

# Psychotherapy Approaches

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## Introduction

Psychotherapy (individual, group and couple/family) is a practice designed to support individuals' mental health through several different methods. It is usually intended to provide symptom relief, reduce future symptomatic episodes, enhance quality of life, promote adaptive functioning in work/school and relationships, increase the likelihood of making healthy life choices, and offer other benefits established by the collaboration between client/patient and psychotherapist (e.g. Barlow, 2008; Carr, 2009; Hofmann & Weinberger, 2007; Wampold, 2010).

One commonly discussed factor in psychotherapy is the therapeutic alliance between therapist and client/patient, which involves both a bond between them as well as an agreement about the goals and tasks of the treatment (Karver, Handelsman, Fields, & Bickman, 2006; Lambert, 2004; Norcross, 2011). Many types of psychotherapy are available, differing in their procedures and assumptions. Some treatments are based on evidence from research and studies (Evidence Based Practice), while others are difficult to examine in an empirical way and are based more on theoretical models of human nature. Treatments may also vary in response to the “client”, who is not always one individual, but can be a couple, a family or a group of people sharing the same difficulties.

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The aim of this chapter is to describe the history and the development of psychotherapy, and to provide an overview of some of the best-known schools of thought in psychotherapy. The most effective contemporary approach is Cognitive Behavior Therapy, which will be thoroughly discussed later in this chapter. Other therapy schools described in this chapter are psychoanalytic and psychodynamic therapy, person-centered therapy also known as client-centered therapy, and systemic psychotherapy.

## History of Psychotherapy

For many years, humans have tried to explain and control problematic behaviors. These efforts have always been driven from the theories and models of behavior that were popular at the time (Barlow, Durand, & Hofmann, 2016). The origins of planned therapy for mental disorders likely lie within Greek culture. Hippocrates was among the first to view mental illness as a medical condition and approach it without superstition (Maher & Maher, 1985). While their initial understanding of the nature of mental illness was not always correct (e.g., believing that hysteria affected only [women](#), due to a wandering uterus), and their treatments rather unusual (e.g., bathing for [depression](#), blood-letting for [psychosis](#)), they recognized the treatment value of encouraging and consoling words.

With the fall of the Roman Empire, the established Greek spiritual and psychological methods virtually disappeared. The Middle Ages in Europe brought on the belief of the supernatural as a cause for mental illness. Mental illness was blamed on the Devil, demonic possession, magic, and witchcraft. Treatments were then based on the exorcism of the evil spirit or included torture to gain confessions of demonic possession (Kemp, 1990). It was obvious that the mentally ill were considered threatening and needed to be removed from society. Alongside those interventions, some mental illnesses, such as depression or anxiety, were recognized as illnesses and were treated with rest, sleep, baths and potions (Kemp, 1990). During the same time period, the first hospitals with a humanitarian motivation to treat patients with mental illness were developed. However, in the eighteenth century these hospitals were used to isolate the mentally ill people.

During the first half of the nineteenth century, a strong psychological approach to mental disorders, entitled Moral Therapy, became influential. France was first to lead this approach by establishing a reform within mental institutes to end the isolation of patients. Their reform included removing restraints and treating patients as normal persons by providing them opportunities for appropriate social and interpersonal contact (Bockoven, 1963). This Moral therapy was primarily a social intervention in which individuals were treated on large farm-like hospitals where they were required to participate in the work on the farm. The basic tenet of moral therapy was that if individuals who are profoundly ill are treated with respect and dignity and are required to participate in normal social activities, rather than be imprisoned and punished, they will once again acquire the social attributes of normal

members of society (Hersen & Sledge, 2002). This approach to patients suffering from mental illness spread to England and the U.S and eventually led to large, state-supported public asylums. However, the dissemination and use of moral therapy did not last long as hospitals became too crowded to carry out this treatment.

In the second half of the nineteenth century, new approaches to the treatment of psychopathology started to emerge from both the biological and psychological perspectives. Psychoanalysis can be traced back to 1880, when the Austrian physician, Joseph Breuer, who treated “Anna O.” She coined the term “the talking cure” to describe her psychotherapy. One of his protégés, Sigmund Freud, decided to continue this line of work by describing psychoanalysis as both the science of the unconscious mind and the medical treatment of mental disease. By the 1930s, a majority of American psychiatrists embraced Freud’s psychoanalysis (Mitchell & Black, 2016).

The twentieth century brought on enormous progress in the field of treatment, medically and in psychotherapy. In the 1930s the physical interventions of electrical shock and brain surgery were often used. Insulin was found to help with psychoses, and for a short term, Insulin shock therapy was used (Sakel, 1958). During the 1950s, scientists developed the first effective drugs for severe psychotic disorders, and shortly after that, benzodiazepines were discovered. This development in medicine coupled with the increasing awareness of individuals’ rights in the 1960s promoted the deinstitutionalization movement. The movement started with the noble aim of treating and rehabilitating mentally ill patients within the community itself to reduce human rights violations and mitigate their suffering. As a result, more people were moved from the asylums back into community, and thus, community mental health centers were established (Barlow et al., 2016).

In the field of psychotherapy, different theories, models and approaches were explored. Freud’s original psychoanalysis theory was greatly modified and expanded upon in a number of different directions (e.g. Anna Freud, 1937; Kohut, 1971). Many of Freud’s students rejected his ideas and went on to new directions (e.g. Adler, 1916; Jung, 1931). A variety of new approaches were also introduced in and after the 1950s, including behavioral (Skinner, 1953; Wolpe, 1958) and cognitive (Beck, 1964; Ellis, 1958), humanistic (Rogers, 1959), Existential (May, 1961) and gestalt therapy (Perls, 1969). Instead of only focusing on psychotherapy for the individual, psychotherapists started to experiment with new settings for treatment; e.g. group and family therapy. With the advancement of science, psychotherapy evolved into a research based practice, influenced by theories and tools from biological, cognitive, social, neuro, and various other perspectives.

An overview on the history of psychotherapy reveals the progress that has been made in how we think about people with mental disorders. Today we do not consider the mentally ill as immoral or possessed by demons; instead we attribute their disturbance to a complex interaction of heredity, environmental history, personality style, and habitual ways of thinking and behaving. In the same vain, treatments have evolved from inhumane methods to empirically validated practices, and research continues to emphasize the development of new treatments that are safe and effective (Thomason, 2005).

In the following sections we will describe the main and most common approaches to psychotherapy. For each approach we will describe the theoretical foundation, treatment goal and techniques, the therapist role, and its support and critiques. We will start with a broad overview of cognitive behavioral therapy and then will more concisely describe psychoanalysis and psychodynamic therapy, person-centered therapy and systemic therapy.

## **Traditional Cognitive Behavioral Therapy**

Cognitive Behavioral Therapy (CBT) combines elements of behavioral therapy and cognitive therapy whose theoretical and procedural approaches are highly compatible. The central notion of CBT is that behaviors and emotional responses to external events and situations are not directly caused by these events or situations per se, but by the perceptions and interpretations of these events and situations (Hofmann, 2014).

### ***Theoretical Foundation***

A detailed description of the development of CBT and its theoretical models follows.

*Learning principles.* One important influence of CBT comes from learning theory and behavioral models. At its most extreme version of behaviorism, the nurture position is the idea that nothing is predisposed and individual behavior is shaped as a result of experiences. Even though this extreme point of view was abandoned (Öhman & Mineka, 2001), CBT stresses the importance learning experiences and the here and now. This implies that behaviors in psychopathology are developed through the same laws of learning that influence the development of all behavior.

In the 1920s Pavlov started to research conditioning and associative learning in dogs. In short, he posited that classical conditioning happens when a neutral stimulus (e.g. a tone) acquires meaning after repeatedly being paired with a stimulus that elicits a spontaneous biological reaction (Unconditioned stimulus—UCS/Unconditioned Reaction—UCR, e.g. food and salivation reaction). If the association is well established, the neutral stimulus becomes conditioned (Conditioned Stimulus—CS) and will elicit the same biological reaction (Conditioned Reaction—CR, e.g. salivation reflex) without the appearance of the actual cue that originally elicited the biological reaction (the food). Building on this basic learning idea in dogs, Pavlov was the first to link general associative learning to psychopathology. By requiring dogs to make difficult sensory discriminations, when the result was them not receiving food that they were expecting, Pavlov's dogs engaged in new (aggressive) behaviors, like barking, agitation, biting the equipment; Pavlov described this as 'experimental neuroses' (Pavlov, 1928). Around the same time Watson and Rayner (1920) introduced the term 'conditioned

emotional reaction'. They described a case of an 11-month old infant, Albert B. (Little Albert), who arguably became the most well-known baby in psychological science. In the first phase of the experiment, Watson and Rayner presented a rat to the infant, and he didn't show any fear reaction. The rat was considered a neutral stimulus. In a second phase of the experiment, touching the rat was paired with a loud noise, an aversive reinforcer. After a few pairings, Little Albert, who at first did not show any anxiety reaction when white animals with fur were presented to him, became upset and anxious when he was exposed to any stimulus that resembled the rat, like a rabbit, a white beard, a dog, a fur coat, a Santa Claus mask, etc. Watson and Rayner concluded that fear can be learned and that conditioning plays an important role in developing fear reactions. They also learned that conditioned reactions can disappear if they are not continually reinforced by the consequence, which resulted in a process called extinction. This idea was adopted and implemented by Mary Cover Jones to treat children with phobia's. Until now, almost 100 years later, these conditioning procedures are used to study new forms of CBT treatments (Craske, Hermans, & Vansteenwegen, 2006; Hofmann, 2008).

Apart from classical conditioning, defined as a procedure that involves reflexive responses, Watson's ideas (1913) that the science of human behavior had to be based on observable events and the relationships among those events, influenced the work of Skinner and colleagues. Based on Thorndike's Law of Effect, Skinner described the process of operant conditioning (Hermans, Eelen, & Orlemans, 2007; Skinner, 1948). This type of learning happens when an organism's initially random behavior increases or decreases based on a reward or punishment that follows the behavior. Thus, behavior changes as a function of the consequence of the behavior and becomes controlled by its reinforcement. The first experiments were done with animals; for example, a rat can learn that a light predicts food if it pushes a lever or a dog can learn that it can escape a shock by jumping to the other side of the cage. Skinner even made pigeons play Ping-Pong by reinforcing successive approximations to a final set of behaviors. Every time the pigeon moved towards the Ping-Pong ball, he was reinforced by a food pellet, which resulted in the ability to play Ping-Pong; this process is known as *shaping*. Another type of conditioning that is relevant for the current understanding of behavior and psychopathology is *vicarious conditioning* (Bandura, Ross, & Ross, 1963). The main idea in various conditioning is that all behavior (adaptive and non-adaptive) can be learned by observation.

Although conditioning is incomplete in the conceptualization of psychopathology, classical and operant conditioning is still very relevant in behavioral assessment and for understanding the maintenance of psychopathology. The fundamental research of stimulus (over)generalization, modeling, and other forms of learning, still influences the current clinical case conceptualization and popular therapy techniques. In summary, learning psychology substantially contributed (and still is contributing) to the current and widely used treatments of (cognitive) behavior therapy (Craske et al., 2006; Hofmann, 2008).

Disappointed in the outcomes of psychoanalysis and inspired by learning psychological principles, Wolpe (1961) created systematic desensitization, a new technique to treat people with anxiety. This technique was not that different from Watson and Jones'

approach to the children that suffered from phobia's in the 1920s, but times had changed, and the 1960s allowed more room for new therapy approaches besides psychoanalysis. With the founding father, Wolpe, as their supervisor, Rachman and Eysenck disseminated the new therapy approach in the United States and United Kingdom, respectively (Eelen & Vervliet, 2006; Eysenck & Rachman, 1965; Rachman, 1967).

Behavior therapy is often misperceived as a set of techniques that therapists apply to reduce symptoms without any knowledge of the problems that a client is presenting. This interpretation is vastly incorrect; behavior therapy is influenced by the empirical tradition and uses the empirical cycle to approach a client's problem: collecting information, making (behavioral) assessments, creating hypotheses, applying therapy techniques, and evaluating the results of treatment followed by a feedback loop in case the results are not as expected (Hermans et al., 2007). So, before applying behavior therapeutic techniques, a behavior therapist starts with a thorough behavioral assessment in order to make a case conceptualization and a functional analysis. The analysis entails the following questions: what is the problematic behavior, what maintains the problematic behavior, what is the frequency of the behavior, and in what contexts does the behavior appear or disappear. Attention is focused on the learning history using (semi)structured interviews and objective behavioral measures. Clients are asked to monitor their problematic behaviors, their antecedents and consequences. Nowadays there is more of an integration of cognitions in functional analysis, but behavior therapists initially only made the distinction between the stimulus (what triggers the behavior), the organism (reactions that are triggered in the organism, like emotions, cognitions or physiological sensations), the response (the overt behavior) and the consequence of the behavior (different types of reinforcement). The functional analysis investigates how the function of a behavior serves the person. For example, if someone takes the stairs instead of going into an elevator, it is possible that this person is apprehensive to be stuck in an enclosed place, but it is also possible that this person wants to be healthy and exercise more. In the first case, it would be appropriate to teach the person to respond differently to the anxiety for enclosed places; in the latter case, it is likely healthy behavior that a therapist wants to encourage. Therefore, it is important to identify the different functions of a particular behavior as it defines the techniques that will be applied in further treatment. In behavior therapy, evaluation of the therapy outcome is important. The thorough assessments prior to the start of therapy are typically used to create a baseline measurement to evaluate the results of therapy at a later stage or at the end of therapy; this data can show if a client made progress or not.

*Cognitive influence.* In the 1950s–1960s behavior therapy achieved the status of a major treatment beside the preceding psychoanalysis and Rogers' humanistic person-centered therapy (Eelen & Vervliet, 2006). In the meantime, cognitive psychology, with its computer analogies and information processing language, was beginning to influence the field of clinical psychology. From their perspective, behaviorism was too strict. The role of thought processes and mental constructs became appealing for the scientific world, and was soon welcomed as a tool for behavior therapists to work with appraisals, beliefs and attributions that clients presented in therapy. Cognitions were perceived as mediators between contexts and behaviors. Independently from

each other, Ellis (1973) with his Rational Emotive Therapy and Beck (1976) with his cognitive therapy for depression, made the distinction between an Activation event (A), that activates the individual Belief System (B) and results in an (emotional) consequence (C). The basic notion of cognitive therapy is that the cognitive interpretation of a certain event influences emotions and behaviors in reaction to that event, but does not influence the situation itself (Beck, 1995; Hofmann 2016a, 2016b; Hofmann, Asmundson, & Beck, 2013). Cognitive therapists assume that personal schemas (based on their learning history) are underlying constructs that influence how people perceive themselves and the world. Based on these schemata or core beliefs, people have all kinds of automatic (irrational) thoughts in specific situations, which often confirm their underlying schema (Beck, 1995). For example: if a group of peers continues to talk with each other when a person with social anxiety enters a room, it is likely that this person interprets this behavior of the group (not talking to him) as a confirmation that those people are not interested in him. He would likely draw the conclusion that this is as a sign that he is boring, and therefore, that people are not interested in conversing him. Cognitive therapists use techniques like Socratic dialogue and behavioral exercises to identify thought distortions and to change thought processes because they assume that changing the irrationality of these thoughts will change the emotional responses as a result. Certain sets of self-defeating thoughts were identified for particular disorders; this has been called the cognitive specificity hypothesis and helps in conceptualizing specific disorders and their treatments (Beck, 1976; Hofmann et al., 2013). Later in this chapter we will expand on the therapy technique of cognitive restructuring.

More recently an interesting contribution was made from the theoretical models of cognitive psychology. Unconscious cognitive processes like attentional bias, priming and subliminal perception can be used to measure implicit attitudes (De Houwer, Teige-Mocigemba, Spruyt, & Moors, 2009). The advantage of these measures is that researchers do not have to rely on introspection; people are not asked what they think or feel, rather people's cognitive processes can be measured via behavioral responses on particular tasks. A common example is the emotional Stroop task (Gotlib & McCann, 1984), which is simply an adaptation of the original Stroop task (1935). In the emotional version, the words that are presented are not colors, but are emotionally relevant words. The idea behind this task is that people process emotional relevant words slower, and therefore, show a longer reaction time. This fundamental research has become very popular and shows continued promise as it provides knowledge about cognitive mechanisms that may underlie behaviors and, therefore, may influence future psychotherapies.

Over the years the distinction between behavior therapy and cognitive therapy has faded. CBT is the most extensively researched form of psychotherapy (Hofmann, 2014; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). This empirically supported therapy approach is systematic and goal-oriented. The focus of the intervention lies on current problems and what maintains the symptoms, rather than on the original cause and onset. The majority of the CBTs are described in manuals designed around specific DSM diagnoses (for examples, see Safren, Sprich, Perlman, & Otto,



2005; Barlow & Craske, 2006; Hofmann & Otto, 2008; Gilson, Freeman, Yates, & Morgillo Freeman, 2009; Hope, Heimberg, & Turk, 2010). These manuals provide detailed descriptions about specific disorders, often including an empirical model for case conceptualization and accompanying assessment tools. There is also a detailed description of prescribed interventions and how they have to be conducted in an effective treatment. The treatments are short-term by definition and include a limited number of sessions.

CBT is a problem-oriented approach that aims to alleviate symptoms of psychopathology leading to an improvement in behavioral functioning or a total remission of a psychiatric disorder (Hofmann et al., 2012). The focus lies on problematic behaviors, maladaptive cognitions, and accompanying emotions. More so, goalsetting is an important part of the therapy process (Beck, 1995). In the beginning of therapy, the client and the therapist discuss the client's goals and expectations, delineating concrete observable outcomes that indicate the attainment of each goal. Based on these goals and expectations, a therapy plan is developed and presented to the client.

In CBT, the therapist and the client collaborate together in a transparent way (Hermans et al., 2007). The therapist is viewed as an expert in the therapy techniques and the psychopathology or maladaptive behavior and the client is viewed as an expert in their own life and problem presentation. The salience of this collaborative relation is highlighted in the ongoing monitoring of thoughts, behaviors etc., that clients are asked to do (through homework assignments and exercises in session) and the active role that clients take on during therapy sessions. The CBT therapist plays an educational role as a skill trainer, who can be directive and confronting, but also supportive and empathetic (Kramer, Bernstein, & Phares, 2009). The therapeutic relation is used to create an environment where a client can learn to respond differently to an emotional state in order to decrease problematic symptomatology. Additionally, in newer applications of CBT, like online therapy programs or psycho-educational courses, there is minimal use of the therapeutic relationship.

## ***Techniques***

The following sections aim to describe the therapy techniques that were developed in both behavioral and cognitive therapies because they are often combined and incorporated in CBT together. This is not an all-inclusive list, but an overview of the most commonly used therapy techniques in CBT today.

*Psycho-education.* Cognitive-behavioral therapy usually begins with psycho-education. The main goal of this session is to inform the client about the diagnosis and its cognitive behavioral conceptualization. By providing this information, the therapist aims to increase the client's understanding of the presenting problems in order to increase acceptance (White, 2000). Ideally psycho-education happens in an interactive dialogue with the client; it encourages the client and therapist to reach a mutual understanding of the presenting problems and devise a treatment plan accordingly. This process also typically increases the client's therapy adherence.



*Three component model.* One of the main CBT tools used to break down a patient's emotional experience is the three-component model, which consists of cognitions, behaviors, and physical sensations/feelings (Barlow et al., 2011). The cognitive component represents the thoughts an individual has in response to a particular emotion, e.g. anxiety. In psychopathology, these thoughts are often automatic, distorted and negative. The behavioral component is a description of what a person does (or has the urge to do) when responding to an emotional state. These behaviors are also defined as emotion driven behaviors. The physical component describes the way the body reacts in response to the emotional state. For example, an emotional experience of a person suffering from panic disorder can present as follows: experiencing physical feelings like heart pounding, sweating, and shortness of breath that are accompanied by the thoughts, "If this gets worse I will die of a heart attack, I can't handle this!" A behavioral response to said panic symptoms could then be: refraining from drinking coffee or physical exercise. The three-component model is interactive with each component impacting the other two. There is often a negative influence of one component on another and individuals can get stuck in a vicious cycle of negativity and/or self-destruction. For example, in the panic disorder case, avoidance of exercising (behavior) associates exercising with the thought (cognitive): "Exercising is dangerous; a raise of my heart beat is dangerous", which will increase the anxiety and the accompanying physical sensations, like heart pounding and shortness of breath. In this case, the person with panic disorder can be stuck in high anxiety and high avoidance behavior that maintains and often intensifies the panic disorder (Barlow & Craske, 2006). There are variations of this model; for example, some CBT therapists use the distinction proposed by cognitive psychologists and break the client's experiences up into situations, thoughts, emotions and behaviors (Beck, 2005; Hofmann, 2011; Hofmann et al., 2013).

*Cognitive restructuring.* To understand why cognitive restructuring is a helpful therapy technique, clients must understand the basic assumption that the situation in which we find ourselves does not determine our emotional state, but rather that our thoughts are responsible for our perceived emotional state (Beck, 2005). Thoughts are very influential on the client's mood, behavior and physical feelings. Thoughts happen automatically and, in people with psychopathology, are often distorted, negative, and internalized (Beck, 1967; Hofmann, 2011, 2014). This results in a cascade of maladaptive behavior and negative emotions that reinforces the negative thought process. Cognitive restructuring involves treating thoughts as hypotheses, rather than truths. It aims to challenge clients' thoughts in order to change the emotional state and motivate engagement in behavioral experiments. To identify maladaptive cognitions, therapists encourage clients to use monitoring forms where they can recognize and record their distorted thoughts, behaviors, and emotions during particular situations (Buhrman, Fältenhag, Ström, & Andersson, 2004; Mattila et al., 2010). Based on the data from these monitoring forms, the client's maladaptive thought patterns can be identified and addressed in therapy.

Restructuring is ideally done in a Socratic dialogue so that clients discover for themselves that their thinking is irrational or distorted, and that in-turn, their thinking affects how they behave in certain situations. After identifying concrete negative

thoughts in an objective situation, the therapist challenges the distorted beliefs by questioning the thoughts: e.g. 'Is this thought true?', 'What is actually the worst that can happen?', 'If the worst consequence were to happen, would you be able to cope with it?', 'Do you have evidence for that?' ... Being asked these questions, in a non-judgmental and gentle manner, helps the client adopt a more rational view of the situation and identify conflicting and supporting evidence of their particular assumptions. Through hypothesis testing, cognitive restructuring aims to modify the client's behavior and lets them experience a more realistic perspective about the targeted situation. There are other cognitive techniques with the same objective: listing pros versus cons, creating downward arrows, pie charts and so forth (Dattilio, 2000; O'Donohue & Fisher, 2009). Using these cognitive restructuring techniques in concrete situations helps the clients generalize their conclusions to a broader perspective about the world. Different ways that thoughts can be distorted are outlined in a list of thinking traps such as: catastrophizing, probability overestimation, jumping to conclusions, and mindreading. For a more in-depth list of thinking traps, refer to the work of Greenberger and Padesky (1995). The aim of identifying these patterns of distorted thinking is to automatize a more adaptive way of thinking.

*Behavioral experiments and exposure with response prevention.* Following cognitive restructuring (or independent from it), it is useful for clients to test their hypothesis by engaging in behavioral experiments, i.e. new behavior. Behavioral experiments provide the opportunity to examine the validity of their assumptions and engage in adaptive coping strategies. For example, a person that never expresses his opinion because he is concerned that people will not listen to him is encouraged to share his opinion and observe what happens. Designing behavioral experiments is an idiosyncratic process and needs to be taken with careful consideration (Barlow, 2008; Hofmann & Reinecke, 2010; Vorstenbosch, Newman, & Anthony, 2014).

Behavioral experiments often mean exposing oneself to a feared or highly uncomfortable situation. It is mostly used in the context of anxiety disorders, but in the modern CBT, it has been applied in broader contexts, e.g. experiencing emotions for people with experiential avoidance behavior (Craske & Barlow, 2008), as behavioral activation in depression (Dimidjian, Barrera, Martell, Muñoz, & Lewinsohn, 2011; Lejuez, Hopko, & Hopko, 2001), as cue exposure in addictive behavior (Drummond, Tiffany, Glautier, & Remington, 1995), or even as exposure to cues of a deceased loved one in therapies for complicated grief (Bryant et al., 2014). In short, exposure as a therapy technique for anxiety disorders means confronting clients with a feared stimulus (e.g. situation, image, activity, sensations, etc.) in order to learn that their feared outcome does not happen (no harm) (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014) and that their fear declines as they stay in the situation without attempting to decrease the threat (Foa & Kozak, 1986). Exposure can be conducted in vivo (in the feared situation itself) or imaginal (in client's imagination). For example, a useful in vivo exposure exercise for a client with social anxiety disorder, who is very apprehensive about being judged by others, could be giving a public speech for a large audience. Another example of exposure could be doing a hyperventilation provocation for a client with panic disorder who is afraid of internal sensations like dizziness or shortness of breath. For people with PTSD, a combination of imaginal

exposure (reliving the trauma memory) and in vivo exposure (e.g. revisiting the place where the trauma took place) is indicated (Foa & Rothbaum, 1998). An adequate amount of time in the feared situation is vital so that the client can reach the conclusion that what they expect to happen, in fact does not happen. Starting exposure with the client's most feared situation, or alternatively, gradually building upon a hierarchy of feared situations does not impact the outcome of the exposures as long as the exercises are conducted systematically and repeatedly (Craske et al., 2014). Moreover, in some situations, it is less useful to conduct exposures gradually; for example, for people with the fear of flying, one either gets on the plane or does not. Once one is aboard the plane, it is very difficult to get off. This type of exposure is called *flooding* and can be equally as effective as gradual exposure.

Avoidance behavior is the central target of exposure exercises. Therefore, it is important to include response prevention in conducting exposure exercises. If people engage in exposure to a threat, they should not be able to escape the threat or engage in safety behaviors. The underlying assumption is that escaping or avoiding the threat maintains the anxiety (or maladaptive behavior patterns) (Hofmann & Otto, 2008). Therefore, clients must refrain from all behavior aimed at decreasing the feeling of anxiety or escaping the perceived threat. For example, the person with social anxiety disorder who gives a public speech as an exposure exercise must focus on looking at the audience if looking away makes them feel safer. Similarly, for the person that suffers from panic disorder, it is important to do the hyperventilation provocation without carrying anxiety reducing medication or water. Exposure exercises are designed to give clients the opportunity to learn that they are still able to function despite their anxiety, that their fear is often not as bad as they expect, and that they can tolerate the discomfort elicited by the exposure exercise (Craske et al., 2014).

*Contingency management.* Contingency management is a therapy technique based on operant conditioning. It is used to change maladaptive behavior into desired behavior. Through this technique, adaptive behavior is rewarded and maladaptive behavior is punished (punishments are nowadays less used as positive punishment, e.g. not slapping a child, but rather taking away privileges). Tokens are often used as symbols that can be exchanged for real reinforcers. This form of behavioral analysis aims to change behavior; the challenge of the analysis is to target the correct behavior and to find the most effective reinforcement and punishment. It is commonly used and shown to be effective in treating children with behavioral problems, like ADHD (Dovis, Van der Oord, Wiers, & Prins, 2012) and addictive behaviors (Schumacher et al., 2007). Stimulus control techniques are also necessary to reinforce adaptive behavior in the appropriate context. For example, a child with ADHD has to learn to sit still in class, but can play loudly at the playground to release energy. In a contingency management program, sitting still in class will be reinforced in class, but not at the playground. Certain behavior (sitting still) becomes controlled by a certain stimulus (class context), but is not by another stimulus (playground context). Operant conditioning techniques like shaping (as described above, behavior tendencies reinforced until the goal behavior is achieved) and time-out (removing a child from a desired environment as a punishment) are useful contingency management techniques to change behavior.

*Problem-solving.* Problem-solving is another important skill that is addressed in CBT protocols (Beck, Rush, Shaw, & Emery, 1979; Leahy, Holland, & McGinn, 2012; Nezu, Nezu, & D’Zurilla, 2014). D’Zurilla and Nezu (2010) define problem solving as a self-directed cognitive behavioral process by which a person (or a group of people) attempts to identify or discover effective solutions for specific problems in their everyday life. Although its origins are in behavior modification, the cognitive tradition broadened the scope of its application. Cognitions are used to facilitate feelings of self-control in clients and maximize the generalization and maintenance of behavioral change. When under distress, whether due to anxiety or depression, one’s attention narrows due to a more limited cognitive processing capacity. Therefore, it is very useful to help clients find possible solutions for their problems (Bilsker, Anderson, Samra, Goldner, & Streiner, 2009). Problem solving therapies exist in different forms and are applied to many areas of psychopathology, like depression (Nezu, Nezu, & Perri, 1989), anxiety (Ladouceur, Blais, Freeston, & Dugas, 1998), internalizing and externalizing problems (Kazdin, Esveltd-Dawson, French, & Unis, 1987), etc. By definition, problem solving starts by identifying the formulation of the problem, coming up with alternative solutions, and then generalizing the solutions. Coming up with alternative solutions involves a phase of brainstorming possible solutions and their respective consequences. When a list of all possible solutions has been generated, clients are then encouraged to make a decision and select their solution. The final step is implementing and verifying the solution. Clients are encouraged to observe and evaluate the outcome of their selected solution. It is noteworthy to understand that problem-solving coping is helpful for clients with solvable problems (for example if the problem can be solved by changing one’s behavior or when a person has an influence on the situation). In situations with unsolvable problems that may be ambiguous or uncontrollable (e.g. death of a loved one, chronic pain, etc.), focusing more on emotion regulation and relaxation is a more effective approach (Livneh & Antonak, 1997).

*Relaxation.* Relaxation techniques, like Progressive Muscle Relaxation (PMR), are useful tools to reduce distress and arousal in the body (Barlow, 2008; Day, Eyer, & Thorn, 2014). PMR is the most commonly used technique in CBT manuals. It was created by Jacobson in 1934 and then later adapted by Bernstein and Brokovec to fit Cognitive Behavioral Stress Management (Bernstein & Borkovec, 1973). PMR involves tensing and relaxing various muscle groups, one at a time. Experiencing the difference between tension and relaxation alters the perception of relaxation. There is a sequence of steps (with a number of muscle groups addressed) that must be followed in a specific order to obtain full body relaxation. The end phase of PMR is a conditioned cue (i.e. ‘relax’), which can direct people to relax in just a few moments without tensing the muscles in advance. Relaxation is a skill that needs to be practiced before it becomes automatic, so it can be applied to stressful situations.

*Homework practice.* The systematic practice of a client’s acquired CBT skills and techniques in between sessions (at “home”) is a vital part of effective CBT. By engaging in homework assignments, a client can practice his or her learned skills in daily life and become their own therapist. It encourages clients to generalize the

skills from a therapy context to reality; this is a crucial determinant of their long-term emotional health. Individuals who complete the assigned homework have significantly better outcomes than those who fail to do the homework (Kazantzis, Deane, & Ronan, 2000) or that only focuses on work during sessions (Beutler et al., 2004). Moreover, the more homework that is completed, the better the therapy outcomes (Burns & Spangler, 2000).

## Contemporary CBT

During the last three decades, psychologists have been developing a number of therapies that differ from the traditional CBT described above. Some authors have called this collection of therapies “the third-generation CBT”, or “the third wave” (Hayes, 2004; Öst, 2008). The “first wave” is considered to be behavior therapy developed in reaction to the 1920s unscientific therapy techniques. The first wave’s behavior therapy is characterized by scientifically applied techniques based on learning psychology, with a focus on changing behavior and emotions. The “second wave” (1970–1980) is understood as the addition of cognitions, which shifted the focus from solely behaviors to altering thoughts in order to change problematic behavior. Finally, the third-generation CBT therapies are characterized by several common components: the focus on mindfulness (being in the present moment), acceptance or acknowledgement of inner sensations, behavior change motivated by the focus on client’s values and life goals, interpersonal relationships, etc. (Öst, 2008). In summary, the third wave seems to broaden the attention to psychological, contextual and experiential areas. However, it has been argued that the so-called third wave is not that different from traditional CBT (Hofmann & Asmundson, 2008). In the following section, we describe three examples of therapies developed in this new generation of CBT.

### *Mindfulness-Based Therapy*

Mindfulness is a mental state achieved by focusing one’s awareness on the present moment, acknowledging one’s feelings, thoughts, and bodily sensations, while encouraging openness, curiosity, and acceptance (Bishop et al., 2004; Kabat-Zinn, 2003; Melbourne Academic Mindfulness Interest Group, 2006). Mindfulness differs from traditional CBT in that it does not aim to change thoughts, but encourages clients to perceive thoughts as just thoughts. Therefore, it is not necessary to dig deeper into the content of these creations of the mind, nor to challenge them. Mindfulness originates from Eastern traditions and has been practiced for thousands of years. Mindfulness-Based Therapies (MBTs) integrate the essence of traditional mindfulness practices with contemporary psychological practices in order to improve psychological functioning and wellbeing (Gu, Strauss, Bond, & Cavanagh,

2015). Mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1982) and mindfulness-based cognitive therapy (MBCT; Segal, Williams & Teasdale 2012; 2013) are the most scientifically evaluated and implemented MBTs.

At its core, mindfulness practice assumes that intentional awareness of moment-to-moment cognitive experiences and automatic cognitive processing cannot occur simultaneously. Thus, when practicing mindfulness and experiencing the present moment non-judgmentally and openly, it is more difficult to be affected by stressors or engage in repetitive negative thinking such as worries and ruminations. For example, if a person with depressive thoughts observes his thoughts and sensations in a non-judgemental way, he will not engage in a rumination process about what he could have done differently (and better) in life and then judge himself for any perceived shortcomings. Mindfulness practice is about the willingness to observe inner sensations, acknowledge and return, over and over again, refusing to be led by the mind into the past or the future, always coming back to the immediacy of what is actually being experienced. This mindset aims to increase consciousness and awareness in order to detach from maladaptive cognitive patterns, shift to a more functional model of thinking, improve problem solving, and reach inner peace, harmony, and quality of life. During treatment, clients learn to internalize and develop their own mindfulness practice and discover how to adapt and incorporate learned exercises in ways that best fit personal preferences and needs (Twohig, Widneck, & Crosby, 2013).

## *Acceptance and Commitment Therapy*

Acceptance and Commitment Therapy (ACT) emerged from behavior therapy and was developed by Steven Hayes (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Pistorello, & Levin, 2012; Hayes & Wilson, 1994). With Relational Frame Theory (RFT) as its theoretical background (Hayes, Strosahl, & Wilson, 1999), ACT highlights the ways that language (represented through thoughts) traps clients into attempts to wage war against their internal lives. Thus, the goal of ACT is to help clients consistently choose to pursue their values in the presence of difficult or disruptive “private” (cognitive or psychological) events. ACT uses acceptance and mindfulness strategies to promote behavior change compatible with personal values and to increase psychological flexibility. Hayes and colleagues define a person’s psychological flexibility as their ability to make contact with inner experience in the present moment and, given the possibilities involved in that particular moment, engage in value based and goal oriented behavior. Unlike traditional CBT, ACT does not aim to identify and correct cognitive distortions or regulate physiological sensations. It uses an acceptance-based approach to deal with inner sensations: using techniques like mindfulness (being present), cognitive defusion, and self-as-context where inner sensations happen (instead of fusing with them). Metaphors are often used to present these techniques. Commitment to value based action is



important in the pursuit of a person's life goals and results often in skill-development, goal-setting, exposures etc. (Hayes et al., 1999).

Findings indicate that ACT is more effective than treatment as usual or a placebo. It has been found to be beneficial in treating substance abuse, psychosis, anxiety, depression, OCD, chronic pain, burnout at work and eating disorders (For review and meta-analysis see Hayes et al., 2006, 2012).

## ***Dialectical Behavioral Therapy***

Originally Dialectical Behavior Therapy (DBT) was developed by Linehan (Linehan, Heard, & Armstrong, 1993) for borderline personality disorders, especially for people with high suicidality. This approach is the gold standard for borderline personality disorder and has been shown to be effective for substance abuse (Dimeff & Linehan, 2008), eating disorders (Safer, Robinson, & Jo, 2010), ADHD (Hirvikoski et al., 2011; Fleming, McMahon, Moran, Peterson, & Dreesen, 2015), depression (Harley, Sprich, Safren, Jacobo, & Fava, 2008; Lynch, Morse, Mendelson, & Robins, 2003), and childhood abuse with trauma and depression (Bradley & Follingstad, 2001). DBT is a skill-based treatment that aims to help people with dysregulated emotions to become more comfortable with their daily emotional, cognitive, behavioral and interpersonal patterns. The core of the treatment is the dialectical approach (two concepts that seem to be opposite are ultimately connected and can co-exist at the same time). The overarching dialectical dimension takes into consideration acceptance in one way and change in another. Clients are encouraged to accept who they are and their current situation, but in the meantime, understand that change is necessary. Other dialectical strategies represent this overall dialect: problem solving versus validation as core strategy; irreverent versus reciprocal as communication style; consultation-to-the-patient versus environmental intervention for case management and interaction style; and integration strategies like dealing with therapy disruptive behavior, suicidal behaviors, ruptures in the therapeutic relationship, and ancillary treatments. The DBT skill training is divided into modules to increase flexibility: mindfulness and distress tolerance are the acceptance based modules; interpersonal effectiveness and emotion regulation are the change based modules.

## ***Support and Critics***

People who seek therapy often have a specific desire to reduce their symptomatology; CBT is a highly attractive method because it is goal oriented and aimed at reducing problematic symptoms. Moreover, because of its skill training approach, CBT can be adapted into different forms and applied to a variety of populations. CBT is also relatively brief and therefore cost-effective for the average consumer.



CBT is the most researched form of therapy, and has been shown to be highly effective. There is a consistent finding that CBT is equally or more effective than other forms of treatment, including medication and other therapies (Butler, Chapman, Forman, & Beck, 2006; Hofmann et al., 2012).

Alongside this great support, some critics argue that the data about the long-term effects of CBT in comparison to other therapy forms are inconsistent (DeRubeis & Crits-Christoph, 1998). In addition, others claim that since the goal of CBT is symptom relief, it ignores other important components of psychotherapy, such as enhanced insight, improved object relations, or increased self-awareness. Moreover, psychoanalytic critics state that cognitive restructuring only replaces old defenses with intellectualization and rationalization defenses, without dealing with the real conflict that underlies the symptoms (Prochaska & Norcross, 2014). These issues are effectively addressed in future developments of CBT, which focus on therapeutic processes of treatments rather than medically-defined disorders (Hayes & Hofmann, 2017).

## **Psychoanalysis and Psychodynamic Therapy**

Psychoanalysis was made famous in the early twentieth century by one of the best-known clinicians of all time, Sigmund Freud. Psychoanalysis is a theory and a method for understanding the development and function of human psychology and emotions (Hersen & Sledge, 2002). Psychoanalysis therapy was the first systematically designed and organized talk therapy for mental disorders. This approach stresses that mental health problems come from unconscious conflicts, desires and psychological defenses against anxiety. Early childhood experiences are highlighted in determining mental health in later life. Freud initially suggested that mental health problems arose from efforts to push inappropriate sexual urges out of conscious awareness (Freud & Breuer, 1895). Later, Freud more generally suggested that psychiatric problems were the result of tension between different parts of the mind. Freud believed that bringing unconscious conflicts into conscious awareness would relieve the stress of the conflict by reducing defensive mechanisms, and help the client to develop insight into the behavior related to the symptoms (Freud, 1920).

### ***Theoretical Foundation***

Freud presented his psychoanalytic theory of personality through different models that aim to explain how the mind is structured (topographic model) and functions (structural model). He argued that human behavior is the result of the interactions among three component of the mind: the id, ego, and super ego, and that it is influenced by unconscious psychological conflicts between those components. Dynamic interactions among these fundamental parts of the mind are thought to progress through five distinct psychosexual stages of development (psychosexual model).

*The topographic model.* In this model Freud described the mind's structure by dividing it into three conscious levels. The consciousness is on the surface and consists of thoughts that are the focus of the attention in a current moment. Then the preconscious consists of all which can be retrieved from memory and accessed by shifting our attention. The third and most significant region is the unconscious; here lies the processes that are the cause of most behavior, including wishes and impulses that do not enter the consciousness. The unconscious cannot be experienced without the use of special therapy techniques. Freud struggled to find a method that would dismantle or dissolve the defenses rather than temporarily lull them, as he believed hypnosis did. Around the turn of the century, he settled on the method of free association, which became the backbone of psychoanalytic technique and will be explained below (Mitchell & Black, 2016).

*The structural model.* According to Freud, the mind has three major parts of functioning: the id, ego and superego. The id operates at an unconscious level according to the pleasure principle and is the source of the sexual and aggressive drives. These two basic drives of the id are continually working in opposite directions. Eros, or life instinct (libido), helps the individual with survival needs; it directs life-sustaining activities such as respiration, eating and sex. In contrast, Thanatos or death instinct, is viewed as a set of destructive forces present in all human beings. When Thanatos is directed outwards onto others, it is expressed as aggression and violence. Finally, the id processes information through the primary process. This process is the unconscious thinking of the id, that strives for a discharge of energy and focus on immediate gratification of instinctual demands and drives. Primary process uses symbols and metaphor, disregards logic, and manifest itself mainly during dreaming, in patients in psychotic states, and in young children (Freud, 1921).

Counterbalancing the id is the superego: the mental agency that incorporates norms from one's parents, family and culture. It develops during early childhood (when the child identifies with the same sex parent) and is responsible for ensuring moral standards of an individual. The superego operates on the morality principle and motivates us to behave in a socially responsible and acceptable manner. The superego also contains the ego ideal, or how one would ultimately like to be. The id and superego are usually in conflict: the id wants to release its urges and drives, while the superego aims to inhibit these drives to direct behavior in a socially appropriate way.

The ego assumes the role of mediating the conflict between the id and the superego. The ego develops from the id during infancy. The ego's goal is to satisfy the demands of the id in a safe and socially acceptable way. In contrast to the id, the ego follows the reality principle as it operates in both the conscious and unconscious mind.

The basic conflict of all human existence is that each element of the psychic apparatus makes demands upon us that are incompatible with the other two. Thus, inner conflict is inevitable and is the source for anxiety or neuroses, which are functional mental disorders. The ego deals with this anxiety by adopting defense mechanisms that keep anxiety away from awareness, which sometimes interferes with functioning. For example, using sublimation can help in transferring unacceptable impulses into socially acceptable expression, but using denial might distort reality (Kramer, Bernstein, & Phares, 2014; Mitchell & Black, 2016).

*The psychosexual stages.* Freud believed that children are born with a libido—a sexual (pleasure) urge. There are a number of stages of childhood, during which the child seeks pleasure from a different ‘object’. The stages—oral, anal, phallic, latency, and genital—represent distinctive patterns of gratifying the basic needs and satisfying the drive for physical pleasure. Freud proposed that if the child experienced sexual frustration in relation to any psychosexual developmental stage, he or she would experience fixation that would create symptoms of anxiety and persist into adulthood as neurosis (Kramer et al., 2014).

## ***Techniques***

According to Freud, when clients understand the real, and often unconscious, reasons they act in maladaptive ways, they will no longer have to continue behaving in such ways. This understanding is accomplished by recognizing one’s inner wishes and conflicts as well as the systematic tracing of how unconscious factors have determined past and present behaviors and affected relations with other people (Freud, 1890, 1910). Thus, the main goals of psychoanalysis therapy are: (1) Intellectual and emotional insight into the underlying causes of the client’s problems; (2) Working through or fully exploring the implications of those insights; (3) Strengthening the ego’s control over the id and the superego. Taken together, the ultimate goal is to reconstruct the client’s personality (Freud, 1919). Reaching these goals takes a lot of time. In the traditional psychoanalytic therapy, clients have 3–5 sessions per week lasting over several years. Thus, the therapy process is very expensive.

In traditional psychoanalysis the therapist is distanced from the client, both physically (e.g. sitting behind the sofa where the client is laying) and interpersonally (e.g. revealing only little about themselves). In more recent variations of this therapy, the therapist and client sit face to face, but the therapist still remains neutral, like a “blank screen”, so the client can project their unconscious attributes and motives onto the therapist. Therapists build the relationship with the clients through empathic responses using reflection of their comments; they use questions and encourage the client to deeply explore his emotions and perceptions (Kramer et al., 2014). Many techniques in psychoanalytic therapy are designed to reveal the nature of unconscious mental processes and conflicts through catharsis and insights.

*Free association.* In this technique clients are asked to say everything that comes to their mind without censoring to meet social norms. The aim of free association is to help patients recover memories and reveal intrapsychic materials that may be repressed because it is too threatening to bring into consciousness. The therapist’s task is to make sense of the emerging pieces that come from the unconscious mind and interpret it for the client (Ursano, Sonnenberg, & Lazar, 2004).

*Analysis of transference and countertransference.* According to Freud (1912), transference reactions are distortions in the client’s reactions to the therapist. The client brings an unconsciously maladaptive pattern of relating into therapy, which

originate from meaningful figures in his or her life, such as parents. These pervasive and maladaptive patterns determine the way the clients react in other relationships, including their relationship with the therapist. The treatment is designed to reveal and analyze those reactions and eventually change them. Countertransference is a phenomenon in which the therapists project some of their own personal issues and feelings onto the patient. Therapists learn how to deal with those emotions during their training.

*Analytic interpretation.* One of the main techniques in psychoanalysis therapy is suggesting connections between current experience and historically based conflicts to the client. Interpretation is a way of pointing out how the past intrudes on the present. Interpretations can occur during the transference process, through resistance the client might have or feel in session, or through every day behaviors or dreams.

*Analysis of dreams.* Psychoanalysis views dreams as a way to disclose the unconscious ideas and impulses. According to Freud (1900), the content of one's dreams is a symbol of something else, and for each person it can symbolize different impulses or emotions. The patient's dreams may also be considered, as well as his or her ability to think about dreams, as a vehicle for understanding how his or her mind works (Ursano et al., 2004).

## ***Psychodynamic Therapy***

Psychoanalysis is still practiced today, but many theorists have advocated changes in Freudian psychoanalysis to employ a related set of new approaches referred to as psychodynamic psychotherapy. The essence of psychodynamic therapy is exploring those aspects of self that are not fully known or understood, especially as they are manifested and potentially influenced in the therapeutic relationship. Conflicts and unconscious processes are still emphasized in each of the psychodynamic methods with efforts made to identify defense mechanisms and hidden emotions, consistent with psychoanalysis therapy. However, psychodynamic therapists use an eclectic mixture of tactics, with a more social and interpersonal focus, that provides more flexibility between interpreting and delivering empathy and emotional support. They involve less emphasis on sexual and aggressive id-impulses, and give more attention to adaptive functioning of the ego and to close relationships. The focus is more on current experience than on childhood and past experiences (Lewis, Dennerstein, & Gibbs, 2008).

Psychodynamic therapy involves less frequent meetings and may be considerably briefer than psychoanalysis proper. Session frequency is typically once or twice per week, and the treatment may be either time limited or open ended. In the late 1970s, short-term psychodynamic approaches were developed (Malan, 1980; Sifneos, 1979; for more details, see Coren, 2001). These approaches were defined as an explicitly time-limited and focused therapy that works by making people aware of emotions,

thoughts and problems with communication/relationships that are related to past and recent trauma (Lewis et al., 2008). Short-term psychodynamic psychotherapy proved to be an effective treatment in some psychiatric disorders (e.g. panic disorder), but less in others (e.g. eating disorders). Larger studies of higher quality and with specific diagnoses are warranted.

The psychodynamic approaches that emerged from psychoanalysis range from minor modifications to comprehensive denunciation of certain fundamental principles of the original theory.

*Analytical psychology.* Emphasizes the importance of the individual psyche and the personal quest for wholeness. Introduced the concept of the collective unconscious that is stored deep in individual memories and passed down from generation to generation (Jung, 1931).

*Individual Psychology.* Focuses on the feeling of inferiority and the striving for superiority. The current life of the client is the central focus of this treatment, with the past experiences still taken into account (Adler, 1916).

*Ego Psychology.* Behavior is determined mostly by the ego, and not by the id. Treatment aims to strengthen the ego so it can better execute reality-testing, impulse-control, judgment, affect tolerance etc. (Erikson, 1964; Freud, 1937; Hartmann & Rapaport, 1958).

*Object Relation.* Emphasizes the interpersonal relationships that are built early in life. The infant-caregiver relationship is the prototype for later relationships. The therapeutic relationship tries to compensate for the missing parts in the early dyadic relationship and gives the client a new experience of a closer and caring relationship (Fairbairn & Ronald, 1954; Klein, 1935; Mahler, 1952; Winnicott, 1953).

*Self-psychology.* The self is the core of an individual's psychology. Its development is correlated with the environment. Treatment focuses on empathy toward the client and the exploration of fundamental components of healthy development and growth of the self (Kohut, 1971).

*Relational Psychology.* The focus is on the relationships the client has in his life, especially with caretakers. In the therapeutic relationship, they emphasize the therapist's subjectivity, which also influences the therapy process (Mitchell, 1993; Stern, 2004).

## ***Support and Critics***

The main criticism of psychoanalysis is that it is neither scientifically based nor empirically supported. Nonetheless, a significant fraction of the medical community continues to promote it. Some authors have even built their careers on publishing low-quality meta-analytic reviews in prestigious medical journals by summarizing outdated and poorly conducted single studies in an attempt to demonstrate the effectiveness of psychoanalysis. Unfortunately, much of this controversy is more politically than scientifically motivated. For a current summary of this

debate, see Leichsenring et al. (2015) and Hofmann (2016a, 2016b) in <https://www.ncbi.nlm.nih.gov/pubmed/26303562/#comments>).

## Humanistic and Person-Centered Therapy

The humanistic approach views people as responsible for their lives and actions. In other words, individuals themselves have the freedom and necessary willpower to change their attitudes and behavior. The main psychotherapy that was developed from this approach is a non-directive talk therapy established by Carl Rogers; this approach was called person-centered therapy, and is also known as client-centered or Rogerian therapy (Rogers, 1951). According to Rogers, each person has a tendency to grow and fulfill his or her goals, wishes and desires in life; every person has the potential to grow in a healthy and creative way. For this to happen, a person needs an environment that encourages him/her to be genuine (openness and self-disclosure), accepting (being seen with unconditional positive regard), and empathetic (being listened to and understood). If a person does not have this type of environment (e.g. because of restrictions of parents or society), their capacity to grow might not be fulfilled, and psychopathological symptoms may emerge. Therefore, person-centered therapy centralizes uniqueness, authenticity, striving for appeasement and completion, and acceptance of estranged parts of the person, in order to enable full expression of the personality. This therapy doesn't aim to "cure" people or attempt to help them become "normal," but rather targets personal growth and focuses on improving client's quality of life. Clients are viewed as equals and experts in their own inner world and experiences. Having respect and loyalty for the self are very important as humanistic approach stresses the importance of clients focusing on their immediate and current experiential feelings, as well as the courage a person needs to fully experience his inner world. According to this perspective, the therapeutic relationship is highly important and is characterized by empathy, genuineness and an unconditional positive regard towards the client.

### *Theoretical Foundation*

The core of Rogers' theory is the self, which represents a person's experience and one's set of perceptions and beliefs about oneself. It is influenced by values, images, memories, behaviors and current experiences. The self consists of two parts: the real-self (self-image) and the ideal-self (i.e. who the person would like to be or believe he should be). People strive for greater harmony between the real-self and the ideal-self, which results in a more congruent self and a higher sense of self-worth. The overlap between the real self and the ideal self is represented in the degree to which a person reaches 'self-actualization'. According to Rogers, humans have one basic motive: the tendency to self-actualize, or to fulfill one's potential and

achieve the highest level of functioning. This self-actualization occurs when a person's ideal self is congruent with their real-self.

The self develops in the context of relationships with others, with special attention drawn to the parental relationship. While a person is growing up, he or she realizes which behaviors and self-experiences are encouraged and which aren't. If a child grows up with unconditional positive-regard/unconditional-love, meaning that all of their experiences are accepted by others, they recognize these experiences as part of their real-self. Being valued by others results in a sense of self-worth. On the other hand, if a child experiences rejection or disapproval, and love is only provided under certain conditions when behavior is approved by others, the child will internalize this as conditional self-worth. Understandably, conditional self-worth indicates incongruence between the real-self and ideal-self. Personal growth will then typically be hindered and susceptibility to mental disorders increases (Rogers, 1951, 1959).

By increasing the client's awareness of his or her current experience, person-centered therapy aims to help clients grow authentically in order to experience complete self-actualization. The therapist must create conditions in which clients can discover their self-worth, feel comfortable exploring their identity, and alter behavior to better reflect their identity. Thus, the therapist's goal is to provide the client with a therapeutic relationship that is based on unconditional positive regard and acceptance.

Rogers believed that all people have the potential to change. Therefore, the role of therapists is to foster self-understanding and create an environment where adaptive change is most likely to occur (Rogers, 1951). Therapists who correctly follow this approach assume a non-directive role, and make few interpretations and interjections during therapy. They do not try to change patients' thoughts or behaviors directly or raise topics of discussion. Rather, they use the therapeutic relationship as a platform for personal growth in an atmosphere of unconditional acceptance, genuineness, and warmth. This gives the client a chance to develop self-actualization without interrupting the self.

## ***Therapy Techniques***

Because of the extremely non-directive attitude from the therapist towards client's self-discovery, therapy sessions are fairly unstructured. This creates an environment free of approval or disapproval, where clients come to appreciate their own values and behave in ways that are consistent with their own identity.

In order to help clients to grow and reach self-actualization, the therapist uses three interrelated attitudes: (1) unconditional positive regard: by listening to the client, accepting them, and trusting their ability to grow, the therapist makes the client feel valued and free to be as they wish to be; (2) empathy: using reflection to view the world through the client's eyes and help the client feel more understood. Reflection is a process in which the therapist continually restates what the client has said and therefore shows complete acceptance. This allows the client to recognize



their negative feelings; (3) congruence: the therapist earns the client's trust by being honest and consistent with his or her reactions.

## ***Support and Critics***

Person-centered therapy can be highly attractive to clients as they tend to find the supportive, flexible environment of this approach very rewarding. Research on Rogers's core conditions emphasizes the importance of empathy, unconditional positive regard, and congruence to promote progress in therapy. Even though relatively few therapists today describe themselves as primarily person-centered in their orientation, the principles of this approach permeate the practice of many, if not most therapists. Various schools of psychotherapy are increasingly recognizing the importance of the therapeutic relationship as a means to therapeutic change (Kirschenbaum & Jourdan, 2005). The main disadvantage of person-center therapy is that the empirical findings on its effectiveness are inconsistent. This is possibly because the treatment is primarily based on *unspecific treatment factors* (e.g., establishing a good relationship with the patient) without considering *specific treatment factors* to directly target mental problems (Cuijpers et al., 2012; Friedli, King, Lloyd, & Horder, 1997). Further research is necessary to evaluate its utility as a therapeutic approach.

## **Systemic Therapy**

Systemic approaches were developed in the United States of America in the 1950s. After World War II research began focusing more on groups and communities and interactions within them. One of the most influential researchers during this period was anthropologist Gregory Bateson, who together with Jay Haley, John Weakland, and Donald Jackson (Bateson, Jackson, Haley, & Weakland, 1962), studied patterns of family interactions, which laid the groundwork for family-based treatment. This approach eschewed the traditional focus on individual psychology and instead emphasized that individuals should be understood within their social context.

With influences from the General Systems Theory in biology and physiology as well as cybernetics in computer sciences, systemic psychotherapy began to view the individual as a part of a bigger system. A system is defined as a set of units that stand in a consistent relationship with one another. When applied to systemic psychotherapy, a system could be a family, a partner relationship, or even a close-knit community. For a system to function effectively, it requires methods and rules to maintain stability. However, a system must also be dynamic and allow movements inside and among its units/members. Thus, a system needs to have balanced boundaries between its members where individual members know their differentiating roles (e.g., a child and a parent), but can communicate openly to relay and

receive information. Together, these components help maintain a flexible and malleable dynamic in the system.

Nowadays systemic therapy is synonymous with relation or family therapy. The family (or partner relationship) is considered the system and one family member (or one partner) is considered one unit of that system. The independent units are tied together either biologically, emotionally, legally, historically, or geographically (Carr, 2009). The different units within a system are interdependent and connected via positive and negative feedback loops. In essence, if one member of the system is not functioning well, the entire system is affected. On the other hand, one member of the system can also strengthen the entire system. According to systemic therapy, problems in humans originate from interpersonal difficulties. So, in order to understand an individual, the relationships around him or her also have to be examined (Prochaska & Norcross, 2014).

There are several different schools of therapy that utilize the systemic approach. Each type of systemic therapy has its unique way of conceptualizing problems and developing a treatment plan in support of the therapy goals.

*Structural therapy.* Was developed by Salvador Minuchin (1974) and Minuchin and Fishman (1981). As its name suggests, instead of focusing on the pathological symptoms of a person (unit in a system), structural therapy targets the structure of the system. Alleviating the problems in family relationships will in-turn relieve the symptoms of one or more of its members. Balancing stability and flexibility in relationships (alliances, coalitions, hierarchies, generation conflicts, etc.) is important to reduce the pathological symptoms in one (or more) of the members. For example, if a child experiences frequent tantrums, structural therapy will examine the structure of the family to solve any inter-relational problems and reduce or completely eliminate the child's tantrums.

*Communication/Strategic therapy.* Jay Haley and Watzlawick are important figures in Communication/Strategic therapy, which observes patterns of communication within the system. Strategic therapy adds communication theory to the systemic therapy. Watzlawick, Beavin, and Jackson (2011) described a number of ground rules for communication in systems. According to this orientation, members of a system can only be understood if the rules and processes within their system are transparent and well-communicated. If communication patterns are not clear, ambiguity is likely to lead to psychopathology.

*Intergenerational/Bowen family therapy.* This approach was developed by Murray Bowen (1978), one of the family therapy's founders. Bowen's approach observes family behaviors through the lens of intergeneration. According to him, a family's history shapes the values, thoughts, and experiences of each generation, and influences how these values are passed down to the next generation. Thus, each problem in a family is a product of intergenerational developmental processes. In his model Bowen introduced eight interlocking concepts to explain family development and functioning (e.g. differentiation of the self, triangles, the nuclear family emotional process, etc.). One of Bowen's main ideas emphasizes the necessary balance of two forces—togetherness and individuality. An excess of togetherness creates fusion between family members and prevents individuality (i.e. developing the individuals' unique sense of

self). Whereas an excess of individuality results in a distant and estranged family. Thus, an equal balance of togetherness and individuality occurs when individuals differentiate themselves from the family, which means that they have their own opinions and values, but are also emotionally connected to the family.

The goal of systemic therapy is to improve the function of the system by shifting dynamics of current relationships. The therapist aims to increase members' awareness of the function of the system as well as how the system influences and is influenced by each individual.

*Structural* therapists focus on the person within the family context. They aim to help the family conceptualize symptoms as systemic problems rather than individual disorders. Once the alliance is established, the therapist takes a role of a leader that advocates for the benefit of each member against the destructive structure of the system. *Strategic* therapists aim to develop an atmosphere conducive to more congruent and functional communication in the system. The *Bowenian* therapists' role is remain an objective and not emotionally involved member within the system. They act as a model of autonomy, which helps family members understand how they should behave, and they promote awareness of the intergeneration influence, which helps members understand their overarching family dynamic.

## ***Therapy Techniques***

Therapists who are more *structural* in orientation employ activities such as role play in session, and encourage the system's members to engage in particular activities (e.g. ask a mother to talk with her son about a specific topic and come to a decision). This helps the members to experience their reaction with heightened awareness. *Strategic* therapists reflect empathy, caring and congruency to the system's members in order to create an open atmosphere that promotes the communication among the system's members. They also direct members' behaviors and inform members of what to do differently in order to improve the communication. *Bowenian* therapists begin with a family evaluation and a construction of a family genogram to understand and emphasize the intergeneration role in current family behaviors. In addition, they encourage family members to respond with "**I**" statements rather than accusatory statements to increase members' differentiation.

## ***Support and Critics***

Many different studies and meta-analyses found systemic therapy to be effective (Stratton et al., 2015). It is significantly more efficacious than control groups without a psychosocial intervention, and equally or more efficacious than other evidence based interventions (e.g., CBT, family psychoeducation, or antidepressant/neuroleptic medication) (Von Sydow, Beher, Schweitzer, & Retzlaff, 2010). Systemic therapy was found to be efficacious in different age ranges (Retzlaff, Von Sydow,

Beher, Haun, & Schweitzer, 2013), and with different diagnoses, such as affective disorders, eating disorders, substance use disorders, psychosocial factors related to medical conditions, and schizophrenia (Prochaska & Norcross, 2014; Stratton et al., 2015; Von Sydow et al., 2010).

Critics of the systemic therapy claim that this approach is not able to adequately describe an individual's responsibility. For example, if a system member is violent, this treatment would move away from that violent individual and emphasize system interactions, which ignores the morality of this unacceptable behavior (Spronck & Compennolle, 1997). Others think that systemic therapy is over simplified and unable to address more severe psychopathologies, which require more specialized attention. The Bowen therapy was criticized for trying to crossbreed the psychoanalytic approach and the systemic approach in a way that did not effectively emphasize the individual or the system, but instead focused on a vague combination of the two (Prochaska & Norcross, 2014).

## Conclusion

Psychotherapy approaches, methods and techniques have been altered and expanded over the years. Since the beginning of the last century, several schools of thought have emerged for the treatment of mental health problems. In addition to the orientations discussed in this chapter, there are other, less practiced, methods for psychotherapy (e.g., Existential therapy, Gestalt therapy, Interpersonal therapy), that view human nature and the way to change psychopathology through different perspectives.

CBT has the most empirical support, and many therapists conduct therapy according to this therapeutic orientation (Kramer et al., 2014). Recent advances focus on therapeutic processes rather than techniques for DSM-defined syndromes (Hayes & Hofmann, 2017). Other developments in research and technology allow clinicians to disseminate treatments that are effective in treating symptoms of psychopathology. For example, in recent years, treatments delivered through the internet, mobile phones, and computers are increasingly gaining attention and popularity in research and practice (e.g. online CBT, attention/cognitive bias modification, etc.) (Frazier et al., 2016; Price et al., 2016). The primary goal of this dissemination is to reach as many people as possible with effective therapy techniques that can improve people's lives regardless of symptomatology.

Although each psychotherapy approach has its own models and methods, and clinical training typically consists of just one of the many models, today more and more clinicians (between 13 and 42%) identify their own approach as integrative or eclectic. Psychotherapy Integration uses the perspectives and techniques of different schools of psychology rather than rigidly adhering to one. (Norcross & Goldfried, 2005). However, the most important development in the field of psychotherapy is arguably the shift from single therapy schools and DSM-defined treatment approaches toward understanding the processes through which therapeutic change

occurs. This is in line with a general move toward transdiagnostic approaches, as well as personalized and precision medicine. Future research will better allow the field to understand which therapeutic techniques work for which individuals under which context and why. The future of psychotherapy research is likely to gain insight from cognitive, behavioral, social, affective, emotion, and neuro-sciences.

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