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Comparing Psychotherapies by the Stages of the Process

Contemporary American psychotherapy is in conceptual disarray. More than 250 forms struggle for recognition and acceptance. The major categories, psychodynamic, cognitive-behavioral, and existential (1) are laden with conflicting ideologies each of which has powerful supporters, angry critics and pragmatic users. Among psychiatrists and psychologists eclectics or generalists seem to outnumber those who claim adherence to specific schools (2,3). The numerical superiority of non-dogmatic practitioners should come as no surprise in the American culture which has so great an emphasis upon personal choice and pragmatism.

In response to this multiplicity some writers have lifted themselves above the clamor and confusion, and have attempted to describe common factors among these conflicting therapeutic forms. From a cross cultural perspective Frank (4) described universal features across a variety of interpersonal helping situations. He noted that each required an intense, emotionally charged, confiding relationship, a specific healing setting (e.g., a photograph of Freud on the wall or a ceremonial mask), and a rationale which prescribes a ritual (e.g., free association or trance). According to Frank all therapies also perform certain basic functions. Through their rationales and rituals, they strengthen the therapeutic relationship, inspire hope for help, provide opportunities for cognitive and experiential learning often through emotional arousal, enhance a sense of mastery and encourage patients to practice (work through) what they have learned. Marmor (5) perceived common operational factors in American psychotherapies which bore strong resemblance to some of Frank's observations. In addition to the required "good" patient-therapist relationship, emotional release, cognitive learning, and repeated reality testing, Marmor noted operant conditioning by the therapist, direct and indirect suggestion and persuasion, and identification with and emotional support by the therapist. He was careful to add that therapies may be characterized as distinct by the degree of intensity with which they utilize each of these operational factors. Strupp (6) emphasized the leverage achieved through the patient's powerful attachment to the therapist which allows the therapist directly and indirectly to encourage change in the desired direction.

Despite the consistency in identified common factors and the accompanying calls for an end to polemics, the specification of common factors has had little effect on the continuing arguments about theoretical and technical superiority. Luborsky's analysis of outcome studies (7) and Smith and Glass's meta-analysis of a greater number of outcome studies (8) each concluded that common factors had to be of great significance since no school appeared to be more effective than any other, yet they were unable to offer an alternative concept.

Other writers have attempted to compare psychotherapies in order to elucidate their similarities and differences (9,10,11). On the one hand these efforts usually employ a general frame divided into broad categories (e.g., theories of psychopathology, theories of personality, theories of psychotherapy). The reader is often left with an appreciation for the differences among the schools being compared but only a vague understanding of the similarities. On the other hand, those writers who seek to define common factors fail to provide an appreciation for unique differences.

In order for a comparative approach to the psychotherapies to have an effect on practice, it must provide a balanced view of both similarities and differences. The similarities must be operational, i.e., provide practical decision points from which differences may be selected for practical use. The organizing principle described in this paper provides a foundation upon which schools of individual psychotherapy may be placed in order to explicate the situations in the therapeutic process at which their options differ.

The Stages of Psychotherapy

Because psychotherapy is a series of events through time, it may be divided into stages. While any such

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division is ultimately arbitrary most therapies appear to proceed through stage specific subgoals (12, 13, 14). The stages may be defined by their objectives: engagement, pattern search, change, and termination. The goal of the engagement stage is to secure the patient's trust and confidence through the development of a therapeutic alliance. During the pattern search the therapist-patient pair undertakes to define a pattern or cluster of patterns composed of culturally delineated thoughts, feelings, and behaviors which, if changed, would bring significant relief to the patient. The goal of the change stage is to help the patient disavow the old pattern, and to initiate and practice the new one (15). Therapists use a wide variety of influencing techniques to accomplish this end. The goal of termination is usually to break the relationship while maintaining therapeutic achievements.

The Psychotherapies to be Compared

In order to demonstrate the universality of the therapeutic subgoals defined by each stage, I have selected seven therapeutic forms for comparison ranging from traditional cultures through the traditional-Westernizing transitional culture of Japan to three American psychotherapies.

Rather than select a few of the many different traditional healing methods, I have instead divided these treatment forms into two broad categories distinguished by whether or not the healer enters a trance. Shamanism has many different manifestations depending upon cultural and geographical influences. The practice which permits these diverse forms to carry the same name is the use of trance states through which the shaman discovers the cause and treatment of the patient's ills (16). Non-trance folk treatments are more difficult to characterize since they have no apparent unifying practice. A few examples from a variety of different cultures will illustrate that non-trance folk treatments differ from shamanism largely in regard to the manner in which the diagnosis is made. In fact, the division into two separate categories becomes somewhat arbitrary since, as will be suggested, some trances appear to be less profound than others.

Japan provides two therapeutic orientations which demonstrate influences from both Western and traditional religious sources. Morita therapy was developed by Professor Shoma Morita of Jikei University School of Medicine in Tokyo. His seminal article appeared in 1917 under the title "The True Nature of Neurasthenia *(Shinkeishitsu)* and its Treatment" (17). It was designed to treat a neurosis commonly found among the Japanese characterized by obsessive shyness, oversensitivity, and feelings of inferiority, often with somatic symptoms. Naikan ("looking in") therapy which grew rapidly in the 1950's and 1960's was founded by a lay practitioner, Ishin Yoshimoto, and at first was used in prison settings (18). Both Naikan and Morita therapy are heavily influenced by prevailing Zen Buddhist practices. Social isolation and meditation guided by a person in authority are critical parts of both treatment forms and of Zen Buddhist practices.

From the American psychotherapies I have selected ones which appear to enjoy wide popularity among therapists and which are reasonably well delineated. Short-term dynamic therapy is the most common specific treatment from among psychiatrists (as suggested by an unpublished survey of psychiatrists in the State of Washington by Maxim and Beitman). Malan's book (20) is a reasonable representative of this psychotherapy. Paolino (21) has attempted to bring some clarity to the distinction between psychoanalysis and psychoanalytic therapy. He described the thinking of those who believe the boundaries are blurred and those who believe the boundaries are sharp. Malan's approach is to the left of the blurred position (if orthodox psychoanalysis is on the far right); dynamic therapy is short, focuses on specific conflicts, and requires greater therapist activity. Nevertheless the spectrum of psychoanalytic-psychodynamic therapies is so broad and the predispositions of practitioners so varied, that psychodynamic therapy is very difficult to characterize effectively. Systematic desensitization remains popular among behavior therapists (21) and is often used for simple phobias (22). It gained acceptance when Wolpe was able to apply laboratory methods to achieve statistically significant results. Cognitive therapy, sometimes called cognitive-behavior therapy, has gained great popularity in recent years. Beck's explication (23) is one of the leading books in the area and will be used for this study.

The selection of seven psychotherapies provides a broad spectrum of healing rituals from which to demonstrate the universality of stages and the practical value of recognizing them. The reader is invited to ask him/herself the questions asked of each therapy in order to compare his/her predisposing methods of engagement, pattern search, change, and termination. Ultimately each therapist develops a personal brand of therapy which is both similar to and different from the types developed by colleagues.

Engagement Stage

The purpose of the engagement stage is to build trust and confidence between patient and therapist in order to establish leverage through which the patient will accept the therapist's influence (24,25). The techniques and methods by which trust and openness to influence may be achieved are similar across cultures.

Among shamans, Moritists, and psychodynamic and cognitive therapists, for example, reputation is a critical variable in the engagement stage. Reputation is created by a) recognition as an expert in the practice of a certain therapeutic form (Morita therapy, psychoanalysis), b) association with a respected institution (shrine, hospital, or university); or c) testimonials of patients who have been helped or referral by a trusted other.

Another engagement variable consistent across cultures is the use of congruent expectations—both patient and therapist agree about general procedures. Japanese persons seeking Morita and Naikan treatment are quite willing to enter socially isolated meditative situations because they are culturally predisposed to do so. The Amhara of Ethiopia place their confidence in *awdunigist* divination because they believe it will bring them closer to the real order of things (26). They are required to bring personal information which they expect to be handled in a mechanical, non-exalted, and confidential manner. The artifacts, dances, and procedures associated with shamanistic practices are congruent with what help-seekers expect as preliminary activities before a formal, ritual healing. American psychotherapies, on the other hand, are so widely disparate that patients often do not know what to expect. Frequently their expectations are not met and therapy is prematurely ended. Much research on American psychotherapy has indicated that role-induction procedures are helpful in retaining patients in psychotherapy (27,28,29,30).

The culture's notion of the person-who-is-healer also influences each patient's willingness to be influenced. Shamans with the power to contact other worlds are accorded great respect not only for their supernatural ability to heal but also for their ability to injure through these means (31). Among the non-trance folk healers of Peru, healers are thought to be mature, possess definite parental attributes, and a humane and caring attitude (32).

Japanese are taught to respect and obey authority and therefore are willing to follow the direction of a recognized Moritist or Naikan practitioner. In addition, these practitioners are believed to have been greatly aided by the treatment form which they advocate and therefore skilled through personal experience as well as training. For American practitioners such general statements are difficult to make. Therapist images vary from authority enriched by personal experience (psychoanalysis) to egalitarian existential-humanistic practices (gestalt). Prospective patients may select the therapist image to which they feel most attracted.

The manner in which the patient is initially received also aids in engagement. Many shamanistic and non-trance folk procedures take place in groups. The positive expectancy of the audience (33), and the communication and excitement built between shaman and audience (16) provide added emotional tension and more clearly delineated patient expectations. Much Morita therapy takes place in solitude but, since Morita treatment often is found in a hospital setting, the expectations of the social group play a significant part in shaping the patient's behavior outside of isolation. The most powerful use of the group as audience in American psychotherapy was probably the gestalt therapy of Fritz Perls (34) whose psychological drama intensified the performance expectation of his actor-clients.

Perhaps the most prominent, consistent American engagement technique is warm, empathic, regard, and non-judgmental acceptance as described by Rogers (35). This form of reception is also described for non-trance folk healers of Peru (32) and is also probably present in many other locations.

Therapists must sometimes prove themselves competent to specific clients in the absence of reputation, cultural expectations, and supportive audience-groups. De Rios (36) described a South American healer's attempts to establish competence by bragging about his powers. Other therapists may establish their power in more subtle ways which include the demonstration of specialized knowledge and the offer of something which works (37). In some psychodynamic therapies specialized knowledge is demonstrated early in therapy through "trial interpretations" which test the patient's ability to respond to insight-oriented treatment but which also demonstrate that the therapist is able to understand the patient's life in a special way. In systematic desensitization and some other behavior therapies, relaxation training is offered early in therapy supposedly as an aid to the process of change. It is more likely an important engagement technique because it is easy to learn and often effective. Yates (38) has reported evidence that relaxation training is a redundant variable in outcome studies of systematic desensitization. Both specialized knowledge and effective suggestions increase the patient's willingness to believe that the therapist is competent and capable of helping. Beck (23) includes empathic reception, role definition (collaborative empiricism), the offer of something that works (to make the patient feel better after the first session, if possible) and the demonstration of specialized knowledge (self-statements influence feeling).

Pattern Search

The pattern search for each therapy is guided by beliefs about the nature of the forces which create dysfunction. Certain notions embedded in causal

attributions are assumed to be critical to change. Shamans may believe in the destructive functions of certain spirit classes defined by their culture; Naikan therapists are concerned with the deleterious effects of ingratitude; psychodynamic therapists emphasize the pathological effects of certain defensive constellations. Through a wide variety of data gathering techniques, therapists guide their interactions with their patients to discover these embedded patterns as they apply to the individual's life. In spite of the wide variety of theories of dysfunction and the great variety of information gathering techniques, psychotherapists in all cultures seem to share a tendency to define problems in the help seeker's social network.

On the surface, the trance states of shaman place this treatment form well beyond comparison with other psychotherapeutic forms since it is the shaman who gathers the information with little help from the patient. According to a survey of the shamanistic practices of forty-two cultures from four cultural areas, shamans seem to either go on magical flights to spirit worlds where they are informed of the spiritual causes of the patient's difficulty or they become possessed by spirits who directly describe the causes. According to Peters and Price-Williams (16), magical flight and spirit possession can be explained in terms more readily understood by Western psychotherapists. Magical flight closely resembles "active imagination," a therapeutic technique introduced by Jung to extend dream production (39). The patient is asked to take a scene from a dream or related symbolic scene and let the dream proceed while in the office. Leuner's guided affective imagery (40) and Watkins' "waking dreams" (41) are also related in that the imagination is let free under the watchful gaze of the patient's self-observer in response to a set scene. The shaman's flight to the spirit world is likely an active imagination influenced by his intuitive apperception of the patient coupled with information about him/her readily available in most villages.

Possession by a spirit is yet another altered state of consciousness which is more closely related to dissociation. Perhaps spirit possession is best described as "dissociation in the service of reality" according to culturally prescribed patterns. The pronouncements of the spirit possessed shaman are also probably derived from intuition and public information. In Western therapies the free floating attention advocated by Freud for psychoanalysts creates a more moderate autohypnotic state in which the therapist has greater access to intuitive information. Milton Erickson also seemed to place himself in trances in order to perceive his clients from a more intuitive position (42).

Puerto Rican spiritism in New York City may be placed on the borderland between shaman and non-trance folk treatments. The spiritist summons her/his spiritual guide in order to make a diagnosis. During communication the medium makes statements about the client, ostensibly from spirits, with which the client must indicate agreement or disagreement. According to spiritist ideology, the client is duty-bound to answer yes or no. In this way the "spirit" interviews the client usually in regard to problems of love and work appropriate to the client's age (43).

The data gathering techniques of non-trance folk healers vary from the mechanical, numerical-astrological processing of personal information characterized by Amhara divination of Ethiopia (26) to a more straightforward interview by folk healers of Peru (32) to the sometimes impersonal (e.g. letters, telephone calls) contacts of some urban black folk healers (31).

Morita and Naikan therapists spend relatively little time in direct contact with their patients but instead instruct them in how to use their periods of isolation. Morita patients, usually afflicted with the Japanese obsessional nerurosis *shinkeishitsu*, must first undergo a period of absolute bed rest during which they are instructed paradoxially to continue their obsessional worrying about themselves while remaining in bed. They are often instructed to make diaries of their experience to which the therapist adds annotations about correct and incorrect thinking. Naikan clients are told to spend full days in meditation on key interpersonal relationships starting with mother on whom perhaps 25% of the time is focused. The Naikan counselor visits for very brief periods at 90 minute intervals to comment on and guide the content of the meditation and perhaps its style ("You are blaming others. That is gaikan (looking out) not naikan (looking in)." (17).

In their isolated offices American individual psychotherapists gather information through direct verbal communication. They ask questions, listen for a variety of contents (unconscious impulses, automatic thoughts, environmental operants), and utilize a wide variety of other data gathering devices. American psychotherapists select from a variety of ways to organize their data. During systematic desensitization behavior therapists construct hierarchies of events. The feared situation is placed on one extreme and a related but mildly anxious situation at the other with graded situations linking them. Cognitive therapists seek to identify correlations between negative responses (maladaptive behaviors, emotions) and environmental activating events in order to isolate the maladaptive thoughts linking them. They hypothesize that the maladaptive automatic thoughts are the product of

certain underlying constructs which then are to be uncovered. Psychodynamic therapists, as described by Malan, organize their pattern search data according to defensive structures and according to patterns of key interpersonal relationships. Defenses are organized according to type of defense, feared thought, feeling, or impulse, and related dysphoria. Key interpersonal relationships are organized according to the "triangle of person" (19,44). Patterns of interaction between patient and therapist (transference) are correlated with interaction patterns between significant others and with parents. The major differences among Western therapies lie not so much in the manner in which information is gathered (listening and asking questions are basic) but the type of information sought and the way it is to be organized. They differ in the degree of attention paid to certain categories of intrapsychic and interpersonal functioning.

Change

Although therapists of different schools and cultures may wish to deny it, they communicate to their patients culturally acceptable ideals and philosophies. Fervent in their denials of direct and indirect influence are those psychodynamic therapists who believe that interpretation of unconscious conflicts is value free. A questionnaire study of experienced psychodynamic therapists demonstrated that the respondents espoused a therapeutic philosophy of non-influence but described therapeutic beliefs containing value laden suggestions (45). When Truax (46) examined tapes of Carl Rogers demonstrating client-centered therapy, he found that Rogers offered his empathic reflections to certain subjects and remained silent when the client spoke about other subjects. In this way he apparently reinforced the client to talk about certain subjects and to avoid others since the client talked more about the subjects to which Rogers responded and less about others. Positive verbal reinforcement is but one way in which values may be indirectly communicated outside the therapist's awareness. Most therapists are probably not aware of their indirect communications although patients attempt to comprehend them. For example, a therapist may point out to a narcissistic patient that his object relationships were disturbed as indicated by his tendency to treat women as part objects based upon his early family interactions. The patient will tend to hear the following lesson: you should stop treating women like functions and try to treat them as full human beings. This instruction is consistent with the philosophies governing the relationships in which this patient (and probably his therapist) are functioning. In fact he may change because he believes in this value and feels guilty about noting this trait in himself. A psychoanalytic explanation of change would rely instead on shifts in intrapsychic equilibria as defined by psychoanalytic theory.

The lessons of cognitive therapy appear more direct. Generally, the patient is encouraged to examine and question his/her own thoughts. However the thoughts which are selected for testing and the underlying assumptions which may generate them are also open to value projections by cognitive therapists (e.g. what is the underlying thought to be changed?). Behavior therapists doing systematic desensitization appear to be offering a fairly straightforward lesson: face your fears gradually. Yet in the construction of a hierarchy the therapist may determine what fears seem acceptable and which ones are not.

Both Morita and Naikan appear to be derived from Zen Buddhist practices yet their founders, Morita and Yoshimoto, have denied any classification as a religious endeavor. Instead they emphasized the rational scientific base of their methods (17). Each therapy is directed toward breaking the self-centeredness of its clients and accomplishes this end by paradoxically forcing them to focus on themselves through variations of Zen isolated meditation. The desired result is a refocusing away from self. For Morita the new focus is the natural world, the beauty of flowers and sky, the joy of simple manual labor. Patients are gradually relieved from the tedium of absolute bed rest through increasing involvement in the world through simple manual tasks up through resumption of usual work (a kind of systematic desensitization to reality). They are brought along more slowly than they would like, thereby increasing their enjoyment of each next small step. Patients are encouraged to gain an appreciation for the way things are and to accept them as they are. The term *arujamama* is used to describe this state which does not mean passive acceptance but rather the courage to recognize limitations while appreciating what exists. The poor man who is able to grow but one flower in the corner of his yard is capable of achieving the spiritual attainment of a holy man in a wondrous garden since he too may see the glory of nature through the one living flower.

Rather than focus upon an appreciation of work and nature, Naikan therapists encourage their clients to experience with deep emotion, not simply verbal testimony, a profound sense of gratitude to those who have helped them on their journeys through life. Like the Zen notion of *arujamama*, appreciation for one's own predecessors is a key value in Japanese culture.

Because of the authority invested in them by their position as healers in a society which gives power to superiors, Naikan and Morita therapists are able to directly influence their clients by annotating their

diaries (Morita) and commenting on their meditation styles and content (Naikan). In the United States, where authority is respected with greater ambivalence and equality is given greater emphasis, therapists are more discreet about their direct advice. Folk healers are generally considered superior to their clients through their knowledge of mysteries and are therefore far less indirect about giving advice, although much of it is intermeshed with spiritual and arcane beliefs.

My reading of the relevant literature suggests that the methods by which both trance and non-trance folk therapies accomplish change are divisible into three general groups from which each healer and each culture selects certain ones. The three groups are: non-specific physical ministrations, invocation of spiritual powers, and direct advice. The nonspecific physical ministrations include massage, exercise, herbs, and potions. Invocation of spiritual powers may be accomplished through the construction of an amulet, ritual, prayer, and prescribed spiritual behaviors. Direct advice takes many forms and may be very specific. Healers may indicate to whom an apology is to be offered (47), who is to be avoided (32), and what behaviors are to be eliminated, e.g., adultery (43).

Sometimes patients are simply declared healed and invited to leave although no specific transformation of symptoms takes place (33). This method may encompass the other three. Unlike the individual psychotherapists of the United States, many shamans actively utilize group responses in the maintenance of change. Families with a disabled member often consider the family unit to be afflicted if one of its members is suffering and therefore they present themselves as a whole for treatment (33). Since shamanistic ritual often takes place in front of a group, the assembled audience which is usually comprised of significant members of the patient's social system, comes to expect the identified patient to act as if he/she is "cured." In this way apparently non-specific rituals and flat declarations of cures provide the fulcrum around which the patient's social system shifts its expectation from disordered to ordered behavior. This mechanism may play a part in evangelical healing as well. The closest analogue in individual psychotherapy is the patient's desire to live up to the therapist's expectations.

Termination

The methods by which treatment is brought to an end are quite limited. Therapy may never end; it may be time-limited to a few minutes or months; or it may have a generally accepted upper limit which can be exceeded. Some "cures" require that the patient enter into the shaman's cult, e.g., Zar cults. The cult may provide a number of different therapeutic modalities including: a social hierarchy through which to move and thereby gain a sense of accomplishment, models with which to identify (higher-ups and idealized spiritual characteristics), relaxation techniques (meditation, drugs), opportunities for catharsis (e.g. through social permission to enter trance states and become possessed) and removal from uncomfortable social circumstance (either loneliness or unhappy family life) (33). In this way therapy does not end.

Upon release from Morita hospital treatment patients often continue in outpatient work and are encouraged to attend regular meetings and to subscribe to a Morita magazine. Morita therapy also appears to have no prescribed end point. On the other hand, Naikan therapy is generally time-limited to one week of intensive meditation.

Therapists utilizing the three Western psychotherapies emphasized in this report have a general idea about the upper limit of treatment sessions. Malan considers short term psychodynamic therapy to take under 40 sessions for beginners and under 25 for experienced therapists. Cognitive therapy for depression is thought to last approximately 12 sessions (Freeman, personal communication, 1982). Systematic desensitization for simple phobias should take fewer than 10 sessions (John Carr, personal communication). Nevertheless with certain patients therapists may conduct these forms of treatment for many years since the focal conflict, depressive symptoms, or phobia may be embedded in a complex set of difficulties.

Not unlike the "cures" which require entrance into the cult, many therapists become life long adherents of specific schools, repeatedly applying the lessons of that school in their own life and using the social-political structure in much the same ways that cult members might use theirs to gain a social position, strive for and achieve advancement in the hierarchy, and find models for ideal behavior.

Implications

A comparative approach which presents a balanced view of the similarities and differences among the psychotherapies provides an opportunity for each therapist to take a balanced approach toward his/her own method through appreciating both its similarities to and differences from other methods. The major differences among psychotherapies from different cultures center on the content of the pattern search and the accompanying explanations for presenting symptoms. The culture specific beliefs appear to be the medium though which relatively consistent change techniques are applied. To use a pharmacological analogy, cultural beliefs about spirits, ids, and statistical significance form the analogue of the gelatin capsule into which

important lessons and/or advice are poured. Despite the many colors and designs of the capsule the information needed to select the best filler is often quite constant. For example, Christian faith healing may seem very different from conventional American psychodynamic psychotherapy and yet, as Favazza has indicated (48) the pattern search of its practitioners is very much geared toward an understanding of early family life. The advice offered is often sound psychodynamically but is placed within a religious "capsule." In one way or another healers attempt to understand the patient in his/her social context because somatic (and psychological) symptoms usually reflect tension in family, friendship, job and/or community and seem to make up the largest single category of health problems treated by practitioners of all kinds (33).

To recognize and accept differences among people while also recognizing their commonality may be a peculiarly American ideal. In the psyche of most American psychotherapists, who function knowingly and unknowingly as communicators of Western ideals, lies this specific belief. This comparative method is intended to foster recognition of commonalities while accepting differences among American psychotherapists and perhaps those of other cultures.

References

1. Karasu TB: Psychotherapies: an overview. Am J Psychiatry 134:851-863, 1977
2. Marmor J, Scheidemandel PL, Kanno CK: Psychiatrists and Their Patients. Washington, D.C.: American Psychiatric Association, 1975
3. Garfield SL, Kurtz R: Clinical Psychologists in the 1970's. Am Psychologist 34:1-9, 1976
4. Frank J: Restoration of morale and behavior change, in What Makes Behavior Change Possible? (ed) A. Burton. New York: Brunner and Mazel, 1976, pp 73-112
5. Marmor J: Common operational factors in diverse approaches to behavior change, in What Makes Behavior Change Possible? (ed) A. Burton. New York: Brunner and Mazel, 1976, pp 3-12
6. Strupp HH: Psychoanalysis, "Focal Psychotherapy", and the nature of the therapeutic influence. Arch Gen Psychiatry 32: 127-135, 1975
7. Luborsky L, Singer B, Luborsky L: Comparative studies of psychotherapies. Arch Gen Psychiatry 32:995-1014, 1975
8. Smith ML, Glass GV, Miller TI: The Benefits of Psychotherapy. Baltimore: Johns Hopkins University Press, 1980
9. Ford DH, Urban HB: Systems of Psychotherapy. New York: Wiley, 1963
10. Corsini R (ed): Current Psychotherapies. Itasca, Illinois: F. E. Peacock, 1973
11. Prochaska J: Systems of psychotherapy. Homewood, Illinois: Dorsey Press, 1979
12. Rosenbaum CP, Beebe JE: Psychiatric treatment: Crisis/ Clinic/Consultation. New York: McGraw Hill, 1975
13. Cashdan S: Interactional Psychotherapy: Stages and Strategies in Behavioral Change. New York: Grune and Stratton, 1973
14. Tseng WS, McDermott JF: Psychotherapy: historical roots, universal elements and cultural variations. Am J Psychiatry 132:378-384, 1975
15. Pentony P: Models of Influence in Psychotherapy. New York. Free Press, 1981
16. Peters LG, Price-Williams D: Towards an experiential analysis of shamanism. Am Ethnologist 7:397-413, 1980
17. Reynolds DK: Morita Therapy. Berkeley: University of California Press, 1976
18. Morase T, Johnson F: Naikan, Morita and Western psychotherapy. Arch Gen Psychiatry 31:121-128, 1974
19. Malan D: Individual Psychotherapy and the Science of Psychodynamics. London: Butterworths, 1979
20. Paolino TJ: Some similarities and differences between psychoanalysis and psychoanalytic psychotherapy: An unsettled controversy. J Operational Psychiatry 12:105-114
21. Wade TC, Baker TB, Hartman DP: Behavior therapists' self-reported views and practices. Behav Therapist 2:3-6, 1979
22. Wolpe J: The Practice of Behavior Therapy, second edition. New York: Pergamon Press, 1973
23. Beck AT, Rush AJ, Shaw BJ, et al: Cognitive Therapy of Depression. New York: Guilford Press, 1979
24. Strong SR: Social psychological approach to psychotherapy research, in Handbook of Psychotherapy and Behavior Change (ed) C. Garfield and A. Bergin. New York: John Wiley and Sons, 1978, 101-136
25. Strupp HH: The nature of therapeutic influence and its basic ingredients, in What Makes Behavior Change Possible? (ed) A. Burton. New York: Brunner/Mazel, 1976, pp 96-112
26. Young A: Order, analogy, and efficacy in Ethiopia medical divination. Culture, Medicine and Psychiatry 1:183-199, 1977
27. Sloane RB, Cristol AH, Pepernik MC, et al: Role preparation and expectation of improvement in psychotherapy. J Nervous Mental Dis 150:18-26, 1970
28. Frank JD, Hoehn-Saric R, Imber SD, et al: Effective ingredients of successful psychotherapy. New York: Brunner/ Mazel, 1978
29. Parloff MB, Waskow IE, Wolfe BE: Research on therapist variables in relation to process and outcome, in Handbook of Psychotherapy and Behavior Change. (ed) S Garfield and A Bergin. New York: John Wiley and Co, 1978, pp 233-283
30. Garfield SL: Research in client variables in psychotherapy, in Handbook of Psychotherapy and Behavior Change (ed) S Garfield and A Bergin. New York: John Wiley and Co, 1978 pp 191-132
31. Snow LF: Sorcerers, saints and charlatans: Black folk healers in urban America. Culture, Medicine and Psychiatry. 2:69-106, 1978
32. Sequin CA: What folklore psychotherapy can teach us. Psychother Psychosom 24:293-302, 1974
33. Kleinman A: Patients and Healers in the Context of Culture. Berkeley University of California Press, 1979
34. Perls F: Gestalt Therapy Verbatim. Lafayette CA: Real People Press, 1969
35. Meador BD, Rogers CR: Client-centered psychotherapy, in R Corsini (ed) Current Psychotherapies, Itasca, Illinois: FE Penock, 119-166, 1973
36. Derios MD: Visionary Vine. San Francisco: Chandler, 1972
37. Beitman BD: Engagement techniques for individual psychotherapy. Social Casework 60:306-309, 1979
38. Yates AJ: Theory and Practice in Behavior Therapy. New York: John Wiley and Sons, 1975

39. Jung CG: The transcendent function in the Collected Works of CG Jung, Vol. 8 (eds) Sir H. Read, M Fordham, G Adler and W McGuire. RFC Hull transl. Princeton: Bollinger Foundation p 67-91, 1958
40. Leuner H: Guided affective therapy: a method of intensive therapy. Am J Psychotherapy 23:4-22, 1969
41. Watkins MM: Waking Dreams. New York: Harper and Row, 1976
42. Beahrs JO: Understanding Erickson's approach, in JK Zeig (ed) Ericksonian Approaches to Hypnosis and Psychotherapy, New York: Brunner/Mazel, 1982
43. Harwood A: Rx Spiritism as Needed: A Study of a Puerto Rican Community Mental Health Resource. New York: Wiley, 1977
44. Menninger K: Theory of Psychoanalytic Technique, New York: Harper and Row, 1958
45. Buckley P, Karasu TB, Charles E, et al: Theory and Practice in psychotherapy. J Nervous Mental Disease 167:218-223, 1979
46. Truax CB: Reinforcement and non-reinforcement in Rogerian psychotherapy. J Abnormal Psychology 71:1, 1966
47. Lederer W: Primitive psychotherapy. Psychiatry 22:255-65, 1959
48. Favazza AR: Modern Christian healing of mental illness. Am J Psychiatry 139:728-735, 1982