A Policy-based Approach to Psychotherapy

Raymond M. Bergner
Department of Psychology
Illinois State University

Abstract

This paper explores the use of therapeutic policies in the conduct of psychotherapy, and in doing so introduces an alternative way to structure the entire intellectual framework of psychotherapy. Part 1 of the paper explicates the nature of therapeutic policies. Parts 2, 3, and 4 present a large number of representative policies and their rationales. Part 5 discusses the value of policies (a) as common factors in psychotherapy, (b) as embodying an integrative framework, and (c) as lending themselves to enhanced levels of creativity and flexibility in the conduct of psychotherapy.

Keywords: psychotherapy, policy, therapy integration, common factors

The purpose of this article is to introduce an alternative way to think about the enterprise of psychotherapy. The article is a strange beast in that it is at once a radical reconsideration of how to restructure the entire intellectual framework of psychotherapy, and at the same time it might be used as a primer of psychotherapy. The approach is built upon a structure of discrete modules rather than discrete theories or schools of therapy. These modules are therapeutic policies; i.e., recommended procedural guidelines for the conduct of psychotherapy. This approach embodies the virtues that it (a) places much greater emphasis on factors that are pre-empirical--indeed self-evident and not subject to reasonable doubt or empirical disconfirmation in most cases--and recasts the place of what is genuinely empirical; (b) provides a substantial number of *common factors* that are applicable to all of psychotherapy; (c) embodies an *integration* of what are now considered divergent and competing schools of therapy; (d) lends itself to enhanced flexibility and creativity in the practice of psychotherapy; and (e) has a modular structure that permits easy expansion via the addition of new policies.

"Assembling Reminders"

Ludwig Wittgenstein, on many accounts the most influential philosopher of the twentieth century (Biletzki & Matar, 2011), once famously stated that his method was that of "assembling reminders for a particular purpose" (1953, p.127). That is, he asserted, his method was not to offer any new theory or to proffer any new facts. Instead, it was to assemble reminders of things that people had known all along, and to place these into new contexts and arguments that led to solutions of longstanding problems. Similarly, much of the content of this article will be ideas, even definitional and otherwise truistic ones, that many therapists already possess, but these will be placed in a new, simpler, and rather different vehicle than our customary one of therapeutic theories and their associated forms of intervention.

Structure of Article

This article will proceed in the following order. Part 1 will be devoted to a fuller explication of the nature of therapeutic policies, including a discussion of what is empirical and what is not in their formulation and use. Parts 2, 3, and 4 will present a large sample of representative policies, of relevance respectively to the topics of therapeutic integration, the therapeutic relationship, and other general matters. Part 5 will discuss the value of policies (a) as common factors in psychotherapy, (b) as embodying an integrative framework, and (c) as lending themselves to enhanced levels of creativity and flexibility in the conduct of psychotherapy. The employment of policies as described in this article originated with the work of Peter Ossorio within a discipline known as Descriptive Psychology (Ossorio, 2006), and in particular with a psychotherapy developed within that general framework known as "Status Dynamic Psychotherapy" (Bergner, 1999, 2007; Ossorio, 1976/2013, 1997; Schwartz, 1979, 2008).

The Nature of Therapeutic Policies

Therapeutic policies are procedural guidelines for the conduct of psychotherapy. Each guideline has the following general form: "In the large majority of relevant therapeutic situations, it is beneficial to our clients that we follow this policy guideline" (Ossorio, 1976/2013, 1997; Bergner, 2007). As a representative example, let us consider a restatement in policy form of what is generally considered a theory-based, empirically supported approach to psychotherapy, namely cognitive therapy (Beck, 1976; Beck and Weishaar, 2008; Ellis, 1962, 2008). Stated as a therapeutic policy, the central idea of this approach is the following: "Assist clients to (a) eliminate or modify maladaptive beliefs and (b) adopt more adaptive alternative ones." Thus, if the client enters therapy with a belief such as "My value as a person depends on what others think of me," the therapist's task, per conventional cognitive thinking as well as this policy, is to help the client to abandon this debilitating belief and to substitute an alternative belief to the effect that his or her value as a person is not so dependent.

When one examines this policy, one can readily observe that, while it may sound like an ordinary directive to engage in some behavioral process (comparable, for example, to a tennis coach's instruction to "bring your racquet forward in just

this way"), it is not such a directive. Instead, its form is that of an injunction to engage in some (unspecified) action to bring about the achievement of a certain desirable state of affairs. In our present example, the policy does not tell one what specific actions to engage in, but to "do something to bring about a state of affairs wherein the client has abandoned his or her maladaptive beliefs in favor of more adaptive ones." Like instructing a novice chess pupil that he or she is to "try to place your opponent's king in checkmate," it provides enormous direction to behavior, while leaving the details regarding how to achieve this goal an unspecified and potentially quite flexible matter.

Policies Rest on Truisms

Consider further our representative policy to help clients to eliminate or modify maladaptive beliefs and substitute more adaptive ones. Conventionally, cognitive therapy is thought to rest on an empirically supported cognitive theory. However, it is easy to see that it rests on a truism that adaptive beliefs--beliefs that work, that are functional, that when acted upon lend themselves to better outcomes for this person--are to be preferred to maladaptive ones (i.e., ones that bring about the opposite outcomes). Such a proposition is self-evident. It is true by definition: adaptive is by definition better than maladaptive; what works is by definition better than what does not work; what brings about better outcomes is by definition better than what brings about worse outcomes. Such a proposition neither requires empirical support nor could we seriously entertain the validity of any empirical outcome that supported its opposite. In general, all of the policies described in this paper rest on truisms. In particular, like "adaptive ideas are to be preferred to maladaptive ones," they all rest on the obvious or even definitional desirability of the states of affairs at issue in the policy.

So What Is Empirical?

What is empirical in the present picture--what is a matter to be decided by observation--is the effectiveness of specific therapeutic interventions that might be employed to bring about the states of affairs articulated in the policies. Empirically, various methods for bringing these about are either effective or not, and to varying degrees, with different populations, in specific circumstances, and probabilistically so (e.g., "Beck's technique of having clients review the empirical evidence for their maladaptive beliefs has been found effective with X-type clients in N% of cases."). Clearly, any proposition of the form, "Implementing intervention procedure X will result in salutary effect Y with probability Z" states a matter to be decided through empirical observation.

The psychological literature is replete with studies reporting the outcomes obtained with various kinds of therapeutic interventions. It may be noted, however, that many of these report findings that are not on the level of actual behavioral processes. Instead, they report findings such as ones that "In this study, cognitive therapy was found to be effective in the treatment of disorder X" (e.g., Merrill, Tolbert, & Wade, 2003). Specific procedures are never concretely described, leaving these findings at the level of policy, stating in effect that "a therapy devoted to

getting clients to modify their maladaptive beliefs was effective in N% of cases." Other outcome studies, however, do evaluate the effectiveness of concretely described intervention procedures such as systematic desensitization, EMDR, and other exposure therapies, and are on this account more informative regarding what procedures are actually effective (e.g., Foa et al., 1999).

With the foregoing in mind, let us turn our attention to a selection of representative therapy policies and their rationales. These policies will be discussed in three categories: broad integrative policies, policies for the conduct of the therapeutic relationship, and other general policies. Within these categories, no attempt will be made to provide an exhaustive list of every single policy that might be relevant to that category. Rather, the attempt here is to provide a small number of what could be considered highly central or core policies, and thereby to provide a glimpse into how a complete framework for the domain of psychotherapy is possible employing this approach.

Integrative Policies

Four policies are presented in this section. The central idea behind each will be familiar to most readers, and so will not be discussed at any length. The focus here, as in our discussion of cognitive therapy above, is to cast what is familiar and conceived as empirical in a new, more logic-based, and only partly empirical frame. It is also, in the case of these four policies, to exhibit the sense in which the present approach to psychotherapy is integrative in nature.

A brief preamble is in order before we proceed to the policies themselves. In answer to the question, "what *is* mental disorder?", an increasingly popular group of definitions holds that it is best conceived as behavioral disability (aka "functional impairment," "dysfunction"). Wakefield (1992, 2007), for example, in a widely cited and influential account, contends that mental disorder is best considered as a "harmful dysfunction," while Ossorio (1997) and Bergner (1997, 2004) maintain that it is definable as a "significant restriction in the ability of an individual to engage in deliberate action" (cf. Spitzer, 1999; Widiger & Trull, 1991). When one employs this conception of mental disorder, the explanatory question becomes one of *why* persons with these disorders are significantly restricted in their ability to behave in critically important ways--of why they are restricted in their ability to assert themselves, to make love, to mourn losses, to work, to read, to resolve differences with others, or to function in life in other critical ways.

Straightforwardly, the most general explanation of behavioral disability is one that is both simple and *logically* true: If the enactment of a given behavior (or set of behaviors) requires something that a person does not have, that person will be restricted in his or her ability to engage in that behavior (Bergner, 1997, 2004; Ossorio, 1997). Thus, we may explain the behavioral disabilities at issue in psychopathological states by reference to what the client is lacking. For example, to cite the four types of factors that have been the subject historically of the vast majority of theoretical and therapeutic attention, a given person might lack (a) the cognitive wherewithal (knowledge, beliefs, concepts), (b) the skills or competencies, (c) the

biological states (structures, chemical balances, etc.), and/or (d) the relational situations requisite for any given behavior. With this in mind, we turn to the following four policies.

Policy #1: Assist Clients to Eliminate or Modify Maladaptive Beliefs, and to Adopt More Adaptive Alternative Ones.

Truisms*: (1) Adaptive beliefs are preferable to maladaptive ones. (2) If the enactment of a given behavior (or set of behaviors) requires that a person possess certain cognitive wherewithal (e.g., certain beliefs, knowledge, or concepts), and P does not possess this wherewithal, P will be restricted in his or her ability to engage in that behavior. Logically, a person can only do (reliably and successfully) what he or she has the requisite cognitive wherewithal to do.*

Discussion. This policy, discussed above, is essentially a paraphrase of the well-established work of cognitive theorists and therapists, and covers a wide variety of approaches. Included here would be Beck's Cognitive Therapy (Beck, 1976; Beck & Weishaar, 2008), Ellis's Rational Emotive Behavior Therapy (Ellis, 1962, 2008), and White's Narrative Therapy (White, 1993). Aside from these explicitly cognitive approaches, this policy is adhered to by psychoanalysts seeking to modify transference distortions (Freud, 1905/1953), Rogerians seeking to promote clients' knowledge or awareness of their true feelings regarding critical life issues (Raskin, Rogers, & Witty, 2008), and therapists of various schools seeking to modify clients' self-concepts (Baumeister, 1995; Raskin, Rogers, & Witty, 2008).

Policy #2: Assist Clients to Eliminate or Modify their Maladaptive Behaviors, and to Acquire and Enact More Adaptive Alternative Ones.

Truisms: *(1) The enactment of adaptive behaviors is preferable to the enactment of maladaptive ones. (2) If the enactment of a given behavior (or set of behaviors) requires that a person possess certain behavioral capabilities (skills, competencies), and P does not possess these capabilities, P will be restricted in his or her ability to engage in that behavior. Logically, a person can only do (reliably and successfully) what he or she has the requisite skills and competencies to do.*

Discussion. Aside from its focus on behaviors as opposed to beliefs, the rationale for this policy is formally identical to the previous one: behaviors that work, that are functional, that lend themselves to better outcomes for this person, are to be preferred to their opposite numbers. This is essentially a paraphrase of a seminal idea of behaviorally oriented theorists and practitioners such as Bandura (1986), Gottman (2011), and Wilson (2008). Like the previous policy, it covers a wide variety of approaches, perhaps most notably those with a social skills focus such as Gottman's approach to marital therapy (2011), Alberti & Emmon's assertiveness training (2001), and Kazdin's parenting skills training (Kazdin, Siegel, & Bass, 1992).

Policy #3: Assist Clients Involved in Families, Couples, and other Important Relationships to (a) Eliminate or Modify Ongoing Maladaptive Relationship Patterns, and (b) Adopt More Adaptive Alternative Ones.

Truisms: (1) *Adaptive patterns of relating between persons are preferable to maladaptive ones. (2) Logically, a person can only do (reliably and successfully) what he or she has the requisite environmental opportunities (here, especially, interpersonal ones) to do.*

Discussion. This policy is a special case of the previous one, but one in which the focus is on ongoing, recurrent patterns of relational behavior between multiple individuals. Thus, its rationale is the same. The policy is essentially a paraphrase of the seminal idea of all contemporary family systems approaches such as Structural Family Therapy (Minuchin, 1974; Colapinto, 2000), Bowenian Family Therapy (Bowen, 1978; Papero, 2000), MRI Brief Therapy (Fisch, Weakland, & Segal, 1982), and Solution Focussed Therapy (DeShazer, 2007; O'Hanlon & Weiner-Davis, 2003), as well as those devoted to that subset of the family system which is the marital dyad (e.g., Gottman, 2011).

Policy #4: Assist Clients to Eliminate or Modify Biological State Deficits Relevant to their Functional Impairment.

Truism: *If the enactment of a given behavior (or set of behaviors) requires that certain biological states obtain (e.g., biochemical or structural ones), and these states do not obtain in P, then P will be restricted in his or her ability to engage in that behavior. Logically, a person can only do (reliably and successfully) what he or she has the requisite biological wherewithal to do.*

Discussion. This policy is the central rationale for a wide variety of psychopharmacological and other biologically-based interventions. Thus, for example, addressing deficits in serotonin levels via the use of selective serotonin reuptake inhibitors (SSRIs) is the basis for many contemporary pharmacological treatments for depression (Julien, 2008). The matter of which biological deficits (structural abnormalities, neurotransmitter imbalances, etc.) are relevant to which behavioral disabilities is of course a matter to be determined empirically.

Integrative Character of Above Set of Policies

As the above illustrates, our historically most influential forms of explanation--those in terms of cognitive, skill, biological, and systemic-relational deficits--may all be united by their reference to a common state of affairs: the inability of persons to behave or to function in life in critical ways. Each of these forms of explanation may be seen as specifying one or another of the kinds of deficits that persons might have, which deficits would impose significant limitations on their ability to behave, and which deficits, if eliminated or reduced in therapy, would remove these impediments to more optimum functioning. Further, it should be clear that therapeutic efforts to address these different types of deficits are neither mutually exclusive nor competitive one with another. If, for example, at the root of John's depression lie both cognitive and biological deficits, there is no contradiction

inherent in addressing John's maladaptive beliefs and also providing him with medication. This is of course common practice; however, the way in which these two intervention types are both logically coherent and compatible in practice is not always rationalized. (For a formal integration of contemporary schools of psychotherapy, see Bergner, 2004.)

Policies Pertaining to the Therapeutic Relationship

The policies presented in this section all pertain to the conduct of the therapeutic relationship. In order to orient to the approach taken here, a familiar example from the highly influential work of Carl Rogers (1957) may be helpful. Rogers famously enjoined us (one could say, "as a matter of the strictest policy") to regard and treat every client as an unconditionally acceptable person, and to do so, not on the basis of empirical assessment, but a priori. Expressed in the theoretical terms upon which the present article is based, those of Status Dynamics (Bergner, 1999, 2007; Ossorio, 1976/2013, 1998), he enjoined us to make a commitment, prior to and independently of observation, to assign to every client a certain highly accrediting *status* (i.e., relational position in the world), that of *acceptable person*, and to treat him or her accordingly to the best of our ability. Where Rogers recommended a single policy having to do with the assignment of a single status, the present recommendation is that the therapeutic relationship be built far more comprehensively around six policies, five of which involve the making of a different a priori status assignment (Bergner, 1995, 2007; Bergner & Staggs, 1987).

Policy #5. Regard and Treat the Client as Acceptable

Truism: *To believe oneself acceptable to other people is in general a better state of affairs than believing oneself unworthy of such acceptance.*

Discussion. Many clients believe themselves to be unacceptable to other persons. By dint of assigning themselves degraded statuses (e.g., "inadequate," "nobody," "selfish"), they have come to believe themselves unworthy of such acceptance. A therapeutic relationship in which the client is assigned the status "acceptable person"--i.e., one in which he or she is in fact accepted by the therapist--can therefore be highly beneficial for such persons (Rogers, 1957; Raskin, Rogers, & Witty, 2008). Although their rationales are somewhat different, the majority of authors on the therapeutic relationship have stressed the importance of the therapist's acceptance of the client (e.g., Beck & Weishaar, 2008; Kohut, 1977; Wilson, 2008).

Policy #6. Regard and Treat the Client as a Person Who Makes Sense

Truism: *To broadly regard one's perceptions, emotional reactions, and judgments as making no sense is, ipso facto, to call into question the basis of all of one's decisions, actions, and beliefs, and is therefore enormously self-undermining.*

Discussion. It is extremely self-undermining to see oneself as making no sense. A significant number of clients have come to believe that their perceptions, emotions, and judgments are inadequately grounded in reality and/or that they are without logical foundation, and on these grounds have come in some measure to question their very sanity (Raimy, 1975). When individuals continually

doubt themselves in such ways, they increasingly regard themselves as unqualified for competent judgment and action. The self-doubting, even paralyzing effects of such beliefs can be staggering in some cases.

In the therapeutic relationship, it is therefore recommended that the client be regarded, a priori, as *one who makes sense* (Ossorio, 1976; Bergner & Staggs, 1987). In practice, this means that the therapist's basic assumption is that the client's every emotion, judgment, and action has a logic that is in principle reconstructable, and that his or her every perception is an understandable way of looking at things. The client can be mistaken in his or her perceptions, reasons, and judgments, but he or she cannot make no sense (Ossorio, 1976/2013; Bergner & Staggs, 1987). In general, the most powerful means of conveying this to clients is simply to assist them in seeing the sense that their various actions, emotions, and attitudes make as these arise over the course of therapy.

Before leaving this policy, a few brief comments seem in order regarding its application to psychotic individuals. First, the policy is not applicable to those cases where there are strong grounds for concluding that the etiology of symptoms is primarily biological. Second, aside from such cases, there is a substantial literature attesting to the social intelligibility of much psychotic behavior that is quite helpful in elucidating its sense (e.g., Bergner, 1985; Haley, 1980; Ossorio, 1997; Wechsler, 1991). Where the therapist is sensitive to the meanings and strategic implications of much so-called "crazy" behavior, he or she will be able to respond to such behavior in a more understanding, and thus more competent fashion. For example, some years ago, a psychotic young man, upon being exhorted by his therapist to "have a nice Christmas," responded to her by saying "Francis Gary Powers." The therapist, who recognized this riddle-like response as a veiled positive wish (Francis Gary Powers was the American pilot implicated in the famous 1960 "U-2 incident," thus "you too!") was in a better position to respond sensitively and appropriately than another therapist who might have dismissed the young man's rejoinder as nonsensical "word salad."

Policy #7: Regard and Treat the Client as an Agent

Truism: *It is better (specifically, more empowering) to see oneself as an agent, i.e., as an individual possessed of the power to consider behavioral options and to select from among them the one to be enacted, than to see oneself as without this fundamental power to determine one's own actions.*

Discussion. Many clients hold implicit or explicit views of themselves in which they are helpless pawns of internal or external forces (Bergner, 1993). They convey this in expressions like "something came over me," "I found myself doing such and such," "so-and-so made me do it," and the like; and these expressions permeate their descriptions of themselves and their actions. They convey this further when they portray themselves as helpless in the face of their "impulses," their longstanding habitual patterns, their personal histories, or their "natures." A "pawn of forces" (e.g., a puppet or a robot) is incapable of engaging in deliberate

action; i.e., of entertaining behavioral options and choosing from among them. "It" is powerless.

In contrast, to be an agent is to be able to entertain behavioral options and to select from among them the one that is to be enacted. It is to have control, albeit imperfect, of one's behavior. It is to have power. Thus, personal agency is included among the a priori status assignments that it is important to include in the therapeutic relationship (Bergner & Staggs, 1987; Bergner, 2007).

Policy #8: Regard and Treat the Client as a Person Who Is To Be Given the Benefit of the Doubt

Truism: *Within bounds of realism, it is better to see oneself in more empowering, status-enhancing ways than in more disempowering, degrading ways.*

Discussion. As therapists, we have options regarding how to view our clients and to portray them to themselves. These options often differ in the degree of empowerment and status enhancement that they embody. For example, a mother who is overly concerned about her child's safety might be viewed by her therapist as either (a) someone who harbors an unconscious hatred of her child, or (b) someone who is utterly convinced that, for her, nothing so good as her child and their relationship can possibly be lasting. The recommended policy here is to treat the client as one who is to be given the benefit of the doubt; i.e., given a choice between different but at least equally realistic ways of viewing a client, to choose as a matter of policy the most empowering and status enhancing of these views (Ossorio, 1976/2013).

Policy #9: Engage the Client as an Ally and Collaborator

Truism: *When attempting to solve problems, it is generally better to have a collaborative alliance with one's fellow problem solver than a non-allied, non-collaborative relationship.*

Discussion. As the old aphorism "two heads are better than one" implies, working in collaborative alliance with another, and particularly another who has more expertise relevant to the task at hand, is usually more enabling than working alone, and certainly more enabling than being involved in a non-allied, non-collaborative relationship with this other. Thus, involving the client as an ally and a collaborator is recommended (cf. Beck & Weishaar, 2008, on "collaborative empiricism"; Orlinski, Ronnestad, & Willutski, 2004).

"A priori status assignment" has a somewhat different meaning here than it does elsewhere. Where alliance is concerned, one does not assume at the outset that the client is an ally, in the same sense that one assumes he or she is acceptable or sense-making. Rather, it means that the therapist enters therapy from the outset with a commitment to treat the client as an ally. This would ordinarily take the form of initiating the kinds of behaviors toward the client that one would initiate with an ally, thus inviting and encouraging the client to enact reciprocal role behaviors. The client may respond by immediately enacting the complementary role, thus establishing an alliance. Or the client may not do so, necessitating additional efforts to establish the alliance (see Bergner & Staggs, 1987; Schwartz, 1979).

Policy #10: Acquire and Convey an Understanding of the Client

Truisms: *(1) A person who possesses a strong understanding of a problem is more likely to solve it than one who lacks such an understanding. (2) Other things being equal, a person is more likely to cooperate with another person who seems to empathically understand him or her than with another person who seems neither empathic nor understanding.*

Discussion. The policy here, again one consistent with widespread practice (Kohut, 1977; Ossorio, 1976/2103; Rogers, 1957), is to listen carefully to the feelings and concerns being communicated by the client, and then to share our understanding of the important elements. Such an intervention may be used to accomplish a large number of things such as conveying acceptance, demonstrating to clients that we understand what they are saying, clarifying issues for both client and therapist, focusing clients' attention on what is important in their communications, and building rapport and alliance. Further, therapist affirmations can be dismissed by clients if they believe that their therapist does not really know or understand them. It is easy and commonplace for clients to dismiss such affirmations with the following logic: "If my therapist really knew me, he (she) wouldn't find me so acceptable (sense-making, etc.)." Thus, it is imperative that clients be understood and *know that they are understood* if they are to accept the status assignments and other validations of their therapists.

A Final Point

In recommending that all of the above policies be implemented, there is no implication that all of our clients feel deficient in all of these ways. Clearly, they do not. However, in those cases where they do not feel deficient, to eliminate any one of these status assignments from the therapeutic relationship would be a serious mistake. For example, even if a client already believed herself acceptable (or sense-making, possessed of personal agency, etc.), we would obviously be remiss if we regarded and treated her as unacceptable (irrational, helpless to control her own behavior, etc.). The elimination of any of the relational elements listed above presents the danger of a countertherapeutic, degrading relationship between therapist and client in which constructive self-assigned statuses that the client possessed initially might be undermined by the therapist's treatment. Such a relationship would create a risk of serious iatrogenic harm.

Further Key Therapeutic Policies

The following policy recommendations, unlike the foregoing, do not cohere around a single principle of unification. Rather, they represent a miscellany of ideas that the author and his therapeutic colleagues have found especially valuable in their experience.

Policy # 11: Deal With the Basis of Emotions

Truism: *A person is more likely to achieve relief from a problematic emotion when the basis of that emotion is eliminated than when it is not eliminated.*

Discussion. The contemporary mental health establishment, in its explicit or implicit policies, frequently embodies a denial of the truth contained in this truism. Some practitioners, in their exclusive reliance on drugs to eliminate states such as depression and anxiety, in effect follow a policy that it is sufficient to chemically eliminate the painful feelings of clients and not to bother with their source in the client's life and/or thinking. Other practitioners at times rely too exclusively on interventions such as relaxation training and meditation to reduce painful feelings, while failing to attend to the factors triggering these feelings. Finally, the practitioners of cathartic interventions, increasingly rare, encourage clients to deal with their dysphoric emotions by expressing or "ventilating" them. The rationale here is that these emotions are like so much pressure that has built up in the pressure cooker and must be released lest the cooker explode – all the while ignoring the fire that continues to burn beneath the cooker.

The point here is not to assert that the above forms of intervention are without merit. The point, rather, is to say that a fuller and more adequate fundamental policy is needed here. "Deal with the basis of emotions" (Ossorio, 1976/2013) is such a policy. The position upon which it rests is that, first of all, emotions do not exist in a vacuum. They rest on appraisals of events and situations. Fear rests on the appraisal that one is threatened or endangered, anger on the appraisal that one stands provoked, sadness on the appraisal that one has suffered a loss or other misfortune, and so forth (Beck, 1976; Bergner, 2003; Ossorio, 1997). Such appraisals of reality may be well- or ill-founded. The tiger before us may be real or a "paper tiger." The policy to deal with the basis of emotions urges us as clinicians to carefully investigate the perceptions or appraisals upon which the client's problematic emotions rest. Should we discover that the emotion rests on a misperception or otherwise maladaptive interpretation, our therapeutic task becomes the traditional cognitive therapeutic one of assisting the client to modify such problematic appraisals. If the emotion rests on a veridical perception or interpretation--the client's marital situation is indeed abusive, the personal loss has indeed drastically diminished the client's world, etc.--our task becomes that of assisting our client, in whatever way appropriate, to act in such a manner as to deal effectively with their problematic situation.

A final word about medications is perhaps in order before leaving this topic. *Merely* following a policy of narcotizing away one's pain with drugs, on the present view, is akin to disconnecting the flashing oil light in one's car and doing nothing about the failing engine. However, medications may serve a far more valid and valuable purpose. At times, emotional states such as anxiety, depression, and grief are of such proportions that they are immobilizing. They prevent persons from doing what they need to do to deal with the sources of their emotions. In such circumstances, medications are often very helpful in reducing the emotional state and its paralyzing effects. However, in this instance, as the policy and its associated truism suggest, they would ideally be part of a two-pronged strategy: get mobilized *and* deal with the source of the emotion.

Policy #12: Appeal to What Matters

Truism: *A person is more likely to act on the basis of what matters to him or her than on the basis of what does not.*

Discussion. The therapeutic policy to appeal to what matters suggests that therapeutic efforts in general be aligned with the client's existing motivations (Bergner, 1993; Fisch, Weakland, & Segal, 1982; Miller & Rollnick, 2002). Expressed negatively, it recommends that we avoid such actions as promoting therapeutic agendas that are antithetical to the client's motivations, appealing to motives that, however commendable, the client does not possess, or declaring clients "unmotivated" (cf. deShazer, 1984). Expressed positively, the recommendation is that therapists assess the client's existing motivations, and subsequently frame all suggestions, reframes, and other messages in such a way that they tap into what already counts for this person as reasons for or against behaving in certain ways. Thus, for example, if moral considerations are paramount for certain clients, this policy would suggest that we are relatively unlikely to succeed by urging such persons to "give up their irrational shoulds." We are more likely to be successful by portraying problematic behavior as in some way contrary to the person's existing moral values, and new, potentially beneficial behavior as consistent with those values (e.g., as "tough love" or "giving" or "just"). Similarly, clients who value highly such things as personal control, independence, integrity, uniqueness, or rationality may best be approached in ways that are consistent with and that utilize these existing values.

Policy #13: Utilize the Client's Strengths and Resources

Truism: *A person who possesses strengths and resources relevant to solving a problem, and who recognizes how these may be used to do so, is in a better position to solve that problem than someone who fails to recognize these things.*

Discussion. This policy, known famously as Milton Erickson's "principle of utilization" (O'Hanlon & Weiner-Davis, 2003), advocates first of all that we as therapists recognize that every client possesses strengths and resources--that they possess enabling abilities, knowledge, traits, ideas, motives, roles, and/or positions of leverage--that may be brought to bear on the problems at hand. It advocates further that we assist clients in first of all recognizing these strengths and resources, and secondly, in utilizing them to solve their problems.

Policy #14: Establish and Utilize the Client's Control

Truism: *A person who is in a position of control in relation to some problem, and who recognizes this, is in a better position to solve this problem than a person who is not in a position of control or who does not recognize being in such a position.*

Discussion. Many psychotherapy clients hold *victim formulations* of their problems (Bergner, 1993). That is, they conceive their problems in such a way that their source, and thus their resolution, is seen as lying outside their personal control. This problem source may be seen as something *personal* such as their own emotions, limitations, irresistible impulses, personal history, nature, or possession of a mental disorder. Or it may be seen as something *environmental* such as their current circumstances or the actions, limitations, or character of another. In either

case, this source is seen as something that is not subject to the client's personal control. The upshot of such problem formulations is that their holders cannot envision any actions that they might take to bring about change and, in fact, have often come to therapy at a point where they have exhausted the behavioral options afforded by these formulations (Ossorio 1976/2013, Watzlawick, Weakland, & Fisch, 1974).

The therapeutic policy "establish and utilize the client's control" advocates that we carefully investigate the client's portrayal of the problem to determine if he or she in fact occupies a position of control in relation to this problem. Subsequently, should we discover that they do occupy such a position, this policy recommends that we work to enable the client to recognize this position of control and power, to fully occupy (or "own") this position, and to exploit it to bring about change.

Many client complaints, upon inspection, may be found to have both a "perpetrator end" and a "victim end" (Bergner, 1993). Victim formulations result when clients are aware only of the victim end with its attendant emotional pain, low self-esteem, and other liabilities, but remain unaware of the perpetrator end of the problem, the end where they are actively *producing* some sort of unfortunate behavior which creates or maintains the problem. Being unaware of this perpetrator end results in clients believing that this pain, low esteem, or other consequences are visited upon them and are outside their control. Essentially they have left a critical part of the problem out of their formulation, and this has resulted in a failure to solve it. For example, many clients beset with painfully low self-esteem may be found upon assessment to be the active perpetrators of destructive forms of self-criticism (Bergner, 1995). Many individuals who experience behavioral paralysis and an inability to derive satisfactions in life may be found to be persons who, on the perpetrator end of things, coerce themselves excessively, and subsequently rebel against their own oppressive regime of self-governance (Bergner, 1993). By way of final example, many clients experience themselves as victims of mistreatment from others, but fail to realize that the actions of these others represent reactions to their own behavior, often in the context of the sort of interactive "dance" much discussed by family systems therapists. In such cases, the present policy advocates that, while taking pains to avoid doing so in a needlessly blaming way, we help clients to recognize their positions of control and power, and to utilize these positions to bring about change.

Policy #15: Respect Both Sides of the Client's Ambivalence

Truism: *A person whose decision rests on a consideration of all of their significant reasons pro and con is likely to make a better decision than one who attempts to disregard one of these sets of reasons.*

Discussion. To be ambivalent about doing something is to have reasons for and against doing that something. In general, when ambivalent individuals fail to resolve their ambivalence and simply act on one side of it, their reasons for acting on the other side do not cease to exist but, left unsatisfied, become more salient (Bergner, 1993). Consider the commonplace phenomenon, well known to

automobile salespeople, of individuals who are ambivalent about buying a specific car. Frequently, those who buy the car, thereby satisfying the reasons on one side of their ambivalence, find themselves experiencing "buyer's remorse," i.e., a strong preoccupation with all of the reasons why they should not have bought the car. In contrast, those who, before they can make up their mind, learn that the desired car has been sold and thus that they can no longer act on their reasons to buy it, frequently find themselves preoccupied with all of the reasons why they should have acted sooner and bought the car. When one acts on one side of an ambivalence, one satisfies one's reasons for acting on this side, but leaves unsatisfied a whole set of still existing reasons for acting on the other side, thus rendering them highly salient relative to the satisfied reasons.

As psychotherapists, we are confronted frequently with deeply conflicted, ambivalent clients. Should they leave their spouse or not?...quit drinking or not?... give up the affair or not?...cease their punitively self-critical approach to themselves or not? The policy, "Respect both sides of the client's ambivalence," recommends that as therapists we (a) assess the client's reasons for and against important courses of action, (b) respect the fact that both sets represent existing operative reasons for this individual, and (c) assist the client in arriving at a personal decision that is made with full consideration of their reasons on both sides of the conflict. Stated negatively, the policy states that we should not, in the face of a conflicted client, simply ignore or minimize the significance of certain of the client's reasons, and encourage them to act on the other side of their ambivalence (Miller & Rollnick, 2002). Doing so in essence leaves something ignored or insufficiently considered that will undermine the client's ability to make a firm, personally integrated decision, and to act on that decision with comfort and conviction. For example, a therapist, hearing that a client is ambivalent about leaving a spouse who is mistreating her, simply urges her to leave. What this therapist can expect is that the woman will express the other side of her ambivalence (her reasons not to leave her spouse) in such forms as remaining on the fence with respect to her decision, resisting the therapist (who may in these circumstances be perceived as coercive), or, if she leaves her husband, continuing to have doubts and reservations about what she has done. Her ability to make an integrated personal decision, and to pursue a subsequent course of action with comfort and conviction, will have been undermined by the therapist.

Policy #16: Avoid Generating Resistance

Truism: *A person who recognizes that he or she has stronger reason to cooperate with therapeutic agendas than to resist them is more likely to cooperate with such agendas.*

Discussion. Given the relevant ability and opportunity, "if a person has a reason to do something, he will do it, unless he has a stronger reason to do something else..." (Ossorio, 1998, pp. 37-38). For any given behavior, a person has reasons for and against engaging in that behavior. Eating the ice cream would be enjoyable, but it is fattening. Mowing the lawn would make the yard look better, but it is hot, tedious work. And so forth. From the vantage point of Ossorio's maxim,

when therapy clients refuse or decline to engage in some suggested behavior or to accept some alternative view of things, the basic general diagnosis is this: As they see things, they have stronger reason not to.

Ideally, therapy would be resistance-free. Our clients, in the face of some potentially beneficial new behavior or view of reality, would have stronger reason to engage in this behavior or consider this view, and would proceed accordingly. The policy, "avoid generating resistance," advocates that to the extent possible we conduct therapy so as to minimize the presence of resistance; i.e., to minimize the presence or salience of those "stronger reasons not to." (Bergner, 1993; deShazer, 1984; O'Hanlon & Weiner-Davis, 2003).

It may be noted that many of the policies articulated above, along with their other benefits, serve to minimize resistance to our therapeutic agendas. We position ourselves on the client's side in an alliance, thereby giving the client reason to cooperate with us. We seek to understand and to convey this understanding to the client, thereby becoming persons who speak to the client from a true understanding, and thus more likely to be listened to and found credible (cf. Covey's maxim, "seek first to understand, then to be understood" [1989, p. 235]). We offer portrayals of the client's reality that are realistic yet minimally degrading or otherwise invidious, thereby rendering them easier to accept. In our reframes and suggestions for new behavior, we carefully align these with the client's existing motivations. Finally, we custom tailor our messages in terms of the client's favored language, metaphors, world views, and conceptions of the problem. Thus, successful adherence to all of these policies greatly enhances the likelihood that clients will be receptive to and cooperative with our inputs, and greatly reduces the likelihood of resistance.

In addition to adhering to these policies, another critical element if we are to avoid generating resistance is to avoid doing anything in the therapy hour that might in fact be, or might be seen as being, coercive toward the client, on the premise that such coercion tends to elicit resistance (Ossorio, 1976). That is, the presence of any pressure from us as therapists that is perceived as untoward by our clients will tend to elicit resistance on their part. The pressure at issue may be seen as unfair, insensitive, threatening, authoritarian, presumptuous, or in any other way untoward.

At times, of course, whether we have generated it or not, we do encounter resistance. In the face of such resistance, working this policy in reverse as it were, the recommendation is that we attempt to ascertain its source, and address the client's resistance or reluctance depending on what we discover. Have we as therapists been coercive, or been seen as coercive, in some way? Have we miscalculated the client's reasons for and against something, and thereby suggested something that he or she has stronger reason not to accept? Have we asked the client to do something that he or she is not ready to do, or that is currently beyond his or her capabilities? Establishing any of these, we act to adjust our directives and messages in relevant ways, or to remove ourselves from a position of perceived coercer and back to that of supportive and understanding ally.

Policy #17: Establish and Maintain Self as Credible

Truism: *The statements and action implications of credible persons are more likely to be believed and accepted than those of non-credible persons.*

Discussion. If clients are to accept our ideas, suggestions, and status assignments, they must find us *credible* (Bergner & Staggs, 1987; Frank & Frank, 1993; Schwartz, 2008). In practice, this means that we must strive to be honest, knowledgeable, and competent, and that clients must see us in these ways. Behaviors such as interviewing skillfully, conveying an accurate and empathic understanding of the client, providing explanations that are cogent and compelling, citing relevant research and other literature, presenting ourselves in unobtrusive ways as experienced and successful, dressing and behaving professionally, and creating a physical environment with elements such as books and diplomas that suggest competence, are all helpful in achieving credibility with most clients. Behaviors such as denigrating ourselves, conveying undue confusion or tentativeness, espousing theories that appear strange or unconvincing to the client, lying, or behaving unprofessionally will as a rule detract from credibility, and therefore damage our ability to function as effective agents of change.

Policy #18: Assess What Matters

Truism: *An assessment based only on facts that are relevant to the problem at hand is likely to be superior to one that contains many extraneous and irrelevant factors.*

Discussion. This policy advocates that we as clinicians behave in a manner analogous to a detective who first determines the precise nature of the crime to be solved, and then uses this as a guide to determine what other facts seem to be evidentially relevant to solving this crime. On this "detective model," in contrast with assessment methods in which the information to be gathered is predetermined, the clinician begins by getting a clear picture of the presenting concern(s). He or she then uses this picture to determine what kinds of facts are relevant to creating an explanatory account of the problem, and focuses efforts on gathering these facts. Such an approach streamlines the assessment process by minimizing time spent gathering extraneous information. Assessment practices such as *routinely* performing a mental status examination, giving questionnaires or projective measures, administering intelligence tests, and asking about numerous pre-selected topics are ruled out. The recommendation is that such procedures be employed only in circumstances where the specifics of the case indicate that there is probable cause to warrant such use. For example, in certain cases, it might prove very difficult to establish something important unless one administers an MMPI to the client.

Policy #19: Go First Where You Are Welcome

Truism: *A person is more likely to admit his or her own problematic actions and attitudes to another person when they are assured that this other appreciates their point of view with respect to problems and issues.*

Discussion. There is fairly universal agreement in the field of psychotherapy that one of our initial jobs as therapists is to establish an alliance with our clients in which we function as accepting, supportive individuals who are genuinely on their side (Orlinski et al., 2004). Not infrequently, however, clients present a panoply of information during initial assessment which leads us to conclude, not only that they are suffering and struggling to cope with difficult circumstances, but that they are themselves the perpetrators of untoward behavior and/or the holders of quite unbecoming attitudes. In such circumstances, the policy, "Go first where you are welcome" advocates that we initiate treatment by focusing first on clients' distress and complaints, and only later take up the matter of how they themselves may be contributing to these in questionable ways. Thus, early attention would focus on listening carefully to clients' emotional suffering and personal dilemmas, conveying an empathic understanding of them, and establishing both that we genuinely understand their point of view and that we are on their side. Later, once the alliance is established, we tactfully broach the matter of clients' contributions to their own problems. In such a circumstance, clients, assured that we understand and accept them, that we see their point of view, and that we are there for their benefit, are far more likely to disclose these aspects, to be less defensive about them, and to be responsive to our interventions.

Policy #20: If It Works, Don't Fix It

Truism: *If it works, don't fix it.*

Discussion. The recommendation here is that, if as therapists we discern client characteristics, attitudes, or behaviors that are functional, we ought not to portray such elements to the client as problematic or pathological. While this point is obvious, it is also frequently violated. One of the areas where this seems especially so is when clients conduct themselves in ways that are not in conformity with a certain widespread ethos among therapists. When dealing with issues between themselves and others, for example, they may never raise their voice and "get out their anger"; nonetheless, the facts indicate that their message gets across and that they are effective in their negotiations. Other clients may use humor to lighten problematic situations, but there is no indication that they thereby fail to comprehend their gravity or to deal adequately and realistically with them. Yet others communicate more with their actions than with their words; the facts of the case reveal, however, that the message is generally clear and received. The policy, "If it works, don't fix it," advocates that, rather than portraying such clients to themselves in terms such as "can't express anger," "uses humor as a defense mechanism," or "can't communicate," we recognize and appreciate the client's way of doing things so long as we see that "it works."

Discussion

Policies and Common factors

An important topic in the field of psychotherapy has been the exploration of *common factors* that transcend, and are critical to the success of, a wide variety of therapeutic approaches (Luborski, 1995; Messer & Wampold, 2002; Reisner, 2005).

The policies presented in this paper all represent common factors. They do so, not in the traditional sense, but in the logical sense that they are compatible with any approach to therapy. Though historically generated in connection with various schools of psychotherapy, they are not confined to their original homes or to any single theoretical approach, and may be followed beneficially in connection with any of them. It is beneficial, for example, to "respect both sides of the client's ambivalence," "deal with the basis of emotions," and "appeal to what matters" regardless of whether one is undertaking cognitive, behavioral, systemic, or status dynamic intervention strategies.

Policies and Therapy Integration

A further important topic in the field of psychotherapy has been the search for an integrative framework that would unify what are now considered discrete and competitive approaches to psychotherapy (Norcross & Goldfried, 2005). In this regard, it was noted above that various prominent theoretical points of view are integrated into the set of policies described in this paper, and that the overall set is thus integrationist in nature. For example, the first four policies incorporate the core ideas of the cognitive, behavioral, biological, and family systems schools of psychotherapy. Each is presented, however, not as a discrete theory in a balkanized world of competitive theories, but as (a) a prima facie sensible policy to be followed in relevant circumstances, and (b) one that is logically related to the others via its relation to the kinds of deficits at issue when persons are restricted in their ability to behave in critical ways; i.e., when they are in psychopathological states (Bergner, 1997, 2004).

Policies, Flexibility, and Creativity

As noted in the introduction, policies are not posed at the level of concrete behavioral procedure, but at the level of engaging in some (unspecified) action whose desirability rests on definitional or other prima facie grounds. Their form is, "act in accord with this policy guideline," not "engage in this concrete behavior," leaving the latter an open (and more empirically driven) matter. Pragmatically, what policies do is provide enormous directionality to therapeutic behavior. In this respect, again, they are not unlike recommending to the chess novice that he or she "try to checkmate the king." Further, and again analogous to that instruction, policies do not restrict the practicing clinician to a limited number of concrete interventions, such as the set that has currently received empirical support. Aaron Beck, for example, in a commercially distributed demonstration of cognitive therapy with a depressed woman, engages in at least four distinct ways to get her to rethink a maladaptive belief (Beck et al., 1979). In doing so, he is clearly guided in his efforts by the broad, policy-level agenda of helping this woman to abandon her core maladaptive schema. In the session, when he meets with limited success by using certain standard interventions such as reviewing the empirical evidence for her belief, he "goes outside the standard playbook" and intervenes in other very creative and flexible ways. Consistent with this example, policies in general lend themselves to enhanced levels of creativity and flexibility.

Modular Structure Permits Easy Expansion

In this article, I have tried to provide, not an exhaustive list of therapeutic policies, but a sample sufficient to exhibit how a policy framework might be used to form a comprehensive framework for psychotherapy. Rather than introducing further policies, I will conclude only by noting how this essentially modular structure lends itself to easy expansion via the addition of further policies.

Summary

This article has explored the use of therapeutic policies in the conduct of psychotherapy, and in doing so introduced an alternative intellectual framework for psychotherapy. Part 1 of the paper explicated the nature of therapeutic policies. Parts 2, 3, and 4 presented and discussed a selection of representative policies. Finally, part 5 argued the value of policies as common factors in psychotherapy, as embodying an integrative framework for therapy, and as lending themselves to enhanced levels of creativity and flexibility in the practice of psychotherapy.

Author Notes

The author wishes to thank Nora Bunford, Joe Jeffrey, Wynn Schwartz, and Sonja Holt for their very helpful reviews of an earlier version of this paper. Please direct all correspondence to: Raymond M. Bergner, Department of Psychology, Il-linois State University, Normal, IL 61790-4620.

References

Beck, A. (1976) *Cognitive therapy and the emotional disorders.* New York: Meridian.

Beck, A., Rush, A., Shaw, B. & Emery, G. (1979). *Cognitive theory of depression.* New York: Guilford.

Beck, A., & Weishaar, M. (2008). Cognitive therapy. In R. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. *263-291*). Belmont, CA: Thomson/Brooks-Cole.

Bergner, R. (1985). Paranoid style: A descriptive and pragmatic account. In K. Davis & T. Mitchell (Eds.), *Advances in Descriptive Psychology* (Vol. 3, pp. 203-230). Greenwich, CT: JAI Press.

Bergner, R. (1993). Victims into perpetrators. *Psychotherapy: Theory, Research, and Practice, 30*, 452-462.

Bergner, R. (1995). *Pathological self-criticism: Assessment and treatment.* New York: Springer.

Bergner, R. (1997). What is psychopathology? And so what? *Clinical Psychology: Science and Practice, 4*, 235-248.

Bergner, R. (1999). Status enhancement: A further path to therapeutic change. *American Journal of Psychotherapy, 53*, 201-214.

Bergner, R. (2003). Emotions: A relational view and its clinical applications. *American Journal of Psychotherapy, 57*, 471-490.

Bergner, R. (2004). An integrative framework for psychopathology and psychotherapy. *New Ideas in Psychology, 22,* 127-141.

Bergner, R. (2007). *Status dynamics: Creating new paths to therapeutic change.* Ann Arbor, MI: Burns Park Publishers.

Bergner, R. & Staggs, J. (1987). The positive therapeutic relationship as accreditation. *Psychotherapy: Theory, Research, and Practice, 24*, 315-320.

Bowen, M. (1978). *Family therapy in clinical practice.* New York: Jason Aronson.

Biletzki, A. & Matar, A. (2011). Ludwig Wittgenstein. In E. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (URL =<http://plato.stanford.edu/archives/sum2011/entries/wittgenstein/>).

Colapinto, J. (2000). Structural family therapy. In A. Horne (Ed.), *Family counseling and therapy* (3d ed., pp. 140-167). Itasca, IL: Peacock.

Covey, S. (1989). *The seven habits of highly effective people.* New York: Fireside/Simon & Shuster.

de Shazer, S. (1984). The death of resistance. *Family Process 23:* 1-17.

de Shazer, S., & Dolan, Y. (2007). *More than miracles: The state of the art of solution-focussed brief therapy*. New York: Haworth Press.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Lyle Stuart.

Ellis, A. (2008). Rational emotive behavior therapy. In R. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. 187-220). Belmont, CA: Thomson/Brooks-Cole.

Fisch, R., Weakland, J. & Segal, L. (1982). *The tactics of change.* San Francisco: Jossey-Bass.

Foa, E., Dancu, C., Hembree, E., Jaycox, L., Meadows, E., & Street, G. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67,* 194-200.

Frank, J., & Frank, J. (1993). *Persuasion and healing: A comparative study of psychotherapy.* Baltimore, MD: Johns Hopkins University Press.

Gottman, J. (2011). *The science of trust: Emotional attunement for couples.* New York: Norton.

Haley, J. (1980). *Leaving home.* New York: McGraw-Hill.

Julien, R. (2008) *A primer of drug action (11th ed.)*. New York: Worth.

Kazdin, A., Siegel, T., & Bass, D. (1992). Cognitive problem solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology, 60*, 733-747.

Kohut, H. (1977). *The Restoration of the Self.* New York: International Universities Press.

Luborski, L. (1995). Are common factors across different psychotherapies the main explanation for the dodo bird verdict that "Everyone has won and all must have prizes"? *Clinical Psychology: Science and Practice, 2,* 106-109.

Merrill, K., Tolbert, V. & Wade, W. (2003). Effectiveness of cognitive therapy for depression in a community mental health center: A benchmarking study. *Journal of Consulting and Clinical Psychology, 71*, 404-409.

Messer, S., & Wampold, B. (2002). Let's face it: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice, 9*, 21-25.

Minuchin, S. (1974). *Structural family therapy.* Cambridge, MA: Harvard University Press.

Miller, W., & Rollnick, S. (2002). *Motivational interviewing* (2d. ed.). New York: Guilford.

Norcross, J., & Goldfried, M. (Eds.) (2005). *Handbook of psychotherapy integration* (2nd. ed.). New York: Oxford University Press.

O'Hanlon, W., & Weiner-Davis, M. (2003). *In search of solutions* (2d. ed.). New York: Norton.

Orlinsky, D. E., Ronnestad, M. H., Willutski, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behaviour change* (5th Ed.). New York: John Wiley & Sons.

Ossorio, P.G. (2013). *Seminar on clinical topics*: *The collected works of Peter G. Ossorio, Vol. VII.* Ann Arbor, MI. Descriptive Psychology Press. (original work published 1976.)

Ossorio, P.G. (1997). *Essays on clinical topics.* Ann Arbor, MI: Descriptive Psychology Press.

Ossorio, P.G. (1998). *Place*. Ann Arbor, MI: Descriptive Psychology Press.

Ossorio, P. G. (2006). *The behavior of persons.* Ann Arbor, MI: Descriptive Psychology Press.

Papero, D. (2000). Bowen family therapy. In A. Horne (Ed.), *Family counseling and therapy* (3d ed., pp. 272-299). Itasca, IL: Peacock.

Raimy, V. (1975). *Misunderstandings of the self*. San Francisco: Jossey-Bass.

Raskin, N., & Rogers, C., & Witty, M. (2008). Client-centered therapy. In R. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. 141-186). Belmont, CA: Thomson/Brooks-Cole.

Reisner, A. (2005). The common factors, empirically validated treatments, and recovery models of therapeutic change. *The Psychological Record, 55,* 377-399.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.

Schwartz, W. (1979). Degradation, accreditation, and rites of passage. *Psychiatry, 42*, 138-146.

Schwartz, W. (2008). Self presentation and the status dynamics of psychotherapy and supervision. *American J Psychotherapy, 62*, 51-65.

Spitzer, R. (1999). Harmful dysfunction and the DSM definition of mental disorder. *Journal of Abnormal Psychology, 108,* 431-432.

Wakefield, J. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *American Psychologist, 47*, 373-388.

Wakefield, J. (2007). The concept of mental disorder: diagnostic implications of the harmful dysfunction analysis. *World Psychiatry,* 6, 149-156.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: Norton.

Wechsler, R. (1991). Personality and manic states: A status dynamic formulation of bipolar disorder. In M. Roberts & R. Bergner (Eds.), *Clinical topics: Contributions to the conceptualization and treatment of adolescent-family problems, bulimia, chronic mental illness, and mania* (Vol. 6, pp. 203-234). Ann Arbor, MI: Descriptive Psychology Press.

Widiger, T., & Trull, T. (1991). Diagnosis and clinical assessment. *Annual Review of Psychology, 42,* 109-133.

White, M. (1993). Deconstruction and therapy. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations.* New York: Norton.

Wilson, G. (2008). Behavior therapy. In R. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. *223-262*). Belmont, CA: Thomson/Brooks-Cole.

Wittgenstein, L. (1953). *Philosophical investigations.* New York: Macmillan.