the anxiety disorders has seriously challenged this concern, as in the vast majority of clinical trials using manuals, patients have high rates of psychiatric comorbidity. In addition, many of these patients have not responded to alternative treatment strategies in the past, and in this respect, can be considered "treatment refractory" or at least "treatment resistant." Of further interest has been the finding that

some manualized behavior therapies have been found to produce clinical improvement in other not specifically targeted behavior problems.

Taken together, then, it may be more appropriate to suggest that the clinical effectiveness of manualized treatment will be partially a function of presenting problem, nature of comorbidity, and the specific treatment being employed. With the recognition that this is a complex problem in need of further systematic study, it will be critically important for future research to address the generalizability of manualized behavior therapies across different clinical populations and settings. Along these lines, increased attention to questions of effectiveness will assume an increasingly critical role in determining the relative clinical utility and generalizability of particular psychosocial treatments.

IV. EMPIRICAL STUDIES

A. General Treatment Development and Evaluation Model

Psychosocial treatment development and dissemination is based on the stage model used by the Food and Drug Administration for the approval of drugs. Briefly, there are three primary units, each reflecting different stages in treatment development. Stage 1 reflects technological refinement and pilot research aimed at developing theoretically based treatment strategies that can usefully be applied to a specific type of psychopathology. Stage 2 is concerned with demonstrating that a particular treatment can produce positive behavior change in a controlled evaluation. In addition, in Stage 2, research can be aimed at ascertaining the mechanisms of action for a particular treatment (i.e., how it works). Stage 3 is field research involving larger samples of patients for the evaluation of treatments that already have shown initial success in Stage 2.

B. Empirically Supported Treatment Manuals

The empirically supported treatment task force evaluates all manualized therapies according to their efficacy; that is, demonstrations that an intervention improves psychological status in well-controlled, experimental studies. This research differs slightly from questions of effectiveness, defined as the relative degree of utility of a treatment to produce positive outcomes in the context in which treatment most often is sought. Typically, large-scale clinical trials are used to evaluate and demonstrate the efficacy of psychological interventions. Such evaluations are outcome oriented, that is, they typically are an evaluation of a particular type of therapy compared to some type of control group (e.g., placebo, other form of therapy), although a variety of different evaluation formats exist (e.g., series of single case studies).

The criteria for demonstrating efficacy are categorized as either "well-established treatments" or "probably efficacious treatments." Although it is not possible to review the criteria for each of these domains in their entirety, well-established therapies generally have demonstrated superior outcome compared to a control condition (e.g., placebo) or another treatment on two separate occasions by independent investigators. In contrast, probably efficacious treatments generally indicate that a treatment is superior to persons who desire psychological treatment but are on a waiting list for such treatment.

In all cases, the evaluation process involves persons with a particular type of psychological disorder being randomly assigned to a specified treatment condition. For example, patients with panic disorder may either be randomly assigned to receive an "active" psychological treatment or separate treatments such as a medical drug or a placebo pill. In these trials, patients are then evaluated in a standardized manner over the same amount of time using the same types of clinically relevant outcome measures. Overall, these efforts allow one to determine whether a therapy can reduce psychological distress in both a statistically and clinically useful way.

V. CASE ILLUSTRATION

For purposes of this article, a clinical case presentation of an individual with panic disorder may help illustrate the use of a multicomponent treatment manual that is prototypical for other treatment manuals used for the majority of psychological dysfunctions.

A. Case Description

Sam is a 33-year-old married white male with a 10-month history of recurrent panic attacks. His panic attacks occur in an unpredictable and uncontrollable manner and last for approximately 2 to 15 min. Sam indicated that his panic attacks occur at least once every other day and involve chest pain, difficulty breathing, racing and pounding heart, increased sweating, and lightheadedness. As a result of these symptoms, Sam

believed he had cardiac disease. Due to the worry about the panic attacks, Sam had begun to avoid socializing with friends and family and declined professional opportunities to travel for his job as a computer programmer. After a thorough medical exam that found no indication of cardiac or other medical problems, Sam was referred to an anxiety disorders treatment center at a university hospital. After a psychiatric interview and testing, it was determined Sam suffers from panic disorder.

B. Manualized Therapy for Panic Disorder

We now discuss how Sam might be treated with a current well-established therapy for panic disorder and agoragaphoba termed panic control therapy (PCT). This multicomponent cognitive-behavioral intervention is guided by the use of a treatment manual entitled *Mastery of Your Anxiety and Panic–II (MAP–II)* that articulates the procedures for PCT in a step-by-step fashion. Manual-based therapies like the *MAP–II* also include self-report and behavioral assessment tracking instruments that can be readily employed to evaluate treatment progress of individual patients across different time frames.

MAP–II contains a number of key components, including exposure to bodily and environmental situations associated with fear and panic, relaxation, and breathing retraining, as well as cognitive interventions. Briefly, exposure to interoceptive bodily events is achieved through exercises that produce somatic sensations that are similar to panic (e.g., head spinning, breathing through a straw). Situational exposure involves contacting feared environmental stimuli without escaping from them if panic symptoms occur. For instance, a person with panic disorder with agoraphobia who fears crowds might be asked to go to a shopping center and stay there for a specified period of time or until potentially high levels of anxiety have subsided. Relaxation training refers to exercises that serve to decrease base levels of autonomic arousal, as this decreases the likelihood of future panic attacks. Breathing retraining refers to having patients breathe diaphragmatically at a normal rate in an effort to optimize the balance between oxygen and carbon dioxide in the patient's blood. Cognitive strategies typically are aimed at (a) correcting misappraisals of bodily sensations as threatening, (b) helping patients to predict more accurately the future likelihood of panic attacks, and (c) helping patients to predict more accurately and rationally the likely consequences of panic attacks.

C. Treatment Process with Manual

Sam's treatment would most likely be conducted in an individual setting over a period of about 2 months. As is the case for most psychosocial interventions, the *MAP–II* first provides Sam with educational information about the nature, origin, and course of panic disorder prior to the application of specific intervention strategies. This information helps patients realize that they are "not alone" and communicates that professionals understand their specific type of problem. The second and ongoing step in Sam's *MAP–II* treatment would be to have him monitor both negative emotional experiences and stressful life events to facilitate the recognition and identification of environmental events that contribute to the occurrence of recurrent panic attacks. Identifying such negative life events makes the potential occurrence of panic attacks more predictable and perhaps controllable, thereby lessening their aversiveness.

Third, the therapist would train Sam in relaxation and breathing exercises and have him practice these exercises until he has acquired the skill of reducing and controlling bodily arousal. Throughout *MAP–II* therapy, the therapist is instructed to guide Sam in correcting maladaptive cognitive errors related to worry about the negative consequences of panic attacks. For example, during cognitive restructuring, Sam would be taught to reconceptualize his panic attacks as harmless events that occur in response to "natural" stressors. Finally, Sam would participate in repeated trials of interoceptive exposure, and if necessary, exteroceptive exposure exercises in both the clinical setting and his natural environment. Such exercises would be continued until such stimuli no longer elicit significant levels of anxiety. Therapy would be discontinued when Sam's condition improved to a level that he can adequately perform his life tasks and his psychological status has returned to a healthy level.

VI. SUMMARY

In summary, treatment manuals are written materials that identify key concepts, procedures, and tactics for the delivery of a clinical intervention. In this manner, treatment manuals are designed to help modify clinically relevant variables and processes involved with problematic behavior. Although manuals can be quite diverse, all provide rules and statements pertaining to how the therapist is to prepare for treatment, describe what they should do during the session itself, and characterize how the process of therapy is to proceed over

time. Manuals have greatly helped in efforts to improve the evaluation of particular treatment strategies by specifying the nature of the treatment and articulate how it is to be delivered. More recent, manualized behavior therapies have become apparent in clinical service contexts, calling attention to clinical issues that strike at the very heart of what treatment should be considered "clinically useful" and in what contexts it should be implemented (e.g., controlled or real-world settings).

An extension of the treatment utility issue has been the development of empirically supported therapies for target populations pioneered by the Division 12 Task Force on Promotion and Dissemination of Psychological Procedures. Testifying to the established place of manuals in contemporary clinical care, all therapies that are evaluated by the task force have been manualized so as to facilitate the understanding and evaluation of the treatment's key concepts, procedures, and delivery tactics. Perhaps because behavior therapy has always been committed to empirical evaluation and time-efficient strategies, it is not surprising the majority of empirically supported treatments can be considered behavioral in their theoretical foundations, content, and implementation procedures. Although the use of manuals has been controversial in a number of respects, few would challenge the contention that they likely will retain in an important and influential role in continued evolution of psychological treatment in upcoming years.

See Also the Following Articles

Behavioral Consultation and Therapy ■ Behavior Therapy: Theoretical Bases ■ Cognitive Behavior Therapy ■ Collaborative Care ■ Comorbidity ■ Effectiveness ■ Integrative Approaches to Psychotherapy ■ Multimodal Behavior Therapy ■ Panic Disorder and Agoraphobia ■ Research in Psychotherapy

Further Reading

Chambless, D. L., Sanderson, W. C., Shoham, V., Bennett-Johnson, S., Pope, K. S., Crits-Chiristoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49,* 5–18.

Eifert, G. H., Schulte, D., Zvolensky, M. J., Lejuez, C. W., & Lau, A. W. (1998). Manualized behavior therapy: Merits and challenges. *Behavior Therapy, 28,* 499–509.

Garfield, S. L. (1996). Some problems associated with "validated" forms of psychotherapy. *Clinical Psychology: Science and Practice, 3,* 218–229.

Heimberg, R. C. (1998). Manual-based treatment: An essential ingredient of clinical practice in the 21st century. *Clinical Psychology: Science and Practice, 5,* 387–390.

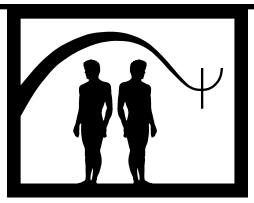
Persons, J. B. (1991). Psychotherapy outcome studies do not accurately represent current models of psychopathology. *American Psychologist, 46,* 99–106.

Society for Science of Clinical Psychology. http://pantheon.yale.edu/~tat22/

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated psychological treatments: Report and recommendations. *The Clinical Psychologist, 48,* 3–23.

Wade, W., Treat, T. A., & Stuart, G. L. (1998). Transporting an empirically supported treatment for panic disorder to a service setting: A benchmarking strategy. *Journal of Consulting and Clinical Psychology, 66,* 231–239.

Wilson, G. T. (1996). Manual-based treatments: The clinical application of research findings. *Behaviour Research and Therapy, 34,* 295–315.



Matching Patients to Alcoholism Treatment

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GLOSSARY

alcoholism Alcoholism (also referred to as alcohol dependency) is an addictive disorder diagnosed by a series of specific DSM defined criteria such as, progressive loss of control over drinking, tolerance, withdrawal symptoms, continued drinking despite adverse consequences, narrowing of usual activities in favor of alcohol seeking.

clinical trial A clinical trial is a prospective experiment in which therapeutic interventions are evaluated. Desirable features which increase the rigor of the experiment include random assignment to treatment group, masking of clinician, research assessor and patient with respect to treatment assignment, and in the case of pharmacologic studies, use of matched placebo.

matching factors Matching factors are patient characteristics that affect outcomes differentially when two or more treatments are compared.

outcome predictors Outcome predictors are characteristics that influence the outcome of treatment across the board but do not have differential effects depending upon the type of treatment.

Patient-treatment matching is the concept that particular treatments may work better for some patients than others and that, in clinical practice, treatment outcomes can be improved by matching subgroups of patients with the therapy most suited to their particular needs using matching rules derived from previous experience.

I. DESCRIPTION OF TREATMENT

Patient-treatment matching occurs when treatment is prescribed based on the needs of the individual patient, as contrasted with providing the same therapy to all patients with the same diagnosis. It has been suggested that triaging clients to treatments based on their particular needs and characteristics might significantly improve outcome. The potential of the matching hypothesis has been of particular interest in the treatment of alcohol use disorders, prompting researchers and clinicians to search for assignment rules to individualize selection of psychosocial treatments. The literature in this area spans several decades and includes small-scale studies, reports from a large multisite clinical trial, and examinations of underlying theory and clinical practice implications. It provides a useful example to illustrate the rationale and implementation of the matching hypothesis and is used as the model here. Although the focus here is alcohol dependency as the target for patient treatment matching interventions, the concept is relevant to other disorders and has been used to varying extents in numerous medical, psychiatric, and educational contexts.

In its most basic form, matching is done informally by providers when, based on their clinical judgment,

they provide treatment "tailored" to specific features of the patient and the patient's disorder. Patients may also practice "self-matching" when they contribute to varying degrees to treatment decisions based on, for example, their beliefs about various treatments and what will benefit them, or other influences, such as availability of resources, advice from others, and so on.

However, the formal practice of matching in clinical and research settings is based on validated rules that link particular patient characteristics with certain treatments. Typical steps in the matching process are: (a) systematic assessment of patient characteristics and needs, (b) availability of specific matching rules, and (c) consistent assignment of patients to well-defined treatment in accordance with the specified matching rules. Ideally, the guidelines should be based on validated research, and patient outcomes should be monitored to determine the extent of improvement and if modifications are necessary.

In addition to matching patients with treatments, matching of patients to therapists has also been of interest and is reviewed by the Project MATCH Research Group in 1998 who concluded that therapist effects on treatment outcome may contribute more toward explaining the variance in outcomes than either specific treatments employed or baseline patient characteristics. Reporting on a study of therapist influence on treatment outcome conducted as a part of the multisite Project MATCH, they found that therapist effects did indeed exert an effect on treatment outcome as well as patient satisfaction with treatment. Interestingly though, most of the observed effects were due to "outlier" therapists whose clients tended to show poorer outcomes. They advise that future studies take into account the potential effect of "outlier" therapists.

Until relatively recently, matching to treatments for alcohol dependence has involved interventions of a verbal nature, such as behavioral therapies, counseling, and psychotherapy. Beginning in the 1990s, the development of medications that target neurochemical systems implicated in the addictive process have brought a new and promising approach to treatment of alcoholism. In addition to clinical trials evaluating the efficacy of these drugs, (both alone and in combination with verbal therapies) matching hypotheses have also been tested. As knowledge emerges on the neurochemical and neurogenetic determinants of alcohol addiction, the rationale is strengthened for hypothesizing that outcome may be improved when particular neuroactive medications are linked to certain patient characteristics of known biological basis.

II. THEORETICAL BASES

Interactions differ from predictors in that predictors affect the outcome of treatments in a similar way (Figure 1A). In contrast, interactions arise when the patient characteristic of interest has a differential effect on the treatments being compared (Figure 1B and 1C). Thus, the main effects of different treatments may suggest that they have similar benefits, however, analyses that examine the interactions between certain patient and treatment types may make differential benefits evident.

The idea of matching is not new, having first been proposed in the alcohol treatment area in 1941 by K. Bowman and E. Jellinek and is common to other fields such as psychiatry, medicine, and education. R. E. Snow in 1991 discussed aptitude-treatment interactions as derived from the educational psychology literature as a framework for research on individual differences in psychotherapy.

Matching came to be of interest to alcoholism treatment researchers when despite decades of outcome research no clearly and generally superior treatment(s) that could be considered the "magic bullet" of alcoholism treatment emerged. In parallel, thinking concerning the nature of alcoholism diversified and a view of the disorder as the end result of a complex interaction of factors—environmental, personal, interpersonal, and biological—competed with the predominant medical model of alcoholism as a unidimensional disease. It was suggested that perhaps the "one-size-fits-all" approach was inappropriate for alcoholism treatment. The notion that perhaps the missing ingredient in the treatment selection process was the matching of patient to treatment began to evolve.

The hypothesis was that perhaps the addition of matching could enhance outcomes above and beyond what could be accomplished by simply choosing generally effective treatments and paying attention to generic curative elements such as support, rapport, and communication from the therapist. This concept was fostered by about 40 studies published in from the 1970s through the 1990s suggesting that a variety of patient features—demographic, drinking relating factors, intrapersonal characteristics, and interpersonal factors—appeared to "match" with particular treatments.

III. EMPIRICAL STUDIES

A. Early Studies

Development of the experimental database pertaining to the patient-treatment matching hypothesis may

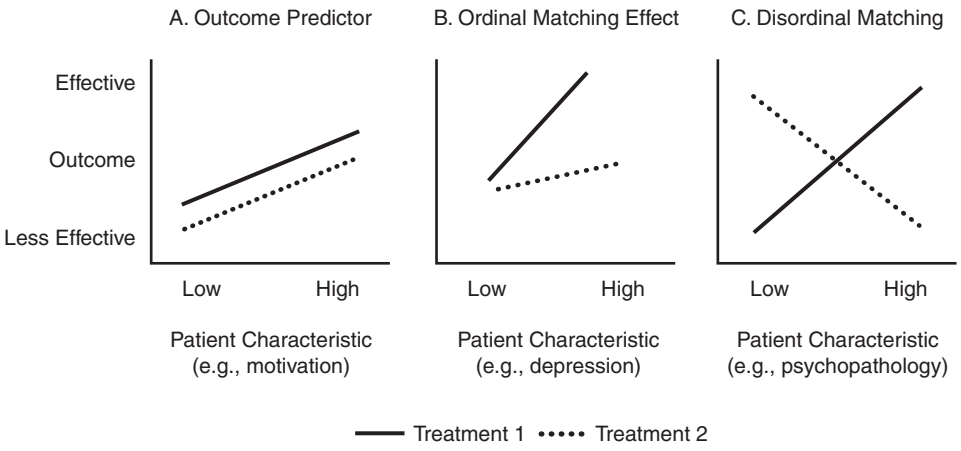


FIGURE 1 Three hypothetical examples of the relation of patient characteristics to treatment success are presented. The X axis (horizontal line) of each graph reflects the degree to which a patient has a certain characteristic. It may be a continuous variable (i.e., a patient may lie anywhere along a spectrum of characteristic levels varying from low to high), such as the degree of a patient's motivation, or a dichotomous variable, such as the presence or absence of a family history of alcoholism (not shown). The Y axis (vertical line) is a measure of treatment outcome (e.g., the percentage of days in a given period that the patient consumed alcohol). The relationship between the two lines that represent the two treatments being compared reveals information about the effects of varying levels of patient characteristics on outcome. (A) The relationship between an outcome predictor and two treatment types is shown. For example, how does a client's motivation affect the outcome of two different treatments? The outcome of treatment with both therapies is related to the patient's characteristic (i.e., the higher the motivation, the better the outcome for both treatments, although Treatment 1 appears a bit more beneficial than Treatment 2). The fact that the lines are parallel indicates that the effect of the patient's motivation is similar for both treatments. Therefore, the characteristic factor is an outcome predictor that does not affect the treatments differentially. (B) An ordinal matching effect is shown. Patients with low levels of the characteristic of interest, such as depression, appear to have about the same success regardless of the treatment they receive. For patients with higher levels of depression, the results diverge, and there is a definite advantage in choosing Treatment 1. (C) Disordinal matching is shown. Patients with low levels of a characteristic, such as psychopathology, have better success when receiving Treatment 2 than Treatment 1. For patients with high levels of psychopathology, the opposite occurs: Treatment 1 is more effective than Treatment 2.

be roughly divided into two eras. The first era consists of about 40 studies from the 1970s through the early to mid-1990s. These were mostly smaller scale, single-site studies. Some of the studies from the earlier portion of this period had methodological shortcomings, such as lack of a priori hypotheses; differing, less well documented therapies, and varying outcome measures that detracted from the studies and made comparisons across studies difficult. Nevertheless, the accumulating body of knowledge was viewed as promising not only for improving patient outcomes but also for making more effective use of ever-decreasing resources as reimbursement polices and other economic forces began to change the face of additions treatment in this country.

During the 1980s and early 1990s, methodologic advances occurred in addictions clinical research and numerous more sophisticated matching studies were reported, further strengthening the hope for matching as a clinical tool. An important catalyst were two reports from the Institute of Medicine in 1989 and 1990 calling for additional definitive and systematic research on this question. The matching hypothesis had become part of the national research agenda.

B. Project MATCH

The second era of matching studies was marked by the 1989 launch of a multisite clinical trial, Project MATCH, by the National Institute of Alcohol Abuse and Alcoholism (NIAAA) the principal sponsor of research on alcohol disorders in the United States. It was conceived of as the largest, most statistically powerful and most methodologically rigorous psychotherapy trial ever undertaken. The stated objective was to subject the matching hypothesis to its most rigorous test to date. Its research questions were based largely on the previous body of published studies and the latest knowledge of treatments believed to be generally effective and suitable for delivery both in a multisite clinical trial and in actual clinical practice.

1. Project MATCH Design

The details of the rationale and design of Project MATCH are described in a publication of the Project MATCH Research Group in 1993 and by D. Donovan and M. E. Mattson in a 1994 monograph. The study tested promising patient-treatment combinations involving 21 patient characteristics and three treatments: twelve-step facilitation (TSF), motivational enhancement therapy (MET), and cognitive-behavioral therapy (CBT). After determination of eligibility and an extensive baseline assessment, 1,726 patients were randomly assigned to one of the three treatments. The treatments were administered during a 12-week period by trained therapists following standardized manuals. Therapist supervision continued during the trial to ensure fidelity to the treatment protocol across all sites. The treatments are described in three therapists manuals written by their developers and published by the National Institute of Alcohol Abuse and Alcoholism as part of the eight-volume Project MATCH Monograph Series.

Drinking outcomes and other indicators of function were assessed at the end of treatment (3 months) and thereafter at 6, 9, 12, and 15 months. A subset (outpatients only) were recontracted 39 months after treatment. The two primary drinking outcome measures were percentage days abstinent and drinks per drinking day.

2. Project MATCH Sample

Patients were treated at nine locations in the United States. Five sites functioned as outpatient clinics, and five sites delivered Project MATCH treatments as aftercare following an episode of inpatient treatment or intensive day hospital. (One site had both an outpatient and aftercare capacity.) Treatment-seeking clients at the 9 locations were recruited from a total of 27 treatment facilities. Individuals with concurrent drug dependence diagnoses (other than marijuana) were excluded from the trial. The participants were almost exclusively alcohol dependent (as opposed to alcohol abuse only) and had an average of six (out of a possible nine) *DSM-III–R* dependence symptoms, and drank on average 25 days per month, with an average of 15 drinks per drinking day. Over one half had a history of prior treatment for alcoholism, approximately 75% were male, and almost all showed chronic effects of alcohol consumption on various areas of life functioning.

3. Project MATCH Hypotheses

Based upon previous research, a series of client characteristics were identified and tested as potential treatment-matching variables. The matching variables and the measures used to operationalize them are described in several publications authored by the Project MATCH Research Group. The patient-matching characteristics were alcohol involvement (i.e., severity of alcohol problems), cognitive impairment, conceptual level (a measure of abstraction ability), gender, meaning seeking (i.e., desire to find greater purpose in life), motivation (i.e., readiness to change), psychiatric severity, sociopathy, social support for drinking, alcoholic subtype, severity of alcohol dependence, psychiatric diagnosis (Axis I disorder), antisocial personality, anger, self-efficacy, social functioning, prior engagement in Alcoholics Anonymous, religiosity, treatment readiness, autonomy, and problem recognition. Hypothesized interactions between each of these client characteristics and the Project MATCH treatments were specified at the beginning of the trial. The matching hypotheses were a priori, that is specified in advance, and were not revealed during the trial to therapists and research assistants to maintain objectivity in treatment and assessment.

4. Project MATCH Results

In the following section, we consider how results of Project MATCH answered two questions: (a) How did patients fare in the different treatment conditions? and (b) Were any treatments particularly effective in subgroups of patients defined by the characteristics listed above?

a. Results: Main Effects. Patients in all three treatment conditions demonstrated major improvements in drinking, as well as other areas of functioning such as depression, use of illicit drugs, and liver enzyme status. Overall, MATCH clients were abstaining over 85% of the days throughout the year following treatment, and alcohol consumption decreased fivefold. Even those not successful in maintaining abstinence who continued to drink experienced a substantial reduction in alcohol consumption. In general, effects for the three treatments were similar, with the exception that 10% more of the outpatients receiving TSF attained complete abstinence over the 1-year follow-up period compared to the other two treatments. In addition, more aftercare patients were able to sustain complete abstinence throughout the year after treatment than the outpatients, despite the fact that the aftercare patients entered the study with more alcohol dependence symptoms.

b. Results: Matching Interactions. The findings of Project MATCH surprised many and challenged the belief that patient-treatment matching was critical in the treatment of alcoholism. Contrary to the expectations

generated by the supporting literature, large and uniform effects for matches between single-patient characteristics did not emerge. Many hypothesized matches were not supported, and those found were, for the most part, of rather modest magnitude and often varied over time, between arms of the trial, and for the two primary outcome measures.

Of the 21 patient variables studied, the four with matching effects deemed more plausible were those involving, in the outpatient arm: psychiatric severity, client anger, and social network support for drinking, and, in the aftercare arm, alcohol dependence. These are briefly described.

Patients in the outpatient arm with low psychiatric severity treated with TSF had more abstinent days as compared to those treated with CBT, a differential as high as 10% for several months during the follow-up period. The largest difference occurred 6 months after the end of treatment, when clients without concomitant psychopathology had 87% days abstinent in TSF versus 73% in CBT.

Motivational enhancement therapy was postulated to be more effective for clients with higher anger scores presumably because of its non-confrontive nature. MET clients in the outpatient study who were high in anger were abstinent more often than clients receiving the other treatments (a differential of 9%, i.e., 85% vs. 76%) and drank less intensely when they did drink. Clients with low anger fared better in CBT and in TSF as compared to MET. The effect persisted throughout the 1 year after treatment and was also present at the 39 months follow-up. This finding was the most consistent matching result across time.

As predicted, clients having a social network supportive of drinking did better in TSF than in MET. This difference was not apparent in the first year after treatment, emerging among the outpatients at the 3-year follow-up. TSF patients reported abstinence on 83% of days versus 66% for the MET patients. This difference of 17 percentage points was largest size effect observed in Project MATCH. The effects appear due to a steady decline among clients with high drinking support in the MET group after the end of treatment, whereas the TSF group maintained their gains. An influential factor may be differences in levels of AA attendance, with attendance levels higher in the TSF group than in the MET group.

It had been hypothesized that clients high in alcohol dependence would do better in TSF whereas those lower in that trait would benefit more from CBT. Because TSF is a treatment that puts greater emphasis on total abstinence, it was postulated to be more effective with highly dependent clients than either CBT (which taught skills to deal with "slips") or MET (which focused on clients' own decision making to motivate them to become abstinent). Aftercare clients low in alcohol dependence had better outcomes when treated with CBT than TSF, (i.e., abstinence on 96% of posttreatment days vs. 89%). However, at higher levels of dependence, the better treatment choice was TSF, (i.e., 94 vs. 84% days abstinent). The effect was consistent for the posttreatment period of 15 months.

c. Results: Clinical Implications. The clinical implications of Project MATCH were described by the investigators in a 1998 publication as follows:

> In summary, the results of testing the *a priori* matching hypotheses showed several matches of modest-to-moderate magnitude, often with variability over time, outcome measures and arm of the study. These results suggest that matching clients on several of the attributes tested in Project MATCH to one of the three treatments appears to enhance outcomes to a modest degree, with the most robust of the confirmed effects constituting a moderate difference of 17 percentage points in abstinent days.

The Project MATCH Research group concluded that viewpoints differ on how clinically important these single characteristic effects are, although, overall, the findings do not suggest that major changes in triaging procedures are warranted. R. Longabaugh and P. Wirtz have extensively analyzed the mechanisms and "active ingredients" involved in the matching hypotheses and have discussed possible reasons for the failure to find a greater number of matches.

C. Medications as Matching Targets

The literature on pharmacological agents in the treatment of alcoholism have been reviewed extensively and point to the increasing potential of pharmacologic agents as aids in treatment of alcoholism.

In the early 1990s interest in the opiate antagonist naltrexone as an adjunct in the treatment of alcohol dependence was illustrated by key studies from two groups in 1992, that of O'Malley and colleagues and Volpicelli and colleagues. Previously used as a treatment for opiate dependence, naltrexone was approved for treatment of alcoholism by the FDA in 1994. Previously, the only approved drug for this purpose was disulfiram (Antabuse). Disulfiram functions as a deterrent to drinking by producing an aversive effect if alcohol is consumed through inhibition of aldehyde dehydrogenase, an enzyme involved in the metabolism of alcohol.

Data from studies of the efficacy of naltrexone were subjected to subsequent post hoc analyses by A. J. Jaffe and associates in 1996. These results illustrate the possibility of matching subgroups of patients to drug/psychosocial combinations. The question examined was "Do patients with certain baseline characteristics respond more positively to the drug/psychosocial combinations than those without these characteristics?" The authors concluded that naltrexone appears more beneficial for alcoholics with high craving and poorer cognitive functioning.

Research by Mason and colleagues in 1996 suggested that the use of the antidepressant desipramine may reduce the risk of relapse in depressed alcoholics, but not in the nondepressed. In 1994, H. R. Kranzler and others found that buspirone appeared more helpful to anxious alcoholics although the same had not been observed in a previous 1992 study by Malcom and colleagues. In 2000, two studies on the agent ondansetron, a 5-HT_3 antagonist, suggested it differentially affected drinking in early versus later-onset alcoholics. Early-onset alcoholics were defined as those who showed drinking problems earlier in life, had antisocial characteristics, and a family history of the disorder in first-degree relatives. They found that ondansetron reduced drinking preferentially in the early-onset group. In a small pilot study also in 2000 the same investigators combined ondansetron with naltrexone and found that the combination reduced alcohol consumption in the early-onset group to a larger degree than either of the two medications alone.

Based on preliminary studies such as these, it is tempting to speculate that perhaps new and better matching algorithms may be found when matches are based on pairing of pharmacologic treatments with biologically based patient characteristics. Much additional research remains to determine if intriguing, but preliminary, results can be replicated and extended. Needed are future studies with larger samples in multiple sites and settings, and greater understanding of the neurochemical mechanisms underlying clinical observations. The future of matching patients to pharmacologic treatments remains open pending further investigation.

IV. SUMMARY

Although many alcoholics indeed benefit from treatment, no single treatment has been shown to be effective for all those diagnosed with the disorder. For many decades it was suggested that assigning alcoholic patients to treatments based on their particular needs and characteristics might improve treatment outcomes. Interest in matching accelerated during the 1970s and 1980s as supporting evidence accumulated in the literature. However, these studies were small scale, and replication was required before specific recommendations for clinical practice could be advanced. In late 1989 NIAAA launched a multisite clinical trial, Project MATCH, with the goal of learning whether different alcoholics respond selectively to particular treatments. The study tested a promising set of patient-treatment combinations in 1,726 patients randomly assigned to three well-defined psychosocial treatments.

Patients in all three treatment conditions demonstrated major improvements in drinking, as well as other areas of functioning such as depression, use of illicit drugs, and liver enzyme status. However, in terms of matching the findings of Project MATCH challenged the popular belief that matching patients to treatment was needed to significantly improve outcome. Of the 21 patient characteristics evaluated, only four statistically significant matches with potential clinical implications were identified. These matches involved psychiatric severity, anger, social support for drinking, and alcohol dependence.

Viewpoints differ on how clinically significant these single characteristic matches are, given their overall variability over time and the rather modest size of most of the effects. The Project MATCH investigators in 1998 concluded that

> matching clients to particular treatment, at least based on the attributes and treatment studied in Project MATCH, is not the compelling requirement for treatment success as previously believed. The matches found, however, are reasonable considerations for clinicians to use as starting points in the treatment planning process.

It may be that other patient characteristics, or other treatments, or settings not studied in this large project may have matching potential. For example, continued future work involving matches of patient characteristics with pharmacological treatments that target the neurochemical pathways involved in addiction will assess the robustness of preliminary findings on this variant on the matching theme. Until such validation is forthcoming, no clinical guidelines can be made with reasonable certainty.

See Also the Following Articles

Addictions in Special Populations: Treatment ■ Controlled Drinking ■ Self-Help Groups ■ Substance Dependence: Psychotherapy

Further Reading

Donovan, D., & Mattson, M. E. (Eds.). (1994). Alcoholism treatment matching research: Methodologic and clinical approaches. *Journal of Studies on Alcohol, Supplement No. 12,* 1–171.

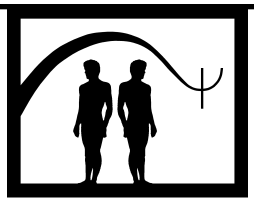
Friedman, L. M., Furberg, C., & DeMets, D. (1985). *Fundamentals of clinical trials*. Littleton, MA: PSG Publishing.

Hester, R. K., & Miller, W. R. (1995). *Handbook of alcoholism treatment approaches: Effective alternatives* (2nd ed.). Needham Heights, MA: Allyn and Bacon.

Project MATCH Research Group. (1998). Clinical implications of Project MATCH. *Journal of Mental Health, 7*(6), 589–602.

Project MATCH Research Group. (1993). Project MATCH: Rationale and methods for a multisite clinical trial matching patients to alcoholism treatment. *Alcoholism: Clinical and Experimental Research, 17*(6), 1130–1145.

U. S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism. (2000, June). *10th Special Report to the US Congress on Alcohol and Health*. Washington, DC.



Medically Ill Patient: Psychotherapy

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GLOSSARY

countertransference The therapist's partly unconscious or conscious emotional reactions to the patient.

psychodynamics The systematized knowledge and theory of human behavior and its motivation, the study of which depends largely on the functional significance of emotion. Psychodynamics recognizes the role of unconscious motivation in human behavior. The science of psychodynamics assumes that one's behavior is determined by past experience, genetic endowment, and current reality.

psychoeducation Information in which the content is psychological or psychiatric in nature.

somatization The unconscious manifestation of psychological conflicts, either fully or in part, as somatic or body symptoms.

transference The unconscious assignment to others of feelings and attitudes that were originally associated with important figures in one's early life.

In this article, we highlight the complex relationship between medical illness and emotional or psychological distress and present options for psychotherapy treatment. This task is complex because of the variety of medical illnesses that individuals experience (e.g., from seasonal allergies to life-threatening forms of cancer), the unique psychological composition and reaction of each individual, and the many available treatment options that have been determined as efficacious.

Is there an association between medical illness and emotional distress? Among many patients, there appears to be. For example, 10 to 15% of individuals with medical illnesses suffer from depression, and among those with chronic illness, the prevalence of mood disorders increases up to 25 to 50%. It has been estimated that up to 25% of cancer patients suffer from depression, and that cancer treatment, itself, results in emotional distress for 40 to 60% of patients. Among patients with active medical illness, depression is one of the most common psychiatric complications in medical treatment and outcome. Surprisingly, not all patients with medical illness suffer from emotional distress, but no one knows exactly why this is.

Does emotional distress truly influence medical treatment and outcome? Among patients with similar types and severity of illness, those with depression remained in hospital for longer periods of time (up to 10 days). Depression among diabetic patients is associated with poor treatment compliance and an increased risk for vascular complications. Among cardiac rehabilitation patients, those who received treatment for depression had lower rehospitalization rates. Finally, following the hospitalization of one family member,

studies indicate that there is an increase in the health care utilization of the remaining family members during the subsequent 3 years. These examples underscore that psychological factors appear to have an effect on one's response to medical illness and treatment.

In examining that effect, it is clear that medical illness is associated with some form of loss. Whether the loss is functional (e.g., use of one's legs), economic (e.g., inability to sustain employment), relational (e.g., loss of significant other, friends, or family), and/or self-esteem, a variety of factors affect how illness will be experienced. For example, there may be factors that predate the medical illness, such as early developmental psychodynamics, major psychiatric disorders, and/or personality traits or disorders, that affect the subsequent experience of illness. In addition, the arrival of medical illness may precipitate major psychiatric disorders as well as psychodynamic issues related to the illness experience.

I. DESCRIPTION OF THE TREATMENT

A. Assessment

1. Patient Reactions to Psychological Referral

Patients may be self-referred or referred by the treating clinician or family for psychological treatment. The patient's perception of the referral for psychological intervention may affect the entry into the treatment process. For example, negative reactions may result in failed appointments and, thus, prolonged psychological distress.

Referrals for psychological assessment and treatment may precipitate a variety of patient concerns. These may include social stigmatization (e.g., "Others will think I'm crazy!") as well as damage to self-esteem (i.e., "I can't do this on my own?"). Psychological referrals may be confusing to the patient who does not understand the relationship between emotions and medical illness. In addition, the patient may resist psychological referral if the recommendation is misinterpreted as an abandonment by the physician.

2. Selection Criteria for Psychotherapy Treatment

The selection criteria for entry into psychotherapy treatment vary from therapist to therapist. In general, the patient must be sufficiently intact on a cognitive level to enable participation in treatment. Among patients with medical illness, common concerns are the cognitive effects of drug treatment as well as delirium. Patients must be able to verbally interact (e.g., exclusions include aphasic patients) and reasonably able to relate to others (e.g., exclusions include severe personality disorders such as schizoid or antisocial personalities).

The ideal patient has a healthy and mature relational capacity. H. Levenson and R. E. Hales note the importance of the patient's ability to view issues in psychological terms, respond to a therapeutic experience in a positive manner, and make adaptations through personal strengths. These authors indicate that psychological pain may actually function as a potent motivation for treatment and emotional growth.

3. Contributory Factors to Psychological Distress among the Medically Ill

In the psychological assessment of the patient with medical illness, the psychotherapist must consider various contributory factors that might account for emotional distress. These factors, which become focal points in the subsequent development of a treatment plan, are described later and noted in Figure 1.

a. Early Developmental Issues Early developmental issues can temper the present-day experience of medical illness. Areas that might be explored with the patient include: (1) the relationship with parents, particularly parental effectiveness as caretakers (i.e., based on past experience, can the patient reasonably trust others to take care of him/her?); (2) the family philosophy of and approach to illness (e.g., acceptability, response patterns

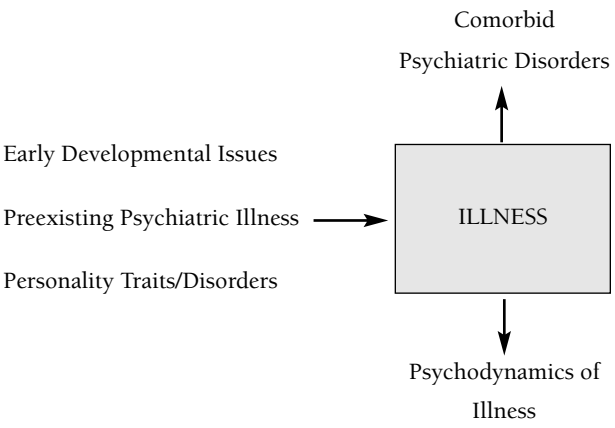


FIGURE 1 Contributory factors to emotional distress in patients with medical illness

to ill members, support and involvement; did parents effectively address, discredit, or dramatize illness in family members?); (3) prior personal experience with illness including illness among family members and friends; and (4) personal tolerability of dependency. It is also important to explore any cultural context or meaning of illness (e.g., the interpretation of hallucinations during delirium as a spiritual visitation from ancestors), and the expected response to illness within a specific culture, if applicable.

b. Preexisting Psychiatric Disorders Some of the current emotional distress may have actually predated the medical illness (i.e., the patient may have a preexisting psychiatric disorder). This possibility is based on the expected prevalence rates of major psychiatric disorders in the general population. For example, according to the National Comorbidity Survey, the lifetime prevalence of any depressive disorder is nearly 20%, anxiety disorder 25%, and substance abuse 27%. Therefore, it is worthwhile to explore for preexisting psychiatric disorders, particularly acute depression (major depression), chronic depression (dysthymic disorder), and substance abuse. These disorders may presently be comorbid, or co-exist, with the medical illness.

In addition to preexisting major psychiatric disorders, some adult patients also suffer from personality disorders. With their onsets in childhood, personality disorders result in long-standing and consistent deviations in cognition, behavior, and interpersonal relationships—all of which may influence the course and management of medical illness (e.g., medication compliance, appointment attendance, cooperation with treatment and medical personnel, reaction to illness, ability to elicit support from others). As an example of personality disturbance affecting illness, we have empirically determined that at least 7% of patients actively sabotage their medical care and that medically self-sabotaging behavior is typically associated with personality pathology, specifically borderline personality disorder.

Personality disorders can be difficult to diagnose during an initial evaluation, particularly if the patient is relatively high functioning and well educated. Oftentimes, diagnosis evolves with continuing or ongoing contact with the patient. However, health care personnel and family members may provide important historical information that suggests personality pathology, which is usually manifest in interpersonal functioning.

c. New-Onset Psychiatric Disorders After the onset of illness, patients may experience new-onset, or secondary, psychiatric disorders, most frequently either depression and/or anxiety. It appears that depression is particularly frequent among sufferers of neurological or cardiovascular disease. According to D. Spiegel and C. Classen, up to 50% of cancer patients experience clinical depression or anxiety, and the rate of depression in oncology patients is four times the prevalence found in the general population. Spiegel and Classen report that nearly 90% of these clinical syndromes are either manifestations of or reactions to illness or its treatment (i.e., secondary).

In addition to other factors, secondary mood disorders may be caused by a variety of medications administered to patients with medical illness. S. M. Valente and colleagues outline an extensive list of these medications (see "Further Reading") that include specific anti-inflammatory drugs and analgesics (e.g., ibuprofen, baclofen, opiates), anticonvulsants, antihistamines, particular anticancer drugs, caffeine, and propranolol. As with preexisting psychiatric disorders, these secondary mood disorders have the same potential to interfere with treatment by reducing compliance, optimism, and cooperation.

d. Medical Illness Psychodynamics There are well-known psychodynamics that are outgrowths of medical illness (see Table 1). Many of these psychodynamics center on the patient's experience of loss.

In addition to the themes relating to loss, D. Spiegel and C. Classen emphasize the importance of the patient's reaction to the disease, itself. For example, with

TABLE 1
Psychodynamics That May Be Associated with Medical Illness

- Greater helplessness and increased dependency on others
- Need for social support
- Loss and mourning (e.g., disability, disfigurement, employability)
- Significant changes in usual activities, routines, life patterns
- Increased responsibility for own care (e.g., medication regimens, follow-up visits)
- Need to reexamine life priorities
- Feelings of alienation from others
- Threat of premature death
- Unpredictable course of illness
- Symptom control
- Secondary gain (e.g., nurturance needs, deserved punishment)

regard to cancer, some patients attempt to overly control their feelings in an effort to literally control the cancer. Some patients believe that maintaining a positive attitude, even at the cost of dealing with and sorting through by-product issues, is a means of curing cancer. These beliefs may result in the patient's unrealistic needs to remain strong and in control. Patients may also struggle to maintain a self-perception of being "normal" which can cause unrealistic overextensions of self.

Following diagnosis, the psychological demands on patients continue. For example, D. Spiegel and C. Classen describe cancer as a series of stressors, from beginning treatment protocols to the changes in the social and physical environment to fears of death. The complex demands of illness, as well as the stigma of illness, may result in social isolation and breaches in social support. In our experience, it appears that genuine support can be maintained in most families for about a year, but gradually, family members may lose their stamina and resilience.

4. Use of Psychological Measures in Medically Ill Patients

a. Mood Assessment Mood and anxiety disorders, the most common psychiatric disorders among the medically ill, may be assessed in a variety of ways. However, sometimes the direct approach is the best approach. In support of this, a group of investigators reported that, among a group of patients with terminal illness, asking the direct question, "Are you depressed?" was more valid than three sophisticated psychological assessments for depression.

b. Psychological Measures of Illness Experience Psychological measures specific to the illness experience have not been broadly utilized in clinical settings. However, examples of general measures include the Millon Behavioral Health Inventory; the Psychological Adjustment to Illness scale; and the Illness Behavior Questionnaire. The latter measure contains seven scales including general hypochondriasis, disease conviction, psychological versus somatic concern, affective inhibition, affective disturbance or dysphoria, denial, and irritability. Examples of illness-specific psychological measures, which are uncommon, include the Mental Adjustment to Cancer scale.

c. Psychological Measures of Health-Related Quality of Life Of the measures available, the Medical Outcomes Study 36-Item Short Form, or SF-36, is probably the most commonly used measure of health-related quality of life. This 36-item questionnaire, with known reliability and validity, contains eight subscales and measures health status, general functioning, and well-being. It has been used among broad samples of patients as a measure of outcome.

B. Treatment

Following assessment, the psychotherapist will hopefully have sufficient information to determine the initial foci of therapeutic work. These foci function as the basis for developing an eclectic and individualized treatment approach. Given the possible short duration of anticipated treatment, the therapist must, according to H. Levenson and R. E. Hales, select the symptoms, behaviors, or conflicts most amenable to treatment.

1. Timing of Psychotherapy Treatment

An important consideration for the therapist and patient is the timing of psychotherapy treatment. Coping strategies are ideally taught to the patient and family when motivation and physical stamina are relatively high (i.e., the early phases of illness), whereas treatment in the later phases of medical illness may limit efficacy.

2. Establishing the Therapeutic Relationship

a. The Paradox of Empathy Although most therapists have an understanding of what it feels like to be depressed or anxious, to suffer the loss of a relationship, or to mourn a death, far fewer have experienced the unique types of compromises precipitated by medical illness. This potential difference poses unique constraints with empathy in the therapeutic relationship because most of us do not understand what it is like to be burned beyond recognition or to deal with a disfiguring surgery. In this regard, we believe that it is important, when applicable, for therapists to actively acknowledge their lack of personal experience with a particular medical process, and the feelings associated with it, in an effort to promote a candid and sincere need to understand the patient. Likewise, therapists can explain their familiarity with a specific disease process and/or the illness experience from work with other patients.

b. Engagement with Emotional Boundaries Because of the potential devastation of medical illness and the resulting biological and psychological regression that occurs, the therapist needs to be sensitive to the extensive support needs of these patients. Spontaneity, genuineness, warmth, and the candid expression of support

are important qualities in the building of rapport. At the same time, realistic internal emotional boundaries need to be established within the therapist to avoid emotional overinvolvement.

c. Transference As the treatment relationship unfolds, various types of transferences may evolve. A transference is the patient's unconscious assignment to others of thoughts and feelings that were originally associated with important figures in one's early life (American Psychiatric Association's *Psychiatric Glossary*). As an example, the patient may have been abandoned by parents as a child and now unconsciously expects that the treatment team will also abandon him or her. Examples of more subtle transferences might be the patient's unconscious resentment about the health and well-being of the therapist. Differences in age, gender, professional backgrounds, and level of education may cause breaches in the therapeutic relationship based on early issues. Finally, the early relationship with caretakers may affect the patient's reaction to being helped and supported by the treatment team as well as accepting the natural and expected dependency that occurs in a treatment relationship.

d. Countertransference Countertransferences may also develop. Countertransference is the therapist's partly unconscious or conscious emotional reactions to the patient (American Psychiatric Association's *Psychiatric Glossary*). As examples, the therapist may not feel comfortable working with patients who are going to die, due to earlier unresolved experiences with death as well as our cultural discomfort with death. The therapist may also be concerned about the patient's medical illness prohibiting an orderly exploration of issues. Likewise, the therapist's own prior experience of illness may affect his or her perception of the patient. As a final example, the therapist may feel uncomfortable with the medical overlay associated with the care of the patient (e.g., hospital setting, liaison with medical personnel, medical communication or jargon, uncertainty about the treatment process or outcome), which may be a reflection of an early sense of helplessness in undefined or overwhelming situations.

Beyond transference and countertransference issues, other relationship dynamics may emerge. For example, as therapy progresses, a mutual denial regarding the severity of illness may develop between the patient and the therapist. This dynamic may function to protect the continuity of the therapeutic relationship.

e. The Therapist with Medical Illness One final issue involving the therapeutic relationship needs to be considered—that of the therapist who suffers from medical illness. In these circumstances, the therapist may experience prominent defenses against his or her own illness including denial, omnipotence, and reaction formation (i.e., the latter being an unconscious defense mechanism in which the individual adopts thoughts and behaviors that are the opposite of what he or she is really experiencing). Reaction formation may be in response to dependency and debilitation. Medical illness may also result in empathic failure in the treatment relationship because of the therapist's emotional preoccupation and subsequent withdrawal from the patient. For therapists with medical illness, there is also the delicate issue of disclosure to patients about the illness, particularly its course and prognosis.

3. Psychotherapy Treatment Components

In the remainder of this section, we discuss psychotherapy treatment from a general perspective in an effort to accommodate the most generic patient with medical illness. We wish to emphasize that most effective therapies with patients with medical illness incorporate an eclectic and individualized approach. Several common components will be discussed (i.e., psychoeducation, acute problem solving, cognitive-behavioral techniques, psychodynamic psychotherapy, family intervention). The resulting treatment structure, including the various treatment components, is not limited to an individual-therapy format but may be incorporated into a group format as well. In addition, different treatment providers may captain the individual components.

a. Psychoeducation Psychoeducation is typically an ongoing process during treatment. Psychoeducation may occur while describing the process of psychotherapy, when inviting the mutual sharing of medical information (e.g., disease effects, prognosis, necessary medical intervention), and while validating key psychodynamic issues such as loss. In this regard, therapists who treat patients with medical illness need to understand the natural course and treatment of the illness, if such information is available.

b. Acute Problem Solving A variety of practical life issues may need to be addressed with the patient. These may include inexpensive resources for medical supplies, financial aid, child care, transportation, sexual functioning, and cosmetic concerns (e.g., hair loss with chemotherapy). The therapist plays an active role in

triaging problems to appropriate adjunctive health care personnel (e.g., social work) and community resources (e.g., wig salons) as well as addressing issues relevant to psychotherapy treatment (e.g., telling a spouse the prognosis).

Acute problem solving may also be addressed in brief psychotherapy treatment models. H. Levenson and R. E. Hales describe two examples of specific models of brief, dynamic psychotherapy for medically ill patients. One model is Time-Limited Dynamic Therapy that is an interpersonal therapy approach based on the premise that present relational difficulties were learned in childhood. The preceding investigators report that this model is particularly applicable to patients with medical illness because chronic illness may initiate a pattern of disturbed interpersonal relationships. A second example of a brief psychotherapy model is Short-Term Dynamic Therapy of Stress Response Syndromes, a 12-session treatment developed by M. Horowitz in 1976. This model focuses on the alleviation of an immediate stressor and is intrapsychic, rather than interpersonal, in format.

c. Cognitive-Behavioral Techniques Cognitive-behavioral interventions can be very helpful for patients with medical illness by modifying thoughts, emotions, and behaviors. Cognitive-behavioral treatment focuses on the elicitation and "correction" of unintentional thinking errors or cognitive distortions that precede the exacerbation of emotional discomfort. Illogical thoughts (e.g., "I'll never feel better") are systematically elicited and processed to determine their nature (are they, for example, a result of magnifying or minimizing situations?). These thoughts, which are actively linked with emotional discomfort (i.e., "notice that when you think this, you feel like this"), are ultimately reformed, relabeled, or replaced ("you don't feel good now; you will feel better, later").

d. Psychodynamic Psychotherapy Although not applicable to all patients, many have early developmental issues, particularly parents' responses to caretaking and illness as well as the patient's experience of dependency, which relate to and affect the current medical illness. In working with the patient, the therapist needs to maintain an active mental checklist of prominent current issues with the intent of threading these back into the developmental history to explore for any former issues that might be affecting the current medical experience. We are fairly candid with patients about the purpose of this historical information (e.g., "I need to understand your childhood background to determine its possible influences on your illness."). When present, an understanding of the association between past and present relationships may help resolve excessive fears and address defenses such as denial.

Psychodynamic psychotherapy can assist patients by alleviating the complex issues related to loss and changing social and family roles. As an example, the therapist needs to explore and clarify the meaning of illness to the patient in terms of possible role reversal (i.e., being cared for by one's children). Other common psychodynamic themes are listed in Table 1.

Terminal illness is a particular challenge in the treatment process, in part because of the therapist's task of ascertaining the meaning and value of defense mechanisms such as avoidance and denial. For example, dying patients may avoid the disclosure of the extent of their disease to loved ones. Patients may even avoid asking the treatment team about the prognosis so as not to confirm a negative one. Denial may limit the patient's reality of being finite as well as sabotage personal closure needs. On the other hand, some of these defenses may be the psychological substance of immediate survival. Therefore, the therapist must delicately explore the function of these dynamics and determine their adaptability. Again, these defenses are not always pathological or problematic.

Another challenging issue in the treatment of patients with medical illness is the patient's personal determinism with regard to his or her own death. Although beyond the scope of this article, the patient's desire to end pain, suffering, family stress, and financial exhaustion may precipitate the contemplation of suicide. Unquestionably, there are a variety of complex social, spiritual, religious, moral, and legal dilemmas entailed in this issue. However, the immediate clinical dilemma is the intended meaning of the patient's disclosure of suicidal thinking. Is the disclosure a "cry for help" or is it the need to explore a difficult decision with another human being? Is the therapist's contemplation of intervention an overt need to rescue the patient or avoid legal prosecution for inaction, or the therapist's intolerance of the patient's decision? What are the legal risks of not intervening with such a disclosure, particularly if the family supports the patient's decision to suicide? Finally, is the decision to suicide a rational one or a decision driven by fear or untreated depression, and does it matter? As a general guideline for therapists, at this juncture, it is particularly important to reassess and treat (or alter treatment of) mood disorders as such intervention may result in the resolution of suicidal ideation.

e. Family Intervention Although most therapists do not undertake intensive family therapy work in the treatment of patients with medical illness, it is usually helpful to meet with the family. The family may provide additional background information, require individual professional support (e.g., the spouse who is depressed and needs antidepressant medication), and/or require a liaison between the patient and/or hospital personnel. In addition, families may require education about specific psychological issues (e.g., the role of depression, emergence of delirium secondary to the treatment) as well as some reframing about their loved one's behavior (e.g., the patient's low frustration tolerance, fear, confusion, inability to make decisions).

f. Group Therapy As noted previously, all the preceding treatment components may be undertaken in group format. The psychological advantages of group treatment of patients with medical illness include the ability to emphasize the universality of experiences, deal with disability on a mutual level, engage in emotional sharing, sort out relationships with family, and acknowledge and attempt to resolve grief and loss.

In working with cancer patients, D. Spiegel and C. Classen describe the goals of group therapy, many of which apply to all group treatments. These investigators emphasize the goals of building social bonds, using the group experience as a working lab to practice and express emotions, processing feelings about death and dying, redefining life goals, increasing social support, comparing health information, improving one's relationship with the health care team, and improving coping skills. With regard to the latter, a group experience is an excellent way to discover how others have dealt with and resolved specific issues or problems (e.g., having sexual relations while wearing a colostomy bag).

Group treatment is determined by the patient's individual needs (e.g., social comfort with groups, level of debilitation, type of medical illness), the available resources, and the availability of sufficient fellow patients (usually 7–10) who meet the group's criteria for entry (e.g., HIV infection). Some groups are very structured including an explicit number of sessions, while others are open-ended and continue as long as the need persists. In addition to patient groups, some therapists provide group intervention to families.

Group treatment is potentially more cost effective than individual treatment. However, potential difficulties in initiating group treatment include establishing the proper working group size, defining entry criteria (e.g., type of illness, stage of illness, age, sex), solicitation of members (e.g., bulletin board advertisements, physician referral only), duration of the group both per session and total duration, and whether the group is open to new members or not. Other potential problems include reimbursement, establishing and maintaining confidentiality, and leadership. Unlike typical psychotherapy groups, members may have to be prepared for the inevitable death of some participants, depending on the composition of the group.

4. Treatment Strategies for Major Psychiatric Disorders

a. Preexisting and Current Mood Disorders As noted previously, patients commonly develop depression and anxiety disorders, either prior to the onset of illness or during it. Mood and anxiety disorders are usually treated in a traditional fashion with antidepressant or antianxiety medications as well as the consideration of psychotherapy. Certain types of antidepressants, the selective serotonin reuptake inhibitors (SSRIs), are favored because of their ability to treat both depression and anxiety, and their minimal side effects, particularly the lack of cognitive and cardiovascular effects. With one exception (citalopram), these drugs tend to be very safe in single-drug overdoses.

b. Somatoform Disorders Somatoform disorders consist of a collection of psychiatric disorders that include somatization disorder (i.e., the presence of multiple physical complaints involving multiple body areas or body systems); conversion disorder (the presence of a symptom complex that is under unintentional but voluntary control and whose onset relates temporally to stress or conflict); pain disorder (pain symptoms in which psychological factors contribute in an unintentional way); and hypochondriasis (nondelusional, but persistent preoccupation with one's body or symptoms with regard to disease). These disorders may be associated with other types of psychiatric disorders, particularly mood and anxiety disorders. Because of the patient's focus on physical symptoms and the oftentimes unintentional generation of symptoms, there may be little interest in mental health support. However, symptoms may be reduced in some patients with supportive psychotherapy geared to stressors and interpersonal conflicts, frequent appointments with the primary care physician, conservative medical intervention, and the treatment of comorbid conditions such as mood and anxiety disorders with antidepressants. With regard to the latter, those antidepressants which exert an antiobsessive effect (e.g., SSRIs) may be particularly

helpful in some patients. Among this group of patients, there is a great deal of heterogeneity and in some cases, more sophisticated types of psychotherapy may be utilized in particular patients as well as more complicated combinations of psychotropic medications. Some of these patients may even benefit from hypnosis (e.g., conversion disorder).

5. Treatment Strategies for Patients with Personality Disorders

We believe that the presence of a personality disorder is one of the most difficult issues in the treatment of patients with medical illness. Because of their long-standing nature, personality disorders tend to be tenacious and difficult to change. Most theorists believe that long-term treatment is required and the outcome or prognosis may be limited. In addition, there are few studies that clarify the efficacy of treatment for personality disorders. Indeed, some disorders, such as antisocial personality disorder, have questionable responses to treatment. The interplay of medical illness and personality disorder can be exasperating for the clinician as well as the family and health care team. For example, the management of diabetes may be extremely difficult among patients who sabotage their administration of insulin, resulting in repeated hospitalizations and medical complications.

It is important to emphasize that the presence of personality disorder is not always a meaningful issue in treatment. For example, in cancer victims with poor prognoses, personality disorder treatment is neither realistic nor appropriate. In these latter cases, the therapist may limit treatment to minimizing the impact and effects of the personality-disordered behavior on family, medical staff, and other patients.

II. THEORETICAL BASES

It is difficult, at times, to accurately measure and describe the psychotherapy process and why it works. Perhaps it is the psychological intimacy that provides immeasurable support. Perhaps it is the revelation of fear, anger, disappointment, and shame—all the feelings that incarcerate the spirit. It may also be establishing new conceptual paradigms to replace the previous ones that no longer work. Whatever the growth-promoting elements of psychotherapy treatment are, they certainly apply to the treatment of those with medical illness. The modifications in psychotherapy treatment of this population primarily center on the additional knowledge base required in working with a medical illness, the biological stress of the illness, and the ever-prominent issue of death. Although suicide is always a concern in working with patients with nonmedical illness, it remains an issue with the patient with medical illness as well, in addition to the threat of death from illness.

III. EMPIRICAL STUDIES

In a 1994 review of the literature, H. R. Conte reported that there were few controlled empirical studies, and only occasional case reports, exploring the efficacy of supportive psychotherapy for patients with medical illness. Results indicated beneficial effects, in general. Although it is impossible to compare outcome studies because of differing patient populations, therapeutic interventions, treatment settings, and types of medical illness, we present some highlights from the literature.

A. Psychoeducation

Among patients with chronical illness, researchers found that classroom as well as home psychoeducation (e.g., instruction on mind–body relationships, relaxation training, and communication skills) resulted in improvements with pain, sleep disturbance, mood, and anxiety. Formalized psychoeducation has also been undertaken with cancer patients and found to enhance both cognitive and behavioral coping skills.

B. General Psychological Intervention

In a group of patients with atopic dermatitis, those who entered into a psychological treatment demonstrated a greater improvement in their skin condition than did those patients in standard medical treatment. In a review of outcomes among those with chronic heart failure, it has been reported that psychological and behavioral interventions have the potential to substantially enhance treatment outcomes. Among patients undergoing coronary artery bypass surgery, those who participated in daily supportive psychotherapy had fewer medical complications and shorter lengths of hospitalization, compared with controls. Through meta-analysis, the efficacy of psychological interventions among both children and adolescents with chronic medical illness has been explored; despite a host of limitations, results support the overall efficacy of psychological intervention.

C. Cognitive-Behavioral Interventions

Cognitive-behavioral intervention has been found to improve depression among patients with chronic illness. Multicomponent behavioral therapy among patients with irritable bowel syndrome resulted in greater symptom reduction compared with controls.

D. Group Therapy

In examining the sense of well-being as an outcome measure for patients with serious medical illness in time-limited (12 sessions) group therapy, researchers found that although somatic concern remained sustained, all patients noted an improvement in their sense of well-being. Likewise, among cancer patients receiving radiation therapy, there were significant decreases in both physical and emotional symptoms for those who participated in 10 group therapy sessions of 90 min each. Through multicenter evaluation, group therapy with breast cancer patients has been empirically assessed and resulted in improved mood, fewer maladaptive coping responses, and improved support. Finally, group therapy (six sessions) among patients with malignant melanoma resulted in decreased stress, greater use of coping skills, and effective changes in the lymphoid cell system.

E. Cost Effectiveness of Psychotherapy

Researchers have found that psychotherapy can be cost effective among certain medical patients with concomitant psychiatric illness. In addition, there is evidence that psychiatric consultation-liaison services for medical patients reduces the overall cost of care. Studies indicate that psychiatric illness, notably depression, usually prolongs hospital stays for medical patients and intervention reduces cost. In summary, it appears that reducing psychiatric morbidity among medical patients also has the potential to reduce their overall cost of medical care.

F. Caveats

Although many studies clearly support the efficacy of psychological intervention in patients with medical illness, there are studies that do not. For example, the provision of group therapy for the relatives of patients with chronic aphasia was appreciated but did not lead to measurable improvements in participants' perceptions of personal, social, or family burdens. Among patients with testicular cancer, psychotherapy did not affect outcome when compared with controls. In examining the impact of treating depression among hospitalized veterans and the effect on participants' preferences for life-sustaining therapy, surprisingly, these preferences did not change, regardless of the improvement in depression.

IV. SUMMARY

The psychotherapy of patients with medical illness must be individualized to the needs of each patient. Treatment components may include psychoeducation, acute problem solving, cognitive-behavioral techniques, psychodynamic psychotherapy, family intervention, and group therapy. The unique aspects of medical illness temper the psychodynamics of the issues in the treatment process. The therapist must integrate both the knowledge of psychology and biological disease to effect an outcome. Although most studies underscore the effectiveness of psychological interventions in the medical patient, the documented limitations of psychological intervention in some populations underscores the importance of further investigation.

See Also the Following Articles

Bioethics ■ Cancer Patients: Psychotherapy ■ Collaborative Care ■ Comorbidity ■ Countertransference ■ Informed Consent ■ Integrative Approaches to Psychotherapy ■ Neurobiology ■ Transference

Further Reading

Levenson, H., & Hales, R. E. (1993). Brief psychodynamically informed therapy for medically ill patients. In A. Stoudemire, & B. S. Fogel (Eds.), *Medical-psychiatric practice* (Vol. 2, pp. 3–37). Washington, DC: American Psychiatric Press.

Spiegel, D. (1999). Psychotherapeutic intervention with the medically ill. In D. S. Janowsky (Ed.), *Psychotherapy indications and outcomes* (pp. 277–300). Washington, DC: American Psychiatric Press.

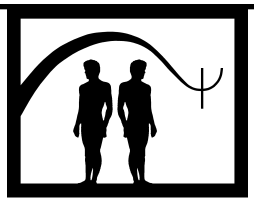
Spiegel, D., & Classen, C. (Eds.) (2000). *Group therapy for cancer patients: A research-based handbook for psychosocial care*. New York: Basic Books.

Spira, J. L. (Ed.), (1997). *Group therapy for medically ill patients*. New York: Guilford Press.

Stoudemire, A., & Fogel, B. S. (Eds.), (1993). *Medical-psychiatric practice*. Washington, DC: American Psychiatric Press.

Stoudemire, A., Fogel, B. S., & Greenberg, D. B. (Eds.), (2000). *Psychiatric care of the medical patient*. New York: Oxford University Press.

Valente, S. M., Saunders, J. M., & Cohen, M. Z. (1994). Evaluating depression among patients with cancer. *Cancer Practice, 2,* 65–71.



Minimal Therapist Contact Treatments

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GLOSSARY

minimal therapist contact treatments (MCT) Rely heavily on out-of-clinic interventions. Often it is referred to as a "home-based" treatment.

cost-effectiveness Percentage improvement per minute of clinician contact.

Minimal therapist contact is a term used to describe psychological interventions that utilize alternative forms of instruction and treatment administration (e.g., written materials, computer programs, videotapes, audiotapes, and portable biofeedback equipment) to reduce professional contact time without compromising treatment intensity. Because minimal therapist contact treatment (MCT) relies heavily on out-of-clinic interventions, it is often referred to as a "home-based" treatment.

* The views expressed in this article are those of the authors and do not reflect the official policy or position of the United States Air Force, Department of Defense, or the United States Government.

I. TREATMENT DESCRIPTION

For the purposes of definition, it is important to distinguish between other forms of intervention that utilize alternative delivery methods and MCT treatments. These other forms of intervention, including certain types of bibliotherapy and many self-help interventions, effectively reduce the amount of contact time, but they accomplish this by decreasing the intensity of the intervention. For example, efficiency may be improved solely by decreasing the number of sessions in the intervention, limiting the patient–therapist interaction to a one-time, informational exchange, or eliminating the patient–therapist relationship altogether (e.g., pure self-help). MCTs on the other hand, seek to deliver an intervention of equal intensity and duration to standard clinic-based treatments (SCT) while maintaining ongoing (although less frequent) patient–therapist contact.

MCTs offer many potential advantages over SCTs. First, at-home skill acquisition and practice eliminates the need for frequent, lengthy clinic visits, improving access to care for many patients. Specifically for patients living in rural areas who must travel significant distances for care, a decrease in clinic visits makes obtaining treatment more feasible due to a reduction in transportation costs and lost work time. A reduction in clinic visits, however, will likely improve access to care for all patients, not just those living in rural areas. For example, recent treatment utilization data suggest that 80% of patients attend fewer than six treatment sessions, suggesting the length of standard interventions may be a barrier to patient care in general.

Second, MCTs reduce the total amount of therapist contact time that results in decreased provider cost per patient treated. Cost-effectiveness, defined as percentage improvement per minute of clinician contact, has been shown to be as high as five times greater in MCTs as compared to SCTs. This characteristic of MCTs fits in well with the prevailing method of health care funding and delivery: managed care. Health maintenance organizations (HMOs) are concerned with treatment cost, treatment quality, and patient access to care. As a method of cost containment, many HMOs limit the number of preapproved clinic visits. MCTs respond to this need to balance cost containment and patient care by decreasing cost without sacrificing treatment efficacy.

Compared to efficiency-enhancing methods that rely solely on reducing or eliminating therapist contact time, MCTs offer the potential benefit of greater patient involvement and skill acquisition without the loss of intervention and monitoring by a trained therapist. In addition, this utilization of alternative mediums of instruction and delivery allows the therapist to focus on tailoring interventions to specific patients and to respond to factors and circumstances that arise during treatment. MCTs are also flexible and can often incorporate the beneficial aspects of other efficiency-enhancing formats. For example, the first author has designed a group administered MCT protocol for the treatment of chronic headaches (HA). Finally, MCT's use of extensive at-home skill acquisition and practice theoretically may facilitate skill generalization and internal attributions for change. However, no studies have examined differences in generalization.

Some potential disadvantages may also exist for MCTs. The first author's experience with MCTs suggests they may require a higher level of motivation or cognitive ability than SCTs, although no studies have investigated such a requirement. In addition, the increased reliance on patient self-administration presents the potential for reduced adherence, although poor adherence has not been reported in the existing literature.

II. THEORETICAL BASES

The term "minimal contact" implies a form of treatment administration and delivery that is not limited to a particular theory. This represents a significant advantage for MCTs because they can potentially be applied to any type of intervention that is translatable into a standard protocol, regardless of clinical orientation. However, the MCTs described in the literature have, almost entirely, been developed from treatments based in cognitive-behavioral theory. This trend is not a random occurrence but is due primarily to the nature and developmental stage of cognitive-behavioral interventions that make them especially suitable for MCT methods.

First, cognitive-behavioral interventions rely heavily on education and exposure to new experiences for treatment efficacy. Both of these treatment components lend themselves to home-based interventions that utilize alternative mediums to communicate information. Second, treatment efficacies of many cognitive-behavioral interventions for a variety of disorders have received significant empirical support. Once an intervention has been established and its efficacy empirically supported, the amount of additional clinical improvement gained by modifying the content of the intervention will eventually plateau. Cognitive-behavioral interventions for chronic headaches reached such a plateau, leading researchers to look toward enhancements in treatment delivery for further improvement of the interventions. MCT methods provide one means by which the efficiency of established interventions can be enhanced while the treatment content, intensity and efficacy remain intact.

III. LITERATURE REVIEW

Research exists to support various forms of MCT for adult patients with both physical and psychological disorders, including migraine and tension HA, hypertension, and panic disorder. In addition, research supports the use of MCT for HA and enuresis in children.

The literature on MCT of HAs in adults consistently finds MCT to be equally as effective as the more intensive SCTs. Results of a recent meta-analysis of 20 controlled clinical outcome trials suggest MCTs, on average, are more cost-effective and require substantially less professional contact time, as well as, fewer clinic visits. In addition, MCTs produced similar or significantly better outcomes than SCTs requiring more professional contact.

More specifically, a 1996 review article including eight studies of MCTs for tension-type HA found MCTs to be equally as effective as SCTs for the reduction of HA activity. MCT for tension-type HA has also been compared to prophylactic, pharmacological intervention (Amitriptyline HCL). The results suggest MCTs are similarly efficacious in terms of decreasing HA frequency and intensity. However, compared to the medication group, additional benefits were realized in the MCT group, such as more internalized locus of control, fewer general somatic complaints, and fewer side effects. Although long-term fol-

low-up studies of these interventions have been somewhat lacking, existing data have consistently shown good maintenance of effects throughout follow-up periods ranging from 3 months to 2 years.

Similar results have been reported for migraine HA. Three investigations comparing the efficacy of MCT and SCT relaxation/thermal biofeedback interventions suggest MCT is equally as effective as SCT for the reduction of migraine HA. One study to date has investigated the efficacy of MCTs as compared to abortive medication (ergotamine tartrate) for the reduction of migraine HA. The results found MCT to be equally as effective as this abortive intervention, although patients treated with medication experienced improvements more rapidly than those treated with MCT.

No research to date has been conducted comparing MCT to treatment with prophylactic medication. However, one study compared MCT alone to MCT plus propranolol (the most commonly used prophylactic agent for migraine HA). The results indicate that, although both interventions were effective, the addition of the prophylactic agent yielded significant enhancements in HA reduction.

MCT methods have also been used in the treatment of essential hypertension with equivocal results. One study investigated the efficacy of a 5-session, thermal biofeedback MCT for adults with essential hypertension who required at least two drugs for hemodynamic control. This intervention was compared to a standard, 16-session, thermal biofeedback SCT. The results suggest that patients in the MCT did significantly poorer controlling their blood pressures without medication than those in the SCT. However, a previous investigation comparing a 9-session thermal biofeedback MCT to a 20-session SCT found equivalent reductions in blood pressure and antihypertensive medication use. Methodological limitations, such as small sample size, suggest that more research is needed in the area of MCTs for hypertension.

A recent study also supports the efficacy of MCT methods in the administration of cognitive-behavioral treatment of panic disorder. When compared to a standard, 10-session cognitive-behavioral intervention for panic disorder, a minimal contact approach involving 5 sessions and supported by self-help materials yielded similar improvements both immediately posttreatment and at 12-month follow-up. In addition to applying minimal contact methods, this particular intervention also reduced the total length of therapy while maintaining the efficacy of the longer, clinic-based intervention.

Data have also been reported that support MCTs in pediatric populations. A review article including three school-based and four home-based MCT interventions concludes that MCT for pediatric and adolescent migraine, regardless of setting, is equally as effective as SCTs. The existing research on pediatric tension HA for both SCTs and MCTs are more modest, however, with the percentage of participants experiencing clinically significant improvement (defined as > 50% reduction in overall HA activity) being low, but similar, for both types of intervention. In terms of mixed-type HA, a recent treatment study of a home-based MCT for children (ages 10–12) found the MCT to be as efficacious as the SCT and over twice as cost-effective.

Similarly, data supporting the efficacy of MCTs for the treatment of nocturnal enuresis in children have also been reported. This treatment relied on the children's parents for the administration of the treatment. Although some limitations may exist for the application of MCTs with children, such as inability to read and the need for significant parental involvement in treatment, more research is needed on MCT in this population.

In general, research has fairly consistently shown MCTs to be as effective as more costly SCT for the treatment of a variety of disorders in both adult and child populations. The extensive body of research demonstrating the efficacy of MCTs for chronic HA suggest MCTs for HA are ready for widespread clinical application. However, additional research is needed to verify MCTs for the treatment of other disorders and to investigate the potential advantages and disadvantages of minimal contact methods beyond increased cost-effectiveness.

IV. TREATMENT ABSTRACT

Although MCT methodologies could result in many different therapy formats, a prototype based on a typical intervention is presented here as an example.

A prototypical MCT might take an 8-session, 8-week SCT and administer it utilizing three in-clinic sessions, two telephone contacts, and a series of audiotapes and manuals across the same 8 weeks. Table 1 compares a typical minimal therapist contact treatment (MCT) to a standard clinic-based treatment (SCT).

The first week of intervention looks almost identical in the two forms of treatment except for the use of training materials. During Week 2, the SCT therapist meets the patient for another 60-min session, while the MCT therapist speaks with the patient briefly on the telephone. During this telephone conversation, the MCT therapist will ask general questions regarding treatment progress, relaxation practice, and any behavior monitoring/recording that was assigned during Week 1. The