Chapter 8
Toward a Unified Psychotherapy

> *[P]sychotherapists behave like members of competing tribes, with different esoteric languages and rituals. Unification assumes that we all work in the same realm with the same processes regardless of the subsystem or specific domain we emphasize and specialize in. A unified model encourages us all to be aware of the larger picture and even if domain-specific treatment is undertaken, an understanding of the system and interconnections of domains and processes keep us alert to other possibilities for further developments.*
> *Magnavita (2008a, p. 273)*

Single-school approaches dominated the practice of psychotherapy in the 1960s and 1970s. The majority of therapists identified with a particular school of thought (e.g., psychoanalytic, behavioral, or humanistic), tended to see their model as representing truth, and many engaged in vigorous—sometimes vitriolic—debates with practitioners from other perspectives. The 1980s saw the rise of eclecticism, which is the unsystematic blending of ideas and techniques from the various schools of thought. Eclecticism is noteworthy because it reflected an attitudinal shift from single-school approaches to more openness to looking at complementary aspects of treatment from different angles. In the 1990s and 2000s, psychotherapy integration became a genuine movement. The *Society for the Exploration of Psychotherapy Integration* (SEPI) formed in the mid 1980s and began swelling in size and influence. The early 1990s witnessed the publication of two handbooks in integrative psychotherapy (Norcross & Goldfried, 1992; Stricker & Gold, 1993), which both detailed a multitude of important developments toward a more integrative approach to the field.

As the psychotherapy integration movement has grown over the years, different approaches to integration emerged, and now four routes to integration are generally recognized, although there certainly are other possible approaches (see Ingram, 2006). The most general approach has been the common-factors approach. Identified strongly with Jerome Frank's (1973) classic work, *Persuasion and Healing*, the common-factors approach is conceptually grounded in a sophisticated folk psychology that emphasizes the general processes of healing that cut across all of the approaches, such as establishing a productive healing relationship,

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giving individuals the opportunity to tell their story and be heard and validated, the instillation of hope and expectation of positive change, and the respected attention of a caring professional. The common-factors approach is empirically grounded in the so-called dodo bird effect, which is the argument that, overall, different theoretical approaches and techniques generally produce similar outcomes, and that the primary variation that is responsible for good outcomes is associated with therapist, client, and relationship variables, rather than specific theories or techniques (Wampold, 2001).

Technical eclecticism is another line of integration, and it focuses on applying techniques that work from any perspective, although relatively little attention is given to the theoretical or conceptual structure that gave rise to the technique. A third approach, assimilative integration, is like technical eclecticism in that an advocate maintains a particular theoretical foundation, but the focus is more on assimilating and integrating key ideas from various perspectives, at both the level of theory and techniques. Sophisticated forms of assimilative integration have been developed from psychodynamic and cognitive behavioral schools of thought. Although I am now characterizing my approach in terms of assimilative integration in that I use the unified theory to assimilate and integrate key insights from the major approaches, theoretical integration is the final route to integration and is probably nearest to the approach adopted by the unified theory. Theoretical integration focuses its attention on the theoretical structure of two or more schools of thought and looks to blend the ideas into a more coherent model.

Although the integration movement has grown and is now certainly part of the mainstream of thought in psychotherapy, it nevertheless has faced obstacles and detractors, and currently it is unclear if the movement will continue to grow, if it will evolve into a unified movement, or if it has reached its apex and conceptual disagreements will remain pervasive. Norcross (2005) listed five obstacles that confront psychotherapy integration: (1) partisan zealotry and the territorial interests of proponents of "pure" schools of thought; (2) inadequate training and the difficulties of developing an effective, comprehensive training program; (3) fundamental differences in epistemology and ontology; (4) the lack of a common language and background of understanding resulting in a Tower of Babel; and (5) the challenge of continually expanding elements that need to be incorporated. I believe that the name of the primary professional organization in psychotherapy integration, SEPI, is telling in this regard in the sense that the most the early pioneers hoped for was individuals who were open to exploring the possibility of some rapprochement, as opposed to the actual vision and commitment to a clearly specified integrative viewpoint.

It is my firm belief that these obstacles can be overcome and when they are, a new phase in the evolution of psychotherapy will emerge, that of unification. Indeed, several pioneering scholars have already carried the baton forward in this direction, and before I articulate how the unified theory advances the shift toward a unified approach to psychotherapy, it is important to review the recent developments that others have made in this domain. Jeffrey Magnavita has probably

done more than anyone else in this area, and has recently founded the Unified Psychotherapy Project, of which I am a proud contributor. In 2008, he and his colleague Jack Anchin co-edited a special issue of the *Journal of Psychotherapy Integration* that was devoted to the movement toward a unified psychotherapy (Anchin & Magnavita, 2008), reflecting a possible shift in the Zeitgeist (see also Curtis, 2009).

In laying his vision toward a unified psychotherapy, Magnavita (2008a) called for the construction of a unified clinical science, which consists of the intersection and amalgamation of personality theory, developmental psychopathology, and psychotherapy in a way that allows for the identification of the structures, processes, and mechanisms that are involved in the major domains of human functioning. In terms of the unified theory, unified clinical science represents the effective cooperation between human psychology and the profession. Much as in the present work, Magnavita outlined a hierarchy of human functioning on a dimension of complexity that began with the neurobiological and extended into the intrapsychic and then into relational processes at dyadic, triadic, and small group levels. Finally, there is the broad sociocultural ecological system in which events taking place at each of these more microscopic levels are embedded.

The utility of this framework is that it provides a holistic picture that allows clinicians and researchers a map of the various places in which one can intervene, and from it Magnavita (2008a) delineated a unified component systems approach that specifies the parts in the system that make up the whole. For example, Magnavita (2005) identified the intrapsychic level as being mediated by neurobiological processes and consisting of broad, interconnected domains or systems that are frequently the focus of intervention. He identified four intrapsychic systems, which included (1) the attachment system, with refers to the constellation of relational needs and internal working models; (2) the affective system, which refers to the emotional feeling states of the individual; (3) the defensive system, which refers to the ways in which individuals consciously or unconsciously structure their internal experience to maintain equilibrium and comfort; and (4) the cognitive system, which refers to the schema or information-processing templates that individuals have for making sense of the world. As Magnavita (2005) noted these systems are closely interconnected and reciprocally influence one another but they nevertheless can be conceptually separated readily enough to have meaning for classifying intrapsychic processes and interventions. With his unified component systems in place, Magnavita (2008a) then broadly characterized psychotherapy as the process of restructuring various aspects of the system to achieve better functioning.

I hope that it is apparent that there is much correspondence between the unified approach to psychotherapy being proposed by Magnavita and the framework offered here. A primary difference is that the unified theory explicitly concerns itself with the deep philosophical, theoretical, and conceptual issues that have plagued the field since its inception, whereas Magnavita has tended to not dive as deeply into these issues but instead his approach has been to invite scholars to see the possibility of a general, unified conceptual scheme. Nevertheless, it is clear that both Magnavita

and I are seeing the outline of the same elephant. Both of us emphasize the need to think in terms of nested hierarchies that range in scope from the biological to the sociocultural, and there are clear similarities in the major intrapsychic component systems that Magnavita delineates and the domains and architecture of the human mind outlined by the unified theory. For example, the affective system has strong parallels to the experiential system, the attachment system parallels the Influence Matrix, and the defensive system with the Freudian and Rogerian filtering processes. From the vantage point of the unified theory, Magnavita's cognitive system would need to be divided into nonverbal perceptual processes and language-based justification systems. Later in the chapter I present a unified component systems approach to conceptualizing people built from the structure of the unified theory that directly corresponds with Magnavita's approach.

Assimilating and Integrating Key Insights from the Major Approaches in Psychotherapy

The unified theory is proposed as a new system of thought that can assimilate and integrate many different lines of research and practice in psychology into a coherent whole via the insights afforded by Behavioral Investment Theory, the Influence Matrix, the Justification Hypothesis, and the ToK System. The introducing of a new meta-theoretical formulation makes the approach to a unified psychotherapy taken here quite different from other approaches to psychotherapy integration. That is, most clinicians and theorists in the integrative psychotherapy movement have based their claims for integration on combining existing theories or on the findings of equivalence of outcomes or combining therapeutic techniques or on the logic of seeing the clients and the world through each of the major perspectives rather than explicitly generating new theoretical formulations that can assimilate the existing paradigms (for one such exception, see Marquis, 2008).

In the next section, I show how the unified theory can help psychotherapists overcome one of the major obstacles to greater unification, which is the lack of a shared language and conceptual framework to guide our inquiries. However, before articulating how the unified theory accomplishes this, I need to acknowledge a caveat. The field of psychotherapy is vast, with an enormous number of perspectives and techniques delineated by a wide variety of variable clusters, such as (a) the nature of presenting problems (e.g., anxiety or marital difficulties) and diagnoses of psychopathology (e.g., Major Depression or Borderline Personality Disorder); (b) schools of thought (e.g., cognitive or psychodynamic approaches), associated techniques (e.g., relaxation, role playing, or dream interpretation), and treatment modality (e.g., individual, couples, family or group therapy, or pharmacotherapy); (c) ethnic and demographic characteristics of the client (e.g., age, race, religion or gender), as well as specific characteristics and values of the client (e.g., the degree of resistance or level of intellectual functioning); as well as (d) the characteristics of the therapist (both general and specific); all of which are influenced by (e) biological functioning; and (F) the larger social context in which the therapy is taking

place. Given the enormous number of variables and the incredibly large body of research in psychotherapy a separate book (at least!) would be needed to cover the relevant issues. As such, I need to hone in on particular areas. I am choosing to focus specifically on the guiding conceptual frameworks for the major approaches to individual psychotherapy with the argument being that the unified theory can go a long way toward providing a shared background of explanation that can assimilate and integrate the key insights from the major approaches in a way that is consistent, coherent, and comprehensive. Thus, the focus here will be on sampling current approaches from the major schools of thought and showing how the key conceptual pieces can be easily understood with the framework provided by the unified theory.

There are six primary domains or schools of thought, represented in Fig. 8.1, which I attempt to integrate into a coherent whole. They are (1) the biological domain, which includes evolutionary theory, genetics, neurophysiology, and biopsychiatry (i.e., mental disease processes); (2) the social domain, which includes the macro-level socio-historical, political, and economic contexts, the community-level context including socioeconomic status, and the more immediate, micro-level relational systems (i.e., the group, the family, and dyadic and triadic relational alignments); (3) Behavioral approaches that emphasize patterns of living, habit formations, associative and operant conditioning, and how individuals adapt to environmental affordances and stressors; (4) Humanistic/Experiential approaches that emphasize the importance of the therapeutic relationship and the centrality of emotional experiencing in mental health; (5) Psychodynamic approaches that emphasize the dynamic relationship between impulses/feelings, anxiety, and defenses, and the centrality of internal working models of self and others, and current interpersonal functioning; and (6) Cognitive psychotherapy approaches that emphasize the structure and content of language-based beliefs, as well as the broad ways individuals make meaning of their lives and the world around them found in existential and narrative therapy approaches. The latter four approaches all emphasize the human psychological level or the level of the individual, whereas the biological approach is "bottom up" and the social systems approach is "top down."

My goal in this chapter is to show that the key concepts, formulations, and insights afforded by the four major individual-level perspectives in psychotherapy

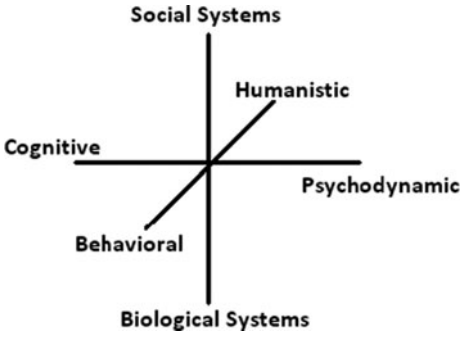

Fig. 8.1 Six primary schools of thought

(cognitive, behavioral, humanistic, and psychodynamic) can readily be incorporated into the conceptual structure provided by the unified theory. To do this, I will review and summarize the key elements, assumptions, and aspects of each therapeutic approach based on the way they were summarized in a recent volume, *21st Century Psychotherapies: Contemporary Approaches to Theory and Practice*, which attempts to provide an overview of "the most popular and widely practice methods in psychotherapy today" (Lebow, 2008, p. 5). For the purposes of demonstrating the utility of the unified theory in assimilating and integrating various perspectives, I chose to utilize a single volume when articulating the key elements of these perspectives because it allowed me to narrow the scope of review and because the authors were given the same outline to follow, and all included information pertaining to history, contemporary practice, key theoretical and treatment principles, and a case study. After reviewing each of the four major perspectives, I will then introduce an approach to conceptualizing based on the unified theory that demonstrates how the key insights from these classic approaches can be assimilated and integrated into a whole.

Key Components of Contemporary Behavior Therapy

Zinbarg and Griffith (2008, p. 8) open their chapter on behavior therapy as follows: "The central defining feature of behavior therapy is that it involves the application of the laws of learning to the modification of problematic behavior." They go on to report that learning theory includes associative and instrumental conditioning and related theoretical concepts like discriminative stimuli, generalization, and extinction. Crucial to the behavior therapy approach is the functional assessment, which involves the attempt to determine the contingencies that are maintaining the problematic behavior and single case designs, usually A/B designs, whereby the therapist obtains a baseline and then intervenes, tracking the changes in the frequencies of emitted behaviors. The authors review the contributions of major behavioral researchers like Pavlov, Watson, and Skinner.

The authors then review major behavioral techniques, such as systematic desensitization and behavioral activation. Systematic desensitization is based on Joseph Wolpe's (1990) idea of reciprocal inhibition, which is the notion that opposite emotional states cannot be experienced simultaneously. In this intervention patients are taught relaxation skills, taught to rate their anxiety and then are exposed either in actuality or via imagination to increasingly threatening stimuli arranged on a fear hierarchy. The theory is that relaxation inhibits the pairing of the stimuli with the fear and enables the individual to habituate. Behavioral activation is a framework for depression that emphasizes the nature of reinforcement in behavioral activity. Based in part on Lewinsohn's (1974) theory that depression arises when there is a scarcity of positively reinforcing contingencies, behavioral activation focuses on ways in which the patient can increase the frequency of positive events and engage in self-monitoring to learn what activities (or lack thereof) were

associated with positive or negative mood states. The authors reported on a dismantling study by Jacobson et al. (1996) that suggested behavioral activation was the most active ingredient in reducing depressive symptoms. Other behavioral interventions described included behavioral rehearsal, flooding and exposure, stimulus control, contingency management, shaping, and skill acquisition.

With regards to the evolution of behavior therapy, the authors note several times in the chapter that there have been two major changes. First, over the past two decades there has been an increasing trend for behavior therapists to incorporate cognitive therapy techniques, and there are now far more therapists who identify as cognitive behavioral as opposed to purely behavioral in orientation. Second, there has been increased recognition of the important role the therapeutic alliance plays in generating good outcomes.

As for the case example, the authors described the treatment of a 55-year-old woman who suffered from chronic depression and generalized anxiety precipitated by losing her job as a nurse 12 years previously. She presented as having lost interest in virtually all activities, low energy, and feelings of worthlessness. She also described many worries, the most troublesome being about her grown son who had had employment difficulties. The treatment initially focused on behavioral activation, which began with psychoeducation about how the withdrawal from activities that afforded mastery and pleasure were likely maintaining her depression because they removed her from coming in contact with positively reinforcing contingencies. Initially, she had a number of negative expectations associated with trying new things, and when she did engage in them she tended to be critical and perfectionistic. Consequently the therapists—who noted that they do utilize cognitive techniques—engaged in cognitive restructuring, which helped her take pride in her willingness to try new things and shifted focus away from negative events.

As her depressed mood began to lift, anxiety became more prominent and the therapist shifted the focus to her worries, especially with regards to her son. The technique known as imagery exposure was used. The authors were informed by Borkovec's model of generalized anxiety (e.g., Borkovec & Inz, 1990), which posits that the shifting attention and linguistic ruminations of those with generalized anxiety disorder paradoxically function to keep the individual from fully experiencing catastrophic images and associated emotions, and this prevents habituation. According to Borkovec's theory, processes of rumination and shifting attention are strengthened through negative reinforcement because they function to avoid the catastrophic image and painful emotional experience. However, the condition is maintained because the unprocessed catastrophic images and associated autonomic arousal continue to emerge periodically and motivate continued avoidance in the form of attentional shifting and linguistic rumination. The therapist in this case worked to maintain exposure to the client's feared images of her son's potentially future failings, such that she was even able to imagine her son committing suicide as a consequence of his employment difficulties. As she became habituated to these images she integrated them into her thought processes and became much less bothered by them. By the end of treatment, her symptoms were greatly reduced.

Behavior Therapy Through the Lens of the Unified Theory

The key insights afforded by traditional behavior therapy can be assimilated and integrated into the unified theory via Behavioral Investment Theory. As the authors articulate, the key principle of behavior therapy is learning theory, which is explicitly listed as the fifth principle of Behavioral Investment Theory. Recall that Behavioral Investment Theory argues that action is a function of the developmental transaction between the animal and the environment, and behavior therapy focuses on and attempts to shift the associations and contingencies in the environment to change the individual's patterns of behavior. If we think about behavior as a form of commerce between the individual and the environment, the behavior therapist focuses on changing what the environment is "selling." This can be seen in how the therapists initially attempted to get the patient exposed to different environments and invest in activities that result in greater mastery and pleasure. Indeed, the primary conceptualization and approach to depression the behavior therapists use is directly consistent with the Behavioral Shutdown Model of depression. Moreover, we can think about the environment selecting the path of behavioral investments via associative and operant conditioning principles. Thus, the logic of Borkevec's model of generalized anxiety would also fall under the conceptual frame provided by BIT.

The problem with a traditional behavior therapy approach is that it historically operates on the assumption that associative and operant learning are all that are necessary to understand people. Consequently, it struggles mightily with effectively explaining complex human relationship processes, intrapsychic experiences, defense mechanisms and conflicts, and sociocultural contextual variables. Given these limitations, it is not at all surprising that the evolution of behavior therapy has been on broadening its focus to include more intrapsychic and relational processes, such as incorporating cognitive perspectives and emphasizing the therapeutic relationship. From a unified theory perspective, this is a good development, but much more needs to be done to effectively incorporate emotional or experiential elements, intrapsychic relational motivations and conflicts, and defensive processes. Behavioral approaches are also vulnerable to criticisms that they are unable to effectively provide a framework for understanding the role of large-scale beliefs, values, and practices, and their influence on assessment and treatment.

Key Components of Contemporary Cognitive Therapy

Kellogg and Young (2008) begin their review of cognitive therapy (CT, or cognitive behavior therapy, which the authors consider as synonymous) by articulating that the approach is based on the foundational assumption that "emotional disturbances are seen as emerging from problematic, maladaptive, and/or unrealistic interpretations or information processing systems" and that the "core of cognitive therapy is the elucidation of these processes into consciousness that is then followed by a jointly enacted project to modify or eliminate these belief systems" (Kellogg & Young,

2008, p. 43). In terms of history, the authors focus primarily on the works of Aaron T. Beck and Albert Ellis, whose approaches they rightly label as *semantic therapies* because the focus and techniques tend to be on the language-based interpretations and belief networks. The authors also include the influence of several prominent therapists who were initially trained in the behavioral tradition but came to incorporate cognitive principles into their models and practice, as well as the influence of the philosophy of constructivism.

With regards to the process of therapy and techniques, the authors emphasize the important role of the therapeutic alliance, which is framed in CT through the concept of collaborative empiricism. Collaborative empiricism is the process whereby both the client and therapist enter into an investigation regarding the accuracy and utility of the patient's interpretive scheme in a manner that parallels the way a scientist would test hypotheses and gather evidence. Active CT interventions usually begin with psychoeducation regarding the relationship between thoughts, feelings, and behaviors, and patients are provided with examples of how different interpretations and meanings of events are associated with different emotional and behavioral responses. This education serves as the rationale for the approach. The therapist then engages in a Socratic-like dialogue with the patient to clarify the problems and the interpretive schemes, and to identify linkages between particular interpretations and responses.

Beck's approach to cognitive therapy has been the most influential, and it characterizes cognitive processes into three levels that range from immediate surface thoughts to deeply organizing schema. Automatic thoughts are the basic, quick evaluations people make of their situation, such as when a socially anxious person arrives at a party and makes the automatic evaluation, "This is not going to go well." Reasoning processes are conceived of as operating on an intermediate level of depth, and Beck's cognitive theory proposes that anxious and depressed individuals tend to make errors in logic that lead to overly negative conclusions, such as when someone starts to do poorly on a test and concludes that because the first section did not go well, the entire test and perhaps even the entire class will turn out poorly. Core beliefs or schema reside at the deepest level of organization. Core beliefs are foundational beliefs about the self, especially self in relationship to others. Individuals who are prone to developing depressive, anxiety, or personality disorders are theorized to have beliefs about the self as being fundamentally unlovable or ineffectual.

Kellogg and Young (2008) describe a host of interventions that are designed to impact the interpretive schemes of patients at each of these three levels of organization. Analyzing the costs and benefits of a particular belief, generating alternative explanations, and positive reframing are techniques focused on changing automatic thoughts. Evaluating patients' assumptions, values, and processes in logic—such as distinguishing progress from perfection—are techniques targeted at the middle-level distorted reasoning processes. Finally, historical identification and letter writing are techniques for eliciting and altering core beliefs. Perhaps the most central intervention associated with cognitive therapy is the Dysfunctional Thought Record (DTR), and Kellogg and Young review this method in detail. The DTR is a form

that systematizes the cognitive intervention techniques, and trains patients to systematically link situations, interpretations, and emotions, and then to develop more adaptive responses.

With regards to the evolution of cognitive therapy, the authors note that CT has grown markedly over the past several decades and is now applied to a multitude of different diagnosable conditions, including psychotic problems, substance abuse and dependence, and eating disorders. Traditional CT approaches have been integrated with other lines of thought, especially with approaches of acceptance and mindfulness that stem from Eastern philosophies and theories of mental health, and psychodynamic and interpersonal approaches. The latter part of the chapter delves into Jeffrey Young's Schema Focused Therapy, which is an integrative therapy for personality disorders that combines the cognitive approach with an integrative psychodynamic approach in an attempt to elucidate and remedy the early maladaptive self-other schema that develop in childhood and then create problems in current relationships.

The case example is of a middle-aged man who suffered from what is known as a double depression. That is, he experienced mild to moderate levels of depressive symptoms chronically, punctuated periodically by Major Depressive Episodes. The man had experienced much conflict about his attitude toward relationships, on the one hand feeling lonely and desiring connection, and on the other fearing intimate relationships and isolating himself. This conflict likely emerged from his childhood experiences, which were marked by the death of his father at age eight and mother at age twelve. These deaths led him to be raised by his stepfather, a man he characterized as gruff and domineering. The case was complicated, and the therapy was divided into short-term and long-term goals.

The short-term goals were to decrease his paralysis at work and ensued using traditional cognitive approaches of identifying his automatic thoughts (e.g., "I am incompetent," "They don't care about me," "I should have learned this before") and learning to develop more adaptive responses both in therapy and at home through the use of the DTR. After some initial improvement in mood and activity, the therapy stalled, and his inability to process his feelings became a focus. The therapist worked with the patient and identified a core schema of defectiveness and helped the patient become aware of when this schema was being activated in his relationships with others. Several meaningful interpersonal exchanges occurred where the client saw how his interpretive schema played a key role in how he responded and this awareness and practice at developing alternative possibilities allowed him to act different in these specific situations. However, there remained little generalized progress. A final pivotal point came in the therapy when the therapist realized that she was working harder than usual to help this patient, and shared this with him. She stopped taking such initiative and waited for him to take responsibility for his life. Although he initially resisted, the intervention finally broke through. His energy level shifted, and he seemed to internalize the prior work, with the final outcome resulting in fairly dramatic changes in mood, identity, occupational and relational functioning.

Contemporary Cognitive Therapy Through the Lens of the Unified Theory

Having spent 4 years working directly with Beck, I have received the most in-depth training in this specific school of thought. CT has many positives, as evidence by the empirical research literature that Kellogg and Young (2008) briefly review and its growing popularity over the past several decades. I think it represents a significant advance over traditional behavior therapy, as it pragmatically incorporates many behavioral therapy interventions and directly and systematically opens up ways to address thought patterns and processes. Support for this opinion is evidenced in the point the authors of the behavior therapy chapter make, which is that the vast majority of behavior therapists now incorporate cognitive therapy principles. The key insights of CT regarding the central role of semantic thought processes and the notion that certain interpretations and ruminative patterns are maladaptive, can contribute to emotional disturbance, and can be changed with a concomitant result in positive functioning are all important.

CT, however, does not succeed as being a general model of psychotherapy for several reasons. Just as behavior therapy is a perspective limited by an almost exclusive focus on one aspect of the whole picture, traditional CT suffers from a similar fate. Although the term cognitive is quite ambiguous and is used to mean many different things ranging from general information processing to, more specifically, reasoning and interpretation (an ambiguity apparent Kellogg and Young's description of cognition), we can use the tripartite model of human consciousness offered in Chapter 5 to clearly identify the primary domain that traditional cognitive therapy targets. With its emphasis on self-talk, dysfunctional thought records, and analyzing beliefs in terms of their accuracy and utility, it becomes clear that cognitive therapists focus primarily on the individual's private justification system and the role it plays in producing negative affect and problematic behaviors. Thus in the language of the unified theory, the cognitive in cognitive therapy translates into the justification system, and Kellogg and Young (2008) are correct when they consider cognitive therapies as *semantic therapies*.

Seeing traditional cognitive therapy as targeting the justification system highlights both its strengths and its weaknesses. The private justification system plays a crucial role in how people experience and respond to various events, and its alteration can potentially result in important changes in the overall system. But it is also the case that the private justification system is only part of the human whole. Traditional cognitive therapy does not say much about the structure of the experiential system, social motivations like power, love, and freedom, conflicts between various motivational strivings, defense mechanisms or the filtering between subconscious, self-conscious, and public domains, nor does it offer much in terms of understanding human relationships, family, or social systems. Of course, it is precisely these areas that experiential and psychodynamic theories focus on and have the most to offer and, as we will see, the unified theory gives rise to an approach to conceptualizing that effectively incorporates all of these elements.

Key Components of Contemporary Experiential Therapy

Pos, Greenberg, and Elliot (2008) begin their chapter on experiential therapy with the central insight from the experiential perspective that there are two ways of knowing: (1) Conceptual (knowledge by verbal, analytic description), and (2) Experiential (knowledge by direct acquaintance or experience), and that experiential therapies emphasize the importance of using the latter form of knowing when facilitating patient change (in contrast to cognitive therapies, which emphasize the former). This emphasis includes fostering in clients the capacity to be better aware of in-the-moment experiences, to find symbols and words that authentically capture, reflect, narrate, and make sense out of felt experiences, and to use that understanding to create a more open, authentic, genuine, and adaptive way of living. The authors note three crucial concepts emphasized by experiential therapists: (1) awareness, which is enabling experience to become the focus of conscious attention; (2) process, which is the way experience either enters or is blocked from consciousness; and (3) dialogue, which refers to the way meaning is constructed about experience in a relational context.

The authors note that modern experiential therapies have their roots in the humanistic "third force" that swept through North America in the 1950s and 1960s. These early movements emphasized a more positive orientation toward human nature, the central role of felt experience, and the human capacity for choice. The authors report that some of the early experiential approaches became associated with many excesses of the counterculture period and, consequently, the momentum for them waned during the 80s, when there was a rising interest in cognitive approaches. However, there is now a renewed interest, particularly with the rise of Emotion Focused Therapy (e.g., Greenberg, 2002). The authors highlight three primary roots that historically ground modern experiential therapies.

Carl Rogers' person-centered (previously called client-centered) therapy is central for two primary reasons. First, Rogers emphasized the centrality of the therapeutic relationship and the importance of following the client via deep empathetic attunement. Rogers' insights along these lines have become so well recognized that virtually all therapeutic perspectives acknowledge that a strong therapeutic alliance is at least necessary (if not sufficient) for good therapy. The second reason Rogers was central to experiential approaches was his general emphasis on phenomenology and the utilization of deep empathy to access aspects of the "true self" that had been hidden, split off, or poorly integrated as a consequence of fear from judgmental others, or internalized self-judgment.

Pos et al. (2008) also highlight the contributions of Gendlin, who developed techniques for deepening experience, and Rice who emphasized the importance of examining of how individuals constructed meaningful narratives out of their experiences and articulated methods for how therapists could actively foster such processes. Gestalt therapy, developed by Fritz Perls, also was a major line of thought in which modern experiential therapies have their roots. Gestalt theory integrated key ideas from a number of sources, including phenomenological philosophy, liberal theology, psychoanalysis, and field theory. The authors also point out the important

role that existential philosophy has played in these approaches, with its central concern on human uniqueness, the importance of focusing on the immediate and the whole person, and its emphasis on the meaningful development of human potential.

In outlining modern forms of experiential therapies, the authors briefly review Dialogical Gestalt Therapy, Mahrer's Experiential Psychotherapy, Focusing-Orienting Psychotherapy, and Emotion Focused Therapy (EFT). I will limit my review here to EFT as this is the primary therapy focused on in the chapter and has probably the largest following and the most empirical support. EFT is a neo-humanistic treatment that views emotions as playing a central role in the experience of self, in both adaptive and problematic ways. It is a perspective that is being increasingly informed on a theoretical level by cognitive and affective neuroscience and investigations of the affect system as an innate, adaptive system that functions to guide thought and behavior in relationship to fundamental motives.

EFT proposes that emotions generally have adaptive potential that, once activated, can help clients change problematic psychological states or unwanted self-experiences. In fact EFT views emotions as templates formed from interlocking networks of images, motivational states, and action tendencies that function to produce felt experience (note the parallel with the P – M => E formulation). Such felt experiences can be accessed, reflected upon, and woven into the conscious narrative of the self. However, it is not always the case that individuals are able to do so in a manner that has adaptive long-term consequences. Instead, for a host of reasons—most notably feared social consequences and threats to one's identity—emotionally derived felt states are often distorted, denied, or redirected.

EFT classifies emotional responses into four broad categories, only one of which is considered truly adaptive. Primary adaptive emotional responses are responses to immediate stimuli that foster adaptive action, such as when an individual gets angry in response to a personal violation and sets an appropriate boundary. Primary maladaptive emotional responses are also strong and immediate but are not adaptive and arise usually as the consequence of past traumas. Secondary emotional responses are countered reactions to primary emotional responses, such as when an individual initially feels hurt by a comment but processing such hurt feelings is blocked and instead the individual lashes out secondarily in anger. Finally, instrumental emotional responses are habitually learned emotional displays that are used to manipulate others, such as when an older child chronically expresses suffering to her permissive mother so that she will give in to her demands.

Emotional change occurs by means of awareness, regulation, reflection, and transformation of the emotion. Clients are taught to arrive at emotionally charged states, assess the nature of the emotional response as adaptive or maladaptive, primary or secondary, and then create a meaningful adaptive narrative of the experience. This is followed by a leaving phase where the individual lets go of the emotional experience. Therapists are taught to track emotional markers and specific interventions for eliciting feeling states. The two chair and empty chair techniques are common, where clients assume different roles or feeling states and are invited by the therapist to generate feeling-rich dialogue stemming from various parts of themselves that are in conflict (two chair) or their conflicts in relationship to

other people (empty chair). Treatment is broken up into three phases. First, there is bonding and awareness, where primary emphasis is on the development of the therapeutic alliance, creating a safe place to explore emotionally rich experiences, and beginning the development of a frame for understanding the person's core concerns. The next phase is evocation and exploration, whereby evoked emotion is explored and the therapist and client work to delve into successively deeper levels of the individual's emotional experience. Finally, there is the phase of transformation and generation of alternatives, whereby having arrived at the core experiences, the emphasis shifts to the construction of alternative ways of responding emotionally, cognitively, and behaviorally.

The case in the chapter is of a 39-year-old woman who engaged in EFT for depression which, as the authors note, has received substantial empirical support and does generally equal to or better than CBT in randomized controlled outcome trials. EFT for depression is, of course, based on EFT more generally, but it includes some specific components that are often part of the emotional processing and responding of depressed individuals. The woman reported that she had been chronically depressed, but that the past year had been particularly difficult. She was not working and had become increasingly isolated and withdrawn. Numerous problems with her family of origin were reported, including an alcoholic mother with whom she no longer had contact and a critical and judgmental father who frequently employed harsh physical punishments.

The therapy began with a focus on developing the therapeutic bond via empathic affirmations and validations to communicate understanding and trust. The therapist noted that the client could gain access to her felt states with his guidance but would normally work to avoid painful or difficult emotions. A pattern of emotional responding was identified, whereby whenever the woman experienced anger or hurt at not having her needs for closeness or acceptance met, she shifted to a secondary emotional response of helplessness and hopelessness. This pattern suggested to the therapist that there were unprocessed primary feelings about her parents in general and unresolved issues with her father, in particular. The therapist further hypothesized the secondary emotional response of helplessness, and hopelessness became tied into a self-critical narrative for needing things she could not have and not being worthy to be loved in the first place.

In session four, the therapist initiated an empty-chair dialogue, whereby the client voiced some of her split-off feelings about her father. This allowed her to connect to some of her primary adaptive feelings of anger, and it also revealed clearly to both the client and therapist that her reaction to these feeling was to become self-critical and berate herself for making too much of her needs. In session five, the therapist helped the client to initiate the self-critical dialogue, which was then followed by a response to the criticism, justifying her need to be loved and explaining that she was not loved not because she was unlovable, but because her parents were incapable of showing such emotions.

Sessions seven through nine focused on the client's experience of not being loved and how she had coped with that experience, namely through what they labeled "the interrupter," which both criticized her and then proceeded to shut off the needs with

justifications like, "You are wasting your time in feeling bad because you want them and they are not there. So it is best for you to shut your feelings off and not need them" (Pos et al., 2008, p. 114). The therapy continued to stay with her primary adaptive feelings of hurt and anger at her father's cruel and neglectful treatment, encouraging her to give voice and meaning to these primary feelings without reverting to the self-critical interrupter stance. The last sessions were marked by a transformative shift in the affective tone. As she felt validated for her anger, she felt less shame regarding her need for love, and as the anger was processed, another primary adaptive feeling emerged, sadness both for herself and her father in terms of her lost childhood and the relationship that could have been. This shift included a more empathetic view of her father, who was a concentration camp survivor, and she reinterpreted some of his actions through his own trauma and shortcomings rather than stemming out of vitriolic feelings specifically toward her. At the end of the therapy, the client reported symptom relief and that the anger was no longer sitting on her chest, and reported a greater ability to be authentic with herself and communicate and connect with her sisters.

Contemporary Experiential Therapies from the Vantage Point of the Unified Theory

The experiential therapies in general and EFT in particular share much overlap with the perspective of the human mind and consciousness afforded by the unified theory. Most obviously, both perspectives emphasize a dual processing view of the human mind, with one being conceptual, analytical, and linguistic, and the other being experiential, perceptual, and affect based. Moreover, EFT explicitly emphasizes the relationship between these two domains of mind and consciousness, highlighting how maladaptive filtering processes can result in long-term psychological distress and dysfunction. Indeed, the case formulation and treatment detailed in this chapter strongly paralleled the case I was assessing when I developed the Justification Hypothesis, as described in Chapter 1. Specifically, both women had initially experienced anger and hurt at the poor treatment by their fathers. However, in the context of their home life growing up, these feelings could not be channeled in an adaptive direction. Consequently, a justification narrative developed that induced shame, thus interrupting and inhibiting their angry reactions. Although this was somewhat adaptive in that it facilitated submission to powerful authority figures who could be cruel, this shame-based narrative resulted in both women feeling shutdown and feelings about their fathers unprocessed. The EFT helped the woman to develop a narrative that reaffirmed the justifiability of her feelings and, upon their being processed, allowed her to integrate them into her self-narrative, habituate to them, and develop additional adaptive feelings (e.g., shared sadness) about the loss.

The primary weakness of experiential therapies from the perspective of the unified theory is that they emerged more out of technique and philosophical assertions about what it means to be human instead of being grounded in a general theory of human functioning. As the authors note, "A general theory of human functioning

and pathology. . .has tended to lag behind its more developed theories of practice" (Pos et al., 2008, p. 93). Of course, a general theory of human functioning is precisely what the unified theory attempts to offer, and thus it is heartening that the therapeutic practices conform well to the model.

Key Components of Contemporary Psychodynamic Therapy

Magnavita (2008b) began his chapter on psychoanalytic psychotherapy by stating that the key psychodynamic insight is that much of our motivation lies outside consciousness and that we experience conflict from opposing forces or parts of our intrapsychic make-up. He then described the magnitude of Freud's influence on the academic landscape. And he pointed out the cultural context in which psychoanalysis was born, specifically the fact that it was a puritanical, repressive society, and this undoubtedly influenced the form Freud's theories took. Citing Theodore Millon, Magnavita (2008b, p. 208) listed four seminal themes that define psychodynamic thinking:

> 1) The structure and process of the unconscious, that is, the hidden intrapsychic world; 2) the key role of early childhood experiences in shaping personality development; 3) the distinctive methodology he created for the psychological treatment of mental disorders; and 4) the recognition that the patient's character structure is central to understanding psychic symptomatology.

Magnavita then reviewed some of the contributions of seminal figures in psychoanalytic thought, including Harry Stack Sullivan, Heinz Kohut, Habib Davanloo, David Malan, Otto Kernberg, Anna Freud, and Melanie Klein, and then provided a brief summary of the major schools of psychodynamic thought, including drive theory, object relations and interpersonal theory, and self-psychology. The structural model of the mind (i.e., id, ego, superego) and topographical model of consciousness (conscious, preconscious, and unconscious) were then presented, and given their familiarity, I will not repeat them here.

Throughout the chapter Magnavita (2008b) emphasized the relational turn that psychoanalysis has taken in the past several decades. For example, when discussing the topography of the mind he pointed out that rather than the unconscious being seen as a repository for unacceptable sexual and aggressive feelings, it is now considered primarily in terms of unconscious relational schema, scripts, expectations, and desires that people use to navigate the social world. He cited research on implicit social cognition that supports the idea that important self-other schemas can be activated and operate either with or without conscious awareness, that emotion results from the activation of relational schema, and that self-regulatory processes are evoked in response to real or imagined threats to self-other schema.

The key therapeutic elements of psychoanalytic psychotherapy and the dynamics of intrapsychic processes are then reviewed. Magnavita (2008b, p. 215) argued, "The therapeutic foundation on which all psychodynamic therapy rests is the construct of transference." Here Magnavita is using a broad definition of transference, which essentially refers to the patient's relational schema and how those schemas

influence the intrapsychic and relational patterns of the individual, both inside and outside of the therapy room. The psychodynamic therapist seeks to enter the patient's relational system and restructure it through a corrective emotional experience and through insight that is achieved via the interpretations made by the therapist. Magnavita then introduced the two Malan Triangles as the central conceptual frames that guide contemporary psychodynamic approaches. The first Malan triangle, *The Triangle of Conflict* with its three poles of impulses/feelings, anxiety, and defenses, was introduced back in the chapter on the Justification Hypothesis. The second Malan triangle, *The Triangle of Persons*, is depicted here in Fig. 8.2. This triangle takes into account the internal working models of the individual, how they are formed by important others early in life (and are especially impacted by trauma), and how they are impacted by current relations. This provides a framework for the therapist to understand what the patient expects in relationships and why and how those expectations reciprocally influence interpersonal processes.

Magnavita (2008b) then reviewed the psychodynamic view of health and pathology, drawing on the recently published Psychodynamic Diagnostic Manual (PDM Task Force, 2006). According to the PDM, psychological health consists of the following capacities:

- To view self and others in complex, stable, and accurate ways
- To maintain intimate, stable, and satisfying relationships
- To experience self and perceive in others the full range of age-appropriate affects
- To regulate impulses and affects in ways that foster adaptation and satisfaction, with flexibility in using defenses or coping strategies
- To function according to a consistent and mature moral sensibility
- To appreciate, if not necessarily conform to, conventional notions of what is realistic
- To respond to stress resourcefully and to recover from painful events without undue difficulty

Psychopathology is generally viewed developmentally and assumed to be caused by a combination of genetic predispositions interacting with traumas and stressors, especially those of a relational nature, like one's early attachment to caregivers.

In describing the contemporary psychodynamic approach to psychotherapy, Magnavita (2008b) explained how psychodynamic therapists strive to establish a

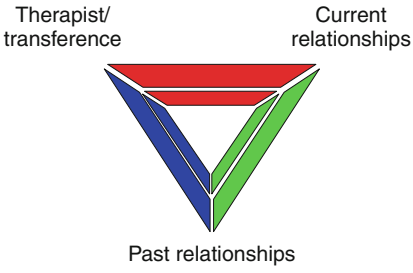

Fig. 8.2 The Malan triangle of persons

collaborative relationship that focuses on the expressed needs of the patient and the developmental issues that need to be addressed. The psychodynamic therapist assesses the individual's level of functioning, especially focusing on the relational (self-other schema, transference and countertransference, history of relationships, current support) and defensive structures (regulation of impulses, awareness of affect). Through assessment and collaboration, the therapist establishes with the patient a framework for the therapeutic process. Magnavita commented that most psychoanalytically oriented psychotherapists utilize the following approaches: (1) long-term therapy in which the individual is seen 1–3 times a week for a period of several years, and the therapist generally takes a nondirective, interpretive stance allowing the process to unfold much on its own accord; (2) brief supportive therapy to help individuals during crisis or longer term supportive therapy to help maintain their functioning; or (3) short-term psychodynamic therapy, which can last anywhere from 4 to 80 sessions, where the therapist takes an active stance in helping the individual restructure their relational, affective, or defensive processes.

In regard to major intervention strategies and techniques used, Magnavita (2008b) highlights the central role of the therapeutic relationship as forming a crucible in which the process of change unfolds. He commented that most contemporary psychodynamic therapists use a variety of different techniques to mobilize the process of growth and development. Some of the more common techniques or processes emphasized include clarification, empathetic attunement, validation, reflection of feeling, interpretation, defense analysis, confrontation, challenging of dysfunctional beliefs, fostering insight, support, working through emotional trauma to desensitize the system to unmetabolized affect, and supporting resilient strategies. He also highlighted that although elements like homework and medication were not utilized historically, they are now regular aspects of psychodynamic treatment.

Change is theorized to occur via a number of mechanisms. The relationship is seen as offering a corrective emotional experience in which the patient, via exposure to intense feelings in the context of a healthy relationship, is able to restructure the representation of self and other, and the manner in which emotional experiences are processed. The interpretations of the therapist allow the patient to develop insight into defensive processes, and together the therapist and patient collaborate to develop new, healthier ways of responding, such that old problematic relational and emotional patterns are not repeated. Magnavita (2008b) noted that systematic research on psychodynamic outcomes is not nearly as well developed as it is for cognitive behavioral therapies, but he commented that data do suggest that short dynamic interventions are as effective as CBT in effecting change.

The case presented is of a divorced male in his 50s, with chronic, refractory depression. The man is described as an other-oriented individual who worked to please people, comply with their wishes, had low self-esteem, and was "cut off" from his anger associated with his relational stance. Medication and supportive psychotherapy had been tried, but he was still quite symptomatic. Assessment revealed that he was functioning at the neurotic level of personality organization, which meant he was in touch with reality and could tolerate some levels of distress without decompensating (e.g., he had never been hospitalized or been suicidal), but he

had many maladaptive relational and defensive coping styles that resulted in his suffering and being unable to grow and effectively meet his needs.

The treatment started by collaboratively developing a psychodynamic conceptualization with the patient. This was achieved by linking his current relational and defensive style with his family life and his role in it. He described his father as a distant man who was not very involved with his life, and it was noted that the patient did not cry or say good-bye at his funeral. On the other hand, his mother was very involved with him and saw him as special. However, as the patient revisited his relationship with his mother, he came to view her as relying on him emotionally, and he connected his suppression of his anger and own needs to being pulled by his mother to support her. The therapy was framed by both the therapist and patient as being the process by which they would, as rapidly as possible, get to the core of his difficulties and face his emotions. Specifically, it was formulated that he experienced core injuries via the neglect of his father and the emotional manipulation of his mother. Therapy would afford him the opportunity to (re-)experience the feelings and relational schema associated with these issues, and metabolize them.

Initially the man presented with a number of defenses in treatment, specifically detachment, intellectualization, and avoidance, which were interpreted by the therapist as a means to regulate the therapeutic relationship and his feelings associated with his core injuries. Over time, as the defenses were made conscious and their maladaptive consequences became apparent, he began to open himself up to experiencing an intimate connection with the therapist. A powerful discussion occurred regarding his tendency to sabotage and attack himself, through which he became increasingly aware that he tended to both subjugate himself and keep others at bay because he feared that if he was intimate with others they would either manipulate him or reject him, like his mother and father had done respectively. He began to re-experience the feelings associated with the patterned interactions with his parents, such as the grief he felt about the fact that his father never attended any of his school events or activities. In the context of the healing therapeutic relationship, he became increasingly conscious of the linkage between his defenses, relational patterning, and avoidance of core emotions. This awareness afforded him the opportunity to rewrite some of his core scripts and develop healthier self-other representations. He found, for example, that he could much more effectively assert himself without becoming paralyzed by fear and withdrawing. In addition, his depressive symptoms drastically diminished, and he found he could significantly deepen his intimacy with his girlfriend and other important relationships.

Contemporary Psychodynamic Therapy from the Lens of the Unified Theory

The unified theory shares much in common with modern psychodynamic theory. For example, the recognition that self-other schemas are central to the psychological health of individuals is captured by and very congruent with the Influence Matrix. Moreover, the perspective regarding the functional organization of conscious

thought provided by the unified theory is very similar to modern dynamic formulations. By that I mean both contemporary psychodynamic theory and the unified theory look at the subconscious, relational, and emotional forces that motivate and guide the functional organization of people's self-conscious justifications. If, for example, we return to the exchange between Dan and Janice in the chapter on the Justification Hypothesis or to the scene from *Ordinary People* analyzed in the chapter on the Influence Matrix, we see a view of the relationship between conscious and subconscious thought that is very congruent with how it would be framed by most modern psychodynamic theorists.

The biggest difference with the unified theory is found with more traditional aspects of psychoanalytic theory. Many psychodynamic theorists do not draw as sharp a line between psychoanalytic and psychodynamic as I do here. Magnavita (2008b), for example, uses the terms psychoanalytic and psychodynamic rather interchangeably in his chapter. In contrast, as noted several times throughout this book, the unified theory explicitly identifies key original components of Freud's psychoanalysis as flawed and erroneous and argues that the good psychodynamic ideas should be explicitly separated from psychoanalytic psychobabble. In particular the model of the unconscious proposed by traditional psychoanalytic theory is unworkable. Instead of primary process symbolism, it is images, impulses, and affects that make up the subconscious (i.e., defended against) mind. Moreover, rather than sex and aggression being primary motivational processes, more realistic and central are relational forces, such as the dimensions of power, love, and freedom represented by the Influence Matrix. It is important to note that, as Magnavita's review indicated, these are generally changes that have already occurred in contemporary psychoanalytic circles. Nevertheless, the old analytic tradition maintains strong ties on current practice, and it is those ties that tend to prevent more effective integration with other more contemporary approaches and, consequently, the unified theory advocates for separating the systems.

We have embarked upon a review of the major individual-level approaches to psychotherapy to give one a clear sense of how practitioners from these primary paradigms are conceptualizing and treating cases. It is also important to be clear that each of the above perspectives comes from a separate theoretical tradition in psychology and psychotherapy, and they tend to be taught at separate schools and by separate faculty, although over the past three decades the cognitive and behavioral approaches to therapy have largely merged together, such that there are now three primary schools of thought that guide individual psychotherapy: (1) Cognitive Behavioral; (2) Psychodynamic; and (3) Humanistic/Experiential. I am arguing that if we approach each perspective with the meta-theoretical lens afforded by the unified theory, we can identify what piece of the puzzle of the human condition each perspective is emphasizing and see the whole. In the next section, I outline how the unified theory gives rise to a way to conceptualize people that cuts across the different paradigms and shows how they can be integrated.

In a real sense, then, we have come full circle, back to the place that provided the initial spark that resulted in the quest for the unified theory. We are now back to the question as to whether one could develop a meta-theoretical perspective that

incorporates the key insights from the major schools of therapy in a coherent and holistic manner. Before proceeding, however, I must again note that there are many elements that need to be considered to develop a truly unified approach to psychotherapy. Not only are there issues of fact—that is, developing a comprehensive and coherent descriptive explanatory framework for why people are the way they are—but we must also be prepared to deal with questions of value. To highlight some questions in this domain: Should we be thinking of the people who enter psychotherapy as patients or clients? Should we be more concerned with promoting their understanding of their situation or emphasize the reduction of suffering? What is the relationship between individual interests and the interests of the social systems in which the individual is embedded? Are psychiatric diagnoses and individual psychotherapy helpful social constructs or do they pathologize normal suffering or promote victimized mentalities and naval gazing? A comprehensive treatment of a unified approach to psychotherapy would address these questions. However, as mentioned earlier, space limitations prevent a comprehensive treatment of how the unified theory gives rise to unified psychotherapy, and in the remainder of the chapter, I am honing in on how the unified theory leads to a unified component systems approach to conceptualizing that effectively cuts across the major perspectives.

The Unified Component Systems Approach to Conceptualizing People

I teach my students that there are three broad domain sets to consider when breaking down the enterprise of psychotherapy. First there is the counseling and relational skill set, which refers to the abilities to consistently: (a) create a setting of trust, hope, understanding, and acceptance; (b) generate therapeutic flow (i.e., engage in deep, meaningful, well-flowing conversational exchanges); and (c) build a strong, collaborative therapeutic relationship with clear, mutually agreed upon goals. Research consistently finds that the ability to create a good relationship, collaboratively set goals, demonstrate effective empathy, and instill hope in patients is a (if not *the*) major factor associated with treatment outcome (Norcross, 2011). Because I am convinced that an accurate understanding of how people work can lead to better working relationships and faster and better ideas for problem identification, treatment goals, and assessment of outcomes, I am not of the opinion that the therapeutic relationship is all there is to psychotherapy. Nonetheless, counseling skills and the capacity to develop such relationships are crucial and can be conceptually separated from the theoretical approach and specific interventions used.

The second domain of psychotherapy is the conceptualization skills, which refers to the ability of the therapist to develop a comprehensive picture of the patient that is grounded in good psychological science, resonates with the client, and leads to a formulation of the kinds of changes that will be adaptive as opposed to maladaptive for the individual. The outline of my approach to using the unified theory to develop such conceptualizations is the focus in the remainder of this chapter. The third domain of psychotherapy refers to the interventions the therapist uses, and

includes the therapist's awareness of evidence-based techniques, timing and skill in employing them, and tracking their impact on the client's functioning by monitoring outcomes. Although I will not spend much time on the interventions, the conceptualization is intimately intertwined with how a therapist intervenes.

Before I introduce the unified component systems approach to conceptualizing people, let me explicitly define what is meant by the conceptualization. *The conceptualization weaves a narrative together from the various relevant domains of human functioning that tells a story of who the person is and how and why they got to where they are and what will influence their trajectory in either an adaptive or maladaptive way*. It is this last component that directly links the psychotherapeutic conceptualization with intervention, as the goal of the intervention is to form a relationship with the individual (or couple or family) that maximizes the likelihood that they will experience an adaptive outcome. This definition begs the question of what are the relevant domains of functioning, and it is here that the map of the component systems depicted in Fig. 8.3 comes into play. As I articulate below, this map for conceptualizing people systematically aligns behavioral, cognitive, experiential, and psychodynamic perspectives onto a comprehensive view of human functioning. It also explicitly enables us to consider the biopsychosocial perspective, heralded by many in the field. And because it is grounded in the unified theory, it allows for effective bridges to be built not only between the various paradigms in psychotherapy but with more recent advances in personality psychology as well.

Over the past two decades there has been a veritable explosion of research on human personality, and several researchers are now working toward developing more holistic and integrative models of personality functioning. One prominent example was promoted by McAdams and Pals (2006) in an article titled *A New Big Five*, and it is useful to briefly review their proposal here so that linkages between the unified component systems approach and recent research on personality can be seen. McAdams and Pals (2006) stated that it is crucial that personality researchers move beyond the success of the "Big Five" trait theory and return to the field's original

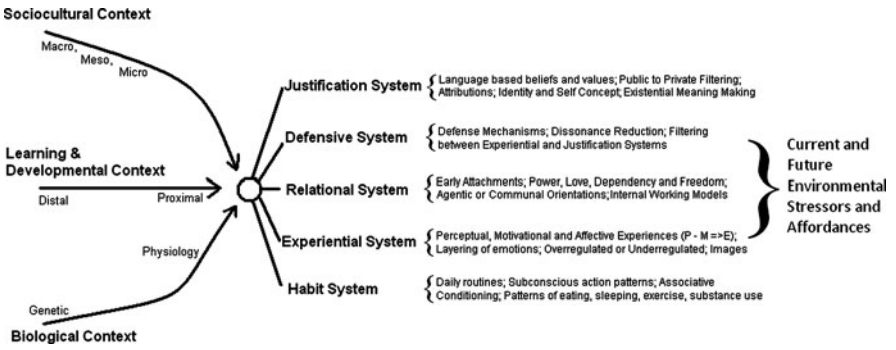

Fig. 8.3 The unified component systems approach to conceptualizing people: three contexts, five systems

mission as envisioned by its founders to develop an integrative vision for understanding the whole person. Toward that end, McAdams and Pals (2006) proposed a new big five for conceptualizing personality as. . .

> (a) an individual's unique variation on the general evolutionary design for human nature, expressed as a developing pattern of (b) dispositional traits, (c) characteristic adaptations, and (d) self-defining life narratives, complexly and differentially situated (e) in culture and social context. (p. 204)

McAdams and Pals (2006) go on to specify the elements that go into each of the five domains listed above. For example, in regard to the first domain they describe the importance of human evolutionary history and the insights from evolutionary psychology. The second domain, the dispositional traits, are "the broad, nonconditional, decontextualized, generally linear and bipolar dimensions" that "constitute the most stable and recognizable aspect of psychological individuality" (McAdams & Pals, 2006, p. 207). Of course, the primary traits researchers have identified are the "Big Five" of extraversion, neuroticism, agreeableness, conscientiousness, and openness. In contrast to traits, characteristic adaptations are mid-level personality units that "include motives, goals, plans, strivings, strategies, values, virtues, schemas, self-images, mental representations of significant others, developmental tasks, and many other aspects of human individuality that speak to motivational, social–cognitive, and developmental concerns" (McAdams & Pals, 2006, p. 208). The authors note that it was the trait researchers Costa and McCrae (1994) who introduced the term characteristic adaptations, a term they chose because such aspects of the personality system help the individual fit into the ever-changing social environment and make up the unique core of the individual. Importantly, McAdams and Pals (2006, p. 208) note that "there exists no definitive, Big Five–like list of these kinds of constructs." As we will see, the unified component systems approach offers a direction to fill in this gap and articulates five different characteristic adaptational systems.

The fourth domain in McAdams and Pals (2006) system refers to the life narratives that people generate to make sense out of themselves and the world they live in. They review the literature on the way that people construe their lives as stories and how these stories regulate behavior, solidify identity, and help people connect with and navigate within the larger social and cultural context. The fifth and final domain is the sociocultural context in which personality develops. McAdams and Pals (2006, p. 211) define culture "as the rich mix of meanings, practices, and discourses about human life that prevail in a given group or society" and articulate how culture has a modest effect on the expression of dispositional traits, exerts more sizable effect on characteristic adaptations, and plays a major defining role in the development of life narratives.

I have reviewed McAdams and Pals's (2006) proposal in some detail for three reasons. First, it shares parallels with the unified component systems approach, and thus by reviewing their proposal, we are in a better shape to frame and understand the current approach. Second, I wanted to introduce the distinction between traits and characteristic adaptations because the unified component systems approach

focuses more on the latter than the former and offers up a new way to conceptualize characteristic adaptations. And, although I will not elaborate on it here, the unified theory provides a new way to think about the relationship between traits and characteristic adaptations. This is seen perhaps most clearly in the formulation offered by the Influence Matrix, which provides a framework for thinking about both traits and the dynamic ways people engage in the social environment. Finally, as both Singer (2005) and Magnavita (2005) have pointed out, there is currently a substantial gap between modern personality theory and psychotherapy that needs to be filled in, and I wanted to highlight the fact that not only does the approach taken here integrate the various psychotherapy paradigms, but it also jives well with modern broad proposals in personality research.

The Unified Component Systems Approach to Conceptualizing People, depicted in Fig. 8.3, consists of three broad contexts and five intrapsychic systems. This is the map I use to teach my students about the key elements to consider when developing an effective conceptualization. Starting with the left side of the figure, there are three broad contexts delineated. The arrows are drawn as such to indicate the time trajectory and the relationship between the contextual levels and the individual psychological level, which is the focus of the diagram. Thus, the biological context represents a "bottom up" conceptualization, whereas the learning and developmental context is horizontal (i.e., at the psychological level), and the sociocultural context is "top down" in the sense that one considers the society or social context as the whole and moves downward to the individual. The circle in the middle of the diagram represents the individual in question and extending outward are the five characteristic adaptational systems that are derived from the unified theory, along with brief definitions describing their key elements. Finally, on the right side of the diagram is a place holder to put the individual in a current and future environmental context that consists of both valued affordances (resources in the environment the individual could use to grow and develop or meet important needs) and stressors. Below I briefly describe each component (three contexts and five systems) and connect it to conceptualizing individuals in the context of psychotherapy. The descriptions will not be comprehensive but will instead be described with enough detail so one can see how the approach provides a unified framework for conceptualizing people that emerges from the unified theory and is consistent with modern personality theory and the major approaches to psychotherapy reviewed earlier in the chapter.

The Biological Context

The biological context refers to three broad domains: (1) the evolutionary history of the species; (2) the unique genetic make-up of the individual; and (3) the current functioning of the individual's physiology and anatomy. Evolutionary biology and psychology provide the lenses and approaches to consider the first element. As represented clearly by the unified theory, we need to understand the shared evolutionary history of the species and the phylogenetic forces that have shaped the basic human

psychological architecture during the environment of evolutionary adaptation. The science of behavioral genetics is the province of the second element of the biological context, and research has demonstrated that virtually all major categories of mental behavioral dispositions (e.g., psychological traits, intelligence, tendencies toward psychopathology like schizophrenia and depression) have a genetic component. Finally, all psychological processes are mediated by physiological processes, and medicine (especially neurology, endocrinology, and biopsychiatry) provide the lens to consider the impact of physiological functioning on human mental behavior.

From the vantage point of conceptualizing a patient presenting in psychotherapy, the biological context is crucial. Family histories of illness and temperamental tendencies are useful to place traits and dispositions toward psychopathology in a behavioral genetic context. And allergic reactions, infections, hormonal fluctuations, diseases, and side effects from medications can all have a substantial impact on psychological functioning. It is, of course, the nursing and medical professions that have the primary charge to assess biological functioning and intervene when necessary and possible, and it is always a good idea to have a medical consult when conducting psychotherapy, especially if there are any unusual or unexpected symptoms, symptoms that do not change with environment, or symptoms that are not readily understandable given the psychological conceptualization of the individual.

The Learning and Developmental Context

Mental behavior evolves through time and one can only understand the current response tendencies by placing them in a temporal context. As noted in the chapter on Behavioral Investment Theory, we need to consider the learning history, specifically what patterns of investment have been selected for and what have been selected against, along with the life history stage or developmental context the individual is in. The diagram also notes the distal, which refers to the early learning and development that laid the foundation for growth, and the proximal, which are the recent significant events (e.g., break up, failure to get into school, new job) contributing to current functioning.

In terms of conceptualizing people, it is crucial to consider reinforcement and punishment histories, important role models, past environmental affordances and stressors, early patterns of attachment, parental discipline, emotional expressiveness in the family system, domains of success or failure (such as academics or sports), early peer relations, formative memories from childhood and adolescence, as well as major traumatic events. In terms of development stages, I find Erik Erikson's psychosocial developmental stage model to be particularly useful, not so much in terms of the specific stages and timeframes, but as a heuristic for the kinds of developmental tasks individuals are likely to be facing. For example, as one who regularly treats or supervises college students in psychotherapy, issues pertaining to the development of identity and intimacy regularly surface.

The Sociocultural Context

The sociocultural context refers to the societal and relational context in which the individual is embedded and, following Bronfenbrenner (1979), we can consider the socioecological spheres ranging from the broadest macro-level context where customs, values, roles, and norms function as the large-scale justification systems that coordinate the population, to the more intermediate range of community-level influences, such as local cultural tones and socioeconomic status, and finally the micro-level relational environment consisting of the individual's family and friends.

In conceptualizing individuals, the macro-level cultural context is crucial for understanding individual identities, values, and existential narratives. Notions about healing, traditions, and rites of passage, and elements like collectivist versus individualistic cultural orientations are crucial to take into consideration when framing the psychotherapeutic enterprise, which was born in a Western individualistic culture and often carries assumptions associated with that worldview. In addition, human identities are very much formed from the dialectical tensions between self and society, and it is crucial to understand which beliefs about purpose, meaning, change, and destiny that are swirling around in the social sphere have been internalized by the individual and those that have not been. In regards to the meso-level sphere, issues of class and social status and quality of the living community (e.g., noise, traffic, daily hassles) are enormously relevant for psychological functioning. Finally, as will be made directly apparent when we explore the nature of the characteristic adaptational systems, it is difficult to overstate the impact of the immediate relational world on psychological development.

The Habit System

The most basic system of adaptation is the habit system. Habitual responses are automatically initiated upon the presence of specific environmental cues and are shaped based on associations and consequences. The relatively automatic and rigid nature of habits has remained a central assumption in several contemporary areas research in human as well as animal behavior for many decades. Whereas consciousness is activated in response to unexpected changes, routine actions conversely become engrained in the habit system. I informally characterize the habit system as that which involves doing without thinking. For example, a couple of months ago, I had to drop something off at a friend's house prior to going into work. Despite knowing this consciously, on the drive to work I shifted into my regular routine and it wasn't until I was pulling into the parking lot at work that I realized I had been on autopilot and completely forgot to make the drop off. My habit system had kicked in and I was nonconsciously following a routine. William James (1890) argued that habits were extremely useful because they enabled people to perform actions in an automatic mindless fashion, opening up more attentional resources for conscious thought. The concept of habit was, of course, central to the behaviorists, many of whom argued that all behavior could be reduced to habit formation.

From the vantage point of the unified theory, the habit system is the most foundational system of mental functioning and consists of sensorimotor patterns and reflexes, fixed action patterns, and procedural memories that can be produced without any conscious awareness. If one returns to the Architecture of the Human Mind diagram in Chapter 3, the habit system corresponds to the first level of mental processes. From a neurological perspective, the habit system is made up of many different components. Nonetheless, we can identify it as a key aspect of human psychology.

In terms of conceptualizing people, we can look at an individual's daily routines, general activity levels, patterns of eating, sleeping, sexual activity and exercise, and stimuli or triggers that evoke particular kinds of responses patterns. The lens of the habit system is particularly useful in considering addictive or maladaptive behavior patterns (e.g., drinking, smoking, or gambling) that a client or patient wants to alter. Indeed, many, if not most of the actions that people consciously wish they did not engage in will have a strong habitual component to them. In addition, because of its direct connection to and elicitation by environmental stimuli, thinking about the habit system opens up ways to think about how to potentially restructure the environment that might minimize the triggering of bad habits, a lens well developed by behavioral psychology.

The Experiential System

The experiential system refers to the nonverbal feelings, images and sensory aspects of mental life. Examples of experiential phenomena include seeing red, being hungry, and feeling angry. The unified theory posits that such first person mental experiences are a form of cognitive process and are emergent phenomena that somehow arise from waves of neural information processing (what neuroscientists studying sentience call the binding problem). As mentioned previously, how exactly such neurocognitive processes give rise to sentience or even which animals are sentient and which are not remain unanswered questions. Nevertheless, the unified theory posits that the experiential system operates on the P – M => E equation, whereby objects and events are perceptually categorized, made meaningful, and then referenced against motivational goal templates that then result in action orienting affective response tendencies. This formulation connects the experiencing mind to operant behavioral principles. In addition, the experiential system also includes imagination, fantasy, and remembered images, as it includes the capacity to simulate objects, events, and actions. Levels two (Operant-experiential) and three (Imaginative) on the Architecture of the Human Mind diagram correspond to the experiential system.

Emotions play a key organizing role in the experiential system and when conceptualizing individuals from the vantage point of psychotherapy, it is probably most useful to focus on first emotions when analyzing the functioning of the experiential system. Specifically, one can focus on how emotions are expressed and experienced. Questions to help the conceptualization of the experiential system include

the following: What is the range of emotional expression and experiencing? Are there emotional states that dominate an individual's experience, as is the case in depressive and anxiety disorders? Are certain emotions restricted, warded off, over-regulated, or inhibited? Other questions pertain to the cohesion and sensibility of the individual's experiential world. Are images or feeling states constantly vying for conscious attention in conflicted ways? Are aspects of the experiential system split off, disconnected, or repressed in some way? In addition to emphasizing emotions, images, and fantasies, felt experiences within the body are important components to assess and consider when getting a full picture of an individual's experiential system.

The Relational System

The relational system is a specific aspect of the experiential system, but it is so important to human psychological functioning that it needs particular specification. The relational system refers to the internal working models and self-other schema that guide people in their social exchanges and relationships. The Influence Matrix is the framework employed here to understand social motivations, how self-other representations are coded, and how (real or perceived) changes in important relationships are associated with particular kinds of affective responses.

In conceptualizing people in this domain, I think first in terms of general social influence. Recall that social influence refers to the capacity to influence important others in accordance with one's interests. This is not meant in a Machiavellian sense of consciously manipulating others but instead is considered more in the fundamental indicators of social influence, such as the amount of admiration, love, respect, and positive relative to negative attention received from others. The amount of influence is then considered both in an absolute sense (How do others view this person?) and in a relative sense in relation to important others (Does the individual have more or less influence than their friends or family members?) and to the individual's past (Have they recently lost or gained social influence?). In many instances, psychotherapy is initiated primarily because of recent changes in social influence, such as the break-up or loss of a romantic relationship, humiliation at failing at school or in one's job, or the sense that one is not respected or valued either by one's family or society at large.

The lens afforded by the Influence Matrix also raises the question of where individuals tend to fall on the agentic-communal dimension in most circumstances. Are they self-focused, tending to emphasize power, autonomy, and self-reliance, or are they more communal, relationship centered, and adopt more of a go along to get along stance? More specifically, we can look at their motives for power and love, and freedom and dependency, the extent to which needs are being met or not in these domains and the extent to which there is a conflict between them. Of course, as was discussed in the chapter on the Influence Matrix, current patterns emerge in part based on schema formed in early childhood, thus it is frequently useful to draw connections between past and present relational patterns.

The Defensive System

The defensive system refers to the ways in which individuals manage their actions, feelings, and thoughts, and shift the focus of conscious attention to maintain a state of psychic equilibrium. In more everyday terms, the defensive system can be thought of in terms of how people cope with distressing thoughts and experiences. In many regards, the defensive system is the most diffuse of the characteristic adaptational systems because it doesn't directly correspond to domains in the Architecture of the Human Mind diagram. Instead, it refers more to the interrelationships between the domains and the strategies utilized to maintain mental harmony and coherence. This is not to say that the defensive system cannot be identified or studied. Psychodynamically oriented clinicians and theorists have long documented and analyzed defense mechanisms. And the Freudian filter, described in Chapter 5, provides a framework within the unified theory to understand repression and avoidance of threatening material emerging from the experiential system into self-consciousness. Closely related to psychodynamic conceptions of defense, social psychologists have experimentally examined defensive processes under the guise of cognitive dissonance, and have documented the enormous tendencies to arrange one's beliefs and actions in such a way as to maintain a justifiable narrative of the self.

In conceptualizing people in regards to psychotherapy, the nature of their defensive system is crucial in understanding the nature of psychopathology and to understand both the kinds of changes that are possible and those that will be very resistant to change. Many different kinds of defense mechanisms have been catalogued and are indicative of levels of psychological functioning in patients that have clear treatment implications. Many psychological problems can be understood as arising from maladaptive defenses, whereby individuals perceive something as threatening—often particular feelings, images, or memories—and develop ways of avoiding such experiences, but this in turn ends up creating more problems.

The Justification System

As should be familiar by now, the justification system refers to the language-based beliefs and values that an individual uses to legitimize actions and develops a meaningful worldview. Especially from the vantage point of psychotherapy, we can think about the justification system from two lenses. One is the more cognitive and social psychological view that emphasizes the interpretations people make and the expectations they have of their environment and their ability to influence it. These are the semantic elements characterized by Beck as automatic thoughts, the immediate self-talk an individual engages in during an activity or moment of reflection. Some important constructs in the social cognitive literature relating to these kinds of justifications include pessimism and optimism, self-efficacy, and an internal versus external locus of control. The other lens that is useful is the broader and deeper lens of existential perspectives articulated by Victor Frankl and more recently narrative therapists who focus on the guiding justification narratives that people tell

regarding who they are, what their purpose is, and why they are doing what they are doing in an autobiographical way. This is the level of identity and life narrative that is so central to personality that McAdams and Pals (2006) characterize it as a fully separate component of personality.

In many ways, the justification system is the most important component to conceptualizing adults in psychotherapy. The reason is because in the vast majority of cases of individual psychotherapy, the most direct window into the personality structure and circumstance of the client is the justifications that are shared by the individual defining the presenting problem. That is, although as therapists we observe appearance and mannerisms of our patients in the consulting room, we usually get to observe only a very small slice of the patient's behavioral repertoire. And although we can certainly obtain clues and patients can verbally share their experiential world, we can never know that experience directly. Thus, as therapists, what we have direct access to is the justification narrative given by patients of the problems they are facing. It is usually from that we must infer about habits, experiences, relationships, and defenses. And, of course, we don't even get full access to the justification system, only to the portion of the justification system that is shared and not filtered. This is in large part why the quality of the therapeutic relationship is so important. The better the relationship and the more accurate the empathy, the less the filtering between the public and the private justification systems there will be.

Cognitive psychotherapy provides a useful lens to think about the nature of private self-talk and how interpretations and expectations can impact subsequent feelings and actions. Catastrophic automatic thoughts and negatively biased errors in reasoning are part of the mental cycles that drive people toward anxious and depressed moods, although there are more reciprocal feedback loops with the other systems than traditional cognitive psychotherapy suggested. At structurally deeper levels, it is crucial to consider the depth and breadth of the individuals' justification system. Question such as, "How much does the individual reflect on the meaning of life?" and "What role does religion or philosophy play in guiding the individual?" and "How open and reflective relative to closed and rigid are the individual's justification systems?" are crucial.

Far more could be said about each of these domains. Indeed, each of these domains has been a primary focus of assessment, conceptualization, and intervention in major schools of psychotherapy. But the point of this section in the chapter is not to fully delineate each characteristic adaptational system and their relationships to the others, but to share an outline that articulates a system of thought built off of the unified theory that is congruent with modern personality theory and can incorporate key insights from the major psychotherapy paradigms. To further facilitate this linkage, Fig. 8.4 maps the unified component systems approach both to the four pieces that make up the unified theory and the four major approaches to individual psychotherapy. The linkages between the psychotherapy paradigms and the five characteristic adaptational systems should be particularly clear. Specifically, the behavioral paradigm corresponds with the habit system, the experiential paradigm (especially Emotion Focused Therapy) corresponds to the experiential system, the psychodynamic paradigm corresponds to both the relational and defensive systems, and the cognitive paradigm corresponds to the justification system. If one returns to

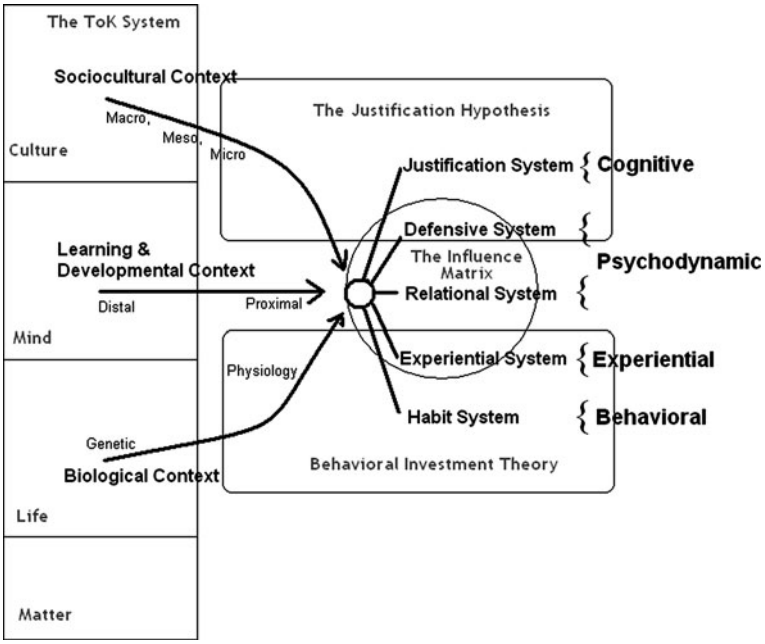

Fig. 8.4 Mapping the unified component systems to the unified theory and major psychotherapy paradigms

the review of the key components of the major perspectives and to the approaches to treatment and how the cases were detailed, one will see how the various perspectives tend to each hone in on an adaptational system and develop interventions with that system in mind.

It is my hope that the relationship between the unified theory and the unified component systems view is also relatively clear. The ToK System provides the broad overarching frame, clearly delineating what is meant by the (physical) biopsychosocial context. Behavioral Investment Theory provides the conceptual linkages between the biological context and the habit and experiential systems. The Influence Matrix, as an extension of Behavioral Investment theory, maps out the relational system. The Justification Hypothesis links our linguistic reasoning apparatus both with our social motivations mapped out by the Influence Matrix and with the uniquely human cultural dimension of existence. Now, to see more precisely how the unified component systems approach can be applied, I offer an example of a case conceptualization.

An Example Applying the Unified Component Systems Approach to Conceptualizing

I attended a conference presentation in 2010 at the annual meeting of the Society for the Exploration of Psychotherapy Integration in Florence, Italy, that starkly affirmed the need for the unified component systems approach. The presentation

consisted of Leslie Greenberg (who is one of the founders of the Emotion Focused perspective) and Paul Wachtel (an integrative psychodynamic therapist) critiquing a videotape series of cognitive behavioral therapy for perfectionism conducted by Dr. Martin Antony (Wachtel & Greenberg, 2010). The patient was a motivated, attractive, verbal young woman completing a graduate degree in psychology who strove for perfection in many areas of her life. She was extremely focused on organizing, planning, and succeeding at everything she did. She also had occasional panic attacks and issues concerning her body image. What was striking about the presentation was how Dr. Antony focused almost exclusively on the habit system and her automatic thoughts, the portion of the justification system emphasized by traditional cognitive psychotherapy. In contrast, emotions and felt experiences, her relationship processes and internal working models, and her defenses were essentially ignored. For example, at one point in the first session, Dr. Antony inquired about the woman's eating patterns and, with tears welling up in her eyes, she hesitantly reported that, self-conscious about her body image, she purged about once a day. Dr. Antony made little acknowledgement of her feelings or of her pained experience sharing this information. Not surprisingly, it was precisely these elements and the way they were ignored that Drs. Wachtel and Greenberg criticized the video. Indeed, at one point, Dr. Greenberg commented that he did not believe that cognitive behavioral therapies treated the whole person. I am arguing here that the unified component systems map provides a conceptual frame to justify that assertion.

To make that point and to help get a flavor for how the system works, I offer one example here of a case presentation, followed by a conceptualization guided by the unified approach. Reducing individuals to paragraph descriptions always results in a poverty of information, and I should note that the conceptualization that follows is, of course, not inevitably correct based on the brief case description. Instead, this example is simply intended as a prototype of how a description of an individual can be plugged into the unified component systems approach in a way that leads to a conceptualization, which in turn could easily lead to ideas about ways of intervening that might be effective in assisting the individual.

> Emily is a 29-year-old Caucasian female who entered psychotherapy because she was concerned about the direction her life was headed. Her mood over the past year has worsened, a mood she described as "sour" and "joyless", and she reported to you in the first session that she finds herself wondering what the point of her job, her marriage, and even her life is. Her family of origin was intact and upper middle class. She has two younger sisters, aged 26 and 24, both of whom have children. She described her mother, a librarian at a University, as strict, protective, and loving. Her father is good natured, but distant. He is a pediatrician. She indicated that negative emotions were generally dismissed in her family. She stated her relationship with her father is the same as it has always been, but she did not elaborate. She did report that her mother seemed closer to her younger sisters than to her. She was raised Methodist and is not currently attending church. She reported she is religious, although she does not like "institutionalized" religion. She has always had a lot of friends, but few of them have been very intimate. She graduated from a good law school in the top 20% of her class, and always achieved good marks in school. She also described herself as a feminist. She was treated once previously with anti-depressants at 23.
>
> Her most immediate concern is that her marriage of four years to Jacob (28) is experiencing difficulties. Both are lawyers in a local firm. They are doing well financially, but she

reported they have lost the spark. Much of the difficulty according to her stems from her not wanting to have children. Although when they got married, she thought she wanted kids, she now doesn't. In reporting this, she somewhat defensively asked the intake interviewer "Don't I have the right to change my mind?" They have sexual relations approximately once a month and have "yelling" arguments at least weekly. She stated that she frequently feels irritated and annoyed by other people and came across to the interviewer as guarded. She describes her job as "fine" but did not elaborate. She did mention that if she wants to make full partner, she needs to increase her billable hours.

From this description, what follows presents an example of how we might translate the case presentation into a holistic conceptualization based on the unified approach. After each aspect of the conceptualization, I label how that aspect of the conceptualization relates to an aspect of the unified component systems approach.

It seems Emily is at an important developmental stage in her life and it is likely that the avoidance of certain important emotions (Experiential and Defensive System), rigid beliefs (Justification System), and conflicts regarding relational needs (Relational System) have combined with environmental and social stressors leaving her feeling empty, stuck, or dead-ended in her life trajectory. Associated with these problems, she is shutting down in some areas and may meet criteria for a Major Depressive Episode, probably of mild severity. Depressive episodes impact brain functioning in a way that makes individuals more susceptible to future episodes and since this may be a recurrent episode, it increases the importance of getting symptom relief and thus medication should be considered (Biological Context). The important developmental life stage pertains to her struggles between love and work, specifically as a career-oriented woman in America in the twenty-first century (Macro Sociocultural Context). On the one hand, she is facing significant demands at work (Environmental Stressors), and likely has a self-concept grounded in high achievement (Justification System). Her long history of achievement (Learning and Developmental Context), her entering into a competitive and traditionally male domain (Macro Sociocultural Context), and her difficulties with intimacy (Defensive and Relational System) suggest a strong agentic orientation (Relational and Justification System), meaning that she likely values independence and self-reliance, along with self-promotion and high achievement relatively more than connection, sharing, and emotional solidarity. And although she has achieved much in that domain, to go farther (i.e., make partner), she is being asked to invest more and more in the direction of agentic achievement (Environmental Stressor and Affordance).

There are a number of indicators that, from an emotion-focused perspective, Emily over-regulates, avoids, and is cut-off from a number of primary emotions (Experiential and Defensive Systems). Evidence for this is seen in her indication that emotions were "dismissed" in her family (Learning and Developmental Context), that she has had few, if any, "intimate" relationships (Learning and Developmental Context and Relational System), her sense that her father was "distant," that her mother was likely closer to her sisters than to her, her difficulties in her current marriage (Micro-Level Social Context, Learning and Developmental Context, Relational System, and Current Stressors), and, perhaps, in her decision not to have children (Relational, Defensive and Justification System). This relatively poor track record on forming and maintaining close relationships, coupled with her success in the achievement domain, suggests the possibility that Emily has unmet needs for belonging, intimacy, and affiliation (Relational System), which in turn likely give rise to feelings of guilt, shame, or self-doubt. However, given her success in competitive domains and her developmental history of dismissing emotions, it is very likely that such feelings of guilt or shame or dependency are threatening, and she is likely highly motivated to avoid them (Defensive and Justification Systems).

One can thus readily hypothesize that if Emily experiences primary feelings of guilt or shame or even loving feelings that make her more dependent, her intrapsychic system would likely become disequilibriated (i.e., confused and unsteady), she would feel anxiety and then shift her attention to more familiar ground of valued independence and self-reliance (Defensive System). Consider, for example, the comment regarding her "right" to change her mind regarding having children (Justification System). Very likely from the vantage point of her husband, the issue is not whether she has the "right" to change her mind, but instead the implications her changing her mind has for their shared future (Micro-Relational Context; Current Stressor). If her husband were invested in having children, then her changing her mind would have a tremendous negative impact on him. Given the above formulation regarding Emily's conflicts about relational motives and associated affects, one can readily hypothesize that the idea of children is anxiety producing and likely activates a host of images that are conflicted and affect laden (Experiential, Relational, and Defensive Systems). If she does experience such conflicts and then is feeling pressured by her husband, there is a very high likelihood that she will shift from experiencing what may well be adaptive primary affects (e.g., love at the thought of her child, guilt/shame/fear at not being a good enough mother or about having to give up career goals) into secondary emotions of indignant anger. If such processes are occurring, they would almost certainly have maladaptive consequences for both of them (e.g., he would feel unfairly attacked; she would be confused about what the "real" issues are). Although the focus here is on likely dynamics between the two in terms of children, it is clear that there are significant relationship troubles, and thus more information is needed about other common domains of marital strife, such as money, sex, in-laws, careers, religion, and daily responsibilities.

Another crucial area to assess, intimately related to the above, is Emily's beliefs about herself, her world, and her future (Justification System). Given Emily's high achievement motivation, it is important to ask what needs she has that are associated with this. Specifically, we could hypothesize that such achievement motivation might be a compensation for underlying insecurities (Defensive System). There could, for instance, be a core belief that gets activated when she is depressed that she is "incompetent," and it is possible that her achievement strivings function to compensate for this. Or, perhaps more likely, she has core doubts about her "lovability" and she compensates for difficulties in "love" by excelling at work and being self-reliant. Her family history would be consistent with this hypothesis (Learning and Developmental and Micro Relational Context). Several other domains of belief would be important to explore. For example, given her achievement strivings, we can wonder about her beliefs about certain feelings, such as feeling sad, guilty, or anxious. In addition, any histories of trauma or abuse would be important to screen for. Furthermore, it would be important to discuss her grander notions about what it means to be human, life's ultimate purpose, and how her autobiography fits into that larger narrative. It would also be important to get a clear sense of her daily routines, eating and sleeping patterns, and substance use (Habit System), and consider if any major changes in these areas might be helpful. Finally, it is extremely important to note that Emily brings with her many strengths that can be valuable resources in helping her more her life in a more adaptive direction. She is bright, verbal, high achieving, and financially secure.

My goal in this section has been to introduce a way of conceptualizing people grounded in the unified theory that is congruent with the key insights from the major paradigms in individual psychotherapy and modern research in personality more generally. As is well documented, one of the major roadblocks to greater unification has been the absence of a shared language and conceptual framework to move the field forward. The point of this chapter has been to show that a unified approach to conceptualization is feasible, which in turn is a major step toward a unified psychotherapy. Of course, there is more to psychotherapy than the conceptualization,

and work is currently being done on a project that systematically develops a holistic approach to psychotherapy, which includes formal assessment of an individual's functioning, specified treatment guidelines, and the assessment and measurement of treatment outcomes.

Conclusion

The intellectual journey that ultimately resulted in the unified theory began with questions about how various approaches to psychotherapy might be integrated. As I delved into this question, it became apparent that to effectively develop a unified psychotherapy, it must be based on a clear answer to the question of "What is psychology?" The first seven chapters of the book were devoted to that question, in many ways providing the background of explanation that I intuitively sensed was there as my professor in graduate school showed me how each of the perspectives might be akin to the blind men and the elephant. This chapter has thus brought us full circle, and we have shown how the understanding of the unified theory provides a way to assimilate and integrate key insights from the major therapeutic perspectives into a coherent whole. But there remain questions, especially questions of value and of the tensions between scientific and humanistic visions of the discipline and the human condition. In the final concluding chapter, we consider these questions and the implications the unified theory has for the academy at large.