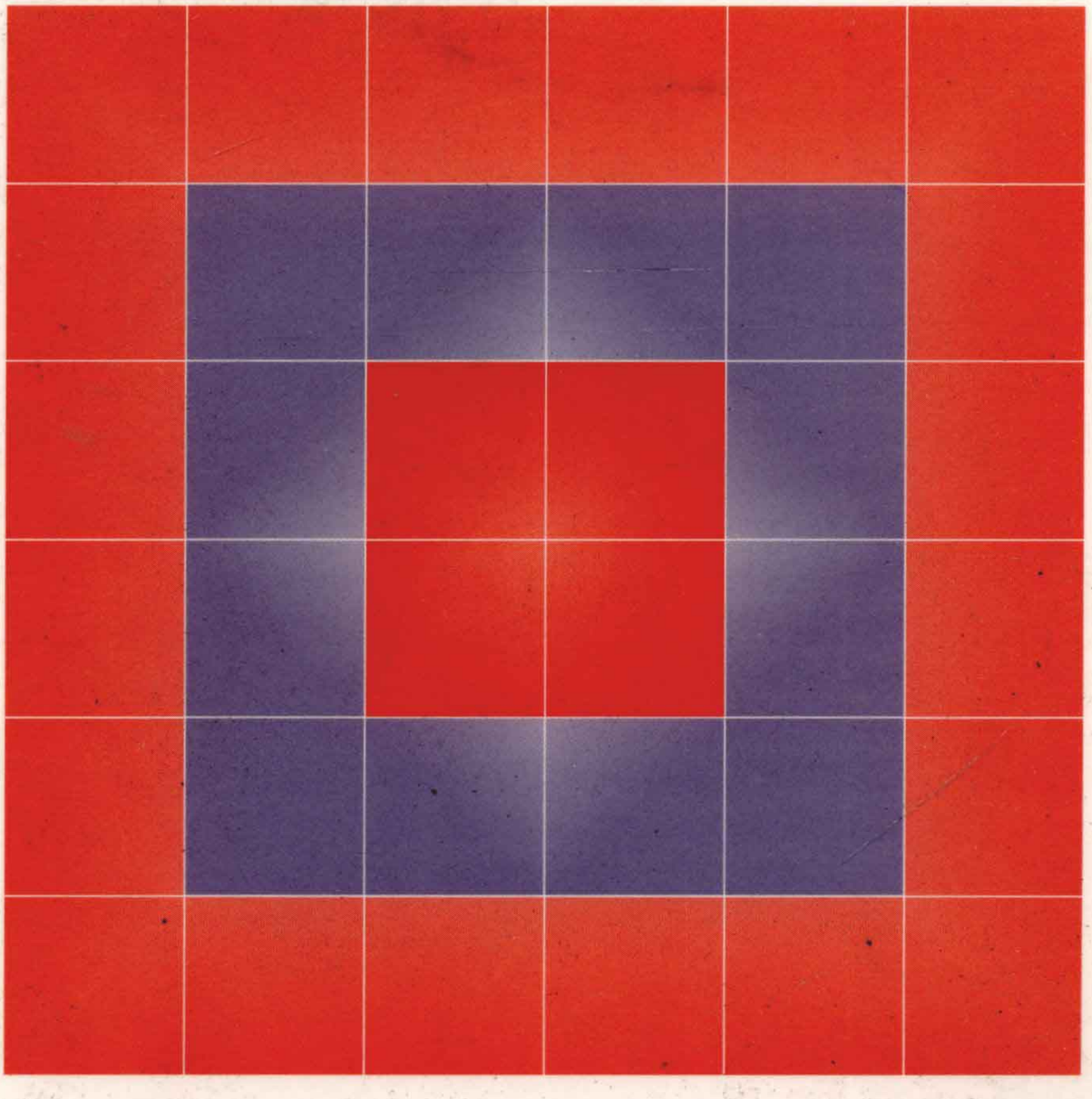
Essential Psychotherapies

THEORY AND PRACTICE



Edited by
ALAN S. GURMAN
STANLEY B. MESSER

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Theory and Practice

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To our children,
Jesse and Ted Gurman,
Elana, Leora, and Tova Messer

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Contents

1

Essential Psychotherapies: An Orienting Framework

ALAN S. GURMAN
STANLEY B. MESSER

As the title indicates, this is a book about the theory and practice of essential psychotherapies. In using the term "essential," we are excluding those psychotherapies that may generate faddish enthusiasm but soon pass from the therapeutic scence. Essential psychotherapies, in our view, are those that form the conceptual and clinical bedrock of the field. They are also therapeutic systems that are indispensible in the training and education of psychotherapists. We use the term "essential" to connote two categories of contemporary approaches to psychotherapy. First, there are those treatments that have been developed relatively recently; have had demonstrably powerful effects on practice, training, and research; and are likely to endure for a very long time. Examples include the brief, cognitive, family, and integrative psychotherapies. Second, the "essential" psychotherapies considered here include several whose origins are found in the earlier, and even earliest, phases of the history of psychotherapy. Although the core of each of these methods has endured through several generations of psychotherapists, they have been considerably revised and refined over the years. Examples are traditional and relational approaches to psychoanalytic psychotherapy, existential–humanistic and person-centered psychotherapy, Gestalt, group, behavior therapy, and Transactional Analysis.

This volume is intended to serve as a primary reference source for comprehensive presentations of the most prominent conceptual and clinical influences in the field today. While there may exist hundreds of differently labeled psychotherapies (Garfield & Bergin, 1994), we believe that they can be subsumed by a mere dozen genuinely discriminable types. As editors, we have challenged our contributors to convey not only what is fundamental to their ways of working, but also what is innovative and forward-looking in theory and practice. We believe that the contributors, all eminent clinical scholars and noted representatives of their treatment approaches, have collaborated on a volume that is

well suited to expose advanced undergraduates, beginning graduate students or trainees in all the mental health professions, and more experienced psychotherapists to the major schools and methods of modern psychotherapy. Each chapter offers a clear sense of the history, current status, assessment approach, and methods of the therapy reviewed, along with its foundational concepts of personality and psychopathology. Regarding the latter, we have attempted to balance practice and theory, and to emphasize the interplay between them. As academicians and practicing psychotherapists, we agree with Kurt Lewin that "there is nothing so practical as a good theory."

Before presenting and discussing our organizing framework for the chapters, two comments about the content of this book are in order. First, while *Essential Psychotherapies* provides substantive presentations of the major "schools" of psychotherapeutic thought and general guidelines for practice, it does not include treatment prescriptions for specific disorders or populations. Although there is presently a movement to specify particular techniques for particular disorders and populations, we believe that the vast majority of practitioners continue to approach their work from the standpoint of theory as it informs general techniques of practice.

Second, there is today a thrust toward integration of principles of psychotherapy across "schools," one illustration of which is presented in Chapter 11. While we value the search for integrative and common factors that transcend given therapies (Gurman, 1992; Messer, 1992), we endorse the current practice of teaching about distinct schools or systems of psychotherapy. It would be irrational to teach therapists about therapeutic integration without their first understanding the foundational theories of the field. In addition, theoretical integration cannot advance without these basic theories remaining intact (Liddle, 1982).

Indeed, the separate models can be seen to stem from different views of human nature, about which there is no universal agreement. Schools also embrace fundamentally different ways of getting to know clients, which stem from different epistemological outlooks (e.g., introspective vs. extraspective; Messer & Winokur, 1980). Furthermore, the therapies encompass distinct visions of reality, such as the extent to which they incorporate the belief that fundamental change is possible, or even what constitutes that change (e.g., tragic vs. comic views of life; Messer & Winokur, 1984). As such, it is important for the field, and a volume such as this one, to respect the search for common principles in theory or practice while continuing to appreciate and highlight the different perspectives each model or school of therapy exemplifies.

A FRAMEWORK FOR DESCRIBING THE PSYCHOTHERAPIES

It is not the answer that enlightens, but the questions.

—EUGENE IONESCO

An important feature of *Essential Psychotherapies* is the comprehensive set of "Authors' Guidelines" that served as a point of reference for the contributors. They were adapted from those used by Gurman and Kniskern in their *Handbook of Family Therapy* (1981, 1991). Such guidelines may facilitate the reader's comparative study of the major models of contemporary psychotherapy (and may also be used by the student as a template for studying systems of therapy not included here).

In offering these guidelines to the chapter authors, we hoped to steer a course between constraining the authors'

creativity, and providing the reader with anchor points for comparison across chapters. We believe that our contributors have succeeded in adhering to these guidelines while describing their therapeutic approaches in a lively way. We encouraged authors to sequence the material within chapter sections according to their own preferences. Authors were also advised that they need not limit their presentations to the matters raised in the guidelines, or even include every point, but that they should address these matters in some fashion if they were relevant to the clinical approach being described. It was also acceptable for the authors to collapse or merge sections of the guidelines, if that seemed warranted, in order to communicate their ideas meaningfully and fluidly.

In the end, we believe that the contributors' flexible adherence to the guidelines has helped to make clear to the reader how theory helps to organize clinical work and facilitates case conceptualization. It has also allowed authors to convey the variety that exists even within a given clinical model. The inclusion of clinical case material in each chapter serves to illustrate the constructs and methods described previously.

Rather than summarize each chapter, we will present the Authors' Guidelines we have been alluding to, along with the rationale for each section included.

I. Background of the Approach

History is the version of past events that people have decided to agree on.

—NAPOLEON BONAPARTE

Purpose: To place the approach in historical perspective within the field of psychotherapy.

Points to include:

1. Cite the major influences that contributed to the development of the approach (e.g., people, books, research, theories, conferences). What were the sociohistorical forces or *Zeitgeist* that shaped the emergence and development of this approach (e.g., Victorian era, American pragmatism, modernism, etc.)?
2. The therapeutic forms, if any, that were forerunners of the approach (e.g., psychoanalysis, learning theory, organismic theory, etc.).
3. Types of patients with whom the approach was initially developed, and speculations as to why.
4. Early theoretical speculations and/or therapy techniques.

Understanding the professional roots and historical context of psychotherapeutic methods is an essential part of therapy education. Without such awareness, therapeutic theories and methods remain disembodied abstractions, seeming to rise from nowhere, and for no discernible reason. An important component of a therapist's persuasiveness is found in his/her belief not only in the technical aspects of an approach but also in the world view that is implicit in that approach (Frank & Frank, 1991). One cannot comprehend the worldview of a therapy without an appreciation of its origins. Just as being emotionally cut off from one's own biological family of origin may sow the seeds for current relationship difficulties, not being connected to one's therapeutic origins may lead to a mechanized and affectless therapy-by-the-numbers. The reader interested in a more detailed study of the history of the first 100 years of psychotherapy may wish to consult the volume edited by Freedheim et al. (1992).

In addition to appreciating the professional roots of therapeutic methods, it is always fascinating to understand why particular methods appear on the scene at particular historical junctures. The intellectual, economic, and political con-

texts in which therapy methods arise often provide meaningful clues about the emerging social values that frame clinical encounters, and may have a subtle but powerful impact on the staying power of new approaches. We firmly believe that systems of therapy are no more value free or free of societal forces than are therapists themselves.

II. The Concept of Personality

Children are natural mimics—they act like their parents in spite of every attempt to teach them good manners.

—ANONYMOUS

Purpose: To describe within the theoretical/therapeutic framework the conceptualization of personality and/or behavior.

Points to include:

1. Is the concept of "personality" meaningful within your approach, or is there some other unit that is more meaningful?
2. What are the basic psychological concepts used to understand the person/family/group? (Discuss whichever unit is most appropriate for your chapter here and elsewhere.)
3. What is the theory of development of the person/family/group?
4. Is there a concept of the healthy, well-functioning, adaptive personality/family/group?

III. The Pathological or Dysfunctional Individual/ Family/Group

Utopias will come to pass when we grow wings and all people are converted into angels.

—FYODOR DOSTOYEVSKI

Purpose: To describe the way in which pathological functioning is conceptualized within the approach.

Points to include:

1. Describe any formal or informal system for diagnosing or typing individuals/families/groups.
2. What leads to individual/family/group dysfunction?
3. How do symptoms or problems develop? How are they maintained?
4. What determines the type of symptom or character style to appear?
5. Why are some people symptomatic and not others?
6. Are there other dimensions that need to be considered in describing dysfunctional individuals, families, or groups?

These two sections of the Authors' Guidelines deal with two questions: (1) What is your approach's understanding of the essence of personality formation and of the psychologically "healthy" person? (2) In your approach, what constitutes pathological or "unhealthy" behavior, and how is it established and maintained? The first question begs the issue somewhat in that, as Messer and Warren (1990) have pointed out, "Not all theories of personality explain the process of personality change, nor are all efforts to effect psychological change supported by a personality theory" (p. 371). Some theories of psychotherapy are virtually mute on the matter of how personality develops, or indeed, assert that the concept of personality is not needed for effective clinical practice. Yet even those theories that steadfastly avoid the use of language and labels that pathologize human experience speak clearly about what constitutes "maladaptive" behavior. Thus, even schools of therapy that do not formally judge the "health" of a person based on criteria external to that person (or family or group), do attend to the consequences of behavior in terms of that person's welfare and interest, phenomenologically defined.

Messer and Warren (1990) go on to note that "the terms of a personality theory and the goals of its related system of psychotherapy are not neutral . . . they are embedded in a value structure that determines what is most important to know and change . . ." (p. 372). Even schools of psychotherapy that attempt to be neutral with regard to what constitutes healthy (and, therefore, desirable) and unhealthy (and, therefore, undesirable) behavior inevitably, if unwittingly, reinforce the acceptability of some kinds of patients' strivings more than others. Not even Carl Rogers, the originator of "nondirective" therapy (as it was called in the past) was able to provide facilitative therapeutic conditions, such as empathic understanding and unconditional positive regard, uniformly, but responded differently to certain categories of client speech (Truax, 1966).

IV. The Assessment of Dysfunction

If you are sure you understand everything that is going on, you are hopelessly confused.
—WALTER MONDALE

Purpose: To describe the methods, whether formal or informal, used to gain understanding of a particular individual/family/group's style or pattern of interaction, symptomatology, and adaptive resources.

Points to include:

1. At what *unit* level is assessment made (e.g., individual, dyadic, triadic, family system, group)?
2. At what *psychological* levels is assessment made (e.g., intrapsychic, behavioral, systemic)?
3. What tests, devices, questionnaires, or observations are typically used?
4. Is assessment separate from treatment or integrated with it (e.g., what is the temporal relation between assessment and treatment)?
5. Are the individual/family/group's strengths/resources a focus of your assessment? If so, in what way?
6. What other dimensions or factors are typically involved in assessing dysfunction?

Up to this point in our guidelines, the therapist has not yet met the patient, so to speak. Equipped with particular views of normal and abnormal human psychological functioning, the therapist now encounters the patient. The therapist is obligated to take some purposeful action with regard to understanding the nature and parameters of whatever problems, symptoms, or complaints are presented. Therapists typically will be interested in understanding what previous steps patients have taken to resolve their difficulties and what adaptive resources the patient (and possibly others in the patient's everyday world) has for doing so.

How therapists go about engaging in a clinical assessment will vary from approach to approach, but all will include face-to-face clinical interviews. A smaller number will also observe the problem directly, apart from conversations between patient and therapist *about* the problem. Still fewer will call upon specific tests and questionnaires to complement interviews and observations.

The major dimension along which clinical assessments will vary is the intrapersonal–interpersonal. Some approaches will emphasize "intrapsychic" process and events while others will emphasize social transaction and interaction. But note that there is a constant interplay between clients' "inner" and "outer" lives and that emphasis on one domain "versus" another reflects arbitrary punctuation of human experience that says as much about the theory of the perceiver as it does about the client who is perceived.

V. The Practice of Therapy

All knowledge is sterile which does not lead to action and end in charity.

—CARDINAL MERCIER

Purpose: To describe the typical structure, goals, techniques, strategies, and the process of a particular approach to therapy and their tactical purposes.

Points to include:

Basic structure of therapy

1. How often are sessions typically held?
2. Is therapy time-limited or unlimited? Why? How long does therapy typically last? How long are typical sessions?
3. Who is typically included in therapy? Are combined formats (e.g., individual plus family or group sessions) ever used?
4. How structured are therapy sessions?

Goal setting

5. Are there treatment goals that apply to all or most cases for which the treatment is appropriate (see "Treatment Applicability," below) regardless of presenting problem or symptom?
6. Of the number of possible goals for a given person/family/group, how are the central goals selected for this unit? How are they prioritized?
7. Do you distinguish between intermediate or mediating goals and ultimate goals?
8. Who determines the goals of treatment? Therapist, individual, both, or other? How are differences in goals resolved? To what extent and in what ways are therapist values involved in goal setting?
9. Is it important that treatment goals be discussed with the individual/family/group explicitly? If yes, why? If not, why not?
10. At what level of psychological experience are goals established (e.g., are they described in overt behavioral terms, in affective–cognitive terms, etc.)?

Techniques and strategies of therapy

11. Identify, describe, and illustrate major commonly used techniques.
12. Are psychotropic medications ever used within your method? What are the indications/contraindications for their use?
13. Are "homework" or other out-of-session tasks used?
14. How is the decision made to use a particular technique or strategy at a particular time? Are different techniques used for different individual/family/group problems?

Process of therapy

15. What techniques or strategies are used to create a treatment alliance?
16. What are the most commonly encountered forms of resistance to change? How are these dealt with?
17. What are both the most common *and* the most serious technical errors a therapist can make operating within your therapeutic approach?
18. On what basis is termination decided and how is termination effected?

VI. The Stance of the Therapist

It is only an auctioneer who can equally and impartially admire all schools of art.

—OSCAR WILDE

Purpose: To describe the stance the therapist takes with the individual/family/group.

Points to include:

1. To what degree does the therapist overtly control sessions? How active/directive is the therapist?
2. Does the therapist assume responsibility for bringing about the changes

desired? Is responsibility left to the individual/family/group? Is responsibility shared?
3. Does the therapist use self-disclosure? What limits are imposed on therapist self-disclosure?
4. Does the therapist "join" the individual/family/group or remain more "outside"?
5. Does the therapist's role change as therapy progresses? Does it change as termination approaches?
6. Is countertransference recognized or employed in any fashion?
7. What are the clinical skills or other therapist attributes most essential to successful therapy in your approach?

Section V, "The Practice of Therapy," and Section VI, "The Stance of the Therapist," taken together, reflect the core considerations in the actual practice of psychotherapy. They subsume the large majority of technical and relational factors operating in treatment. The kinds of essential facets of therapy considered in these sections, in aggregate, make up what therapists refer to when they identify their primary therapeutic orientation. And just how do therapists choose their therapeutic orientations, their preferred ways of working? For better or for worse, therapists do not advocate or practice different approaches mainly on the basis of their relative scientific status. For example, Norcross and Prochaska (1983) found that the four most influential factors in orientation choice were one's clinical experience, values and personal philosophy, graduate training, and personal life experiences. Therapists are attracted to different approaches on the basis of a large number of both rational and irrational factors. The choice of a favorite method of psychotherapy often derives from personal factors. For example, therapists with a "take charge" personal style may be better suited to practice clinical methods requiring a good deal of therapist activity and structuring than those requiring a more reflective style. Given the presumed equivalence of effectiveness of the major methods of psychotherapy (Garfield & Bergin, 1994), it is not surprising that idiosyncratic personal variables should exert such an influence on therapists' preferred ways of practicing. As Robin Skynner (personal communication, March 1982) has quipped, we need "different thinks for different shrinks."

In addition to the personal meaning to therapists of adopting particular models of therapy, the meaning of a given technique within a particular context also deserves our attention. While all therapeutic techniques are born within an originating "home theory," so to speak, these techniques are often exported for use within other clinical frameworks. While potent techniques may not lose their effectiveness when "exported," their introduction into a given course of therapy may significantly alter the nature of the patient–therapist relationship and, therefore, the thrust of the therapy (Messer, in Lazarus & Messer, 1991). A technique is an intervention, but it is also a communication within a specific context.

VII. Curative Factors or Mechanisms of Change

You can do very little with faith, but you can do nothing without it.

—SAMUEL BUTLER

Purpose: To describe the factors, that is, mechanisms of change, that lead to change and to assess their relative importance. Include research findings if possible.

Points to include:

1. What are the proposed curative factors or mechanisms of change from the standpoint of your theoretical approach?

2. Do patients need insight or understanding in order to change? (Differentiate between historical–genetic insight and interactional insight.)
3. Are interpretations of any sort important and, if so, do they take history (genetics) into account? If interpretations of any kind are used, are they seen as reflecting a psychological "reality," or are they viewed rather as a pragmatic tool for effecting change?
4. Is the learning of new interpersonal skills seen as an important element of change? If so, are these skills taught in didactic fashion, or are they shaped as approximations occur naturalistically in treatment?
5. Does the therapist's personality or psychological health play an important part in bringing about change?
6. How important are techniques as opposed to just "being with" the person/family/group?
7. Is change in an "identified patient" (where relevant) possible without interactional or systemic change? Does systemic change necessarily lead to change in symptoms?
8. What factors or variables enhance or limit the probability of successful treatment in your approach?
9. To what extent does the management of termination of therapy determine outcome?
10. What aspects of your therapy are *not* unique to your approach, that is, common to all therapy?
11. Can you give an example of the kind of research that backs up the proposed mechanisms of change?

VIII. Treatment Applicability

Society has always seemed to demand a little more from human beings than it will get in practice.

—GEORGE ORWELL

Purpose: To describe those individuals/families/groups for whom your approach is particularly relevant.

Points to include:

1. For what kinds of individuals/families/groups is your approach particularly relevant?
2. For whom is your approach either not appropriate or of uncertain relevance? For example, is it less relevant for severely disturbed individuals/families/couples/groups? For marital and/or sexual problems? Why?
3. What is the applicability of your approach to children, adolescents, and the elderly?
4. What kinds of modifications are typically introduced in treating any or all of these age groups?
5. When, if ever, would a referral be made for another (i.e., different) type of therapy?
6. When would *no* treatment (of any sort) be recommended?
7. Are there aspects of your approach that raise particular ethical issues that are different from those raised by psychotherapy in general?
8. How is the outcome, or effectiveness, of therapy in this model evaluated in clinical practice?
9. What are the data supporting the value of the approach?

Taken together, Section VII, "Mechanisms of Change," and Section VIII, "Treatment Applicability," ask two fundamental questions: (1) How effective is this method of therapy, and for whom? and (2) When change occurs in this method of therapy, through what processes does that come about? Ultimately, such important questions are best answered through painstaking research rather than by testimonials, appeals to authority and tradition, and other unsystematic methods. Psychotherapy is far too complex to track the interaction among, and impact of, the most relevant factors in effective-

ness via individuals' participation in the process alone. The relative contributions to the outcomes of psychotherapies of therapist factors, patient factors, and technique factors probably vary from method to method. Moreover, it is unlikely that many of these factors by themselves exert strong, reliable effects on treatment outcomes, other than in interaction with other variables.

Yet, as noted previously, most psychotherapists are not easily persuaded to adopt unfamiliar treatment methods simply because research suggests they are helpful, or to stop using more familiar methods because research casts doubt on their helpfulness or because relevant research barely exists. While we would personally be pleased to see research findings affecting practice to a greater extent, there is another prominent way in which research can influence and enhance clinical practice, namely through clinicians learning the practical importance of critical thinking. Psychotherapists should be very concerned about the quality of evidence they accept in their daily clinical decision making. Some common errors in critical thinking among therapists (and among the members of many other helping professions, as well!) are the following: confusing description and naming with explanation; mistaking correlation for causation; ignoring alternative plausible explanations; failing to identify, or incorrectly identifying, implicit assumptions; failing to operationally define key concepts and terms; and reasoning only by analogy. Two outstanding recent books we recommend to therapists to hone their critical reasoning skills are by Browne and Keeley (1994), written for all disciplines, and Gambrill (1990), written especially for psychotherapists.

IX. Case Illustration

A good example is the best sermon.
—YANKEE PROVERB

Purpose: To illustrate the clinical application of this model by detailing the major assessment, structural, technical, and relational elements of the process of treating a unit viewed as typical, or representative, of the kinds of individuals/families/groups for whom this approach is appropriate.

Points to include:

1. Relevant case background (e.g., presenting problem, referral source, previous treatment history).
2. Description of relevant aspects of your clinical assessment (e.g., functioning, structure, dysfunctional interaction, resources, individual dynamics/characteristics), including how this description was arrived at.
3. Description of the process and content of goal setting.
4. Highlight the major themes, patterns, etc., of the therapy over the whole course of treatment. Describe the structure of therapy, the techniques used, the role and activity of the therapist, etc.

Note: Do *not* describe the treatment of a "star case," in which therapy progresses perfectly. Select a case which, while successful, also illustrates the typical course of events in your therapy.

Someone once said that the main function of professional psychotherapy workshops is to help clinicians feel more confident by watching renowned experts fail in demonstrations with "impossible" patients. Conversely, published case illustrations not infrequently seem designed to showcase the clinical genius of their authors, resulting in reader demoralization and feelings of relative ineptitude. It was with such thoughts in mind that we cautioned our contributors to elucidate rather than intimidate.