

A Metamodel of Theories of Psychotherapy: A Guide to Their Analysis, Comparison, Integration and Use

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Every theory of psychotherapy is composed of a myth and an associated ritual. A myth is a conceptual scheme for explaining clinical problems. A ritual is based upon a myth and is a model of the clinical change process. This article goes far beyond the observation that theories of psychotherapy consist of a myth and a ritual to propose that they share a common underlying structure. The central purpose of this article is to delineate this structure. This structure constitutes a metamodel of theories of psychotherapy. The article shows how the metamodel is a fresh conceptual tool (a) for understanding, analysing, comparing and contrasting, and integrating the basic concepts and principles of theories of psychotherapy and (b) for building case formulations and treatment plans from a theory of psychotherapy. Copyright © 2003 John Wiley & Sons, Ltd.

INTRODUCTION

Every theory of psychotherapy is composed of a myth and an associated ritual (Frank, 1982).¹ A myth is a conceptual scheme that provides an explanation for clinical problems. It is an aetiological model of psychopathology. A myth answers the questions: What are the determinants of psychological problems and how do they develop? A ritual is based upon a myth and is a model of the clinical change process. A ritual consists of the psychological methods for treating clinical problems together with their rationale.

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¹The words "myth" and "ritual" are used advisedly to emphasize that, although typically expressed in scientific terms, therapeutic rationales and procedures cannot be disproved' (Frank, 1982, p. 20). In adopting Frank's words, I do not intend to disparage theories as false or imaginary, but to convey the idea that they represent different visions of reality.

It answers the questions: What clinical activities produce therapeutic improvement and how do they work? Succinctly put, theories of psychotherapy include 'rationale(s) for change, and rituals aimed at facilitating that change' (Mahoney, 1995, p. 477).

This article goes far beyond the observation that theories of psychotherapy consist of a myth and a ritual to propose that they share a common underlying structure. The central purpose of this article is to delineate the common structure of myths and rituals. This hypothetical structure constitutes a metamodel of theories of psychotherapy. By delineating the structure of theories, the metamodel provides a framework for analysing, comparing and contrasting, and integrating the basic concepts and principles of theories of psychotherapy. In addition, the metamodel provides a framework for constructing case formulations and treatment plans for any theory of psychotherapy.

In the next section I present an analysis of the structure of myths and rituals—the metamodel. After presenting the metamodel, I illustrate its utility for understanding theories of psychotherapy

by applying it to four prominent theories. Next, I show how the metamodel generates a systematic method for constructing a case formulation and a treatment plan from a theory of psychotherapy. Finally, I discuss the unique contributions that the metamodel makes to understanding and using theories of psychotherapy.

THE METAMODEL

The Structure of Myths

Myths consist of three chained components: psychological problems, dysfunctional personal characteristics, and the origins of these personal characteristics. The upper panel of Figure 1 depicts the relationship between the three components of myths. The solid arrow represents the causal relationship ('process') between dysfunctional personal characteristics and psychological problems and the broken-line arrow represents the contributory role that the origin plays in the development of personal characteristics.

Psychological problems are any conditions that merit clinical attention. In rational emotive behaviour therapy (REBT; Ellis, 1994, 2000), for example, inappropriate emotions (emotional upsets) and self-defeating behaviours are the primary categories of psychological problems. At the most basic level, psychological problems consist of patterns of behaving (including physiological responses

as well as verbal behaviour and overt motor behaviour), thinking and feeling that are associated with distress or impairment (Corsini, 2000; Persons, 1989; Persons & Tompkins, 1997; Stevens & Morris, 1995; Strupp, 1988). Consistent with this characterization of psychological problems, the goals of psychotherapy consist of changing how clients think, feel and behave (Cormier & Cormier, 1999; Corsini, 2000; Frank & Frank, 1991; Persons, 1989; Persons & Tompkins, 1997; Prochaska & Norcross, 1999; Stevens & Morris, 1995; Strupp, 1988). Thus, psychological problems and treatment goals can be described in terms of their cognitive, affective and behavioural components (Persons, 1989; Persons & Tompkins, 1997; Stevens & Morris, 1995). For example, the 'academic problems' of a college student might include difficulty in concentrating (a cognitive deficit), test anxiety (a negative mood), and procrastination (a maladaptive behaviour). This perspective on psychological problems is compatible with the approach to defining mental disorders used in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV-TR, American Psychiatric Association, 2000). 'Most DSM disorders are clusters of correlated symptoms at a syndromal level. . . A syndrome is a group or pattern of symptoms, *affects, thoughts, and behaviors* (italics added) that tend to appear together in clinical presentations' (Frances, First, & Pincus, 1995, pp. 16–17). For example, fear (a negative mood) and avoidance (a maladaptive behaviour) figure

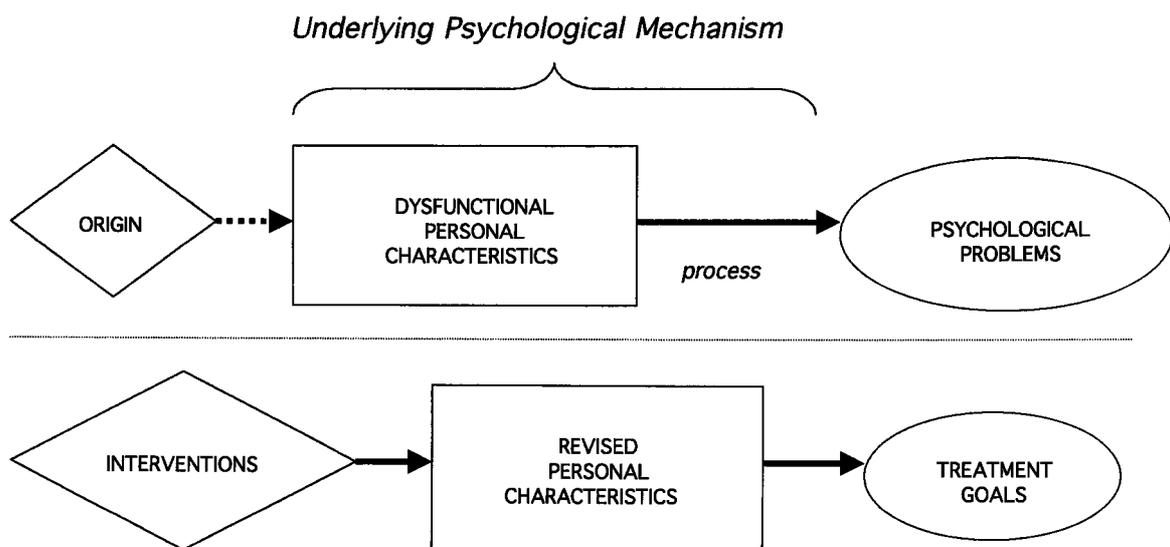


Figure 1. The structure of myths and rituals

prominently in the definition of the various anxiety disorders.

Theories differ in how they portray psychological problems and the corresponding goals of treatment. Consistent with the metamodel, some theories construe psychological problems as symptoms, or overt difficulties in thinking, feeling and behaving. These theories are often contrasted with theories that construe psychological problems as disorders of personality or character (Messer & Wachtel, 1997). For example, psychodynamic theories (like Freudian psychoanalysis) reject a characterization of psychological problems that emphasizes overt difficulties (i.e. symptoms). Rather, they view symptoms as the symbolic expression of an underlying problem (disease) not the problem itself. By contrast, behavioural theories portray symptoms as *the* problem. Consequently, symptom-focused theories conceive the goals of psychotherapy as a matter of symptom relief, whereas personality-focused theories conceive the goals as a matter of personality reorganization or characterological change (Frank, 1987; Messer & Wachtel, 1997; Yalom, 1995). However, these two perspectives are not as disparate as is commonly regarded. After all, personality refers to distinctive, stable and enduring patterns in thinking, feeling, and behaviour (Mischel, 1993; Pervin, 1996). Accordingly, personality reorganization ultimately involves changes in patterns of thinking, feeling and behaving. The two perspectives do differ in that the personality-focused theories emphasize more pervasive and global patterns in thinking, feeling, and behaviour, whereas the symptom-focused theories emphasize more specific and circumscribed patterns (Corey, 2001; Frank, 1987).

Even when a theorist argues that the crux of a psychological problem is some underlying pathology (e.g. an unconscious conflict), this pathology is a problem only because it is manifested in overt difficulties or symptoms. If there were no overt difficulties associated with the underlying 'pathology', there would be no psychological problem. According to Freud (1926/1989), everyone defends against unbearable ideas, but what distinguishes 'neurotics' is that their defences produce symptoms. People seek treatment because of distressing and debilitating thoughts, feelings, and behaviours, not because of some hypothesized underlying pathology. From the perspective of the metamodel, the underlying pathology is viewed as the cause of the psychological problem not the problem itself. To illustrate this subtle distinction, consider how

Ellis (2000) characterized the goals of psychotherapy: 'REBT is not just oriented toward symptom removal... The usual goal of REBT is to help people reduce their underlying symptom-creating propensities' (p. 170). From the perspective of the metamodel, these 'symptom-creating propensities' are the immediate causes of psychological problems—not the problems *per se*.

In the metamodel, *dysfunctional personal characteristics* are the immediate determinants, or causes, of psychological problems. Theories of psychotherapy posit that particular characteristics of the individual cause psychological problems or psychopathological conditions. These personal characteristics are central personality constructs in the theories. For example, REBT (Ellis, 2000; Ellis & Harper, 1997) posits that irrational beliefs are the cause of psychological problems (emotional upsets and self-defeating behaviour). Irrational beliefs have a quality of demandingness, magically insisting that the universe should, ought, or must be as the person wishes it to be (Ellis, 2000; Ellis & Harper, 1997). One example is the idea that 'I MUST be approved or accepted by people I find important!' This belief can lead to anxiety or depression.

In addition to identifying problem-creating personal characteristics, a myth provides an account of how these characteristics produce psychological problems. That is, a myth posits a causal process by which the personal characteristics produce the problems. The causal process is expressed as propositions explaining how dysfunctional personal characteristics lead to psychological problems. This process might involve a diathesis-stress model with the dysfunctional personal characteristics serving as a diathesis (stable vulnerability factor) and identified events serving as stressors that activate the personal characteristics. The *underlying psychological mechanism* consists of the hypothesized personality characteristics (constructs) together with the hypothesized process (in the form of a nomological network) that explains how these characteristics lead to psychological problems. To illustrate, REBT (Ellis, 1994, 2000) uses the ABC formula to explain how irrational beliefs lead to psychological problems. According to this formula, in emotional disturbances Activating events are always interpreted in terms of irrational Beliefs and interpreting current Activating events in terms of 'demanding' irrational Beliefs inevitably produces dysfunctional Consequences (emotional upsets and self-defeating behaviours). Consider a woman who holds the belief that 'I MUST be approved or accepted by people I find important!' She might interpret a fight

with her sister as 'awful' or 'terrible' and become depressed as a result.

The *origin* is an account of the genesis of dysfunctional personal characteristics. It specifies the nature of the life circumstances or learning experiences that contribute to the development of those personal characteristics that are presumed to cause psychological problems. Although the origin may include genetic or biological influences, theories of psychotherapy tend to emphasize the role of nurture rather than nature. The origin may involve a theory of personality development (e.g. Freud's theory of psychosexual development) or principles of learning (e.g. Wolpe, 1982). REBT (Ellis, 1994, 2000) postulates that physiology (innate tendencies to think irrationally), cultural messages and familial messages contribute to the development of irrational beliefs.

The Structure of Rituals

Theories of the aetiology of psychopathology are fruitful sources for developing theories of the clinical change process. As Frank (1982) noted, rituals are derived from myths. Indeed, the structure of rituals (depicted in the lower panel Figure 1) parallels the structure of myths. The three components of rituals are linked to counterparts in myths: treatment goals involve the undoing of psychological problems, revised personal characteristics involve the undoing of dysfunctional personal characteristics, and interventions undo the effects of the origin. As Figure 1 shows, interventions work by revising dysfunctional personal characteristics. Revised personal characteristics serve as mediators (or mechanisms) of change. Presumably, interventions result in revised personal characteristics that in turn result in the amelioration of psychological problems—the treatment goal. The solid straight arrows in Figure 1 represent the causal relationships between interventions and revised personal characteristics and between revised personal characteristics and treatment goals.

Treatment goals are the desired clinical outcomes and are defined vis-à-vis psychological problems (Kanfer & Busemeyer, 1982). The aim of therapy is to move clients from their current psychological condition (the psychological problem) to a desired condition (the treatment goal). For example, if recurring and unexpected panic attacks are the problem (current psychological condition), then freedom from panic attacks is the treatment goal (desired condition). Like psychological problems,

goals are described in terms of patterns in thinking, feeling and behaviour (Cormier & Cormier, 1999; Corsini, 2000; Frank & Frank, 1991; Persons & Tompkins, 1997; Prochaska & Norcross, 1999; Strupp, 1988). REBT, for example, construes psychological problems to consist of emotional upsets and self-defeating behaviour, and it construes the treatment goal to be their elimination. As defined here, treatment goals are very close to Rosen and Proctor's (1981) concept of ultimate outcomes, which 'address the reason for which treatment is undertaken and reflect the objectives toward which efforts are to be directed' (p. 419).

Revised personal characteristics are the hypothesized changes that occur within a client as a result of clinical intervention and that lead to clinical improvement in thinking, feeling and behaving. The underlying premise is that clinical improvement results from modifying those dysfunctional personal characteristics that are responsible for psychological problems. Thus, dysfunctional personal characteristics serve as the treatment targets that are to be revised by interventions. In REBT, for example, the revised personal characteristics involve the substitution of rational beliefs (or the adoption of a rational philosophy) for pathology-inducing irrational beliefs.

Revised personal characteristics are similar to Rosen and Proctor's (1981) concept of instrumental outcomes, those effects of intervention that 'serve as the instruments for the attainment of other outcomes' (p. 419), notably ultimate outcomes. Instrumental outcomes typically represent variables that are hypothesized to be causally linked to ultimate outcomes (Nezu & Nezu, 1993). The distinction between ultimate outcomes and instrumental outcomes parallels the distinction between treatment goals and revised personal characteristics. This distinction is very important for the clear explication of theories. In discussions of theories, revised personal characteristics (instrumental outcomes) are often confused with the treatment goals (ultimate outcomes). To illustrate, insight is erroneously presented as the goal of some theories of psychotherapy (Weiner, 1975). From the perspective of the metamodel, insight is a revision in a personal characteristic (or an instrumental outcome) not a treatment goal (or an ultimate outcome). As Weiner (1975) suggested, insight is a means to an end not an end in itself. Many people lack insight without suffering psychological impairment or distress. Therapists foster insight because they believe that doing so will reduce psychological problems and restore mental health.

How does therapy promote therapeutic revisions in dysfunctional personal characteristics? That is, how does therapy achieve instrumental outcomes that, in turn, lead to ultimate outcomes? It does so by providing corrective learning experiences (Goldfried, 1980, 1988; Strupp, 1988). 'All psychotherapies are methods of learning' (Corsini, 2000, p. 6; see also Goldfried, 1988; Strupp, 1988). *Interventions* are the learning experiences or conditions that the therapist arranges because they are presumed to change those dysfunctional personal characteristics that produce the client's psychological problems. From the perspective of REBT, treatment is an educational process involving persuasion and confrontation. A central technique is to dispute clients' irrational beliefs and to teach them to do so by themselves. Presumably, disputation leads clients to revise or abandon their pathology-producing irrational beliefs, leaving rational beliefs in their place.

Interventions encompass all the strategic actions of the therapist, including general listening and interviewing behaviour, theory-based techniques, and the therapeutic relationship itself. Theories vary in the interventions they prescribe. For example, theories offer different prescriptions for using the therapeutic relationship as a vehicle for corrective learning experiences (Gelso & Carter, 1985). Theories also vary in how they conceptualize the learning process (i.e. how interventions lead to changes in behaviour, cognitions and feelings). The same intervention may be conceptualized differently by different theories. For example, exposure therapy for treating anxiety disorders looks one way through the lens of social cognitive theory (Bandura, 1986) and another way through the lens of implosive therapy (Levis & Hare, 1977). Viewed through the lens of social cognitive theory, exposure provides information that enhances the client's self-efficacy expectation of being able to handle the anxiety-provoking situation. Viewed through the lens of implosive therapy, exposure involves the extinction of a conditioned anxiety response.

THE METAMODEL APPLIED TO FOUR THEORIES OF PSYCHOTHERAPY

In this section, I apply the metamodel to four prominent and familiar theories of psychotherapy: Freudian psychoanalysis, Roger's person-centred therapy, Wolpe's behaviour therapy, and Beck's cognitive therapy. This exercise serves to illustrate

the metamodel and to demonstrate its utility as a guide to theories. My purpose is not to present the theories in detail, but to illustrate how the metamodel maps out the essential structure of theories and in so doing illuminates them. The presentation of each theory is streamlined and simplified, but adequate for the purpose at hand. A number of excellent texts (e.g. Corey, 2001; Corsini, 2000; Ford & Urban, 1998; Patterson & Watkins, 1996; Prochaska & Norcross, 1999) provide more comprehensive accounts of the theories. Obviously, the most comprehensive treatment of a theory is to be found in the writings of the author of the theory.

Psychoanalysis (Freud)

The myth of Freudian psychoanalysis is well known. According to Freud, neuroses arise out of unconscious conflicts involving forbidden sexual or aggressive wishes of the id and restraining forces of the ego and the superego. The ego would risk danger (punishment) and overwhelming anxiety if the forbidden wishes (or 'unbearable ideas'; Fine, 1979) were represented in consciousness and directly expressed. Consequently, the ego erects defences that inhibit conscious expression of the id's wishes (i.e. repression) and which transform these wishes into symbolic disguises. This results in symptoms that serve as a defence against unacceptable wishes and, in many cases, an indirect expression, or gratification, of these same wishes. 'The symptoms of neuroses are, it might be said, without exception either a substitutive satisfaction of some sexual urge or measures to prevent such a satisfaction; and as a rule they are compromises of the two' (Freud, 1940/1969; p. 43). Symptoms are the symbolic manifestation of the unconscious conflict involving a forbidden wish (or unbearable idea). From a psychoanalytic perspective, the symptoms of hysteria reduce anxiety by resolving an internal conflict between forbidden wishes and superego injunctions (e.g. paralysis of the arm to prevent hitting one's father); and the symptoms of hysteria are compromise formations that express both a wish and a punishment and keep the conflict out of consciousness. In addition to symbolizing the particular conflict that underlies them, symptoms deplete the neurotic's store of psychic energy. Neurotics are unable to enjoy life and to function adaptively because their ego is weakened and drained of the energy required to defend against forbidden wishes.

According to the Freudian myth, the roots of adult neuroses are found in childhood experiences.

'It seems that neuroses are acquired only in early childhood (up to the age of six), even though their symptoms may not appear until much later' (Freud, 1940/1969; p. 41). Indeed, Freud (1926/1989) claimed 'Signs of childhood neuroses can be detected in *all* adult neurotics without exception' (p. 80). Specifically, the unconscious conflicts underlying adult neuroses involve the revival of childhood conflicts from pregenital stages of psychosexual development (Arlow, 2000). In the face of a precipitating event (e.g. attempted seduction by a married friend), the adult neurotic re-experiences at an unconscious level an earlier childhood conflict (e.g. a struggle between a desire for taboo sex with the opposite sex parent and the fear of punishment). In sum, childhood experiences and resultant fixations leave the adult neurotic vulnerable to regression to these past ego states of childhood conflict (Giovacchini, 1987).

The Freudian ritual is derived from this understanding of neuroses. The mechanism of change consists of patients' insight into their underlying unconscious conflicts. If the repressed wish—the unbearable idea at the root of neurotic symptoms—could be made available to consciousness and to the conscious control of the ego, the symptoms become unnecessary and disappear. The analyst's 'knowledge' makes up for the patient's 'ignorance' and gives the patient's 'ego back its mastery over lost provinces of his (sic) mental life' (Freud, 1940/1969, p. 30). With access to the repressed material, the adult ego can resolve the unconscious conflict that overwhelmed the helpless, immature ego of childhood. Thus, clinical improvement comes from making the unconscious conscious so that 'Where id was, there shall ego be' (Freud, 1933/1964; p. 80).

Treatment goals include a reorganization of personality that goes beyond mere symptom relief. As symptoms abate and drain less of its energy, the invigorated ego finds more adaptive ways of dealing with life's demands. This results in personality reorganization with the patient exhibiting more deliberate, realistic control of affect, thought and action (Ford & Urban, 1998). The ideal goal is a mature genital personality, expressed in the ability to love altruistically and to work productively.

The techniques of psychoanalysis aim to uncover the underlying unconscious conflict and its origins. Free association (reporting whatever comes to mind without censorship) is the primary method for gaining access to unconscious material (Auld & Hyman, 1991). The principal technique of treatment is interpretation (Giovacchini, 1987; Greenson, 1967). With

interpretations, the analyst provides the patient with the unconscious meaning of material revealed in free associations, dream reports, symptoms, resistance, and transference. Interpretation is a means of illuminating an unconscious conflict and tracing it back to its origin in childhood. Thus, interpretations are intended to help patients gain insight into the unconscious conflicts that are the source of their problems.

The myth and the ritual of psychoanalysis are summarized in Figure 2. The origin of psychological problems consists of early childhood experiences that result in fixations. These fixations leave the adult vulnerable to regression to a state of mind that echoes childhood neuroses. This state of mind consists of unconscious conflicts involving defences against unbearable ideas (forbidden wishes). The unbearable ideas arouse anxiety that sets the defences in motion. Unconscious conflicts are the dysfunctional personal characteristics that are at the root of neurotics' psychological problems (i.e. symptoms). The ego's defences against unbearable ideas are manifested in symptoms that symbolize the unconscious conflict. Now consider the Freudian ritual. The interventions of the analyst, especially interpretation, promote insight, an undoing of the unconscious conflict. Insight—making the unconscious conscious—leads to symptom relief as well as to personality reorganization (i.e. enhanced ability to love and to work).

Person-Centred Therapy (Rogers)

According to Rogers (1951, 1959), the development of psychological problems (maladjustment) is a story of socialization gone awry. The basic story is simple. As children, clients come to realize that to earn parental love, they must act—they must be—precisely as their parents wish. As a result, they develop a falsified self, disowning aspects of themselves that jeopardizes the love and approval of their parents and others important in their lives. They then defend this falsified self against experiences that contradict it. The result is psychological maladjustment.

A more complete and rigorous account of the Rogerian myth goes as follows. All people have a compelling need for positive regard (a need for love, respect, approval, affection and so on). This need renders people vulnerable to the influence of others, notably their parents. Out of the need for positive regard, people develop a need for self-regard (a need to like oneself independent of the attitudes of others). These two needs are

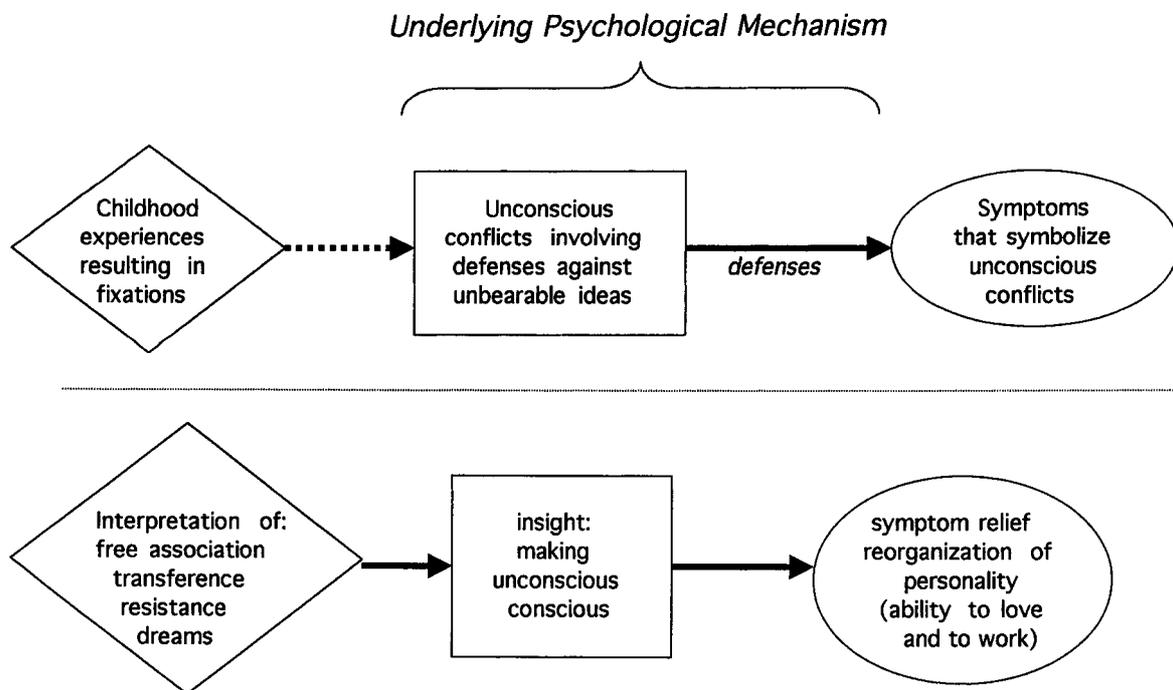


Figure 2. The myth and the ritual of psychoanalysis (Freud)

universal and compelling. What sets the stage for maladjustment is conditional positive regard (when others impose conditions that children must fulfil in order to be loved). When parental regard is conditional, rather than unconditional, children introject their parents' conditions of worth, making them their own. Self-regard becomes contingent upon fulfilling these internalized conditions of worth and a person feels worthy only when acting in accord with these conditions. Consider the case of Courtney whose parents always insisted on 'nice' behaviour. Because of her introjected conditions of worth ('I must be nice'), Courtney feels good about herself, feels lovable and worthy, only when she is agreeable and 'nice', not when she is angry and assertive. In order to feel good about themselves people deny or distort organismic experiences that violate their conditions of worth. 'Because of the need for self-regard, the individual perceives his (sic) experience selectively, in terms of the conditions of worth which have come to exist in him' (Rogers, 1959, p. 226). People accurately perceive and symbolize in awareness those experiences and behaviours that accord with conditions of worth. As for experiences that contradict conditions of worth, they are distorted to fit their conditions of

worth (i.e. they are symbolized in distorted form in consciousness) or they are denied symbolization in awareness. Courtney is able to accurately perceive instances when she behaves 'nicely', but she denies genuine feelings of anger or she distorts them (e.g. perceiving unfair treatment as her own fault). Out of their symbolizations of their experience—accurate as well as distorted—people construct a self (a self-concept or conscious view of the self). Because some experiences are distorted or denied symbolization, the constructed self is false. In Roger's terms there is incongruence between experience (what the person genuinely experiences, for example, feels) and the self (what is symbolized as part of the self). For example, Courtney views herself as a 'nice' person who is incapable of anger—even though she does at times feel angry. The incongruence between self and experience is the cause of psychological maladjustment. If a person were to become aware of incongruent experiences, their self-concepts would be threatened, their conditions of worth would be violated, their need for self-regard would be compromised, and they would be flooded with anxiety. Defences, including symptoms, develop to keep these threatening experiences (i.e. experiences incongruent with the self) from awareness,

thereby preventing the painful consequences of such awareness. Defences involve the distortion or denial of experience. 'Defensive behaviours include not only the behaviours customarily regarded as neurotic—rationalization, compensation, fantasy, projection, compulsions, phobias, and the like—but some of the behaviours customarily regarded as psychotic, notably paranoid behaviours and perhaps catatonic states' (Rogers, 1959, pp. 227–228). More serious psychological problems arise when the process of defence is unsuccessful. When this happens, the person becomes aware of the incongruent experience. This shatters the self and leads to a state of disorganization. 'The disorganized category includes many of the "irrational" and "acute psychotic behaviors"' (Rogers, 1959, p. 228). If Courtney were to become aware of her long denied anger, she would suffer panic and psychological disintegration.

The path toward psychological adjustment, the path of person-centred therapy, involves the development of a self, which is congruent with experience (along with the dissolution of conditions of worth). The therapeutic relationship provides the necessary and sufficient conditions for moving in this direction (Rogers, 1957). 'If the therapist is successful in conveying genuineness, unconditional positive regard and empathy, then the client will respond with constructive changes in personality organization' (Raskin & Rogers, 2000). Thus, the person-centred therapist communicates acceptance and understanding of clients as they reveal themselves in counselling. In the safety of this therapeutic relationship, the client comes to accurately symbolize in consciousness those experiences that were previously denied or distorted. Once these experiences become conscious, the self is gradually revised and expanded to include them, giving rise to increasing congruence between the self and experience. This results in psychological adjustment. Psychological adjustment is synonymous with openness to experience which is 'the polar opposite of defensiveness' (Rogers, 1959, p. 206). It is reflected in increased spontaneity, less defensiveness, more realistic perceptions, more effective problem solving, decreased anxiety, enhanced confidence and self regard, and greater acceptance of others (Rogers, 1959).

Figure 3 summarizes the Rogerian myth and ritual. The origin is conditional positive regard in conjunction with the universal needs for positive regard and self-regard. Conditional positive regard leads to introjected conditions of worth, which

result in incongruence between self and experience—the immediate determinant of psychological problems. The process that links incongruence with the psychological problems begins with anxiety. Anxiety is aroused by the prospect that experiences that are incongruent with the self will enter consciousness. This activates the process of defence that keeps these experiences out of consciousness and in so doing protects the self. The resulting defensive behaviours are one form of psychological maladjustment. The other form is disorganized behaviour, which arises when the defences break down. The ritual identifies a necessary and sufficient intervention for therapeutic improvement: a therapeutic relationship characterized by unconditional positive regard, empathy and genuineness (the core conditions). This relationship fosters congruence between self and experience as well as dissolution of the conditions of worth. This leads to psychological adjustment (openness to experience and less defensive behaviour).

Behaviour Therapy (Wolpe)

All approaches to behaviour therapy are built upon two fundamental assumptions. The first assumption is that learning is the basis of the development and the treatment of psychological problems. The second assumption is that psychological problems and treatment goals consist of behavioural, cognitive and affective responses to specific situations. Consistent with these assumptions, Wolpe's theory (1982) emphasizes classical conditioning (and unconditioning) of unadaptive anxiety (or fear) responses.

Wolpe's (1982) theory deals only with neuroses. By neuroses Wolpe (1982) meant 'a persistent unadaptive habit that has been acquired by learning in an anxiety-generating situation (or succession of such situations) and in which anxiety is usually the central component' (pp. 9–10). Inappropriate fears, particularly social fears, are most common. Once anxiety becomes a conditioned response to specific stimuli, it often has secondary effects (or symptoms) that cause suffering including stuttering, shyness, sexual dysfunction, exhibitionism, kleptomania, fetishism, substance abuse, neurotic depression, obsessions and compulsions. Wolpe's theory specifically excludes organically-based disorders (e.g. psychotic illness) because they are not learned and, therefore, not amenable to behavioural treatment.

Neurotic anxiety (or fear) is the core of all neuroses and is established through learning. It is a product of classical conditioning or of

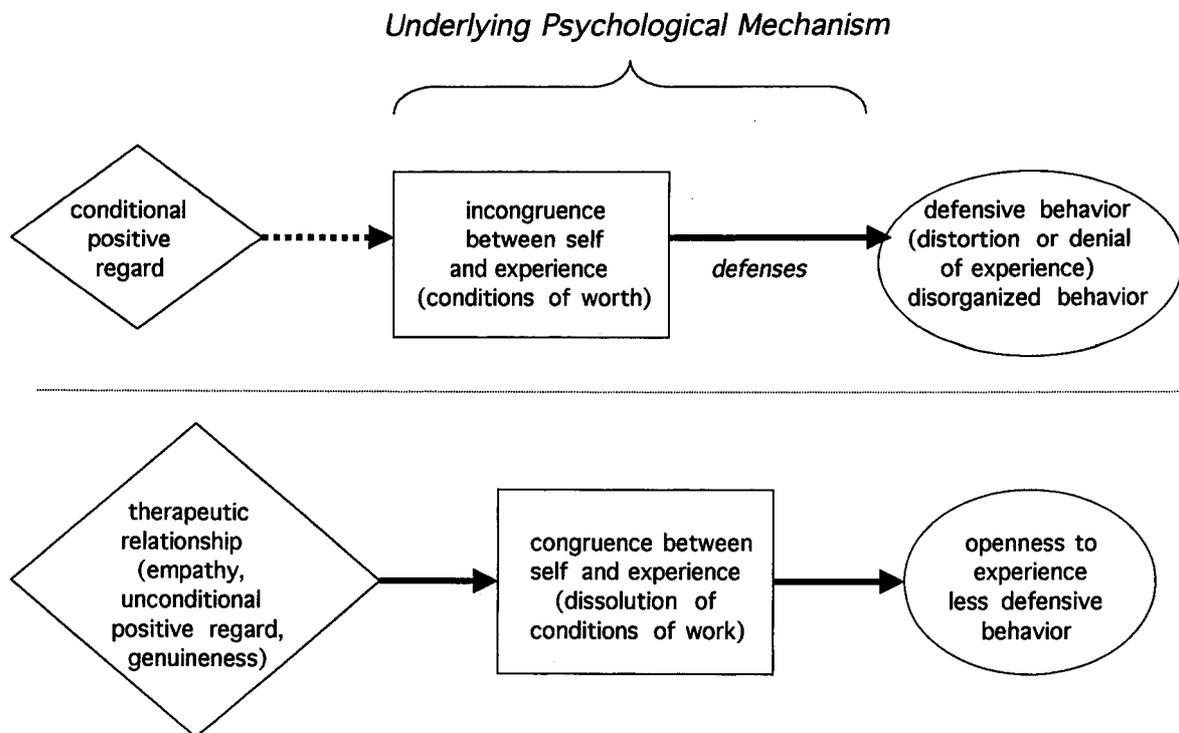


Figure 3. The myth and the ritual of person-centred therapy (Rogers)

misinformation (cognitive learning). In either case, neurotic anxiety is a reaction to a stimulus situation that is not objectively a source or a sign of danger. (For the sake of simplicity, I will ignore cognitively-based neurotic anxiety in the following analysis.) The classical conditioning of neurotic anxiety may result from a single event (single-trial learning) or it may be progressively built up over the course of a series of related events. These learning experiences strengthen a stimulus–response bond (i.e. a bond between the conditioned stimulus and the conditioned response of anxiety), which is coded in functional connections formed between neurons. There is specificity in these stimulus–response bonds. Thus, behaviour problems (neuroses) involve conditioned anxiety that is highly specific in both the stimuli that elicit it and in the consequences that follow from it.

This analysis of neuroses implies that successful treatment requires the elimination of specific anxiety responses. Because anxiety responses are learned through conditioning, they can be unlearned through counterconditioning. Counterconditioning is based upon the principle of reciprocal inhibition: 'if a response inhibiting anxiety can

be made to occur in the presence of the anxiety-evoking stimuli, it will weaken the bond between these stimuli and anxiety' (Wolpe, 1973, p. 17). With enough pairings of the anxiety-inhibiting response with the anxiety-eliciting stimuli, the maladaptive anxiety response is eliminated, as are the secondary effects that flow from it.

Figure 4 summarizes the myth and the ritual of Wolpe's theory. The origin of patients' problems can be traced to their conditioning histories, which establish bonds between conditioned stimuli and conditioned anxiety responses. These stimulus–response bonds are the personal characteristics that are the immediate determinants of psychological problems. Conditioned stimuli trigger the conditioned neurotic anxiety responses that lead to secondary symptoms. These unadaptive habits (neurotic anxiety as well as its secondary effects) are the psychological problems that patients suffer. To treat these problems, the behaviour therapist first identifies precisely what stimuli trigger the neurotic anxiety responses and then arranges counterconditioning experiences to weaken the bonds between these stimuli and the anxiety responses. This weakens or eliminates the unadaptive habits.

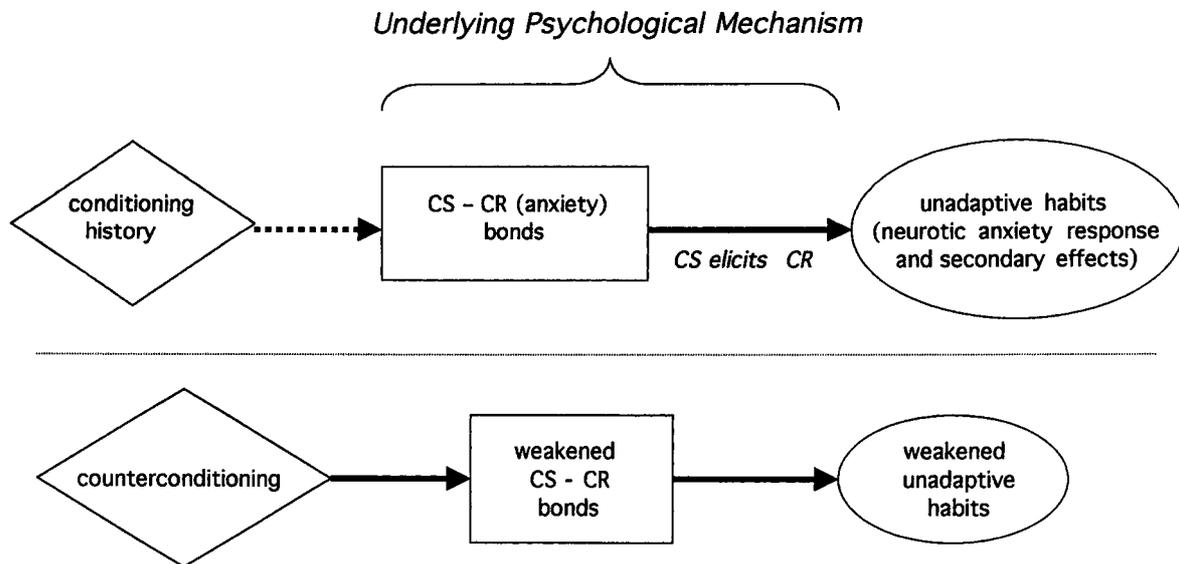


Figure 4. The myth and the ritual of behaviour therapy (Wolpe)

Cognitive Therapy (Beck)

Cognitive therapy (Beck, 1991; Beck, Freeman, & Associates, 1990; Clark, Beck, & Alford, 1999) emphasizes the role of dysfunctional thinking in psychological disorders. Presumably, if thinking goes askew, then so do feelings and actions. 'As ye think, so shall ye feel and act'. It follows that treatment provides symptomatic relief by correcting dysfunctional thinking.

As a vehicle for presenting the myth and the ritual of cognitive therapy, consider the following scenario. Two college students, David and Paul, earn an 'F' on their first paper in freshmen rhetoric. David attributes his failing grade to his inferior ability ('I'm too stupid for college'), becomes despondent and withdraws from the world. Paul attributes his failing grade to an unfair professor ('The professor wants to screw me over!'), becomes angry, and verbally assaults the professor. This scenario illustrates a fundamental postulate of cognitive therapy: individuals' interpretations of a situation rather than the objective situation *per se* determine their emotional and behavioural responses. Beck refers to these spontaneous interpretations (e.g. 'I'm too stupid for college') as automatic thoughts. Why did David and Paul have different interpretations of their objectively identical situations? An answer can be found in a second postulate of cognitive therapy: individuals' schemas (beliefs about the self and the world) shape their interpretations of

events. Schemas are tacit assumptions that people use to understand their experiences. They are the 'meaning-making structures of cognition' (Alford & Beck, 1997, p. 15). When a schema is activated, a person interprets information in terms of that schema. As information (including memories) is processed, it is biased or distorted to fit the activated schema. This biased processing results in schema-consistent interpretations or automatic thoughts. 'Cognitive distortions are evident in automatic thoughts' (Beck & Weishaar, 2000, p. 254). For example, David viewed his failing grade through the lens of his 'incompetence schema' and consequently interpreted it as another instance of his stupidity. Paul viewed his failing grade through the lens of his 'mistrust schema' and interpreted it accordingly. In sum, when schemas are activated, they are used to interpret information, yielding schema-consistent automatic thoughts that lead to consistent feelings and behaviours.

Psychopathology results from dysfunctional schemas constructing 'maladaptive meanings' (i.e. dysfunctional automatic thoughts) about the self and the world (Alford & Beck, 1997). 'Psychological disorders are characterized by dysfunctional thinking derived from dysfunctional beliefs' (Beck, 1997, p. 56). Indeed, each psychological disorder is associated with a unique cognitive profile with a characteristic theme in the dysfunctional schemas and allied automatic thoughts about the self, the world and the future. For example, depressed

patients' interpretations of their experiences are shaped by characteristic beliefs such as 'I am incompetent', 'I am worthless', or 'I am unlovable'. Paranoid patients' automatic thoughts about their experiences reflect other beliefs such as 'You can't trust anybody', 'It's a cruel world', or 'I'm always mistreated'. The characteristic automatic thoughts of a particular disorder lead to its characteristic affective and behavioural symptoms. For example, David reacted to his failing grade as a depressed patient might, interpreting it as a sign of his incompetence which gave rise to symptoms including sadness, a sense of worthlessness and anhedonia. Paul's suspicious thinking and the other symptoms it generated (e.g. anger, counterattacking) are characteristic of a paranoid personality disorder.

Cognitive therapy posits that change in dysfunctional automatic thoughts and schemas is critical to symptomatic relief. 'Improvement results from modification of the dysfunctional thinking and durable improvement from modification of beliefs' (Beck, 1997, p. 56). Therapeutic interventions are designed to identify, reality-test, and correct distorted automatic thoughts and the dysfunctional schemas that generate these thoughts. The therapist

and the patient become co-investigators who systematically gather and examine the evidence for or against the patient's cognitions. They regard automatic thoughts and schemas as testable hypotheses and they employ the scientific method of hypothesis testing to evaluate their validity and utility. For example, the therapist helps patients to design behavioural experiments to test the validity of their thoughts and beliefs. When therapists employ behavioural techniques, they view them as methods for helping patients to test and disconfirm their faulty interpretations and beliefs (e.g. exposure treatments viewed as involving experiences that disconfirm unwarranted fears). David's cognitive therapist might arrange graded task assignments to provide successful experiences that would disconfirm David's incompetence schema.

Figure 5 summarizes the Beckian myth and ritual. Life experiences shape the development of dysfunctional schemas. As people interact with the environment, they construct these meaning-making structures to comprehend and adapt to the world. Although Beck emphasizes the role of a person's learning history (particularly, negative experiences with caregivers in childhood) in the development of dysfunctional schemas, he acknowledges

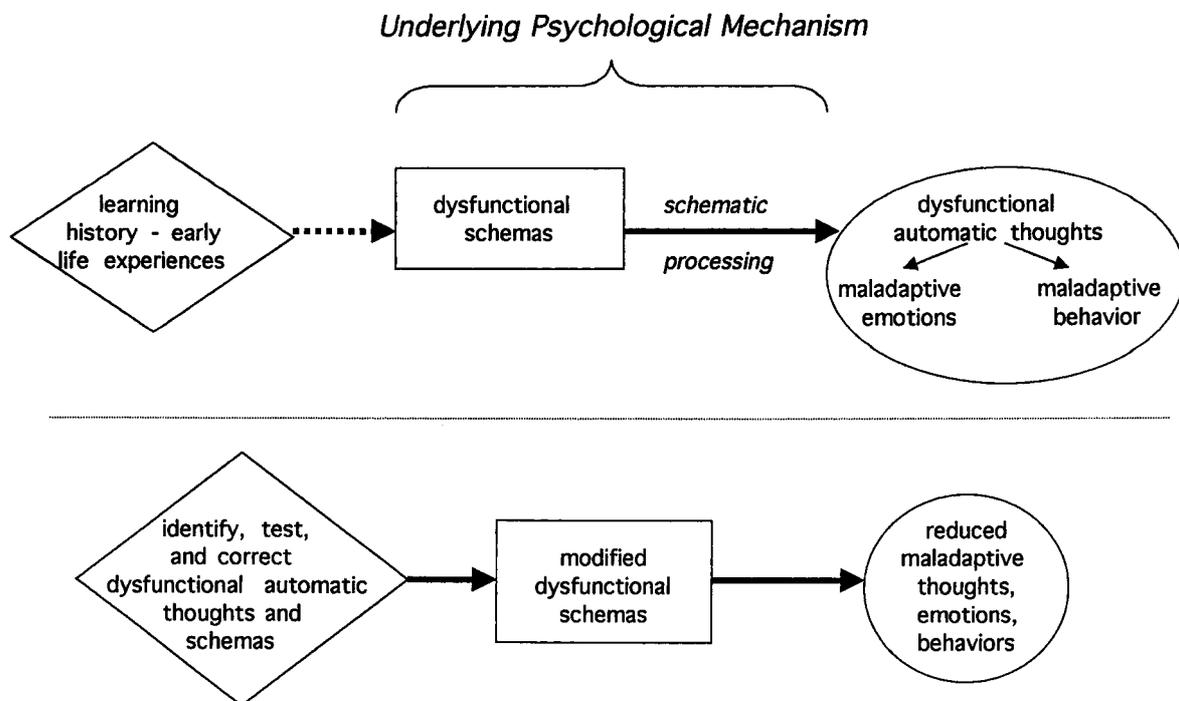


Figure 5. The myth and the ritual of cognitive therapy (Beck)

that biology also plays a role. As Figure 5 shows dysfunctional schemas are the personal characteristics that generate maladaptive thoughts, emotions and behaviours. When dysfunctional schemas are activated, they guide the processing, or interpretation, of information. Schematic (meaning) processing biases information to conform to the content of the schema. This results in schema-consistent automatic thoughts (interpretations). These dysfunctional automatic thoughts are cognitive symptoms that lead to specific affective and behavioural symptoms. Psychological problems are construed as maladaptive thoughts, emotions, and behaviours. They are often packaged in the language of the standard psychiatric syndromes of DSM-IV. Indeed, Beck and his colleagues have attempted to identify the cognitive profiles associated with various psychiatric disorders.

The Beckian ritual maintains that the modification of dysfunctional schemas leads to cognitive, emotional and behavioural improvement (i.e. symptom relief). The treatment goal is to reduce the patient's cognitive, emotional and behavioural symptoms. To accomplish this, cognitive therapists arrange specific learning experiences to teach patients to identify, evaluate, and alter dysfunctional automatic thoughts and schemas.

CASE FORMULATIONS AS INSTANTIATIONS OF MYTHS

A case formulation (or case conceptualization) is an individualized model of the mechanisms that cause, control, or maintain a particular client's psychological problems (Eells, 1997c; Meier, 1999; Persons, 1989; Stevens & Morris, 1995). A sound case formulation is vital in therapy because selecting an appropriate treatment requires an understanding of what is causing or maintaining a client's problems (Eells, 1997a; Eells, Kendjelic, & Lucas, 1998). In other words, a treatment plan is based directly upon a case formulation (Eells, 1997c; Meier, 1999; Persons & Tompkins, 1997). There are a variety of systematic methods for constructing case formulations (see Eells, 1997b). These methods are based upon a guiding theory and show how to use the concepts and principles of that theory to construct case formulations from clinical data.

In this section I introduce a systematic method for constructing case formulations that is not based upon any particular theory. This method is generic and it provides guidelines for translating any theory of psychotherapy into a case formulation. It is based

upon the premise that a case formulation is an instantiation of a myth in that a case formulation particularizes the concepts and principles of a theory's myth to a specific client. To illustrate, the myth of REBT maintains that irrational beliefs are the causes of emotional upsets. In developing a case formulation of a particular client, an REBT therapist would need to identify the client's particular emotional upsets (e.g. depression) and the particular irrational beliefs that give rise to them (e.g. 'I MUST be approved by people I find important!').

Because a case formulation is an instantiation of a myth, the format of case formulations parallels the structure of myths: (1) a list of psychological problems, (2) the dysfunctional personal characteristics that are hypothesized to cause or maintain the problems, (3) the hypothesized process that explains how the dysfunctional personal characteristics cause the problems, and (4) the origin of the dysfunctional personal characteristics. This format (cf. Persons & Tompkins, 1997) lends itself to a systematic four-step process of case formulation that is outlined in Figure 6. The steps consist of answering four questions:

- (1) What particular psychological problems does this client face? In answering this question, the therapist lists the client's overt difficulties in thinking, feeling and behaving (Persons, 1989; Persons & Tompkins, 1997). A psychiatric diagnosis might be used to characterize the overt difficulties or symptoms. As noted earlier, theories vary in how they construe psychological problems; for example, as symptoms of unconscious conflicts (Freud), as defensive or

Case Formulation (based on the myth):

1. Identify the client's specific **psychological problems**
2. Develop hypotheses about the client's **dysfunctional personal characteristics**
3. Develop a working model the **process** whereby these dysfunctional personal characteristics give rise to the client's psychological problems
4. Identify the **origin** of the client's dysfunctional personal characteristics

Treatment Plan (based on the ritual):

5. Negotiate **treatment goals** (ultimate outcomes)
 6. Specify the **revised personal characteristics** (instrumental outcomes)
 7. Select **interventions**
-

Figure 6. Steps in constructing case formulations and treatment plans

disorganized behaviours (Rogers), as neurotic anxiety reactions and their secondary effects (Wolpe), or as maladaptive thoughts, feelings and behaviours (Beck). In general, the therapist uses the language of a favoured theory to characterize the client's cognitive, behavioural and affective difficulties.

- (2) What dysfunctional personal characteristics of the client are causing the client's psychological problems? In addressing this question, the therapist develops working hypotheses about the idiosyncratic personal characteristics that are producing the client's problems. This is the heart of the case formulation. It is the 'linchpin' or 'causal/explanatory source' (Bergner, 1998), the 'inferred mechanism' (Eells *et al.*, 1998), the 'hypothesized underlying mechanism' (Persons, 1989) that organizes the clinical data of a case. To identify a client's underlying personal characteristics, therapists turn to the myths of their favoured theories. Each myth raises different questions. The Freudian analyst asks: What is the nature of this client's unconscious conflicts? What are the unbearable ideas that this client is defending against and that are being expressed in their symptoms? The Rogerian therapist asks: What particular aspects of this client's experience are incongruent with the self and vice versa? What are this client's conditions of worth? The Wolpean behaviour therapist asks: What are the particular stimuli that elicit neurotic anxiety responses in this client? What are the neurotic stimulus-response bonds? The cognitive therapist asks: What are this client's dysfunctional thoughts and schemas (beliefs about the self, others, and the world)? In answering questions like these, the therapist 'identifies the core state of affairs from which all of the client's difficulties issue' (Bergner, 1998, p. 289).
- (3) How are the hypothesized personal characteristics causing the client's psychological problems? In answering this question, the therapist describes the process whereby the client's dysfunctional personal characteristics produce the problems on the problem list (cf. Persons, 1989; Persons & Tompkins, 1997). The therapist draws upon the underlying psychological mechanisms of their favoured myths to develop an account of this process. The account may articulate how stressors activate personality characteristics (i.e. the diathesis) to produce psychological problems. For example, a cognitive therapist might maintain that a

patient with a sociotropic personality becomes depressed whenever a latent, dysfunctional schema (e.g. 'It is horrible to be rejected!') is activated by pertinent stressors like social rejection (Clark *et al.*, 1999).

- (4) What are the origins of the dysfunctional personality characteristics? In answering this, the therapist speculates about the development of the personal characteristics posited to underlie the client's problems. This speculative account is an application of a favoured theory's myth to the life of the client. For example, a cognitive therapist would describe a few incidents or circumstances of the client's life (particularly episodes involving parents) that explain how the client might have learned maladaptive schemas. Most theories provide an historical account of the development of the client's dysfunctional personality characteristics with an emphasis on incidents involving early caretakers.

TREATMENT PLANS AS INSTANTIATIONS OF RITUALS

A treatment plan is an instantiation of a ritual, just as a case formulation is an instantiation of a myth. Thus, treatment plans include the same components as rituals: (a) treatment goals (ultimate outcomes), (b) revised personal characteristics (instrumental outcomes or treatment targets), and (c) interventions (cf. Persons & Tompkins, 1997). As an instantiation of a ritual, a treatment plan is derived from an instantiation of a myth—the case formulation. The treatment goals are derived from the client's problem list. In a treatment plan, the therapist outlines specific interventions to correct selected problems from the client's problem list. The interventions target the dysfunctional personal characteristics that are hypothesized to produce the client's psychological problems. The therapist selects particular interventions that the ritual prescribes for revising these personal characteristics.

CONTRIBUTIONS OF THE METAMODEL TO THE ANALYSIS, COMPARISON, INTEGRATION, AND USE OF THEORIES

The metamodel provides a fresh perspective for understanding and using theories of psychotherapy. The metamodel extends Frank's (1982) concepts of myth and ritual by articulating their structure. In doing so, the metamodel suggests a number

of questions that help to organize thinking about the myth and the ritual of a theory: how does the theory construe psychological problems? What dysfunctional personality characteristics are presumed to cause problems? What is the process whereby these personality characteristics cause problems? How do these personality characteristics come to be? Turning to the ritual, how does the theory conceptualize treatment goals? How do the interventions promote revisions in the dysfunctional personal characteristics that lie at the root of psychological problems? These questions uncover the underlying structure of a theory and capture its essential concepts and principles. Furthermore, these questions provide guidance in analysing, comparing, and integrating theories and for constructing case formulations from them. In this section I consider how the metamodel provides a fresh framework for accomplishing each of these tasks.

Analysing Theories of Psychotherapy

The metamodel provides a framework for the precise and rigorous analysis of theories of psychotherapy. The structural distinctions postulated by the metamodel are not commonly made in the literature on psychotherapy. For example, consider how Corey (2001) characterizes the goals of person-centred therapy in his celebrated textbook: 'To provide a safe climate conducive to clients' self-exploration, so that they can recognize blocks to growth and can experience aspects of self that were formerly denied or distorted. To enable them to move toward openness, greater trust in self, willingness to be a process, and increased spontaneity and aliveness' (p. 469). How can 'to provide a safe climate...' be a treatment goal, an ultimate outcome, the reason for treatment? From the perspective of the metamodel, Corey's characterization confuses intervention ('to provide a safe climate...') and revised personal characteristics ('...experience aspects of self that were formerly denied or distorted') with the actual treatment goals ('openness, greater trust in self...'). In fact, his characterization eloquently captures the *entire ritual* of person-centred therapy—not just the treatment goals. This kind of confusing analysis abounds in discussions of theories of counselling and psychotherapy. As Weiner (1975) observed, some theorists confuse insight with a treatment goal (ultimate outcome) rather than a means for achieving a treatment goal (i.e. an instrumental outcome or revised personal characteristic). Similarly, as noted earlier, Ellis (2000) confuses the goal of treatment

(reduction in the symptoms of emotional upsets and self-defeating behaviours) with the revised personal characteristic necessary to achieve this goal (adoption of a rational philosophy). The metamodel avoids this kind of confusion by providing a framework for distinguishing between the structural components of theories.

Comparing and Contrasting Theories of Psychotherapy

The metamodel provides a fresh framework for comparing and contrasting different theories as well. Using the metamodel to analyse theories reveals the fundamental similarities and differences in their basic concepts and principles. To illustrate, when using the metamodel to analyse psychoanalysis and person-centred therapy, striking similarities and differences become abundantly clear. For example, it becomes clear that in both theories symptoms reflect defences against 'truths' about the self that the client cannot face. In psychoanalysis, the truth involves a forbidden wish; whereas in person-centred therapy, the truth involves an aspect of organismic experience that is incongruent with the self. To illustrate further, a metamodel-based analysis can reveal distinct theoretical explanations (i.e. hypothesized revised personal characteristics) for common intervention strategies. For example, from the vantage point of Wolpe's behaviour therapy, exposure to a feared object works by weakening the bond between a conditioned stimulus and a conditioned anxiety response, whereas from the vantage point of cognitive therapy, exposure works by correcting an exaggerated perception of threat.

Integrating Theories of Psychotherapy

The metamodel provides a fresh framework for psychotherapy integration. Reisman (1975) argued that training programmes 'should provide a system of analysis or a framework by which a multiplicity of theories and methods could be organized into an integrated understanding' (p. 191). The metamodel offers such a framework, one that can be applied to each of the three main approaches to psychotherapy integration: theoretical integration, common factors and technical eclecticism (see Arkowitz, 1997).

Theoretical Integration

'The strongest emphasis in theoretical integration is in integrating different components from

different approaches into a unified framework' (Arkowitz, 1997, p. 240). The most basic question about theoretical integration concerns the units and forms of an integration (Arkowitz, 1997). Different writers have proposed theory integration at different levels or units of analysis, including techniques, goals of change, theories, assumptions about human nature, and methods of verification (Arkowitz, 1997; Schacht, 1984). The ambiguity about units and form has resulted in confusion in the literature on theoretical integration (Schacht, 1984). The metamodel provides a template that clearly delineates the form and units of an integration. For example, the metamodel implies that an integration would combine the dysfunctional personal characteristics of different theories into a new nomological network that accounts for psychological problems (i.e. a hybrid underlying psychological mechanism). In general, the metamodel provides a framework for combining the components of different theories into a coherent and internally consistent synthesis.

Common Factors

The metamodel also provides a framework that is useful to the common factors approach. This approach 'seeks common ingredients across therapies that account for their success' (Westin, 2000, p. 227). Interestingly, myths (provision of rationale) and rituals themselves are among the most commonly cited common factors (Grencavage & Norcross, 1990). A major challenge facing this approach involves determining the type and level of common factors (Arkowitz, 1997). From the perspective of the metamodel, common factors can be viewed as revised personal characteristics (i.e. instrumental outcomes). In a classic paper, Goldfried (1980) argued in favour of identifying commonalities at an intermediary level of abstraction, between broad theories and specific techniques. He called this the level of clinical strategies or change principles. Clinical strategies 'consist of classes of therapeutic activities that may all serve the same underlying function', for example 'to achieve the common goal of helping clients/patients to shift their subjective conceptions and view themselves and their world more objectively' (Goldfried, 1995, p. 223). From the perspective of the metamodel, the 'common goal' or the 'underlying function' of different methods is the revision of a dysfunctional personal characteristic. That is, clinical strategies are classes of therapeutic activities that target a particular dysfunctional personal characteristic, like a distorted view of the

self and the world. Arguably, all forms of psychotherapy are directed at correcting clients' basic misconceptions about themselves, their behaviour and the world around them (Brady *et al.*, 1980; Corsini, 2000; Frank & Frank, 1991; Goldfried & Padawer, 1982; Raimy, 1975). In fact, most of the change processes identified as common factors by Grencavage & Norcross (1990), are designed to revise the client's basic misconceptions (e.g. foster insight, feedback/reality testing, persuasion, success and mastery experiences). The metamodel extends Goldfried's perspective on common factors by offering a framework for thinking about them.

Technical Eclecticism

Technical eclecticism 'is the practice of selecting potentially effective procedures from different therapy orientations' (Wolfe & Goldfried, 1988, p. 448). In modern eclecticism, treatment selection is based on 'an actuarial approach that uses data from past cases to predict what will work best for new cases' (Arkowitz, 1997; p. 252). That is, treatments are selected on the basis of what has worked best for similar people with similar problems (Arkowitz, 1997). The emphasis is on techniques. Theories and theoretical explanations are downplayed. This is a weakness of eclecticism (Arkowitz, 1989; Eysenck, 1970). Eysenck (1970) derided eclecticism as 'a mish-mash of theories, a hugger-mugger of procedures, a gallimaufry of therapies' (p. 145). Arkowitz (1997) concluded that eclecticism requires greater theoretical structure. The metamodel offers a minimal theoretical structure that fits the actuarial spirit of eclecticism. For example, it proposes that techniques should be linked to revised personal characteristics to provide a simple explanation of what causes therapeutic change.

Using Theories to Construct Case Formulations and Treatment Plans

The metamodel provides guidance in building case formulations and treatment plans from any theory of psychotherapy, thereby filling a void in the literature on the mechanics of case formulation. Recent years have seen the development of a diversity of systematic methods for constructing case formulations, each from the perspective of a specific theory of psychotherapy (see Eells, 1997b). However, there remains little consensus regarding the content, structure and goals of a case formulation and case formulation remains an insufficiently taught and practiced skill (Eells *et al.*, 1998; Fleming & Patterson, 1993). Butler (1998)

proposed that 'This process (case formulation) might be facilitated if there was agreement over which were the basic elements of a formulation and an atheoretical way of linking them together' (p. 18). The metamodel-based approach provides just such a generic, atheoretical approach. The few available generic methods (Butler, 1998; Hansen & Freimuth, 1997; McDougall & Reade, 1993; Meier, 1999; Murdock, 1991; Schwitzer, 1996; Weerasekera, 1993) do not adopt the premise that theories have the same structure as case formulations and, thus, do not make the case-formulation theory link as explicit. By linking the structure of case formulations and treatment plans to the structure of theories, the metamodel-based approach provides a fresh perspective to the literature on case formulation.

The metamodel-based method of case formulation is reminiscent of Persons' method of *cognitive-behavioural* case formulation (Persons & Tompkins, 1997; Persons, Davidson, & Tompkins, 2001), but hardly identical. The most unmistakable difference is that the metamodel-based method is generic whereas Person's method is restricted to cognitive-behaviour therapy. Although Persons' analysis of the theory of cognitive-behaviour therapy is compatible with the structural analysis proposed by my metamodel (as it should be) and she implicitly assumes that the structure of a cognitive-behavioural case formulation matches the structure of cognitive-behavioural theory, her model is restricted to cognitive-behavioural therapy. She does not argue that her basic model can be generalized to other theories nor does she suggest how this might be accomplished.

The metamodel provides a generic means for bridging the gap between theory and practice. Not only is the metamodel useful in applying any theory to a particular case, but it is useful in developing one's own personal theory of psychotherapy. It suggests the questions the practitioner must address in constructing a personal theory. With answers to these questions, the practitioner develops a solid theoretical basis for case formulation and treatment planning. With answers to these questions, the practitioner is prepared to provide clients with a fresh and plausible view of their problems together with a credible treatment rationale. According to a number of theorists (Addis & Carpenter, 2000; Frank, 1982; Goldfried, 1980; Rosenzweig, 1936), getting clients to adopt a fresh outlook on their problems is an important ingredient in successful therapy. Indeed, 'provision of a therapeutic

rationale' is widely assumed to be a common therapeutic component in the common factors literature (Grencavage & Norcross, 1990).

CONCLUSION

The metamodel delineates the underlying structure shared by theories of psychotherapy. It is thereby an aid in understanding theories—in analysing them, in comparing them and in integrating them. In addition, it is a guide to using theories to build case formulations and treatment plans out of clinical data. Finally, it provides guidance to practitioners in constructing their own personal theories of psychotherapy.

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REFERENCES

- Addis, M.E., & Carpenter, K.M. (2000). The treatment rationale in cognitive behavioral therapy: Psychological mechanisms and clinical guidelines. *Cognitive and Behavioral Practice*, 7, 147–156.
- Alford, B.A., & Beck, A.T. (1997). *The integrative power of cognitive therapy*. New York: Guilford.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. TR). Washington, DC: Author.
- Arlow, J.A. (2000). Psychoanalysis. In R.J. Corsini & D. Wedding (Eds), *Current psychotherapies* (6th ed.; pp. 16–53). Itasca, IL: F.E. Peacock.
- Arkowitz, H. (1989). The role of theory in psychotherapy integration. *Journal of Integrative and Eclectic Psychotherapy*, 8, 8–16.
- Arkowitz, H. (1997). Integrative theories of psychotherapy. In P. Wachtel, & S.B. Messer (Eds), *Theories of psychotherapy: Origins and evolution* (pp. 227–288). Washington, DC: American Psychological Association.
- Auld, F., & Hyman, M. (1991). *Resolution of inner conflict: An introduction to psychoanalytic therapy*. Washington, DC: American Psychological Association.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Beck, A.T. (1991). Cognitive therapy: A 30-year retrospective. *American Psychologist*, 46, 368–375.

- Beck, A.T. (1997). Cognitive therapy: reflections. In J. Zeig (Ed.), *The evolution of psychotherapy: The third conference* (pp. 55–64). New York: Brunner/Mazel.
- Beck, A.T., Freeman, A., & Associates (1990). *Cognitive therapy of personality disorders*. New York: Guilford.
- Beck, A.T., & Weishaar, M. (2000). Cognitive therapy. In R.J. Corsini & D. Wedding (Eds), *Current psychotherapies* (6th ed.; pp. 241–272). Itasca, IL: F.E. Peacock.
- Bergner, R.M. (1998). Characteristics of optimal clinical case formulations: The linchpin concept. *American Journal of Psychotherapy*, 52, 287–300.
- Brady, J.P., Davison, G.C., DeWald, P.A., Egan, G., Fadiman, J., Frank, J.D., Gill, M.M., Hoffman, I., Kempler, W., Lazarus, A.A., Raimy, V., Rotter, J.B., & Strupp, H.H. (1980). Some views on effective principles of psychotherapy. *Cognitive Therapy and Research*, 4, 269–306.
- Butler, G. (1998). Clinical formulation. In P.M. Salkovskis (Ed.), *Comprehensive clinical psychology* (pp. 1–24). Oxford, UK: Pergamon/Elsevier.
- Clark, D.A., Beck, A.T., & Alford, B. (1999). *Scientific foundations of cognitive theory and cognitive therapy of depression*. New York: John Wiley.
- Corey, G. (2001). *Theory and practice of counseling and psychotherapy* (6th ed.). New York: Brooks/Cole.
- Cormier, S., & Cormier, B. (1999). *Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions*. Pacific Grove, CA: Brooks/Cole.
- Corsini, R.J. (2000). Introduction. In R.J. Corsini & D. Wedding (Eds), *Current psychotherapies* (6th ed.; pp. 1–15). Itasca, IL: F.E. Peacock.
- Eells, T.D. (1997a). Preface. In T.D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. ix–xiii). New York: Guilford.
- Eells, T.D. (Ed.) (1997b). *Handbook of psychotherapy case formulation*. New York: Guilford.
- Eells, T.D. (1997c). Psychotherapy case formulation: History and current status. In T.D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 1–25). New York: Guilford.
- Eells, T.D., Kendjelic, E.M., & Lucas, C.P. (1998). What's in a case formulation? Development and use of a content coding manual. *Journal of Psychotherapy Practice and Research*, 7, 144–153.
- Ellis, A. (1994). *Reason and emotion in psychotherapy*. Seacus, NJ: Carol Publishing Group.
- Ellis, A. (2000). Rational emotive behavior therapy. In R.J. Corsini & D. Wedding (Eds), *Current psychotherapies* (6th ed.; pp. 168–204). Itasca, IL: F.E. Peacock.
- Ellis, A., & Harper, R.A. (1997). *A guide to rational living*. North Hollywood, CA: Melvin Powers.
- Eysenck, H.J. (1970). A mish-mash of theories. *International Journal of Psychiatry*, 9, 140–146.
- Fine, R. (1979). *A history of psychoanalysis*. New York: Columbia.
- Fleming, J.A., & Patterson, P.G. (1993). The teaching of case formulation in Canada. *Canadian Journal of Psychiatry*, 38, 345–350.
- Ford, D.H., & Urban, H.B. (1998). *Contemporary models of psychotherapy: A comparative analysis* (2nd ed.). New York: John Wiley.
- Frances, A., First, M.B., & Pincus, H.A. (1995). *DSM-IV guidebook* (4th ed.). Washington, DC: American Psychiatric Association.
- Frank, J.D. (1982). Therapeutic components shared by all psychotherapies. In J.H. Harvey & M.M. Parks (Eds), *Psychotherapy research and behavior change* (pp. 5–37). Washington, DC: American Psychological Association.
- Frank, J.D. (1987). Psychotherapy, rhetoric, and hermeneutics: Implications for practice and research. *Psychotherapy*, 24, 293–301.
- Frank, J.D., & Frank, J.B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.
- Freud, S. (1964). New introductory lectures. In J. Strahey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22, pp. 3–182). London: Hogarth Press (Original work published 1933).
- Freud, S. (1964). *An outline of psycho-analysis*. (J. Strahey, Ed. and Trans.). New York: W. W. Norton (Original work published 1940).
- Freud, S. (1989). *Inhibitions, symptoms and anxiety*. (A. Strahey, Trans., & J. Strahey, Ed.). New York: W. W. Norton (Original work published 1926).
- Gelso, C.J., & Carter, J.A., (1985). The relationship in counseling and psychotherapy. *The Counseling Psychologist*, 13, 155–243.
- Giovacchini, P.L. (1987). *A narrative textbook of psychoanalysis*. Northvale, NJ: Jason Aronson.
- Goldfried, M.R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist*, 35, 991–999.
- Goldfried, M.R. (1988). A comment on therapeutic change: A response. *Journal of Cognitive Psychotherapy: An International Quarterly*, 2, 89–93.
- Goldfried, M.R. (1995). Toward a common language for case formulation. *Journal of Psychotherapy Integration*, 5, 221–244.
- Goldfried, M.R., & Padawer, W. (1982). Current status and future directions in psychotherapy. In M.R. Goldfried (Ed.), *Converging themes in psychotherapy: Trends in psychodynamic, humanistic, and behavioral practice* (pp. 5–37). New York: Springer.
- Greenson, R. (1967). *The technique and practice of psychoanalysis*. New York: International Universities Press.
- Grencavage, L.M., & Norcross, J.C. (1990). Where are the commonalities among the therapeutic common factors?. *Professional Psychology: Research and Practice*, 21, 372–378.
- Hansen, N.E., & Freimuth, M. (1997). Piecing the puzzle together: A model for understanding the theory-practice relationship. *The Counseling Psychologist*, 25, 654–673.
- Kanfer, F.H., & Busemeyer, J.P. (1982). The use of problem-solving and decision-making in behavior therapy. *Clinical Psychology Review*, 2, 239–266.
- Levis, D.J., & Hare, N. (1977). A review of the theoretical rationale and empirical support for the extinction approach of implosive (flooding) therapy. In M. Hersen, R.M. Eisler, & P.M. Miller (Eds), *Progress in behavior modification*, vol. 4 (pp. 300–376). New York: Academic Press.

- Mahoney, M.J. (1995). The modern psychotherapist and the future of psychotherapy. In B.M. Bongar & L.E. Beutler (Eds), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 474–488). New York: Oxford University Press.
- McDougall, G.M., & Reade, B. (1993). Teaching biopsychosocial integration and formulation. *Canadian Journal of Psychiatry*, 38, 359–362.
- Meier, S.T. (1999). Training the practitioner-scientist: Bridging case-conceptualization, assessment, and intervention. *The Counseling Psychologist*, 27, 846–869.
- Messer, S.B., & Wachtel, P.L. (1997). The contemporary psychotherapeutic landscape: Issues and prospects. In P.L. Wachtel & S.B. Messer (Eds), *Theories of psychotherapy: Origins and evolution* (pp. 1–38). Washington, DC: American Psychological Association.
- Mischel, W. (1993). *Introduction to personality* (5th ed.). Orlando, FL: Harcourt Brace Jovanovich.
- Murdock, N.L. (1991). Case conceptualization: Applying theories to individuals. *Counselor Education and Supervision*, 30, 355–366.
- Nezu, A.M., & Nezu, C.M. (1993). Identifying and selecting target problems for clinical interventions: A problem-solving model. *Psychological assessment*, 5, 254–263.
- Patterson, C.H., & Watkins, C.E. (1996). *Theories of psychotherapy* (5th ed.). New York: Harper Collins.
- Persons, J.B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York: Norton.
- Persons, J.B., Davidson, J., & Tompkins, M.A. (2001). *Essential components of cognitive-behavior therapy for depression*. Washington, DC: American Psychological Association.
- Persons, J.B., & Tompkins, M.A. (1997). Cognitive-behavioral case formulation. In T.D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 314–339). New York: Guilford.
- Pervin, L.A. (1996). *The science of personality*. New York: Wiley.
- Prochaska, J.O., & Norcross, J.C. (1999). *Systems of psychotherapy: A transtheoretical analysis* (5th ed.). New York: Brooks/Cole.
- Raimy, V. (1975). *Misunderstandings of the self*. San Francisco, CA: Jossey-Bass.
- Raskin, N.J., & Rogers, C.R. (2000). Person-centered therapy. In R.J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (6th ed.; pp. 133–168). Itasca, IL: F.E. Peacock.
- Reisman, J.M. (1975). Trends in training for treatment. *Professional Psychology*, 6, 187–192.
- Rogers, C.R. (1951). *Client-centered therapy: Its current practices, implications, and theory*. Boston: Houghton Mifflin.
- Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.
- Rogers, C.R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science* (pp. 184–256). New York: McGraw-Hill.
- Rosen, A., & Proctor, E.K. (1981). Distinctions between treatment outcomes and their implications for treatment evaluation. *Journal of Consulting and Clinical Psychology*, 49, 418–425.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods in psychotherapy. *American Journal of Orthopsychiatry*, 6, 412–415.
- Schacht, T.E. (1984). The varieties of integrative experience. In H. Arkowitz & S.B. Messer (Eds), *Psychoanalytic therapy and behavior therapy: Is integration possible?* (pp. 107–132). New York: Plenum.
- Schwitzer, A.M. (1996). Using the inverted pyramid heuristic in counselor education and supervision. *Counselor Education and Supervision*, 35, 259–267.
- Stevens, M.J., & Morris, S.J. (1995). A format for case conceptualization. *Counselor Education and Supervision*, 35, 82–94.
- Strupp, H.H. (1988). What is therapeutic change? *Journal of Cognitive Psychotherapy: An International Quarterly*, 2, 75–83.
- Weerasekera, B.A. (1993). Formulation: A multiperspective model. *Canadian Journal of Psychiatry*, 38, 351–362.
- Weiner, I.B. (1975). *Principles of psychotherapy*. New York: John Wiley.
- Westin, D. (2000). Integrative psychotherapy: Integrating psychodynamic and cognitive-behavioral theory and technique. In C.R. Snyder & R.E. Ingram (Eds), *Handbook of psychological change: Psychotherapy processes and practices for the 21st century* (pp. 217–242). New York: John Wiley.
- Wolfe, B.E., & Goldfried, M.R. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology*, 56, 448–451.
- Wolpe, J. (1973). *The practice of behavior therapy* (2nd ed.). New York: Pergamon.
- Wolpe, J. (1982). *The practice of behavior therapy* (3rd ed.). New York: Pergamon.
- Yalom, I.D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.

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