

**Eclecticism:
A Book Review of
Current Psychotherapies, 7th Edition
Raymond J. Corsini & Danny Wedding (Eds.), 2005
Belmont, CA: Thomson, Brooks/Cole**

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Table of Contents:

Introduction	3
Psychoanalysis (Freud)	5
Adlerian Psychotherapy	9
Analytic Psychotherapy (Jung)	14
Person-Centered Therapy	19
Rational Emotive Behaviour Therapy (REBT)	22
Behaviour Therapy	25
Cognitive Therapy	27
Existential Psychotherapy	30
Gestalt Therapy	33
Multimodal Therapy (MMT)	39
Family Therapy	43
Psychodrama	48
Experiential Psychotherapy	55
Conclusion	58
References	60

Corsini and Wedding (2005), the editors of *Current Psychotherapies*, put forth thirteen varying modalities for the practice of psychotherapy that are written by the current leading theorists and practitioners within each paradigm. The presentation of each modality is constructed along a straightforward framework whereby each author historically situates her/his theory, outlines the main theoretical concerns, gives an overview of important terms and techniques, and finally supplies an illustrative case study.

Corsini (2005), an editor and the author of the introduction, begins the book by broadly defining the work of psychotherapy as a practice that involves at least two people for the amelioration of distress. To further clarify this definition, Corsini (2005) presents a concise division between counselling and psychotherapy. In contrast to counsellors, whom he suggests work with expertise in specified areas of behaviour, psychotherapists “are generalists who tend to hold a variety of unusual theories or combinations of theories and who may use one or more procedures to try and achieve desired results”(p. 3). The importance of this broadly defined framework for psychotherapists is that it provides a space within which the thirteen different modalities of theory and practice can be presented. Corsini (2005) then invites the reader to explore which paradigms hold a “fit” for the reader/practitioner, suggesting that the person of the therapist (i.e. philosophy of life, personality, etc.) often works in congruence with a particular modality. Thus, Corsini (2005) lays the groundwork for an eclectic vision for the practice of psychotherapy, much like a banquet table from which techniques and models might be freely chosen. In addition, in the last chapter, Wedding (2005) provides a brief overview

of ethical and professional guidelines that all psychotherapists need to be cognizant of, regardless of which psychotherapeutic modality they practice.

While Corsini (2005) provides a boundary for the discussion of psychotherapy, he does not clearly contextualize this book within an intellectual historically situated milieu. Each author of the respective paradigms does a brief overview of how they understand the historical genesis of their own theory; however, this does not provide a well-defined conceptual map for navigating the material as a whole. To bring the book into sharper focus it is important to recognize each paradigm's relation to the canon of psychoanalytic thought. This canon consists of the historical movement of psychoanalytic theory from its beginnings with Freudian Psychoanalysis through its modifications in Ego Psychology, Object Relations, Self Psychology and finally, Intersubjective Psychotherapy (Greenberg & Mitchell, 1983). This canon can be conceptualized as the trunk of the psychological tree. The psychotherapies presented in this book, excluding Freudian Psychoanalysis, are the branches that emerge from this trunk. Some of the branches draw from and expand or modify concepts and techniques from the canon, while others challenge and sever their connection to these roots. Regardless of the nature of each paradigm's response to the canon, a dialogue ensues that holds all of these different perspectives in a loosely knit whole.

For the sake of simplicity, each modality will be discussed separately. Each will be briefly contextualized within the streams of thought that provided their genesis. Then each paradigm's salient concepts involving the nature of psychopathology, mechanisms for therapeutic change, and finally specific therapeutic techniques will be discussed. Additionally, fundamental concepts or terms from each paradigm will be defined

throughout the discussion of each modality. A discussion of the relationships between and among the varying perspectives will not be taken up in this review, nor will an evaluation of the efficacy of any of the paradigms be postulated as it is outside the scope of this paper.

Psychoanalysis (Freud):

Jacob Arlow (2005) writes this chapter on Psychoanalysis. Psychoanalysis, as developed by Freud, grew out of mid-nineteenth century Europe in a context of scientific positivism. It was an intellectual period marked by great advances in both the physical and biological sciences; not the least of which was Darwin's paradigmatic shifting theory on evolution. Within this milieu, psychology was beginning to be established as a scientific discipline in its own right separate from philosophy. Great strides in neurophysiology, neuropathology, chemistry and the application of physics to psychological research deeply impacted this burgeoning field. Another important intellectual stream within psychology was the research and interest in "split consciousness". The French neuropsychiatrists (Jean Charcot, Pierre Janet, Hippolyte Bernheim, and Ambrose Liebault)(p. 19) were studying conditions such as somnambulism, multiple personalities, fugue states and hysteria and hypnotism was their principal tool for this research. Another technique utilized within the therapeutic modalities emerging at that time was the use of free association. It is from this rich soil that the seeds of Psychoanalysis grew.

Freud, considered the Father of psychoanalysis, was trained as a doctor in neurology. Both his medical training and the intellectual, cultural milieu of his time leave deep impressions upon his theorizing. It is important to note too, that the genesis of

Psychoanalysis was an on-going process for Freud and his followers. Over time, Freud revised and extended aspects of his theoretical body of work as he and his followers were met with new and challenging clinical discoveries and observations. To this point, Arlow (2005) places the canon of psychological thought within the purview of Psychoanalysis, citing the revisions brought about by ego psychologists, the object relations school, self-psychology and the intersubjective paradigm. For the sake of clarity, only those contributions considered uniquely Freudian will be considered here.

It is important to note that Freud was fundamentally interested in describing the interconnections between the human psyche and body, a philosophic conundrum predating Descartes' famous claim "I think, therefore I am". Thus, Freud's overall orientation seeks to explain these interconnections of bodily energy (*drives*) and development to psychic events and psychological expression. Furthermore, Freud clearly understood the embeddedness of individuals within societal constellations that met with, and sometimes clashed with these bodily energies.

Psychoanalysis then, finds the cause of psychopathology to be located in unconscious conflicts and compromise formations. These conflicts and compromises are often the result of clashes between inner *drives* (the libido and the death instinct) and the demands of "civilized" society. While this definition of psychopathology appears quite straight forward, the mechanisms at work within the mind that produce conflicts/compromises and the fact that these conflicts/compromises are, to varying degrees, unconscious requires a careful mapping of this apparatus called "mind". Hence, there are a number of basic concepts that structure the investigation of the human psyche. The first of these is the concept of *determinism*. Determinism is the understanding that

“psychological events are casually related to each other and the individual’s past” (p. 15). Another important concept is that of *dynamics*. Dynamics refers to the principle that there are multiple forces acting upon the mind. These forces are sometimes in conflict and sometimes they work together. Regardless they produce psychological effects that are frequently compromise expressions of these varying forces. *Topography*, the third concept, refers to the relationship of psychic elements to levels of awareness. While Freud revised this notion of topography over time, he never changed his assertion that the mind consists of both conscious and unconscious elements. Furthermore, he illuminated many of the mechanisms of the unconscious through his work on dreams, slips of the tongue and jokes. In fact, some might argue that his notions of unconscious dynamics are his most long lasting and fundamental contributions to psychotherapy. Finally, the *genetic* principle asserts that the present with all its thoughts, feelings and behaviours is fundamentally shaped by the past.

In conjunction with the above broad frame work for investigating the psyche, there are three fundamental theoretical constructs that help define Freudian Psychoanalysis. The first involves Freud’s developmental model of the psychosexual stages. Neurosis is frequently the result of unconscious conflicts and compromise formations generated through the unsuccessful passage of a client through one or more of these stages. Arlow (2005) outlines four stages in psychosexual development. They are: the *oral*, *anal*, *phallic* phases and the *latency* period. Each of these phases has particular psychological achievements and developmental tasks that coincide with both biological and social development. Embedded in this developmental model are the other two fundamental theoretical constructs. The first is the *Oedipal complex*. Culminating in the

phallic phase (ages three to six), this complex involves “intense erotic longings for the parent of the opposite sex and a hostile competitive orientation toward the parent of the same sex” (p. 30). These wishes and desires create psychic conflict that are negotiated through any number of defensive and compromise formations. The second construct is that of the tripartite structure of the mind. Freud posits that the mind consists of the *id* (the seat of instinctual drives that are unconscious), the *ego* (the executive of psychological functioning mediating between the *id*, *superego* and reality) and finally the *superego* (the internalized moral rules of the parents or more precisely society). This tripartite structure is another lens for viewing the complex dynamics of conflict management and compromise formation.

The mechanisms of Psychoanalysis involve bringing what is unconscious to consciousness. Freud understood this process as fraught with psychic defenses against such awareness. *Defense mechanisms* can be defined as repetitive, stereotyped, and automatic means to defend against the anxiety produced by the breaking through of unconscious wishes, thoughts, feelings and memories into consciousness (p. 41). Hence, an aspect of Psychoanalytic work involves identifying, dismantling and confronting defensive mechanisms that maintain the psychological “status quo” of the individual. The work further involves the development and working through of what Freud termed *transference*. This phenomenon can be understood as the projection of past conflicts (especially as they relate to relationship configurations of significant people in the client’s past) onto the therapeutic relationship. The therapist’s work then is to demonstrate and bring to consciousness these psychic expressions as belonging to the inner world of the client. Consciously locating these experiences as artifacts of the past

allows for cathartic release and a working through that can redirect the neurotic expression of inner forces.

As stated earlier, the goal of Freudian Psychoanalysis is to bring the unconscious to consciousness. The fundamental techniques for achieving this involve *free association, dream analysis, and interpretation*. Free association is the process whereby without interference or suggestion on the part of the therapist, a client is asked to freely report without criticism or censor whatever comes into her/his mind (p. 32). Dream analysis unearths unconscious wishes (affects and thoughts) that are disguised and distorted from conscious recognition. Finally, interpretation involves the analysis of the transference and the attendant recollections of significant childhood experiences that “consolidates the patient’s insight into conflicts and strengthens his or her conviction concerning the interpretive reconstruction made in the course of treatment” (p. 36). These interpretive reconstructions allow for conscious and mature responsiveness in the present over unconscious reactivity. The work of Psychoanalysis can be a lengthy process characterized by the development, interpretation and working through of transferences. As Arlow (2005) states, “One or two experiences of insight into the nature of one’s conflicts are not sufficient to bring about change. Analysis of transference has to be continued many times and in many different ways” (p. 36).

Adlerian Psychotherapy:

Harold Mosak (2005) authors this chapter on Adlerian Psychotherapy. Adlerian Psychotherapy grew out of the work and theorizing of Alfred Adler. Like Freud, he was trained as a medical doctor and demonstrated an early interest in community outreach by writing a book on the health of industrial workers. In early 1902, Freud took notice of

Adler and invited him into the “inner-circle” of the Wednesday evening discussion circle held in Freud’s home. This invitation was only forthcoming to those deemed loyal to the theory and practice of Freudian Psychoanalysis. In time, Adler even became the president of the Vienna Psychoanalytic Society. Hence, the seeds of Adlerian Psychotherapy began in the soil of psychoanalysis. Adler posits, like Freud, the purposefulness of symptoms and meaning in dreams, as well as sharing a similar deterministic and genetic view of psychic development. However, Adler’s ideas began to diverge in significant ways from Freud and by 1912 the break with the Vienna Society was unavoidable. Freud insisted that Adler’s theories were clearly outside of psychoanalytic thought, thus forcing a schism that led to the creation of the Society for Free Psychoanalytic Research for those sympathetic to Adler’s ideas.

Adlerian Psychotherapy is holistic, sociological, educational and action oriented. This broad framework lends a particular view to conceptions of pathology and the mechanisms and techniques of therapeutic change. The individual is not understood as existing in isolation, rather the individual is seen as firmly embedded in a social and cultural context. Furthermore, the client is understood holistically and therefore common polarities found within other modalities (conscious/unconscious, mind/body, etc) become meaningless except as subjective experiences of the client. Rather than viewing neurosis as sickness, Adlerians understand it as *discouragement* from full social engagement. Neurosis is an issue of motivation and/or fear of the inevitable risks involved in meeting and achieving *life tasks*. These tasks or goals involve the attribution of value and meaning to life. According to Adler, the greatest human value is *Gemeinschaftsgefühl* or social interest. Hence, his conception of pathology flows from a belief in the fundamental social

nature of humanity. Therefore, engagement in activities that promote the common welfare of society is a hallmark of mental health. Discouragement is a problematic of cognitive organization and thus the work of therapy is largely re-educative.

To further clarify the Adlerian perspective on discouragement it is helpful to examine his concepts of *life-style*, *inferiority complex*, *basic mistakes*, and *the family constellation* as they impact psychological development and functioning. Life-style is the cognitive map or lens through which a person interprets her or his experiences. Adlerians suggest that life-style is composed of four convictions drawn from the biased apperceptions of the individual. These four convictions are: *self-concept* (convictions about who self is), *self-ideal* (convictions about who self ought to be), *weltbild* (convictions about the not-self, or world and its demands) and finally *ethical convictions* (ideas of personal right and wrong). Discrepancies between any of these convictions, i.e. between one's self-concept and one's self-ideal for example, lead to feelings of inferiority. While feelings of inferiority are normal for everyone, people who act as if and behave as though they are, in fact, inferior have what Adlerians refer to as an *inferiority complex*. An inferiority complex is synonymous with discouragement because it interferes with the courage and flexibility needed for full engagement with life and society. As Wolfe (as cited in Mosak, 2005) suggests, "The psychologically healthy or normal individual has developed social interest and is willing to commit to life and the life tasks without evasion, excuses, or 'side shows'"(p. 66).

The discrepancies discussed above are often the product of *basic mistakes*. Basic mistakes are "myths" that a client confuses with "truth". These myths become a personal mythology that clients use to structure their lives and behaviour. The basic mistakes can

take the form of *overgeneralizations*, *false or impossible goals of “security”* (e.g. belief in having to please everyone to be happy), *misperceptions of life and its demands* (e.g. belief that life is too hard), *minimization/denial of one’s worth*, and finally, *faulty values* (e.g. belief in survival of the fittest). Life-style and the development of basic mistakes are forged within the *family constellation*. It is a child’s understanding and experience within the particular arrangements within their family and the striving for a significant place inside that family structure, which significantly impact the growth and development of the individual.

The mechanisms for psychotherapeutic change within this paradigm involve an educational, empathic and action oriented thrust. It is a psychology of use, concerned with movement, behaviour and motivation. Insight by the client, as commonly conceived, is not enough. This paradigm views insight as understanding translated into action. The work of the therapist then, involves uncovering the life-style of the client and their basic mistakes and encouraging personal responsibility for these convictions and consequent behavioural change. The Adlerian therapist understands the client as active, creative, self-consistent and responsible for choosing and creating their personalities, affects and destinies and therefore works as a collaborator to facilitate change. This focus on movement, personal responsibility and action lends itself to a present and future oriented perspective. While the past is important for understanding the development of life-style and orientation towards life tasks, it is a client’s expectations about future outcomes that determine present behaviour, feelings and functioning. In light of its emphasis on cognitive “maps”, holism and present movement, the unconscious has little impact upon the therapeutic endeavour.

The techniques of Adlerian therapists involve an empathic therapeutic relationship that focuses on the encouragement of discouraged clients, as well as on cognitive and action-oriented interventions. Encouragement focuses on strengthening faith in self, accentuating positives and building hope. From a cognitive framework, life-style and basic mistakes are illuminated and dialogue ensues about the usefulness or uselessness of such convictions. A therapist may also utilize a number of action-behavioural techniques such as: role-playing, talking to an empty chair, and task setting (simple tasks that are set to encourage and challenge behaviour outside the clinical office).

There are three clinical techniques that are specifically Adlerian. The first is known as *The Question*. This is a diagnostic tool by which the therapist can assess whether the presenting problem is largely psychogenic (meaning social or psychological in origin) or organic (of somatic origin). The therapist asks “If I had a magic wand or a magic pill that would eliminate your symptoms immediately what would be different in your life?”(p. 54). If the answer alludes to changes in behaviour or circumstance (i.e. I would be more outgoing) the symptom is likely psychogenic; however, if the answer refers to the elimination of pain the symptom is most likely organic. Another important Adlerian technique is the behavioural initiative to “*act as if...*”. This involves challenging the client to assume behaviours and attitudes outside the clinical office that she or he does not presently possess. In so doing, the client creates novel experiences that can lead to changes in affect, feelings about self and consequent modifications to convictions and behaviours. Finally, Adler developed the technique of the *antisuggestion*. Premised on the belief that a client can unwittingly reinforce symptoms by fighting them,

the client is encouraged to intend and even increase that which she or he is fighting against (p. 76).

While Adlerian psychotherapy is a modality in its own right, its concepts and techniques have also been subsumed into many other schools of thought. Thus Wilder (as cited in Mosak, 2005) suggests that it is not a question of “whether one is Adlerian but how much of an Adlerian one is”(p. 89). Hence, the length of therapy is dependent upon an individual therapist’s own orientation and theoretical commitment. Nonetheless, the goal of Adlerian psychotherapy is to make the therapist superfluous to the client by encouraging self-reliance and self-sufficiency in releasing social interest and becoming active and cooperative members of society.

Analytic Psychotherapy (Jung):

Claire Douglas (2005) writes this chapter on Analytic Psychotherapy. Carl Gustav Jung is the progenitor of Analytic Psychotherapy. Like Adler he was trained as a medical doctor and invited into Freud’s inner circle of psychoanalysts. Jung himself believed that all psychological theorizing is subjective and thus reflects the personal history of its originator. In light of this, it is worth noting the indelible stamp that his father’s vocation as a country pastor had upon Jung’s later theorizing. While firmly embedded within the scientific milieu of his time, his interests lent themselves to the mystic, symbolic and esoteric. In the early 1900’s Jung was the heir apparent to Freud’s “kingdom”; however, both his mystic leanings and a fundamental divergence on the understanding of libido created a schism between the two men. Freud held that one’s libido is fundamentally a drive related to sexuality, whereas, Jung posited the libido as a generalized energy that moves the individual outward from self. Furthermore, Jung did not view himself as a

student of Freud, but rather a colleague. While he appreciated much of Freud's theorizing, he continued to develop understandings that placed him "outside" psychoanalysis as defined by Freud. Thus, like Adler, Jung met a theoretical impasse with Freudian Psychoanalysis and developed his own unique stream of psychotherapy.

The unique stream of Jungian thought shifts the metapsychological substrate of psychoanalysis. Whereas Freud conceived of the psyche in terms of conflicting elements within a closed energy system consisting of mechanisms that release bodily tensions bringing the system into quiescence, Jung asserts that the individual must be understood as a self-regulating system who strives towards wholeness. While both agree that psychic energy is dynamic, Jung stresses holism as the fundamental quality of mind consisting of a system of balancing and compensatory opposites. This is typified by Jung's utilization of the *mandala* (a geometric figure of concentric organization in which a circle and square lie within each other and are further subdivided there within) as a symbolic representation of wholeness and the personality. Analytic Psychotherapy further stresses the notion that the psyche is made up of spirit, soul and idea. This thrust towards the spiritual incorporates the importance of myth, metaphor and meaning into the therapeutic endeavour.

Psychopathology is conceived of as the product of conflicts brought about by problematics in the early infant-mother dyad and subsequently from the frustrated urge towards wholeness. The focus on wholeness changes the view of pathology from isolated symptoms to *complexes* that engage the entire system. Complexes can be defined as "emotionally charged associations of ideas and feelings that act as magnets to draw a net of imagery, memories, and ideas into their orbit" (p. 97). Like Freud, Jung placed much

emphasis on the work and mechanisms of the unconscious. He also expanded the parameters of the unconscious by subdividing it into the personal unconscious (much like Freud's, but more extensive) and the *collective unconscious*. The collective unconscious is defined as the shared human psychic resource of symbols and *archetypal* images that conform to universal patterns and flow into the personal unconscious. *Archetypes* are dynamic organizing principles that structure energy flow within the psychic apparatus in patterned ways. As Douglas (2005) states, "Jung believed that humans have an inherited predisposition to form their personalities and to view reality according to universal patterns"(p. 97) – these are archetypes. Some examples of archetypal images that Jung illuminated are: the Heroic Quest, the Inner Child, the Maiden, the Mother, the Goddess, the Wise Old Man, and the Wild Man (p. 97). As stated earlier, these archetypes find expression through the personal unconscious and become realized through complexes. The work of psychotherapy then is to bring conscious that which is unconscious and thereby dissipate the "knot" of energy surrounding a complex that draws more psychic energy into its orbit. This process however, does not eliminate complexes necessarily but rather, works to facilitate harmony between conscious and unconscious elements. It is a matter of balancing the whole and creating an expanded sense and knowledge of self. As Douglas (2005) suggests,

The principal aim of psychotherapy is ultimately neither curing nor alleviating patients' unhappiness but increasing patients' self-respect and self-knowledge. A sense of peace and a greater capacity for both suffering and joy can accompany this expanded sense of self. (pp. 110-111)

The mechanisms of therapeutic change involve illuminating complexes and facilitating a balanced appreciation for the wholeness of the psyche. As stated earlier, psychopathology is a function of frustrated urges toward wholeness and thus requires the

integration of all elements of personality into a higher level of development. Jung believed that infants begin in an initial state of wholeness (a unitary Self), which develops into fragmented subsystems. It is the work of psychotherapy to facilitate the return to wholeness. An important aspect to this process involves the dynamic balance between *ego* (the seat of consciousness that includes thoughts, feelings, wants and bodily sensations, which mediates between the unconscious realm and the outer world) and the *personal shadow* (the counterforce of unconsciousness). The personal shadow includes all those elements of the psyche that the ego refuses or denies to develop. These elements can be considered “split off” aspects of the personality which reside in the unconscious and yet produce forces upon the conscious ego. Confronting shadow material then becomes an important therapeutic goal for enlarging the domain and capacity of self.

In line with this conceptualization of wholeness, Jung postulated the ideas of both *Enantiodromia* and *Compensation*. *Enantiodromia* is the law that all things eventually transform into their opposite. As Douglas (2005) states by way of illustration,

Jung liked to tell the story of the man who laughed on the way up a precipitous mountain path and cried on the easy way down. While climbing, he anticipated the effortless descent, but while ambling down, he remembered the difficult ascent he had made. (p. 106)

It is this law that governs the cycles of life and personal development. Through consciousness, one can escape such cycles. Compensation is related to *Enantiodromia* in that Jung posits that the personality holds this dynamic balance between opposites. This is particularly evident between the conscious and unconscious element of the psyche. Thus, that which is held or expressed in conscious life will find its opposite expressed in the unconscious either through dreams, fantasies, or somatic symptoms that break into

conscious life. Rigidly held conscious positions will have equally strong unconscious responses. This returns the work of therapy to integrating both elements within the entire personality.

Another important theoretical construct within Analytic Psychotherapy that flows from the notion of dynamic balance is that of *Typology*. Jung's theory of typology is a binary system describing habitual ways of responding to and interpreting the environment. The first two elements, *introversion/extroversion*, involve the energetic response to the environment. An introvert's energy is directed inward, whereas, an extrovert's energy is focused outward. Four functional elements, *thinking/feeling, sensation/intuition*, involve the processes of perceiving the environment. The principle of wholeness and development "consists of first refining one's predominate type and then cultivating one's less-evolved functions" (p. 106).

The techniques of Analytic Psychotherapy rest on the foundation of a profound encounter of asymmetrical mutuality between the therapist and client. The concept of asymmetrical mutuality implicates the therapist in therapeutic outcomes and thus confers upon her or him a special responsibility towards self-analysis. The therapeutic relationship is typified by empathy, trust, openness and risk and is understood as an essential aspect in tapping into the self-regulating and latent healing capacities within each client. Analytic Psychotherapists follow a four-stage process that includes, confession (a cathartic exploration of a client's past), elucidation (drawing attention to transference, dreams and fantasies as they connect to infantile origins), education (moving insight into responsible action), and finally transformation (a stage of self-realization/actualization beyond symptom relief). Analytic Psychotherapy also uses the

techniques of *dream analysis*, *active imagination* (a form of meditative imagery used to bring forth unconscious material), *body/movement therapy* (the expression of psychological and emotional experiences through movement which can be observed or mirrored by the therapist), *art therapy*, and *sand tray therapy* (another method of expressing unconscious elements through play and creation in a sand tray). Analytic Psychotherapy, with its emphasis on unconscious elements and complexes, tends toward a lengthier therapeutic endeavour.

Person-Centered Therapy:

Carl Rogers and Nathaniel Raskin (2005) both write this chapter. Person-Centered Therapy grew out of the work of Carl Rogers during the 1940's and 1950's. It is largely a phenomenological view of human life arguing that people are organisms who respond to the world as they experience it and the work of the therapist involves engagement in the client's subjectivity. Furthermore, it asserts a fundamental actualizing and formative tendency within each person that can be observed "in the movement toward greater order, complexity and interrelatedness" (p. 131). Thus, health resides in the client and the therapist is a facilitator in activating these latent potentials towards growth and health. This paradigm is infused with a non-directive therapeutic modality. Interestingly, Rogers' academic and theoretical underpinnings are in child guidance and education. These streams, as they were taught then and to a large part even today, support a very directive approach. However, during Rogers' clinical experience, he found that the prescriptive methodology of child guidance was ineffective. He successfully utilized techniques of listening and following the client's lead in the therapeutic moment. It is

from these clinical experiences that Rogers developed his methodology and theory of nondirective therapy.

Rogers asserts that psychopathology is a result of an incongruence between a person's sensory and visceral experiences and her/his self-concept. The *self* or *self-concept* can be defined as the "organized, consistent, conceptual gestalt composed of perceptions of the characteristics of the 'I' or 'me' and the perceptions of the relationships of the 'I' or 'me' to others and to various aspects of life, together with the values attached to these perceptions" (Meador & Rogers, 1984, as cited in Raskin and Rogers, 2005, p. 143). As a person's self-concept clashes with the environmental surround, as she/he experiences it, significant aspects of the environment are denied access to the individual's awareness. The process whereby experiences are brought into awareness is called *symbolization*. These unsymbolized experiences therefore, are not assimilated nor organized into the overall gestalt of the client's self-concept. When this occurs, experiences and conceptions of self become rigid, growth-promoting adaptation fails and psychological tensions develop.

The work of psychotherapy then, involves creating an environmental surround that will promote experiences of congruence through changes in self-concept, fluidity of experiencing, whereby all aspects of the sensory and visceral world can be assimilated into the gestalt of the self, and finally moving the *locus-of-evaluation* from others to self. All of these goals coincide with the organism's own developmental thrust toward actualizing, maintaining and expanding the experiencing self. An important concept relating to psychological health is that of the *organismic valuing process*. Rogers defines this as "an on-going process in which individuals freely rely on the evidence of their own

senses for making value judgments” (p. 144). Thus, the healthy individual responds to the environment in a fluid and more direct fashion as opposed to reacting to the environment based on fixed introjections of the values of others. An underlying premise of this conception of health is that growth moves towards greater independence and autonomy.

The mechanisms for psychotherapeutic change involve three tenets for the therapist who practices Person-Centered Therapy. These tenets are: *empathy*, *unconditional positive regard* and *congruence*. Before defining these tenets, it is important to restate that the therapist’s primary role is to create an environment that engages the latent developmental strivings towards health within the client. This environment is created through the fostering of the three tenets of the psychotherapeutic stance. Empathy refers to a therapeutic stance that seeks to understand the subjective world of the client from “within”. Empathy is active, immediate and continuous. The therapist works to understand the meanings that the client attributes to her/his experiences and demonstrates the willingness to be corrected by the client. Unconditional positive regard involves an attitude of acceptance, warmth, prizing, and nonpossessive caring that is also nonjudgmental. This attitude communicates acceptance of the client in totality – her/his feelings and ways of being in that moment with the therapist. Finally, congruence refers to the therapist’s active participation, reflection and expression of her/his experiences of the therapeutic relationship as it unfolds in the moment with the client. This requires an openness that “flies in the face” of a professional veneer.

Person-Centered Therapy’s orientation toward the provision of a growth-promoting environment by the therapist focuses therapeutic attention on the present

experiences of the client and her/his experience of the therapeutic relationship as it is currently unfolding. Thus, explanations of the past, issues of transference and interpretation in the classical sense are not particularly important. Furthermore, while Rogers held that not all experiences are within immediate awareness, he does not postulate any formal understanding of the unconscious.

The techniques of Person-Centered Therapy largely revolve around the therapeutic stance outlined above. Through the adoption of the three core tenets for the therapist, a constructive process of self-directed change is facilitated. Intensive group work and peace and conflict resolution have successfully utilized such an approach. This paradigm also makes use of play therapy for children. The fundamental technique of Person-Centered Therapy, as stated earlier, is about providing the kind of environment that engages an individual or a group in a process of internally generated growth. Such an approach relies on the premise of trust; trust in the client or group that they contain the innate capability for growth and development and thus can set, monitor and evaluate their own goals. As Rogers defines it, the client-centered therapist respects the unique experience of every individual client and seeks to responsively follow the client's lead and to do nothing that might disempower the self-directing client (p. 131). To this end, decisions about the length of therapy, the goals of therapy, and so forth are determined by each individual client.

Rational Emotive Behaviour Therapy (REBT):

Albert Ellis (2005) authors this chapter on REBT. Albert Ellis developed REBT in the 1950's. The genesis of his ideas are drawn from an Adlerian perspective on pathology which holds that it is not experiences that disturb an individual, but rather it is

the meanings that individuals make from those experiences that disturb the individual. Further, Ellis was influenced by a psychotherapeutic milieu that endorsed an active-directive technique within clinical practice.

As the name of Ellis' therapeutic paradigm suggests, psychopathology is understood as a condition of irrational beliefs that create emotional distress. This follows the *A-B-C's* of human disturbance as originally outlined by Adler. This concept suggests that disturbance is the consequence of a sequential relation between the activating event or adversity (A), the beliefs about the event (B), and the emotional/behavioural consequence of these beliefs (C). Treatment utilizes the same sequence but adds "D" – disputing irrational beliefs. Irrational beliefs are often grandiose and perfectionistic towards oneself, others or the world in general and distort the reality of circumstances. Irrational beliefs are produced *biosocially*, thus they are the product of biological tendencies toward irrational and empirically misleading cognitions as well as a product of social learning. While a client may not be immediately aware of her/his beliefs, REBT does not endorse a formal conception of the unconscious. Additionally, this paradigm is oriented towards the present as the focus of therapeutic work with a particular view towards self-responsibility and choice. In other words, it is the choice of a client to persist in currently held irrational beliefs that perpetuate psychological disturbances and trauma.

Ellis suggests that there are a number of rational-emotive problems that underlie psychological distress. He describes *awfulizing* as the tendency to hold an intolerance towards disappointments, frustrations, and problems within the environmental surround. *Musturbation* refers to irrational beliefs cantered on "shoulds, oughts, and musts" that create affective disturbances because they create perfectionist and rigid expectations of

self, others, and the world. These maladaptive rational-emotive responses towards self, others and the environment lead to self-defeating beliefs and behaviours. REBT replaces these responses with more life-enhancing alternatives that promote the ability to adapt realistically to the social environment.

The mechanisms of psychotherapeutic change involve an adversarial approach and behavioural strategies to defeating client's dysfunctional and illogical beliefs. Thus, the therapist teaches, disputes, encourages, gives homework and continually draws therapeutic attention to ideas rather than feelings. Therapy is more didactic. This more adversarial approach creates a unique tenor to the client/therapist relationship that discourages dependency on the therapist and encourages self-discipline and self-direction.

The technique employed by REBT therapists involves "a rapid-fire, active-directive-persuasive-philosophic methodology"(p. 182). The therapist remains one step ahead of the client so that she/he may quickly pinpoint and illuminate irrational beliefs that maintain pathology. The goal is to encourage self-responsibility for emotional and behavioural responses to the environmental surround. To this end, homework is an invaluable tool for therapeutic change, as the only way to uproot beliefs is to act against them. Frequently, homework involves keeping self-monitoring journals that follow the A-B-C-D's of human disturbance as mentioned earlier. Once the A-B-C-D component is outlined a further step (E), involves setting goals around new philosophies, healthy emotive responses and constructive behavioural changes. REBT works well within a brief therapy framework and is therefore well suited towards cost-effective managed care treatment modalities.

Behaviour Therapy:

Terence Wilson (2005) takes up the discussion of this modality. Behaviour Therapy also emerged during the 1950's through the application of modern learning theory to complex human activities. Both theories of behaviourism and experimental psychology have deeply impacted this paradigm. Behaviourism argues that the only scientifically valid data are those that are immediately observable. Therefore, as cognitive activities fall outside of observable phenomena it is considered beyond the scope of scientific investigation. Experimental psychology, which examines conditioning and learning principles within the laboratory, emphasizes the need for verifiable research and results according to scientific protocols (i.e. validity, reliability, replication of results, generalizability, etc.). It is within this soil of scientific positivism and laboratory research that modern Behaviour Therapy has grown. It is important to note, however, that modern Behaviour Therapy has expanded to include the mediating effects of thought processes on behaviour and thus has been greatly influenced by Bandura (Social-Cognitive Theory) and Beck (Cognitive Therapy).

Modern Behaviour Therapy acknowledges the link between thoughts, feelings and behaviours, but places the emphasis on direct experience as the locus of psychotherapeutic change. Behaviour Therapy utilizes the broad theoretical framework of *classical* and *operant conditioning* as the lens for approaching psychotherapy. In brief, the fundamental assumption of these models is that behaviour is a function of its consequences. Therefore, interrupting behaviour will modify consequences or changing consequences will modify behaviour. Psychopathology then, is seen as maladaptive behaviours that can be targeted through very specific behavioural interventions that are

antecedent to changes of affect and thought. Furthermore, the assessment of clients focuses on present determinants of behaviour within the current environment and develops a systematic breakdown of those determinates into component parts that can be targeted separately.

The mechanisms for psychotherapy, as suggested above, focus on behavioural interventions that produce changes in affect and thought. The techniques employed by Behaviour Therapists are multi-faceted and change is often accomplished through learning strategies that utilize methods of positive or negative reinforcement, homework assignments (especially real-life performance-based techniques and self-monitoring journals), body-based interventions of learned relaxation techniques, assertiveness training, coping-skills training, *exposure treatment* (desensitization to anxiety-provoking events through systematic exposure) and *response prevention* (interrupting behavioural responses to anxiety). There is a strong emphasis on real world activities between therapeutic sessions that is a distinctive feature of this modality. Furthermore, Behaviour Therapy introduces a cognitive-behavioural component that examines beliefs around *self-efficacy*. Self-efficacy “refers to clients’ beliefs that they can cope with formerly feared situations”(p. 222). Through cognitive conditioning and corrective learning experiences, self-efficacy can be improved. The therapeutic relationship is directive and focused on problem solving. To this end, manual-based treatments have been developed which outline specific treatment techniques for specific clinical disorders providing standardized approaches.

Some commonly used techniques utilized by Behaviour therapists involve *imagery-based modalities*, *cognitive restructuring* and *self-control procedures*. It is

worth noting here that Behaviour therapy is often directed at broad-spectrum anxiety disorders and thus many of its therapeutic interventions are tailored to this kind of pathology. Imagery-based techniques involve, as the name suggests, active visualization. It can be used as a method for producing physiological incompatibility to anxiety through visualizing highly stressful events while in a state of deep relaxation. This is repeated until the event can be visualized without producing anxiety. Additionally, visualization can be utilized to produce aversive reactions towards addictive or problematic behaviour. A client is encouraged to imagine unpleasant consequences resulting from the behaviour that they wish to overcome. Cognitive restructuring draws on similar techniques as REBT, however, it often focuses on reducing anxiety through normalizing bodily sensations. Self-control procedures involve self-monitoring and goal setting. Goals are designed to be highly specific, unambiguous, and short-term so that self-control can be accomplished and easily evaluated thus producing positive reinforcement. This form of psychotherapy is often short-term, cost-effective, and easily evaluated because of its concretized treatment outcomes.

Cognitive Therapy:

Aaron Beck and Marjorie Weishaar (2005) write this chapter on Cognitive Therapy. Cognitive Therapy began in the early 1960's as a method of treatment developed by Aaron Beck. Beck was formally trained in Freudian psychoanalysis and through his own research and clinical observation developed numerous assessment scales for psychopathology and cognitive strategies and techniques for dealing with them. His ideas were further influenced by Ellis' REBT and cognitive-behavioural theorists like

Bandura. The approach fits within the “hard” scientific paradigm that values empirical evidence, reason and scientific methodology like hypothesis testing.

Cognitive Therapy defines psychopathology largely as a matter of maladaptive *cognitive schemas* (or biases) that structure experience and therefore produce problematic affects and/or behaviours. These schemas include how a person views themselves, others, their goals, expectations, memories, fantasies and previous learnings. Furthermore, cognitive schemas and *biases* (the “colouring” and selective interpretation of life events through a structured lens) are the product of complex developmental and social learning processes over time. Additionally, individuals have idiosyncratic vulnerabilities or sensitivities that predispose her/him to psychological distress based on temperament and cognitive schemas known as *cognitive vulnerabilities*. *Cognitive distortions* occur during times of psychological distress and are characterized by systematic errors in reasoning. According to Cognitive Therapy, schemas can be consciously changed through reason and the empirical testing of the veracity of such schemas.

The mechanisms for psychotherapeutic change involve a collaborative approach between therapists and client to explore and modify dysfunctional interpretations of experience. The client is understood as a “practical scientist”(p. 239) who actively engages in discovery and hypothesis testing with the therapist in a process of *collaborative empiricism*. Cognitive Therapy examines both present cognitive distortions as well as examining the threads that link the present beliefs to analogous experiences from the past. Beliefs are not considered to be terribly difficult to access and thus there is little attention focused either therapeutically or theoretically on unconscious dynamics or motivations, although therapeutic assistance in recognizing core beliefs and/or

assumptions is needed. Affective engagement is considered important to therapeutic outcomes even as the focus remains on the core beliefs and assumptions that lead to pathology.

A defining characteristic of Cognitive Therapy involves the technique of *Socratic Dialogue*. This is a method of asking carefully designed questions that promote new learnings for the client by clarifying problems, illuminating underlying beliefs and assumptions, discovering the meanings of life events, and demonstrating the problematics of maladaptive thoughts and behaviours. Other therapeutic techniques involve both cognitive and behavioural approaches. Some specific cognitive techniques are *decatastrophizing, reattribution, redefining, and decentering*. Decatastrophizing involves preparing clients for feared consequences through a “what if” technique and the development of coping plans. Reattribution involves suggesting alternative causes of events that depersonalize circumstances and encourages reality testing. Redefining changes the frame of a situation that is believed by the client to be out of her/his control. Finally, decentering is a technique used to assist anxious clients by asking them to consider the logic behind believing that they are the center of everyone’s attention. As with Behaviour Therapy, any of these techniques can utilize active visualization to aid in the therapeutic process.

Cognitive Therapy also uses some behavioural techniques. These include *exposure therapy, role-playing, homework, diversion techniques, activity scheduling, graded task assignments, and hypothesis testing*. As the former three have been discussed previously or are self-evident, only the latter will be defined. Diversion techniques involve encouraging behaviours outside the clinical office that provide outlets

for strong emotions or negative thinking through social and physical activities, work, play, etc. Similarly, activity scheduling creates structure and opportunities for developing feelings of mastery and engagement with the client's own social environment. Graded task assignments encourage clients to engage in behaviours that they would normally avoid beginning with tolerable levels of involvement that gradually increase at the therapist's discretion. Finally, as discussed previously, clients are encouraged to be practical scientists and thus test their underlying beliefs and assumptions through real-world experiences and experiments. All of the above techniques and therapeutic interventions lend themselves to a short-term therapeutic process.

Existential Psychotherapy:

Rollo May and Irvin Yalom (2005) take up the treatment of Existential Psychotherapy in this chapter. Existential Psychotherapy arose during the 1940's and 1950's largely in Europe among practicing psychiatrists and psychotherapists in response to the prevailing modes of therapy of that time such as Freudian, Jungian, behaviourism, and cognitive therapies. Its tendency towards the philosophical places its genesis within the rubric of great philosophers such as Sartre, Kierkegaard and Nietzsche. Within this intellectual stream a cultural critique is levied around the alienation of modern "man" and the need to rediscover "the living person amid the dehumanization of modern culture" (p. 277). Existential Psychotherapy is an orientation towards the client that asks about the "who" that experiences the drives, behaviours, and archetypes put forth by other psychotherapeutic modalities. It is not prescriptive in technique, but rather opens the landscape to an exploration of the deeper meanings of being human. Thus, the

proponents of this form of psychotherapy see it as being absorbed into various schools of psychotherapeutic thought.

Existential Psychotherapy understands psychopathology as the manifestation of defences against the core existential crises of human existence which can create neurotic anxiety (terror) and guilt. These crises or ultimate concerns are: death, freedom (responsibility), isolation, and meaninglessness. It is the confrontation with these ultimate concerns that create inner conflict and provide the textures and nuances of character structure. Each of these core crises hold a deep tension that is negotiated through the therapeutic process so that the client can come to tolerate the inevitable anxiety associated with “being”.

Three fundamental conceptualizations create the frame within which the clinical practice operates. The first of these is the concept of the “*I-Am*” *experience*. This is an allusion to the experience of being. As May and Yalom (2005) suggest, “The human being will be victimized by circumstances and other people until he or she is able to realize ‘I am the one living, experiencing. I choose my own being’”(p. 270). Existential psychotherapy understands this “I-Am” experience as the precursor to therapeutic work.

The next fundamental concept is the recognition that to understand a client one must understand her/his being-in-the-world. To this end, Existential psychotherapy divides the world or environment into three mutually influencing spheres. The first of these spheres is known as *Umwelt* (the “world around), meaning the physical and biological environment. The second sphere is *Mitwelt* (literally, “with-world”), this includes the world of interrelationships with fellow human beings. Finally there is the *Eigenwelt* (“own-world”), which refers to the inner world of the individual where

personal meaning, self-awareness and self-relatedness occur. All three spheres comprise the environment within which a client lives and experiences.

The last fundamental concept involves that of time. From an Existential therapist's perspective, time is infinite and transcendental, captured in the present moment which is continually unfolding and becoming. "Being" is a function of the present moment and a commitment to a future as yet to be unfolded. The present and the future therefore, are the most salient aspects to the therapeutic endeavour. The past is relevant only in so far as it impacts this present moment and can only be understood through the present subjectivity of the client. Hence, time is no longer attached to a linear conceptualization that follows "clock time".

The mechanisms for therapeutic change involve increasing a client's reflective capacities so that she/he may come to terms with and bear the anxiety associated with human existence. Therapy then, is not focused on pain alleviation, but rather on strengthening a client's capacity to face death, isolation, meaninglessness and freedom/responsibility and to hold the tension inherent in all of these aspects of existence. The work of psychotherapy is to uncover how these existential themes "play out" in a person's three worlds. This occurs through *boundary situations* and through a constant reflection upon a client's responsibility in the present for the creation of their own life. Boundary situations can be understood as moments that force a confrontation with one of the four ultimate concerns mentioned previously. For example, being confronted with one's own mortality is a boundary situation that can propel an individual to shift her/his way of being in the world. The therapeutic importance of these boundary

situations is that they provide opportunities to explore the painful and yet inevitable consequences of living.

Personal responsibility and freedom are primary sources for therapeutic change, however, Existential Psychotherapy understands that this source is also an ultimate concern. As such, personal responsibility produces anxiety that can block its utilization. The Existential therapist must both point out instances of responsibility avoidance and facilitate the latent capacities for wishing (desire) and engagement with life that provide a counter-balancing experience to existential crises. It is worth noting that the qualities of wishing and engagement are affect-laden experiences and thus, in affect-blocked individuals the therapist must work to remove such blockages to feeling first. Through the facilitative presence of the therapist a client is assisted in his or her own unfolding – the uncovering of what was there all along (p. 294).

As Existential Psychotherapy is an orientation or sensitivity towards the ultimate concerns of being that weave themselves like themes through a client's life, it does not set forth specific therapeutic techniques. As stated earlier, its founders propose that its broad landscape inform other psychotherapeutic modalities and schools. It is a lens for viewing and interpreting human suffering around specific thematics. It grants a particularly rich view of the struggles that can emerge around the issues pertaining to death. However, its philosophic thrust creates a gap in its application to praxis.

Gestalt Therapy:

Gary Yontef and Lynne Jacobs (2005) are the writers of this paradigm. Gestalt Therapy was developed out of the work of Fritz Perls during the 1950's and 1960's in Frankfurt Germany. Perls was trained both as a medical doctor and in classical

psychoanalysis. Additionally, there was a rich intellectual milieu of existential and phenomenological philosophers, liberal theologians, and psychoanalytic thinkers who were wrestling during that time period with questions of what it means to be human. These streams would weave into the intellectual tapestry of humanistic thought. The impact of this thought on psychology imprinted such ideas as the importance of conscious experience, the body as the container of emotional wisdom and conflict, the importance of active engagement between the therapist and client, and finally the belief in the client as the locus of her/his own health and creativity.

Another important stream of thought that greatly influenced Gestalt Therapy was field theory emerging from Einstein's theory of relativity. Field theory lent the vision of a contextualist understanding of human functioning and existence. Individuals cannot be understood outside of their current field of functioning or in other words, outside of their current environment. In many respects, Gestalt Therapy asserts an ecological view of human life stressing interdependence, subjectivity/relativity, adaptability, emergent properties, and an intensely present focused approach that views the past as relevant only to the extent of how it is held or remembered in the present. Both the humanistic and ecological orientations towards psychology lead to Gestalt's fundamental concept of holism. Holism refers to an understanding of an organism as a self-regulating and growth-oriented entity.

All of the above intellectual streams informed Perls' theorizing and the development of Gestalt therapy. However, it is also important to note that his theorizing was also a response to the dominant therapies of his time – psychoanalysis and behaviourism. Gestalt Therapy posits a process-based postmodern field theory in

response to the mechanistic, reductionistic, Newtonian thrust of both psychoanalysis and behaviourism. To further clarify, Gestalt, while having no literal translation in English, refers to the concept of “a perceptual whole or configuration of experience. People do not perceive in bits and pieces, which are then added up to form an organized perception; instead, they perceive in patterned wholes”(p. 306). It is this organization of perception, of viewing everything as interrelated aspects of an integrated whole that is the overarching theoretical stance of Gestalt Therapy.

Gestalt Therapy understands psychopathology as a problematic involving the lack of awareness of things that are vital, powerful and relevant to the current environmental requirements and responses. Pathology then is an issue of adaptability or in Gestalt terms, creative adjustment. Health then is defined as the ability to identify with one’s on-going moment-by-moment experiencing and allowing this identification to organize one’s responses and behaviour. Thus, the work of therapy is to facilitate expanded awareness within the present moment, especially within the dynamic, unfolding or currently emerging relationship with the therapist, as it is in this present moment that creative adjustment unfolds. It is also important to note that Gestalt therapy posits the primacy of relationship and human relatedness as fundamental components of consciousness or awareness. There is no self without other. Hence, the unfolding, emerging relationship between the therapist and the client are essential aspects to therapeutic change.

Creative adjustment and the importance of relationality are fundamental components to both the theory and practice of Gestalt Therapy. From these building blocks a number of important conceptualizations form such as *disturbances at the boundary* and *figure/ground formation*. Disturbances at the boundary refer to the on-

going and vital movement between connecting and withdrawing from the environmental surround (people, ideas, beliefs, identities, etc.). Rigidity or lack of awareness can create problematics in organismic functioning. Connecting meets organismic needs (socially, psychologically, and biologically), while withdrawal or separation maintains autonomy and protects against harmful intrusion and overload. Issues of awareness lead to problems of disowned or unconscious aspects of the self that prevent adequate environmental responses.

Figure/ground formation refers to the perceptual schemas that create understanding or consciousness. As Yontef and Jacobs (2005) state,

We perceive in unified wholes, and also...through the phenomenon of contrast. A figure of interest forms in contrast to a relatively dull background....one can only perceive one clear figure at a time, although figure and grounds may shift very rapidly. (p. 310)

The implications of this understanding relate to both conceptions of consciousness/unconsciousness and the fluidity of movement within the perceptual frame as a function of creative adjustment and responsive flow to the current field conditions. Those aspects of the current field that remain blocked from awareness (unconscious) lead to pathological responses or inadequate responses to the environmental surround. Furthermore, figures that are poorly differentiated from the ground create problems of confusion and lack of clarity. Hence, the work of Gestalt therapy is to facilitate the fluid movement of figure and ground and promote clarity, responsive flow and creative adjustment to the current field conditions.

The mechanisms for therapeutic change within Gestalt Therapy involve processes that facilitate the expansion of present awareness, promote deepening experiences of interrelatedness, and lead to an ability to respond one's new awareness. These processes

are: *contact, awareness of the awareness process, “what & how; here & now”* and *dialogue*. Contact refers to the relationship between the client and therapist over time. As stated earlier, the therapeutic relationship is a fundamental component to therapeutic change. The awareness of how this relationship unfolds and what is happening in the relationship become aspects to the therapeutic dialogue and experience. Empathy (the ability to enter into a client’s subjective experience, while remaining firmly grounded in one’s own self-experience) is an essential ingredient to the therapeutic alliance.

Awareness of the awareness process (the continuum of flow of awareness) refers to a client’s ability to allow a fully descriptive awareness of the present moment with all its demands, needs, and nuances to emerge and to be able to respond in a relevant way to this emerging field. Through continually calling attention or focus into the present moment this awareness is deepened and developed.

Likewise, “what & how; here & now” refers to the dual focus of what the client does and how the client does it within the context of the here and the now of the therapist/client relationship. Thus, even the past is examined through the lens of its impact on or relation to the present experience of the client. As Yontef and Jacobs (2005) suggest, “Gestalt therapy requires technical work on the patient’s awareness process but at the same time it involves a personal relationship in which careful attention is paid to nuances of what is happening in the contact between therapist and patient” (p. 318).

Dialogue refers to the basis of the therapeutic relationship between client and therapist. It implies a reciprocity of relationship, as the therapist allows the therapeutic relationship to impact and change her/him in the unfolding, emergent qualities of the

interaction. This includes self-disclosure by the therapist with the client at appropriate moments as demanded by the field. Furthermore, dialogue requires a true appreciation of the subjective relevance and importance of the client's experiences of the therapist in the unfolding relationship and moment. Dialogue can enhance a client's sense of efficacy and worthiness.

Gestalt therapists utilize a number of techniques for facilitating psychotherapeutic change. Experimentation is the overarching orientation toward techniques that promotes an open-ended, present focused experience. Clients are encouraged to experiment and share the experience of such experimentation. *Focusing* is the technique that draws the client's awareness into the present moment. While there are numerous ways of achieving this, one common technique is to ask the client "what are you aware of, or experiencing, right here and now" (p. 322). It can also include encouraging clients to remain with painful affects reported in the moment. A corollary to focusing is the therapist's awareness and focus on experiences where the client's awareness is interrupted before it is completed. These are fertile moments of catching the emerging moment and drawing the client's attention to aspects of the field that might otherwise go unnoticed.

Enactment is another technique that involves encouraging a client to experiment with putting feelings or thoughts into action. It can include role-playing, psychodrama, creative expression or the empty-chair technique (speaking to an empty chair as though an actual person were sitting there facing the client). Likewise, *mental experiments*, *imagery* and *guided fantasy* encourage alternative ways of expressing and experiencing present moment happenings. These methods can side-step simple linear verbalization and promote deeper emotional experiencing in the moment.

Deepening *body awareness* is another important technique used by Gestalt therapists. Breathing and breathing patterns are especially important aspects to this technique. Deep, regular and rhythmic breathing supports body awareness and thus centres a person within her/his body and present experiencing. On the other hand, rapid or shallow breathing or holding one's breath are common indicators of anxiety and thus defensive positions that hinder responsiveness to the current field.

Gestalt Therapy's goal for therapeutic change involves enhancing a person's creative adjustment to her/his environmental surround which is accomplished through deepening and expanding her/his present moment awareness. As stated earlier, its roots are in part a response to reductionist models of psychological health and well-being. Therefore, Gestalt Therapy is not satisfied with mere symptom removal and/or adjustment. For this reason, Gestalt Therapy does not fit as well within managed care models of brief therapy.

Multimodal Therapy:

Arnold Lazarus (2005) is the author of this chapter. Multimodal Therapy (MMT) developed out of the work of Arnold Lazarus during the 1950's and 1960's. Lazarus was trained as a clinical psychologist within a climate of classical Freudian psychoanalysis and Rogerian approaches to psychotherapy at a time when these models were also being challenged by new discoveries in experimental psychology in the fields of behaviourism and neo-behaviourism. Like REBT, Behavioural Therapy and Cognitive Therapy, MMT is strongly influenced by the positivistic stance in the laboratories of experimental psychology. Within this milieu of theory and research, there was a plethora of data that suggested that behavioural and cognitive approaches on their own did not provide lasting

solutions to psychopathology. Thus, Lazarus posited a multidimensional perspective that would utilize the strengths of behavioural approaches and combine them with extrabehavioural assessment, treatment procedures and strategies. It is important to note too, that MMT draws on recent research on genetics and the impact of DNA on behaviour and personality and hence, places physiological components within the overall psychological health of the individual. Thus, MMT not only accepts pharmaceutical interventions as part of its therapeutic endeavour, but also includes exercise, hygiene, nutrition and concepts of the physiological substrate of behaviour and personality.

MMT conceptualizes psychopathology as maladaptive behaviours, cognitions or learning deficits in areas of the social and personal repertoires of response and coping strategies. The work then of psychotherapy is to improve adaptation and coping skills. Personality (or psychopathology) stems from the interplay among genetic endowments and the physical and social learning environments. Because problems can arise within and across any of these dimensions of personality, MMT posits the need for an assessment strategy that pinpoints weaknesses and deficits along these differing dimensions and thus provides specific treatment modalities for specific problems.

Assessment and treatment strategies are formed out of the systematic examination of what Lazarus calls a person's *BASIC I.D.* The BASIC I.D. is an acronym that stands for behaviour, affect, sensation, imagery, cognition, interpersonal relationships and drugs/biology. It is the interaction of all these components that make up personality and as such, each one must be assessed and targeted through treatment. The assessment process involves developing a detailed understanding of the excesses and deficits within each component and creating a *structural profile* of the person. For example, is the

presenting issue one of maladaptive behaviours, affective disorders, negative sensations (i.e. tension headaches, troubling bodily sensations), intrusive images (mental images that are disturbing or self-defeating), faulty cognitions, interpersonal difficulties or biological factors? These profiles are often generated via a self-administered test (*Structured Profile Inventory or SPI*) that requires subjective ratings across all seven of the personality/temperament components. People tend to favour some components over others and this becomes the basis for treatment decisions and therapeutic interventions. Thus, both assessment and treatment follow the BASIC I.D. of the client.

Mechanisms for psychotherapeutic change involve developing structural profiles and then implementing specific therapeutic interventions that target weakened areas of the client's BASIC I.D. The fundamental question of the MMT therapists is "what works, for whom, and under which particular circumstances?" (p. 342). This paradigm, like other behavioural and cognitive models relies upon a re-educative model of psychotherapy and is often action oriented. However, unlike the above mentioned therapies, MMT utilizes *bridging* and *tracking* as important therapeutic procedures that create "common ground" between the therapist and client. Bridging refers to the technique of tuning into the client's preferred modality within their BASIC I.D. before engaging other components that may prove to be more productive to therapeutic change. For example, a client may be more comfortable within the cognitive domain and avoid expressions of feelings. Rather than challenging this, the therapist will enter and meet the client in the cognitive domain and then gently lead them into other modalities (i.e. affective expression) that may prove meaningful.

Tracking refers to discovering the “firing order” of the different modalities. In other words, some clients may begin with faulty cognitions (C) that create negative affects (A) and self-defeating imagery (I) which then leads to maladaptive behaviour (B). Others may have a firing order that begins with unpleasant sensory experiences (S) - an accelerated heart rate that is then followed by disturbing images (I) – the image of fainting on the spot, which is followed by faulty cognitions (C) – “I’m going to die” and finally the disturbing affect (A) of a panic attack. Understanding a client’s firing order in any particular situation provides the therapist with specific methods of intervention, whether that is cognitive restructuring or relaxation techniques that can interrupt the maladaptive outcomes of these firing orders.

The techniques of MMT involve procedures that can be utilized within each specific modality of a person’s BASIC I.D.. Within the behaviour modality techniques such as extinction, counter conditioning and positive/negative reinforcement are used. Disturbing affects can be treated through abreaction (the reliving and recounting of painful emotions with a supportive therapist) and the owning and acceptance of feelings. Issues pertaining to sensation are often handled through relaxation techniques and biofeedback. Troubling images are replaced through techniques that facilitate changes in self-image and coping images (imagining future moments of self-efficacy). Faulty cognitions are targeted through cognitive restructuring and expanded awareness. Techniques such as modeling (the therapist becomes a role-model for the client), role-reversal exercises, paradoxical manoeuvres (countering responses that create double-binds) and nonjudgmental acceptance target issues within the interpersonal realm.

Obviously, psychotropic drugs and/or interventions that target nutrition, hygiene or exercise fall within the parameters of the biological modality of personality.

Throughout treatment, re-evaluation of the client's BASIC I.D. and therapeutic goals are important aspects for successful treatment outcomes. MMT, like other behavioural therapies, is goal directed and utilizes the breakdown of psychopathology into its component modalities and thus works toward the symptom relief of specified problematics along the BASIC I.D. As such, MMT is present/future oriented and pragmatic. Thus issues pertaining to the past, the unconscious, and defensive mechanisms are not considered important elements to therapeutic theorizing, interventions and change. Furthermore, because MMT is solution focused on specified problems it lends itself to short-term therapy.

Family Therapy:

Goldenberg & Goldenberg (2005), the authors of this section on Family Therapy, cast a very large net over the theoretical genesis of family systems theory. They include diverse approaches within this paradigm that make clear delineations of its theoretical roots difficult to pinpoint. Some of the modalities included under the rubric of family therapy are: cognitive-behavioural, social constructionist, structural, object relations, and experiential. As each of these has its own rich intellectual history and theoretical impetus, only those intellectual streams that inform a family systems approach will be highlighted here.

Goldenberg & Goldenberg (2005) trace two fundamental theoretical streams that changed the locus of psychological understanding from the individual to the family as the unit of analysis. The first of these streams was growing research during the 1950's on

work with schizophrenic patients. Researchers began to hypothesize that problematic communication patterns and skewed marital and infant-mother relationships provided better insight into the symptomology of schizophrenia than an intrapsychic model of the psychopathology. Thus, schizophrenia was reformulated as an interpersonal phenomenon that had “a sense” or logic of its own when examined within the familial context.

The other important intellectual stream greatly influencing this paradigm was developed during the 1970's and grew out of the application of General Systems theory and cybernetics to families and family communication. General Systems theory challenges the reductionist and linear views of complex phenomena, arguing for theories that account for the interrelationships inherent in complex systems, their interdependence and circular causality. Hence, in this way of thinking, the system is greater than the sum of its parts. Cybernetics examines regulatory systems that work on the basis of feedback loops. Feedback loops are communication or information channels that help maintain dynamic equilibrium through adjustments around a set point. For example, a thermostat cues the furnace to turn on or off to maintain a preset constant temperature. In terms of families, the concepts of cybernetics and General Systems theory provide a lens for examining the functionality of communication patterns, feedback loops and the complex and dynamic patterns of interrelatedness. Thus, both the research with schizophrenics and the application of General Systems theory and cybernetics shifted the view of psychopathology away from individual treatment to that of family therapy.

As stated above, Family Therapy understands psychopathology as the product of the system and not that of the individual. Investigation into pathology then, looks at the

interrelationships between its members and how the system organizes itself. Families have both *structure* (the arrangements, organization, and maintenance over a particular cross-section of time) and *processes* (the way families evolve, adapt, or change over time). These aspects must be examined to inform appropriate interventions within the family as organization and adaptive strategies impact each member in specific ways and the family as a whole in particular ways that are different than how it impacts its members. Nevertheless, no member of the family can be understood in isolation from her/his embeddedness in her/his particular family system. Thus, symptomatic behaviour of one member must be understood as a response to that member's current situation and context within the on-going family transactions.

The mechanism for psychotherapeutic change within this paradigm involves therapeutic interventions that promote the adaptive capacities of the family system and expose where adaptation breaks down. As with all living systems, adaptation is the key to health. Systems that are flexible, open, with clear but permeable boundaries are highly adaptable. On the other hand, systems that are rigid, closed, with either diffuse or impermeable boundaries will struggle to adapt and manifest symptomatic behaviour of "illness".

There are a number of systemic issues or concerns that arise within families that can hinder their adaptive capacities such as: *family rules, family paradigms, pseudomutaulity/pseudohostility, mystification* and *scapegoating*. The first two are concerned with organizational patterns either within the family or between the family and its social environment. The latter three refer to process concerns that demonstrate pathological responses to conflict.

Family rules are the established patterns of interaction. They tend to be expected, persistent, repetitive behavioural sequences that characterize everyday life within the family. Family rules that are rigid and cannot accommodate to changing conditions create dysfunction. Family paradigms are the ways that families perceive, interpret and interact with the social environment. Three common paradigms are *consensus-sensitive* (enmeshed members perceive the world as chaotic and dangerous and insist on consensus from all members), *interpersonal-distance-sensitive* (disengaged members striving for autonomy in the belief that closeness is weakness) and finally, *environmentally sensitive* (interdependent members in an open system that sees the world as knowable and orderly). As with family rules, the pathology of the family is in direct relation to its openness and flexibility.

Pseudomutuality/pseudohostility involve a family's affective communication patterns. Pseudomutuality views individuality as a threat to family wholeness and thus discourages any expressions that do not promote the façade of togetherness. Pseudohostility is similar in that it too, prevents genuine and deep intimacy within the family. However, it accomplishes this through the opposite tactic of constant bickering and quarrelling that prevent any genuine sharing. Because family systems operate and regulate themselves on the basis of communication and information channels, breakdown in these channels creates pathology. Similarly, mystification involves an obscuring of family conflict by befuddling or masking whatever is going on between members. Mystification frequently contradicts one member's perceptions of the situation and in extreme or continuous cases leads to the member questioning their "grip" on reality. Finally, scapegoating also shifts focus from family conflict and places the attention on

one member who is then blamed for whatever problems the family is experiencing. In this respect, it is very close to mystification as it obscures the “real” conflict and pathologizes one member so that family interactive patterns need not be changed nor adapted. Hence, all of these concerns, both organizationally and with process, are areas of therapeutic intervention that can facilitate more adaptive patterns of interrelatedness and communication.

Family Therapy utilizes a number of specific therapeutic techniques to encourage both systemic adaptation and to clarify systemic obstacles to adaptation. These techniques are: *reframing, therapeutic double-binds, enactment, miracle-question, externalization, family sculpting and circular questioning*. Reframing refers to recasting the meaning and motivation of a behaviour into a more positive perspective. It does not deny the facts of a behaviour, it only helps the family understand the behaviour in a new light. Therapeutic double-binds refers to the instruction of a therapist to a family to either continue or exaggerate problematic behaviour with the intention of demonstrating the voluntary nature of symptomatic behaviour. This occurs because either the behaviour will be given up or if it can be exaggerated, the individuals involved must admit its voluntary nature. Enactment refers to the technique of encouraging role-plays of actual family scenarios. As the role-plays occur, the therapist can provide interventions that interrupt and thereby change interactive patterns. The miracle-question involves encouraging active imagining so that goals can be identified and potential solutions revealed. Externalization is the technique of separating symptomatic behaviour from a family member’s identity. Thus, the problem becomes an entity that the entire family can combat, as opposed to pathologizing the family or the individual member. For example,

if mom is depressed, externalization would personify the depression as attacking mom, rather than mom is a depressed person who adversely affects the family. As such, depression becomes the problem not mom. Family sculpting refers to the technique of creating a graphic picture of family arrangements (boundaries, roles, alliances, etc.) through positioning members of the family in physical space. Usually, one member is the director and does this positioning. It is a form of therapeutic intervention that relieves the potential threat to certain members by allowing non-verbal expression of feelings, thoughts and attitudes. Finally, the circular question involves allowing one situation to be viewed through the multiple perspectives of each member of the family by posing the same question to each. All of the above techniques involve interrupting “stuck” patterns of interaction and communication and creating space for alternative views, interaction patterns, and communication. Family Therapy, because of its diverse approaches and techniques can either be brief or extended depending on the nature and complexity of family problems and the differing goals that each therapist and family hope to achieve.

Psychodrama:

Adam Blatner (2005) takes up this discussion of Psychodrama. Psychodrama is a form of psychotherapy originally developed by J. L. Moreno during the mid-1930's. Moreno was trained as a medical doctor in Vienna, however, his avocational interest lay in the theatre. Thus, while pursuing a general practice in medicine after WWI, he simultaneously organized an improvisational theatre troupe. Moreno began to see the therapeutic benefits and uses of improvisational drama and its enactments for the members of his troupe and began to hypothesize about the benefits of both drama and the use of groups for therapeutic outcomes. The impoverishment of postwar Europe lead to

his immigration to the United States where he further developed his ideas about drama, role theory, role-playing and group therapy. Moreno worked and consulted for prisons, reformatories and eventually opened a sanitarium where he implemented his growing ideas and commitments to the power of psychodrama to alleviate the compelling influence or energy of psychotic distress (hallucinations and delusions). He built a specially designed stage for the psychodramas and facilitated the symbolic “living out” of the hallucinations and delusions as a way of neutralizing their psychic influence and force. This “acting out” of psychodrama was in direct contradiction to the strict talk therapy of psychoanalysis that was popularly practiced at that time. According to psychoanalysis, acting out entrenches psychological defences and elevates emotional distress rather than alleviating psychological issues. Moreno demonstrated that with appropriate follow-through, the elevated cathartic release could lead to longer-term positive outcomes. Thus, psychodrama became a useful psychotherapeutic tool primarily for group therapy, but with modification, is utilized in family therapy and with individuals. It is important to note though, that the primary thrust of psychodrama is in group processes, as Moreno believed “in the power of people to be therapeutic agents for each other” (p. 410).

A primary orientation of psychodrama is its belief in the therapeutic benefits of creativity, spontaneity, playfulness, self-expression and physical exuberance and its uses within healthy psychological functioning. In terms of an overarching theory of personality and thus of psychopathology, psychodramatists often draw on other psychological theorizing such as psychoanalysis, analytic psychotherapy, transactional analysis, and so forth. Nevertheless, Moreno does postulate social role theory as a means of

understanding the dynamics that can create psychopathology and the potential solutions found therein through role awareness and creative adaptation, expansion or amelioration of those roles. To this end, the theory of *role dynamics* permits both a theoretical framework and a methodology for therapeutic interventions. Role dynamics suggests that there are two levels of mind in dynamic interplay. Actual roles or parts played by an individual make up the first level and the second level is the *meta-role*. The meta-role is the “role beyond the roles, that special part that determines *how* those roles will be played”(p. 412). The meta-role is the director, if you will, of life’s play. Psychodrama seeks to empower the meta-role through illuminating the interactions between the two levels and through demonstrating the creative power to shift roles, change scenes, improvise different responses, and experiment with different behaviours.

Psychopathology then, is conceptualized as not only the product of conflicts (as postulated by other theories), but also as problematics around role repertoires, role balance, and the weakness of the meta-role in its coordinating function. Furthermore, as the concept of roles presupposes a social network within which roles have meaning and take form, psychodramatists acknowledge the social context as an important factor in understanding symptomatic behaviour. Notwithstanding the above discussion of psychopathology and personality, psychodrama is best understood as a technique of psychotherapeutic intervention embedded within a larger and more eclectic approach to diagnosis and treatment as opposed to a stand-alone theory.

The mechanisms for psychotherapeutic change are embedded in the techniques of psychodrama. Furthermore, psychodramatists posit that two or more therapeutic modalities (i.e. talk therapy, expressive art therapy, active imagining and psychodrama)

can operate synergistically, deepening the impact of the therapeutic experience. As the name suggests, dramatic enactments are facilitated to illuminate and explore life situations of any member of the group.

There are a number of technical elements that are requisite parts to any psychodrama: *the protagonist, the director, the auxiliary (or auxiliary ego), the audience,* and finally *the stage*. The protagonist is the main player whose life situation is being explored. At times two people may play coprotagonists in an enactment for the purpose of working through conflict. Additionally, the director or therapist may take the role of a coprotagonist to illuminate transference issues or deal with therapeutic challenges. The director facilitates the enactment through making suggestions around changing parts, bringing in supporting players into the scene, and so on to further the unfolding of the dramatic experience. At the same time, the director remains close to the needs of the protagonist in the moment so as not to overpower the experience with predetermined frames of reference and/or assumptions. Frequently, although not necessarily, the director is the therapist. The auxiliary is the supporting player in the enactment. Often the auxiliary portrays a significant person from within the protagonist's life or the auxiliary may play the part of different aspects of the protagonist's own mind (i.e. the punishing superego, inner vulnerable child, etc.). Auxiliaries can be given direction by the director and at times can intuitively respond to the protagonist in ways that are powerfully therapeutic and unanticipated by the director. The audience is the rest of the therapy group and is important because they create a sense for the protagonist of being witnessed that intensifies the dramatic and cathartic experience and lends a sense of reality to the drama. The audience is also the source of auxiliaries for the enactment.

Finally, the fifth important element to psychodrama is the stage. While it need not be a raised platform, it is important that it is considered a special place in the room where actions are considered exploratory and where the suspension of disbelief can be held. Therefore, the stage should not be crossed for bathroom breaks or ordinary life actions. Stepping on-stage signifies to the group that an enactment is about to begin.

The technique of psychodrama involves a three-step process of enactment. The first step is called the *warm-up*. This step is about getting the group involved and prepared for the coming enactment. It can be signalled by some explanation by the director and/or by her getting up out of her chair and walking around. Again this is a psychological signal that prepares the group for the coming psychodrama. The second phase or step is the *action*. This is the actual enactment and it is as various and unique as each group and person involved. The action usually involves a crescendo of affective intensity that culminates in the working through of insights brought about through the drama. Before the drama is considered over, it is important for the director to “de-role” the protagonist and the auxiliaries. The last phase is *sharing*. In this part of the therapeutic work the director encourages the counter-disclosure by the group, including the auxiliaries, of what the enactment meant for them in terms of their own lives. Thus, every member of the group becomes actively involved in the therapeutic outcomes and impact of the enactment. Blatner (2005) describes the entire process like this,

In classical psychodrama, the process tends to follow a curve of emotional intensity and focus, increasing with the warm-up, culminating with the action, and cooling down as a working-through of insights are pursued, heading toward the sharing phase. (p. 419)

There are also a number of dramatic techniques that are utilized to sharpen the dramatic impact and therapeutic effect of psychodrama. Obviously, the enactment is the foundation and this is a matter of “showing, rather than telling”. Other techniques are *cutting the action, the mirror, the double, role reversal, asides, replay, the empty chair, the encounter, surplus reality and concretization*. Cutting the action and the aside are modeled on theatrical techniques. As with a movie, cutting the action stops the enactment immediately and allows for redirection or discussion to ensue about what just took place. An aside is an opportunity within an enactment to communicate to the audience what might not otherwise be known. The technique of the mirror involves removing the client from the role and having an auxiliary play it so that the client-protagonist can observe her/his own responses in the scene. This technique allows the client to expand her/his abilities for self-observation and knowledge. The double technique involves having an auxiliary play the protagonist’s inner self providing voice to those thoughts not normally expressed. The empty chair technique involves interacting with an imaginary other sitting across from the protagonist, creating an enactment of one. The technique of role reversal allows a client to take the role of another and in so doing provides opportunities for the development of empathy. The replay is a technique of repeating enacted behaviour to bring it into sharper awareness and move the behaviour out of the realm of automatic thinking. The concept of surplus reality refers to “that dimension of psychological experience that transcends the boundaries of physical reality by giving more respect to the potential of fantasy and imagination” (p. 429). Surplus reality gives clients permission to engage in relationships outside of “normal” parameters (i.e. the deceased, God, hallucinatory figures, etc.), to engage in scenarios that may not be

possible in reality, and/or the re-writing of traumatic experiences. As Moreno (as cited in Blatner, 2005) is quoted saying to Freud “You analyze people’s dreams. I try to give them courage to dream again” (p. 430).

Another technique utilized by psychodramatists is the encounter. This involves having the client actually experience a direct conversation with an imagined other, rather than talking about the other or their feelings. These dialogues in the present moment are often experienced more vividly than simply descriptions of events. This technique can also be fruitfully utilized to encourage dialogues between different parts of the inner self. Externalizing these inner dialogues can assist in clarifying confusion and deepening awareness of the multiple inner demands placed upon a client.

Finally, there is the technique of concretization. This takes abstract ideas or diffuse feelings and externalizes them into concrete forms or enactments. Sometimes the kinaesthetic sensation of the enactment of a feeling promotes a deeper experience or awareness of that feeling.

In all, “psychodramatic approaches aim to involve patients in their ability to imagine, think and behave in an *as if* context and to engage in dramatic play as a resource for insight, behavioural practice, the expansion of consciousness and healing” (p. 430). Psychodrama, as stated earlier, is largely a technique embedded within other therapeutic modalities and as such, the length of therapy is dependent upon the specific modality being utilized. It is also important to note that psychodrama was largely developed for use with groups rather than individuals, although some of its techniques have been usefully adapted to individual psychotherapy. As a modality of group therapy then, length of therapy is also difficult to determine.

Experiential Psychotherapy:

Experiential Psychotherapy grew out of the work and writings of Alvin Mahrer, who is, in fact, the author of this chapter, during the 1990's. Mahrer was trained at Ohio State University in clinical psychology during the 1950's under the tutelage and legacy of Rogerian psychotherapy, Rotter's social learning theory, and groundbreaking research and work on postmodern and constructivist models of psychotherapy. Mahrer was deeply influenced by existential philosophy and the philosophies of science and these intellectual streams are evident in his latter theorizing. Most importantly however, to the genesis of Mahrer's Experiential Psychotherapy is his research of approximately 500 audiotapes of actual sessions of over 80 psychotherapists from widely differing psychotherapeutic backgrounds. Mahrer and his colleagues investigated those therapeutic moments of significant and radical psychological change within the sessions – those “aha!” moments. Through the systematic gathering of data around what comprised these dramatic, quantum shifts, Mahrer developed his methodology of Experiential Psychotherapy.

Mahrer's theoretical underpinnings to his methodology are extremely complex and obtuse. He asserts that his psychotherapy is a model of usefulness rather than one that attempts to delineate psychological “truths”. Therefore, for the sake of clarity, Mahrer's techniques and mechanisms for therapeutic change will be outlined in tandem with a brief discussion of the theoretical constructs that inform his methodology.

Mahrer holds that each session of Experiential Psychotherapy is a complete therapy in and of itself. The session involves working through a four step process that identifies and achieves each client's own “ideal state” of being. Thus, it is possible

through one session to gain the life-altering psychological shift that is required for a qualitatively different person to emerge into a state of self-defined health and well-being. Follow-up sessions are only scheduled at the end of each session if both the client and therapist assess that they are necessary. Each session is a completed whole of psychological working through independent of any preceding or subsequent session.

The four-step process of each session involves discovering and accepting what are called *deeper potentials for experiencing*. These potentials for experiencing are channels that exist within each person to feel a multitude of affects and through these channels and the relationships between them, generate a personal external world. Deeper potentials for experiencing are frequently unconscious and “cut-off” from the client. The work of therapy then, is to illuminate and welcome these deeper potentials for experiencing and then to imagine “being” them in future scenarios. Through this process, a qualitatively new way of being in this world is discovered and implemented.

The first step in the session begins with relaxation techniques that are undergone by both therapist and client together. It is worth noting that in Experiential Psychotherapy, the client and therapist are often in reclining chairs that are parallel to each other. Additionally, both therapist and client spend much of the session with their eyes closed. There is no prescribed time limit to sessions beforehand, although most sessions last up to a couple of hours in length. In this relaxed state the client is asked to recall any scene of strong feeling. This scene can be from the past or from recent circumstances, it makes no difference. The therapist then encourages the client to intensify the feelings and observe the moment of peak feeling. It is from this experience of intense affect during the moment of peak feeling that the deeper potential for

experiencing is discovered. As Mahrer does not clearly define what these deeper potentials for experiencing actually are within a session in a precise way, this author posits that these deeper potentials might be a recognition that intense affects can, in fact, be tolerated or might involve feelings of peace or relief after intense cathartic discharge. Mahrer does suggest, however, that transcendental experiences may occur within the moment of peak feeling that then can be accessed and affirmed as deeper potentials for experiencing. Hence, deeper potentials for experiencing are pleasant feeling states.

The second step then, involves naming and describing the deeper potential for experiencing that was uncovered during step one. The client is encouraged to respond, accept and welcome this deeper potential. Mahrer suggests having a sense of fun and playfulness within the next steps as the client is then encouraged in step three to imagine being this deeper potential for experiencing in past scenes and then in step four, to be the qualitatively different person in future scenes. This last step involves both committing to being the qualitatively new person and to rehearsing ways of being this new person.

The goal of Experiential Psychotherapy is to facilitate a quantum shift in the client so that they are free from the “old ways of being” in this world and therefore, free of old difficult scenes of painful feelings. It is a psychotherapy of method or usefulness that utilizes constructivist paradigms and cathartic discharge as fundamental constructs of therapeutic change. With its pragmatic thrust, theories of the unconscious, defense mechanisms, and other theoretical postulates are held loosely and considered largely unnecessary. As stated earlier, Mahrer considers each session to be a self-contained whole and thus it can be the briefest of all psychotherapies.

Conclusion:

Current Psychotherapies puts forth thirteen varying modalities for the practice of psychotherapy that are written by the current leading theorists and practitioners within each paradigm. Except for the review of Freudian Psychoanalysis, the other twelve paradigms comprise branches of psychotherapy that have sprung from the “trunk” of the canon of psychological thought. These branches represent rich and diverse techniques to the practice of psychotherapy as well as varying perspectives on the qualities and conflicts of psychological life. As stated earlier, Corsini (2005) in the introduction to this book, invites the reader/practitioner to explore the multiple paradigms and encourages an eclectic, generalist approach to interventions and treatment modalities that “fit” within the particularities of each therapist’s own philosophy of life, personality and the demands of the clients before them. In the last chapter, Wedding (2005) reviews ethical and professional guidelines that are relevant to any practitioner within the field of psychotherapy. Thus, the book both demonstrates the multiplicity of psychological theories and practices, while holding the commonality that all practitioners, regardless of theoretical commitment, must maintain a shared standard of ethical and professional conduct.

The presentation of each paradigm is constructed along a simple framework that has each author historically contextualizing her/his theory, outlining the main theoretical concerns, giving an overview of important terms and techniques, and finally supplying an illustrative case study. This format provides a clear and concise overview of the multiple modalities in a format that is accessible, readable, and easily utilized for comparative study.

While Corsini (2005) does fail to contextualize the book within the historical genesis of the canon of psychological thought, *Current Psychotherapies* is a valuable resource text in addition to the canon. It provides the reader/practitioner with a large repertoire of techniques and theoretical orientations that can enrich and inform one's practice. Furthermore, it familiarizes the reader/practitioner with other paradigms that are currently practiced and with which one is surely to come across in her/his own practice or community of practitioners. It is through understanding and knowledge that collegiality can be fostered and professional collegiality can only benefit the health, wellness and resources available to our clients. Thus, *Current Psychotherapies* is an important resource text for anyone in the field of psychotherapeutic practice.

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