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In the Hurricane's Eye: A Supraparadigmatic Integrative Model

Roberto Opazo^{1,2}

An overview of the field of psychotherapy reveals that a Supraparadigmatic Integrative Model is urgently needed. The model might provide a general framework and serve as a useful guide to conceptual developments, research, and clinical practice. The Supraparadigmatic Integrative Model proposed in this paper is based on epistemological, methodological, and etiological foundations. The Integrative Model is not merely an addition to existing paradigms but an integration, bringing the different paradigms together into a whole. It also integrates, with the self system as the axial integrative center. The model provides a "synergic framework" that gives extra power to the forces generated by the different paradigms. At the clinical level, an Integrative Model might supply the basis for developing an Integrative Psychotherapy that could join and integrate forces of change generated by different paradigms. Therefore, an Integrative Psychotherapy might be more profound at a conceptual level and be more powerful than the existing psychotherapies; it could become a promising option as a creative process with a scientific basis.

KEY WORDS: integrative model; psychotherapy integration.

INTRODUCTION

An overview of the field of psychotherapy leads to a number of unsatisfactory conclusions: There are hundreds of different approaches to psychotherapy with numerous disagreements among them. As Prochaska and DiClemente (1992) have pointed out, we need "to bring some order to the chaotic diversity in the field of psychotherapy" (p. 301). The effectiveness

¹Centro Científico de Desarrollo Psicológico, Santiago, Chile.

²Correspondence should be directed to Roberto Opazo, CECIDEP, Marchant Pereira 446, Santiago, Chile; e-mail: cecidep@ctc-mundo.net

of psychotherapy has not been demonstrated in some areas and has not been sufficiently strong in others. One of the main goals of this paper is to provide an integrative model that may help to improve this state of affairs.

To integrate is to make a whole out of different parts. The different parts are related to a core, and interact according to the rules of the entire system. Integrating a part into a whole makes sense only when that part contributes to the whole. "Chemists do not usually advocate integrating chemistry and alchemy" (Eysenck, 1994, p. 489). Integration involves the utilization of specific criteria to identify the potentially valuable knowledge that each approach can bring, and to create a whole from the different emerging areas of knowledge. An integrative approach, then, can combine elements from different sources or paradigms.

Psychotherapy integration is characterized by dissatisfaction with single-school approaches and a concomitant desire to look above and beyond the boundaries of different approaches to see what can be learned from other ways of thinking (Norcross & Arkowitz, 1992). Psychotherapists have been looking for integration at different levels of abstraction. The lowest level of theoretical abstraction has been called "technical eclecticism" and includes the Multimodal Therapy developed by Arnold Lazarus (1976) and the Systematic Eclectic Psychotherapy proposed by Larry Beutler (1983). Other theoreticians have sought to find integration at the level of a bridging theory; for instance, a bridge between psychoanalysis and behavior therapy (Wachtel, 1977), or a bridge to a common factors approach (Arkowitz, 1992). The highest level of theoretical abstraction is the Transtheoretical Approach (Prochaska & Diclemente, 1992), where integration is proposed at the level of three basic elements: processes of change, stages of change, and levels of change.

While the above-mentioned efforts have constituted important contributions to the integrative movement, none of them gets to the heart of the problem: The lack of a shared integrative paradigm. However, it would be naive to expect that suddenly any one model will satisfactorily integrate the entire field of psychotherapy. It would be even more naive to think that there could be consensus about a shared integrative paradigm. For these reasons, we ought to look for alternatives. It may be that an integrative paradigm can be proposed as a starting point that could be improved by joint research efforts and by new proposals. Such an undertaking is analogous to the development of the Diagnostic Statistical Manual (DSM), which does not really reflect a consensus, but is nevertheless widely used and continuously being improved by common efforts.

A paradigm can be described as "a set of general background assumptions that shape the methodology employed in subsequent inquiry" (Boyd, Gasper, & Trout, 1991, p. 779). It consists of the conceptions of the nature

of the theory to be used in guiding research, the types of problems worthy of investigation, and the appropriate research methods for investigating those problems (Palermo, 1971). A paradigm reflects the main assumption(s) shared by those who are working in a specific scientific area. "Men whose research is based on shared paradigms are engaged with the same rules and standards for scientific practice" (Kuhn, 1962, p. 11). A shared paradigm not only facilitates communication, but also brings order by providing an epistemological, methodological, and etiological background that in turn guides future research and practice. Thus, shared rules can provide a framework, help define the important questions, establish research methods, guide research, and help define what will and will not be considered worthwhile knowledge. A shared paradigm stabilizes a field, so that the basics of the field do not change from moment to moment. According to Kuhn (1962), psychology and psychotherapy are immature disciplines and still in the preparadigmatic stages. This observation seems to still apply even 35 years later. Kuhn further suggests that the evolution of a science moves knowledge from disorder to order.

An integrative model, then, involves an open minded attitude, an accurate methodology, a clear epistemology, and a comprehensive framework; the model helps to bring some order to the otherwise chaotic dance of data. As Henri Poincaré (1929) has pointed out, science is made of data as a house is made of bricks; but a lot of data isn't science as a lot of bricks isn't a house.

The following are some of the concrete contributions that a supra-paradigmatic integrative model can provide:

1. Common grounds for discussions, more advanced issues can be considered without having to clarify basic assumptions each time.
2. A theoretical openness to knowledge from different approaches, thereby encouraging dialogue and communication.
3. Clear rules for acceptable methodologies.
4. A guide for asking the proper questions and for selecting research goals.
5. Shared rules for evaluating knowledge and efficacy, which can in turn lead to cumulative knowledge.
6. A common conceptual language.
7. The possibility of rescuing specific processes of change from different approaches, taking us beyond common factors.
8. The possibility of developing a comprehensive theory without ideological "segregations."
9. Foundations for the development a more powerful integrative psychotherapy.

The need for a Supraparadigmatic Integrative Model is clear. It is also clear that many arguments will likely appear in opposition to such a model. The proposal for a Supraparadigmatic Integrative Model, therefore, leads into the hurricane's eye.

CORE ASSUMPTIONS OF A SUPRAPARADIGMATIC MODEL

As time goes by, we run the risk of accumulating theories and data without a common body of knowledge. We need a different attitude or, as Jasper (1963) has called it, a different axial point to organize the existing data in a different way. In the words of the epistemologist Rodolfo Lina (1986):

It cannot be said that to reach this new stage we need to accumulate more data. For millions of years we have been observing one another and for one century or more we have been making neuroanatomic and neurophysiological observations. What is urgently needed are more theoretical models.

Like the blind men and the elephant, we not only need to select and unify the existing data, but also give it a sense of wholeness and integrity. The integrative model presented in this paper is based on current evidence and fits well with the existing data. An integrative model should be comprehensive enough to include any valuable knowledge, it should provide some basic criteria for selecting knowledge, and a general framework to contextualize any new knowledge. A Supraparadigmatic Integrative Model should have some guiding core assumptions at the epistemological, methodological, and paradigmatic levels. Guiding assumptions at these levels are related to the role of reality, the accuracy of our perceptions, the assessment of knowledge, research procedures, the role of the paradigms of causality, and the role of the self as an integrative nucleus. At the clinical applications level, the model should provide the foundations for integrative psychotherapy, which in turn involves mechanisms of change, processes of change, levels of change, forces of change, assessment procedures, technical strategies, etc.

Epistemological Assumptions: Reality Revisited

Epistemology is concerned with the theory of knowledge. It inquires into the nature of knowledge, its origins and validating forms. Without a shared epistemological foundation, the basics of what constitutes knowledge in psychotherapy can be questioned at any time.

Although the role of epistemology in psychotherapy has been studied only recently (Mahoney, 1983, 1991; Guidano, 1987; Coddou, 1992; Coloma, 1989; Rosenbaum & Dyckman, 1995), realistic concepts have generally prevailed throughout the evolution of psychotherapy. Traditionally, the major psychotherapeutic approaches, including behaviorism, psychoanalysis, and cognitive-behavior therapy, have accepted that there is a reality whose existence does not depend on an observer's thoughts or images. This reality is understood to be perceptually within reach if the rules established by the corresponding approach are followed.

Recently, constructivist thinkers have begun to question this perspective. Some (e.g., Watzlawick, 1979; Weimer, 1977) have discussed how the nervous system actively creates and constructs at least part of the stimulation that affects it. Others (e.g., Von Glaserfeld, 1984; Maturana & Varela, 1984) assert that we impose laws on reality and that reality itself is not strictly cognizable. According to Von Glaserfeld (1984): "Knowledge does not reflect an 'objective' ontological reality but, exclusively, an order and organization of a world constituted by our experience" (Von Glaserfeld, 1984, p. 24).

Strictly speaking, the epistemological attitudes of "naïve" realism and radical constructivism cannot be integrated. However, it may be possible to extract the "best" parts from each for integration, if neither one is completely right or wrong. Below are presented the core epistemological assumptions of the Supraparadigmatic Integrative Model, along with brief comments on their origins. More detailed discussions of each assumption are beyond the scope of this paper.

At an epistemological level, the Supraparadigmatic Integrative Model favors a moderate constructivism, which is close to Mahoney's (1991) critical constructivism. Moderate constructivism takes from realism the assumption that there is a reality beyond the observer's inner world and that this reality is partially cognizable. From constructivism, it takes the perspective of an active model of the mind, which includes the assumption that our nervous system is a coconstructor of our experience and not just a passive receptor (Hayek, 1952b). Since we cannot perceive from the "non biology" (Maturana, 1992), we cannot make "photocopies" of external reality, and we cannot have what Mahoney (1991) has called "immaculate perceptions." On the contrary, this model assumes that our approaches to reality are indirect, mediated by our biological senses and our schemas, by feed-forward mechanisms and cognitive styles, all of which shape our perceptions. From this point of view, totally objective knowledge is impossible.

Opazo (1992a, b) has proposed the concept of a cognitive biological-environmental unit, which involves the idea that biological components (nervous system activity, inborn dispositions, senses, and perceptive mecha-

nisms) and environmental components (actual stimuli, experiential memories) exist in every knowledge unit, and both make up a cognitive whole. In this view, no knowledge can be 100% biological/subjective or 100% environmental/objective. Every unit of knowledge is always a combination of both. "Each knowledge unit, far from being a copy of the real world, should always be considered a product of the interaction between the knowing subject and the known object, both equally real" (Lorenz, 1963, cited by Guidano & Liotti, 1983, p. 5).

Campbell's (1974) evolutionary epistemology offers added support for the role of our senses and perceptions. From this evolutionary perspective, adaptation is a process of increasing knowledge and cognition. "Every progressive adaptation can be seen as a further acquisition of information about reality and, therefore, ultimately, as a real acquisition of knowledge" (Guidano & Liotti, 1983, p. 3). The increase of neural complexity throughout the evolutionary process makes more complete and accurate cognitions possible, and this in turn improves adaptability. If senses make no sense and reality is unattainable, then neural complexity would be worthless.

The evolution of science and technology adds a kind of "prestige" to our senses. Empirical science relies largely on the data from our senses. These data are organized into theories and knowledge, and technology is the practical result. These practical results have prolonged man's life on earth. In France today, life expectancy is over 70 years. In the 17th century less than 10% of the population reached 60 years of age (Golub, 1996). This progress is not due to chance, but is the consequence of progress in our knowledge about medicine, economy, and life styles. By making our senses act upon reality, we have managed to prolong our lives. Prolonging life, therefore, is not a matter of luck, construction, or invention, but a matter of knowledge. However imperfect that knowledge may be, it helps us manage the environment.

The Supraparadigmatic Integrative Model assumes that knowledge is effective action on a specific environment (Maturana & Varela, 1984). The real value of any knowledge does not depend on aesthetics, internal coherencies, or theoretical speculations, but is instead measured by the resulting action when that knowledge is put to work. In psychotherapy, effective action aids prediction, e.g., the prediction that a given strategy will function well when it is applied in a certain way in a specific case. Effective action also contributes to change in psychotherapy, by applying the forces of change to reach some desired therapeutic goals.

A model presupposes that a theory that generates more hypotheses that are confirmed constitutes a better knowledge than others. Predictive power involves greater comparative objectivity, since absolute objectivity

cannot be attained. A model also presupposes that a clinical strategy that is more powerful than other strategies in the same circumstances is better. To summarize, the model presupposes that in psychotherapy some kinds of knowledge are better than other kinds—that the clinician's task is to discover what action fits best in any given situation. This leads us to a consideration of methodological issues.

Methodological Assumptions: Toward a Science of Human Beings

When we disagree about the existence of reality, about our perceptual possibilities or about the universal or multiversal faces of reality, we are disagreeing about epistemological issues. When we cannot determine the comparative validity of many competing hypotheses and strategies, we are having methodological problems. Since many of the epistemological and methodological issues in psychotherapy have not been settled, it is only to be expected that we know so little about psychotherapy.

A method is an explicit and repeatable procedure, which enables one to come to a reliable conclusion. Without shared and specific criteria regarding what is to be considered valid, and without procedures that can potentially clarify or resolve controversies, we will never generate a significant body of cumulative knowledge.

In the field of psychotherapy, a certain methodological laxity has prevailed. Much of the 20th century in psychotherapy has been characterized by conflict between researchers and clinicians who support the phenomenological/introspective methods (closest to philosophy) and those who favor the empirical/experimental method (closest to the physical and mathematical sciences). The phenomenological/introspective method has been widely applied in clinical practice. Husserl (1931) conceived of phenomenology as research into the essence of things, where their existence becomes an abstraction. This methodology seeks to study the given in knowledge: the phenomena. The only true reality that we can understand is psychic reality. The phenomenological and eidetic reductions proposed by Husserl, and the emphasis on the introspective method from the works of Freud, have given clinicians the chance to explore hidden and complex sectors of the mind. This methodology has reached far inward, but very imprecisely, giving rise to many contradictory theories. Given that hypotheses in this area are formulated very loosely and that the methods of investigation are very imprecise, what is generated is more in the realm of speculation than of knowledge.

The empirical/experimental method is based on verification resulting from experimental research. The tendency has been to favor observable

data over theoretical speculation. This emphasis has provided precision, but within limits that are, by definition, more or less superficial (observable). Finally, a great deal of empirical research has been methodologically deficient.

What are the assumptions that the present integrative model can provide to bring order, capture better knowledge, and accumulate valid and shared knowledge? The above-mentioned assumptions of prediction and change are potential central axes. Bandura (1986) has written that "First, the theories must demonstrate predictive power. Second the methods that the theories yield should be able to effect significant changes in human thinking, feeling and actions" (p. 3).

The next task is to see how we can acquire more predictive and powerful knowledge. This leads us to concrete procedures. At the level of applied methodology, the first assumption of this model is to improve our scientific attitude. This means that we need to overcome the "ideological" wishes of the researchers and their "allegiance effects," which in turn requires greater ideological "neutrality." While therapists continue subscribing enthusiastically to comparatively narrower paradigms and approaches, such enthusiasm on the part of the researchers is likely to bias the research. Scientific behavior also means tolerating uncertainty and learning how to say "I don't know." The second assumption is ideological openness. Hypotheses and theories from different sources will be welcome.

The third assumption is precision. Hypotheses should be defined clearly so that they can be tested. Since we will measure knowledge in terms of how much it contributes to prediction and change, our methodology should facilitate those goals. Introspective methodology and empirical research aimed at these shared goals should join forces.

Research on self-efficacy theory (Bandura, 1977) is a good example of this integrative methodological approach. Using an experimental framework, Bandura demonstrated the predictive value of the construct of self-efficacy. Data based on introspection (self-efficacy ratings) was more predictive of coping behavior than was past behavior.

The fourth assumption concerns methodological improvements. With the correct attitude and an open mind, we can find the proper place for each specific procedure, including experiments, introspections, intuitions, logical deductions, follow-ups, double blind procedures, placebo groups, the concept of clinically significant change, etc. These methodological advances can help us to overcome one of the most typical errors: the tendency to overgeneralize from a few cases.

The correct methodology depends on what we are investigating. For example, a good procedure for investigating overt behaviors might be a bad one to use for investigating emotions. The complexity of human psy-

chology is such that exploring the "surface" (e.g., overt behaviors) is often associated with accuracy while exploring the "depths" (mind, dynamics, conflicts) is more often associated with inaccuracy. Increased accuracy leads us to the surface and exploring the depths leads us to inaccuracy. The challenge, then, is to develop a science of human beings that involves accuracy both on the surface and in the depths. This requires a methodology more sophisticated than we have at the present time.

Paradigmatic Assumptions: Moving Away From Reductionism

The subject of causality is central to psychology and psychotherapy. In the history of psychotherapy, many proposed causal paradigms have emphasized only one set of causes. For example, Burns (1980) described cognitive therapy as follows: "The first principle of cognitive psychotherapy is that all of your affects are created by your cognitions or thoughts" (p. 23). Freud (1948) wrote, "Repression is the cause of all neurotic maladjustments" (p. 303). In a similar emphasis on monocausality, Skinner (1953) wrote, "The causes of behavior are the external conditions of which behavior is a function" (p. 60). Historically, we have had a tendency to reduce psychology to a single major causal factor. Even this brief survey suggests that we need to update our knowledge in light of the best current findings in the area of causal paradigms.

Causality implies a specific set of circumstances that precede the effect and produce it. Two variables have a causal relationship when they show covariance, when the causal variable precedes its effect, and when alternative explanations for the observed covariance can be excluded (Haynes, Spain, & Olivares, 1993). How the cause produces the effect cannot be observed. There are different types of causes. For example, circular causality occurs when the effect turns into a cause, acting back upon its own cause.

The starting point for scientists in all fields is the supposition of an ordered universe. If human behavior does not display some kind of cause-effect sequence, the scientific method is invalid (Grünbaum, 1979). To assume that science aims to find order in disorder means that causality is a prerequisite for all of science, including the science of psychology.

Nevertheless, the transfer of the concept of causality from the macro-physical to the psychological dynamic is not simple. Without causality, human life is impossible and psychological knowledge makes no sense. But complex systems do not easily accept the application of the causal concept: For example, Russell (1948, p. 453) has written that "the concept of cause is not used in any advanced science." These and other considerations have

led us to believe that "searching for and discovering laws is not a hallmark of scientific knowledge but just a characteristic of simple phenomena" (Hayek, 1967, p. 42).

In the more specific area of psychological dynamics, the role of causality is relative. Dilthey (1976) suggested that we explain nature but comprehend psychological events. Jaspers (1963) added that we comprehend psychological relationships from the inside as making sense; we explain them from the outside as simultaneity and succession. Such complexities related to the applicability of the causal principle in psychology could explain many of our difficulties and controversies.

THE SIX PARADIGMS OF THE SUPRAPARADIGMATIC INTEGRATIVE MODEL

The existence of 400 or more different psychotherapeutic approaches (Karasú, 1986) does not necessarily imply that there are 400+ causal paradigms. The major paradigms that have been developed over the years provide us with many opportunities to select what is useful for prediction and change. The Supraparadigmatic Integrative Model recognizes six fundamental causal paradigms: biological, environmental/behavioral, cognitive, affective, the unconscious, and systems views. The self system gives a sense of connectness and wholeness to these causal paradigms. But, why these paradigms and not others?

The six paradigms to be discussed below have been defined with accuracy and are reasonably well researched. Each can provide data relating to prediction and change. These six paradigms, along with the self system, are sufficiently comprehensive that they can include any valid data from any of the more or less 400 psychotherapy approaches.

In the following sections, the six paradigms will be presented. Although each paradigm has its "true believers," the present Integrative Model proposes that each one contributes to understanding, prediction, and change. While each one is relevant, there is no single paradigm that is fully adequate in psychology and psychotherapy:

The Biological Paradigm

Although all psychic processes have a biological foundation, biological processes can also have a causal influence over psychological dynamics. The biological paradigm proposes that certain genetic, endocrine, neuro-anatomic, or neurophysiological characteristics can influence the genesis of

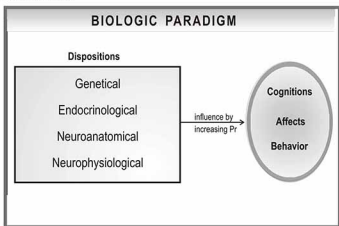
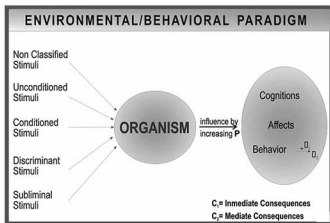


Fig. 1.

specific cognitions, emotions, or behaviors. Figure 1 illustrates some aspects of this paradigm. The etiological importance of the biological paradigm cannot be argued. As Maturana (1990) has pointed out, biological interference can produce psychological interference. For example, Damasio (1996) described the historical case of Phineas Gage, who suffered dramatic cognitive, emotional, and behavioral changes as a result of neuroanatomic lesions to the brain after a work accident. Gage changed from a persistent, honest, and efficient man to an inconstant, impulsive, egocentric, and amoral man. There are enough examples of this kind to clearly support the power of biological factors to influence cognition, affect, and behavior.

The influence of endocrine imbalances on the psychological dynamic are well documented by thyroid maladjustments (Gorbman, 1983), premenstrual syndrome (Hadley, 1984), and postpartum depression (Leshner, 1978). In psychopathology, genetics are rarely the sole determining factor as it is in the alterations of chromosome 21 that produces Down's syndrome, but are important at different etiological levels. A general consensus seems to be that we inherit predispositions or vulnerabilities to certain disorders, but only develop the disorder if certain life stresses activate that predisposition (Davison & Neale, 1980). There is strong evidence for the role of genetics in schizophrenia (Kendler & Robinette, 1983), bipolar disorders, and psychopathy (Rosenzweig & Leiman, 1993), to name just a few. Nonetheless, the environment may have a direct pathogenic role of its own or "may protect individuals from developing disorders to which they are genetically vulnerable" (Reiss, Plomin, & Hetherington, 1991, p. 284).



A number of twin studies also point to heritability coefficients for different personality traits of 40%–50%. Among the personality traits with a high heritability coefficients are the tendency to feel shame (Plomin, 1990), leadership abilities (Bouchard, 1984), neuroticism (Eysenck, 1990), altruism (Rushton, 1989), optimism (Schulman, Keith, & Seligman, 1993), extroversion (Plomin, 1990), aggression (Bouchard, 1984), conservatism (Tellegen, Lykken, Bouchard, Wilcox, Segal, & Rich, 1988), and depressiveness (Baker, 1989). The significant heritability of many personality traits might explain why psychotherapists have so much difficulty in modifying personality disorders (Opazo, 1986).

Therapeutic strategies associated with the biological paradigm run from endocrine treatments to electroshock. Drug therapy is the most widely used biological treatment for certain disorders, and there is strong evidence supporting the effectiveness of drug therapies for a variety of disorders.

The Environmental/Behavioral Paradigm

Paul Bourget has said that those who do not live as they think end up thinking as they live. Karl Marx held that experience conditions conscience. Although neither said so explicitly, both emphasized the causal influence of the environment on cognitions. The environmental/behavioral paradigm postulates that certain specific environmental characteristics can influence the genesis of specific cognitions, emotions, or behaviors. It in-

cludes both classical and operant conditioning. For Skinner, "independent variables, the causes of behavior, are the external conditions of which behavior is a function" (Skinner, 1953, p. 60). Figure 2 illustrates the environmental/behavioral paradigm.

The role of childhood experiences in later psychological development is an important part of the environmental/behavioral paradigm. The role of classical conditioning in the etiology of some anxiety disorders has been widely documented (Ost & Hughdall, 1981), as has the role of operant conditioning in the genesis of stuttering (Flanagan, Goldiamond, & Azrin, 1959), and aggressive behavior (Bandura, 1986). Finally, the recognition of different environmental stressors and the existence in DSM of the category of posttraumatic stress disorder involves an explicit recognition of the etiologic role of the environment.

The environmental/behavioral paradigm has made significant contributions to therapy as well. For example, in vivo exposure has been effective for agoraphobics (Emmelkamp, Kuipers, & Eggerat, 1978) and other phobias (Emmelkamp, 1994, p. 381). According to Barlow (1988), exposure in vivo has had an average success rate of 60%-70%.

The Cognitive Paradigm

The concept of cognition implies information, which is expressed as any event that reduces uncertainty. When we give some significance to facts, or when we are interpreting what occurs, these facts are being cognitively processed.

The cognitive paradigm postulates that certain specific cognitive events or cognitive structures can influence the genesis of emotions and behaviors. Epictetus' postulate (1st century A.D.) is accepted, which states that "men are not worried by things themselves but by the image they form about them." In clinical psychology, the cognitive etiology of psychological maladjustments is expressed by Ellis' A-B-C theory (1977). In this theory, A refers to antecedent environmental events, C to the emotions or behaviors that are frequently maladaptive. B refers to cognitive processing that could be "irrational," producing the emotional and/or behavioral maladjustments in C. "Once you accept that environmental events significantly contribute to but do not cause your feelings, and that your feelings are to a great extent a function of what you think, then you increase enormously your power over your emotions" (Ellis, 1977, p. 8). Thus, the "causal epicenter" of the cognitive paradigm would be in the cognitive processing performed in B.

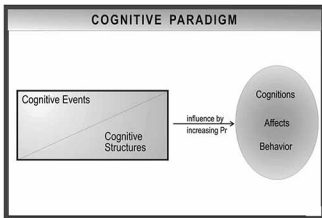


Fig. 3.

Underlying cognitive schemas (Beck, Rush, Shaw, & Emery, 1979) are stable cognitive structures that influence the genesis of cognitive processes and events. When these structures are damaged they lead to the genesis of cognitive errors, self-defeating self-instructions, maladjusted automatic thoughts, etc. The role of cognitions in the genesis of psychological maladjustments is emphasized: "recalling thoughts about ineptitude, individuals can bring themselves to elevated levels of anxiety that exceed the fear experienced during the actual threatening situation" (Bandura, 1977, p. 199). Figure 3 shows a diagram of the cognitive paradigm.

A considerable body of research supports the influence of cognition on emotion (Feasdale & Bancroft, 1977; Velten, 1968). Cognitions have also been shown to activate panic attacks, although the precise cause of panic attacks has not as yet been determined (Wolpe & Rowan, 1989).

A number of questions have been raised about the cognitive paradigm at the therapeutic level. Le Bon (1963) argued that reason justifies behavior more than guiding it. This is consistent with Bandura's findings (1977, 1986) that verbal persuasion is the weakest source of self-efficacy expectations. In addition, Kruglanski (1990) found that a frontal attack on a client's beliefs leads more to reactant behavior than to therapeutic change. Finally, Mahoney has argued that "the least promising cognitive psychotherapies are those that excessively emphasize 'rational thinking' as a primary strategy for emotional control" (1991, p. 446).

Despite these criticisms, there is some evidence for the cognitive paradigm's contribution to therapeutic change. This is the case in the placebo effect, which seems to depend largely on expectations and beliefs. Another

line of evidence is related to training in problem solving (D'Zurilla & Goldfried, 1971), which emphasizes a cognitive procedure: the acquisition of decision-making skills. The effectiveness of this procedure is well documented (Hollon & Beck, 1994; Dobson & Shaw, 1995).

It is difficult to isolate the contribution of specifically cognitive procedures to change since they generally tend to be mixed with behavioral procedures. The combination of cognitive and behavioral procedures does indeed appear to be effective. Reviewing the literature on cognitive-behavioral approaches, Hollon and Beck (1994) conclude that,

Although important questions remain, it appears that the cognitive and cognitive-behavioral interventions may be effective in the treatment of a broad range of disorders and problems in living. These approaches are at least as effective as the best available alternatives for a number of disorders. Moreover, there are indications that these sustained improvements are not always shared by other treatment approaches. (p. 458)

The Affective Paradigm

Einstein stated that "daily efforts do not come from deliberate intention or from a program, they come directly from the heart" (1934, p. 35). Thus, an authority in rationality and logic emphasized the importance of the affective paradigm.

Affective responses, that is emotions (transient affective events) and feelings (more stable affective structures), are essentially characterized by energy. They constitute autonomous, cognitive, and motor elements in a significant whole, and are syndromes of a multidimensional response (Reisenzein, 1983). Above all, emotions provide energy and motivation that evolves into subjective personal experiences and motivation to action (Opazo, 1988, 1992a, b).

Different authors believe it is difficult, if not impossible, to separate emotional processes from those involved in thought and action. From this point of view, cognition and emotion can only be different aspects of a single process, like the two faces of a coin; they are interdependent and indistinguishable (Coyne, 1982; Greenberg & Safran, 1984; Guidano, 1988). There is an emotional component in every cognition and every emotion involves a certain amount of cognition. Mahoney wrote, "feeling is not exclusively limbic, and knowing is not exclusively neocortical" (1991, p. 189).

Despite the above, there is evidence that some emotions are more "cognitive" than others (Buck, 1985), and some only need very slight cognitive participation. Anatomical research has shown that the emotional system can act independently through the visual perception/amygdala route that is shorter than the visual perception/cortex route (LeDoux, 1986).

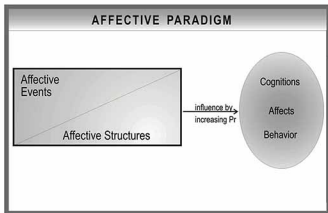


Fig. 4.

Therefore "the case for considering emotions to be a separate system is well established at the neurophysical and biochemical level" (Izard, Kagan, & Zajonc, 1984, p. 25). If postsensation emotions exist—which only need an elementary and passive "cognition"—then the fact that cognition is an essential part of emotion is debatable. The affective paradigm implies that affective events and structures can influence the genesis of cognitions, emotions, and behaviors (Zajonc, 1980, 1984). A diagram depicting the affective model is presented in Fig. 4.

The etiological role of the emotions is well established in psychology. Without emotional arousal, there is no motivation, and without motivation, there is no behavior. For example, emotions have been shown to interfere with the thinking process, facilitate certain memories (Bower, 1983), influence judgment and attention (Forgas, 1995), influence perception (Kennedy & Craighead, 1982), and produce specific changes in self-efficacy expectations (Kavanagh & Bower, 1985). Further, stress produces "negative" cognitions (Parkinson & Rachman, 1980), and stress reduction reduces these cognitions (Emmelkamp *et al.*, 1978). After thoroughly reviewing the existing evidence, Madigan and Bollenbach concluded that "these results taken together provide strong support for the reciprocal position that temporary mood states affect ongoing cognitive processes" (1986, p. 560).

Emotions are an uncertain dimension of experience (Goldberg, 1986) and are difficult to study directly. For this reason, their contribution to the therapeutic process is not easy to evaluate. The effectiveness of experiential interventions that focus on emotion has been difficult to evaluate for a number of reasons: there has not been enough research, the methodology

has often been inadequate, or the studies have employed heterogeneous samples rather than those with specific disorders (Greenberg, Elliot, & Lietaer, 1994).

The evidence for the contribution of other emotionally based procedures is also unclear. This is the case for catharsis, and for "hot" cognitions. At the speculative level, however, it does appear that change is more likely when the patient experiences emotional arousal than when they do not.

Imagery techniques may be considered as calling on both cognition and emotion. For example, Leuner (1984) has suggested that emotion is involved in imagery.

An important contribution of the affective paradigm is that it helps us understand the nature of motivation in psychotherapy. Marchetti and Armijo (1995) have distinguished between the motivation to attend therapy, the motivation to change symptoms, and the motivation to change aspects of the self system. They suggested that the latter is an important indicator of positive outcomes in psychotherapy. Most of what happens in psychotherapy depends on keeping active the patient's motivation to change. "Psychotherapy does require the cooperation of the client" (Garfield, 1992b, p. 179).

The Unconscious Paradigm

In a general sense the term *unconscious* "means those mental activities of which the individual is not aware" (Marx & Hillix, 1969, p. 413).

Different types of unconscious have been identified. The subliminal unconscious implies that stimulation (external and/or internal) is above the sensory threshold but below the perceptual threshold (McGinnies, 1949). A second conception of the unconscious refers to the nonconscious: cognitions, emotions, and behaviors that are not conscious but are easily brought to the conscious level (Meichenbaum & Gilmore, 1984). A third meaning of the unconscious is the repressed unconscious in which we block out or remove material that generates anxiety, guilt, or shame in the conscious (Freud, 1948).

A fourth type of unconscious refers to the super conscious level. Hayek (1978) wrote,

Much of what happens in our mind we are not aware of, not because it proceeds at too low a level but because it proceeds at too high a level. It would be more appropriate to call such processes not "sub-conscious" but "super-conscious" because they govern the conscious processes without appearing in them. (p. 45)

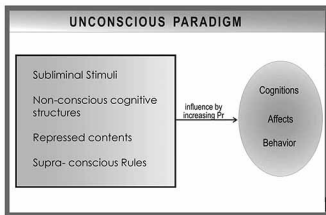


Fig. 5.

The unconscious paradigm (Fig. 5) postulates that specific events or structures that operate outside of awareness can influence the genesis of emotions, cognitions, or behaviors. Research that supports unconscious influences on our behavior comes from the effects of subliminal emotional material (Gonçalves & Ivey, 1987) and unconscious assumptions (Frank, 1974; Markus, 1977).

It has been asserted that "while many of Freud's theories have not stood the test of time, many others (e.g., regression, fixation, projection, symbolism and unconscious processes) have been validated in experiments far removed from the therapeutic hour" (Karon & Widener, 1995, p. 43). Unfortunately, rigorous research on the repressed unconscious has not been an easy task. Experimental evidence for repression has been provided by Bowers (1966) and Kihlstrom (1981). The influence of hypnotic induction on perception and behavior also appears to be well documented (Shevrin, 1973; Grossarth-Maticek & Eysenck, 1990).

The therapeutic contribution of increased awareness of unconscious material is difficult to establish, partly because of the complexity of the topic, and partially because of the scarcity of research relating to psychoanalytic approaches. Surprisingly, some support for the role of the unconscious can be found in research utilizing the environmental/behavioral and cognitive paradigms. This research has demonstrated that an awareness of the relationship between behavior and its consequences substantially enriches learning and behavioral change (Kanfer & Philips, 1970; Paul, Eriksen, & Humphreys, 1962). Bandura (1969) concluded,

The general evidence would seem to indicate that learning can be achieved without awareness, although slowly. Nevertheless, the symbolic representation of the response's reinforcement risks can considerably accelerate the appropriate response. (p. 577)

The research evaluation of short-term psychodynamic psychotherapy has not yet yielded very encouraging results. After reviewing 19 studies, Svartberg and Stiles (1991) found that short-term psychodynamic psychotherapy was better than no treatment at all, but very much inferior to alternative psychotherapies after a one-year follow-up. After reviewing 11 studies, Crits-Christoph (1992) found evidence that brief dynamic therapy was equal in effectiveness to those other approaches with which it was compared. To the extent that psychodynamic therapy is effective, we have little in the way of research to help us understand the underlying mechanisms of change in this type of therapy (Spence, 1984, p. 22).

The Systemic Paradigm

Early systemic conceptions emphasized the concept of totality. In methodological terms, the assumption was that many phenomena could only be studied from a holistic perspective. For example, Lesch (1962) wrote that "the decay of mental life in elements, by analogy with the scientific/natural model of the atom, is contrary to the mental life's integrative and global character" (p. 68).

A system implies a whole that is greater than the sum of its parts. These parts, as well as their attributes, can only be understood as a function of the total system. The parts of a system interact reciprocally. Each system consists of different subsystems, each has limits that are more or less permeable, and each is part of a suprasystem.

Unlike the preceding paradigms, the systemic paradigm assumes circular causality that has no beginning and no end. In this context, Gregory Bateson (1972) asked, Is there a place or a time when one thing begins and another ends? Circular causality is seen as "a process where in the same way that a cause produces and conditions the effect, all effects become causes and act upon its own cause" (Watzlawick, 1979, p. 76).

If one member of a system is diverted from its function, the total system works to make that part return to its previous function. Homeostasis is the tendency of systems to stay balanced, and to remain so despite environmental changes. In the psychological system, the maintenance of systemic coherence has been proposed as a replacement for the concept of homeostasis (Dell, 1982). More recently, Guidano (1987) has noted that the central characteristic of a self-stabilizing system is not so much the pres-

ervation of the homeostatic circular equilibrium, but the maintenance of the coherence of the ordering processes themselves.

This conceptual framework does not allow for the possibility of predicting which specific changes in the total system will produce which specific effect in cognitions, emotions, and behaviors. Specific characteristics of the global system, for example, certain rules of interaction, can favor or resist the change of cognitions, emotions, and behaviors. Morphogenesis favors the changes and morphostasia turns the system resistant to it (Maruyama, 1963, 1977). Figure 6 illustrates the systemic paradigm.

In the systemic paradigm, it is important to determine which influences on the system favor morphogenesis and which favor morphostasia. This brings us to the topic of evidence, which is a complex subject in the systemic paradigm. Traditional research methods accept linear causality (e.g., A causes B) and leads to research methods in which A is manipulated to see its effects on B. But as we have seen, circular causality is quite different from this, and research methods to study circular causality have not yet been adequately developed. Clarkin and Carpenter (1995) have criticized the current state of the systems paradigm as follows: "A striking and serious difficulty in the field is the chasm between those who write about systems theory and the research that is being pursued" (p. 220).

The systemic paradigm has generated some correlational research. For example, correlations have been found between measures of systemic functioning of the family (coherence, cohesion, and optimism) and the physical health of individual family members (Fisher, Ramson, & Terry, 1993, p. 225).

Evaluation of the effectiveness of family therapy is limited by the variety of different therapies and relative lack of carefully controlled research. After reviewing several studies, Gurman and Kniskern (1978) found that 73% of families treated showed significant improvement. Structural family treatment has received some empirical support for the treatment of asthma (Minuchin, 1974) and drug addiction (Stauton & Todd, 1980). When comparing the effectiveness of different family therapy approaches, bias and "wishful thinking" effects seem present. For example, Jacobson and Addis (cited in Alexander, Holtzworth-Monroe, & Jameson, 1994) noted that when differences are demonstrated, they consistently favored the theoretical orientation and expertise of the investigators (p. 605).

THE SELF SYSTEM

The integrative model assumes that the six paradigms are connected, coordinated, and integrated within the person's self system. In the litera-

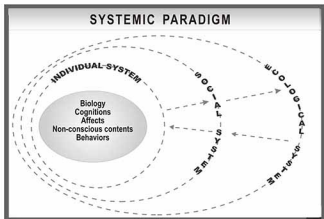


Fig. 6.

ture, the self system concept is quite ambiguous, with little consensus among different conceptualizations. Nevertheless, it is seen as a central concept by many. For example, Wolfe (1995) stated that "The self, whatever it may be, is increasingly thought of as a core locus of psychopathology by virtually all of the existing theoretical perspectives in psychotherapy" (p. 295).

In the integrative model presented here, the self system is conceived of as a focal point of experience (Maslow, 1943; Rogers, 1966), and as a point of confluence of the biological, environmental/behavioral, cognitive, emotional, and unconscious subsystems, within the framework of the total system. From this point of view, the self system is the core of our personality (Kohut, 1971), and expresses the homeostatic balance and the systemic coherence of the whole psychological system.

The Supraparadigmatic Integrative Model also assumes that the self system performs four fundamental functions: identity (James, 1984; Perls, 1976), self-organization (Mahoney, 1991; Guidano, 1987), meaning of experience (Rogers, 1966; Kegan, 1982), and behavioral control (Freud, 1948; Kernberg, 1989).

In serving the function of identity, the self system is the basis for a concept of the self and feelings about the self. Nevertheless, this personal identity is bidimensional. On the one hand, it is a coherent, organized, and relatively stable gestalt. On the other hand, it is a dynamic process of formation and reformation as situations change.

The model assumes that the self system performs self-organizing functions. The self system tries to balance being and becoming. When stumbling

over its world, the self system suffers the impact of novelty, which generates a period of tension and disorganization. Then, a more viable pattern of interaction emerges and a feeling of familiarity is recovered (Mahoney, 1991). In this way, learning and knowing imply an opening of the system to allow the expansion of the assimilable environment (Furth, 1987). It also implies self-organizing mechanisms that prevent the self from disintegrating in the process. These self-organizing mechanisms frequently become defensive when identity is radically threatened. Thus, the self-organizing processes permit the expansion and development of the self system and its world. Self-organization preserves the integrity of the system.

The integrative Model further assumes that the self system gives meaning to experience. People look for and create meaning (Smith, 1978). According to Guidano (1987), the continuous search for personal meaning involves construction and maintenance of a coherent personal meaning. Self-organization provides an interactive balance that maintains an "experiential order" or personal meaning. Experiencing is essentially giving meaning; the self system is a kind of idiosyncratic translator that is co-constructing the experience. In this way, experience becomes a dialectic integration between the subjective and the objective (never directly attainable). In this process of giving meaning to experience, the self system transforms sensory stimulation into effective stimuli that definitively affect experience. These effective stimuli can represent external stimulation with greater or lesser "fidelity." Paradoxically, the self system is partly a builder and is partly being built in each experience. In this way, "we are the changer and the changed" (Willamson, 1975, quoted by Mahoney, 1991, p. 8).

The Integrative Model assumes that the self system performs *behavioral control* functions. Freud (1948) wrote, "We suppose that every individual has a coherent organization of his/her psychic functions which we think of as his/her ego. This ego integrates the conscience, which dominates access to motility" (p. 1193). Additionally, the control of behavior implies the capacity for self-activation (Masterson, 1988). This capacity makes overcoming passivity possible. Finally, the control of behavior implies the capacity to express feelings. Thus, the Integrative Model assumes that the self system facilitates control of impulses, makes possible the repression of unwanted contents, and influences motivational and behavioral activation. Within the area of affective expression, the self system facilitates the management of emotional communication. The model also assumes that the capacity for control, activation, and affective expression varies from one person (self system) to another.

A SUPRAPARADIGMATIC INTEGRATIVE MODEL: DESCRIPTION AND DYNAMICS

The Supraparadigmatic Integrative Model at a Descriptive Level

From the above, it should be clear that the Supraparadigmatic Integrative Model does not recognize any one of the existing paradigms as superior to any other, nor does it mean that any one of these paradigms can incorporate any other. The model is more than the sum of six separate paradigms. It involves an integration of these parts into a whole. Lazarus, Beutler, and Norcross (1992) write, "Theoretical integrationists attempt to meld disparate ideas into harmonious wholes by constructing a superordinate umbrella and by building a coherent framework from the best elements of conflicting theories" (p. 13). Figure 7 illustrates the Supraparadigmatic Integrative Model.

The model integrates the biological, environmental/behavioral, cognitive, affective, unconscious, and systemic paradigms around the individual self system. S are the stimuli, P is person, B is behavior, C₁ are the immediate consequences of behavior, and C₂ are the longer term consequences. The integrating axis in the person (P) is the self system into which the biological, cognitive, emotional, and unconscious subsystems converge. The nuclear self is the person's maximum point of unity and integration. Rigid borders are unusual in the model. The cognitive accentuation does not imply an absence of feeling; nor do the accentuations of the unconscious imply an absence of conscious cognition or feeling. The emphasis is conceptual.

The model emphasizes the role of the parts and the possibility of disrupting the whole. Davies (1993) has written the following:

The word "analysis" frequently used as a synonym for "science" expresses the idea that we can take things apart and study the parts separately in order to understand the whole. Even a system as complex as the human body can be understood by knowing the behavior of the individual genes or the rules that govern the molecules that make up our cells. If we could not understand limited parts of the universe, without understanding the whole, science would be a hopeless enterprise. (p. 78)

Further, it is assumed that the psychological dynamic has an integrative and global character, in which the whole is more than the sum of its parts, and in which systemic principles play a significant role.

The Supraparadigmatic Integrative Model at a Dynamic Level

From a dynamic and functional perspective, the person (P) actively goes to the environment where he or she interacts with the stimuli (S).

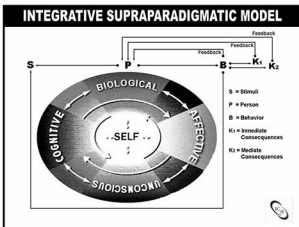


Fig. 7.

The person's active role in perception comes from the constructive role of the nervous system (Weimer, 1977), from the person's needs and tendencies (Lersch, 1962), and from feed-forward mechanisms (Mahoney, 1991). In this dynamic process, the stimuli (S) are perceived by the person (P), who gives them meaning through the self system. Thus, each meaning is a dialectical coconstruction of the self system and the environment that supplies the raw material. The effective stimuli are coconstructed in this dialectic process and these are what effectively influence and "move" the person.

In the psychological dynamic, the environment supplies the "raw material" that is "processed" by the self system, which transforms it into an effective stimulus. The effective stimulus can be very different from the "objective" characteristics of the stimulus. "Objective" stimulus properties put some limits on the constructive activities of the self system.

The self system is not only influenced by the characteristics of the stimulus, but also by the characteristics of the subsystems that form it. Therefore, the biological, cognitive, emotional, and unconscious subsystems also participate in the coconstruction of effective stimuli. In each experience, each subsystem has a differential role; in some experiences the cognitive subsystem has more influence on processing by the nuclear self, while in others, the affective subsystem may have more influence, and so on. Thus, in each coconstruction of meanings, the self system is doubly influenced: from the "outside" by the raw material provided by the stimulus and from the "inside" by its own subsystems.

In the physical sciences, it has been asserted that dynamic systems are always undergoing perturbations; if perturbations exceed a certain thresh-

old (the bifurcating point), a whole new level of principles is required to account for the processes that emerge (Prigogine, 1980). This means that, in physics, perturbations might require a change in the explanatory principles. This further implies that there is not just one principle, but many. We find parallels of this in the psychological realm. For instance, Hilgard (1952) has asserted that learning can be seen as a continuum from automatic (explained through associative principles) at one end to insight learning (comprehensive and rational) at the other. The integrative model encompasses the entire range of this learning scale. The self will operate differentially in the coconstruction of each experience. In some cases it will participate actively, consciously, reflexively; in others it will be more passive, mechanical, and not very conscious.

Once the effective stimulus is coconstructed, it can mobilize open behavior (B) or different cognitive, emotional, and unconscious mediational effects. In the case of open behavior, this could have immediate consequences (C₁) and/or longer term consequences (C₂). The consequences of behavior are in turn processed by the self system and could influence future behavior. Open behavior not only can provide consequences and feedback; it can also modify the environment, thus, modifying the future stimuli that will influence the person.

Occasionally, a subsystem tends to impose a specific kind of processing on the self system. This is the case, for example, in a brain lesion that substantially affects the control of impulses, or in the case of a rigid and drastic cognitive structure of perfectionism that systematically pressures the self system. More often, however, the self system has many influences, and the effective stimulus becomes an integral effect. In turn, this effect can also become a cause, with circularity as an essential aspect of the dynamics of the integrative model.

In psychological dynamics, action can "begin" from an external stimulus or from a mediational activation. A stable change in one part of the system will tend to modify the other parts, together with the homeostatic balance through a process that in the model is called systemic irradiation.

Contributions of the Integrative Model: From the Abstract to the Concrete Conceptual Contributions

The guiding framework provided by the Integrative Model has resulted in the proposal of different concepts: effective stimulus, biological "truth," biological meaning, pulsating behavior, spaces of cognitive meaning, affective inertia, integral awareness, and interactional empow-

erment. Only the principle of influence will be more fully explained, since it has become increasingly more relevant in our clinical practice. To understand a phenomena from a scientific point of view is to know the conditions for its occurrence. We have seen that a law implies a necessary relationship between two variables; this relationship at the same time implies a causality that predicts a certain effect. Nevertheless, even in physics there are predictive ruptures that complicate causality: in small-scale physics, there is only a "weak causality," such that a single cause can produce one of several possible effects, with only some probability that such one effect rather than another will result (De Broglie, 1963). As in chaos theory, the concept of probability is important in quantum physics.

In the psychological realm, the lack of clear-cut and definitive laws has led Kanfer and Saslow (1965) to assert that "No specific family environment, dramatic traumatic experience or known constitutional anomaly has yet been found, that produces the same pattern of disturbing behavior" (p. 287). Of course, this confuses and complicates clinical work, and makes it easy for different people to assert new possible causes. Sandler and Davidson (1977) wrote, "Maybe because human behavior is so multifaceted, almost any statement that expresses a relationship between supposed causes and pathological effects has found support somewhere." (p. 23). The Supraparadigmatic Integrative Model suggests that in the psychological dynamic, the principle of causality is camouflaged in a thicket of the variables involved, and very often the effect tends to become obscured. Further, given the complexity of the psychological system, the effect can be annulled by other parts of the system. For example, an assumed law such as "all mothers who suffer the loss of a beloved child will suffer and become sad" can be contradicted, at least partially. Some years ago, the mother of an assassinated Chilean senator stated that if she felt sad, she would be selfish, since she was absolutely sure that her son was resting magnificently in heaven. We could say that the self system overrode that basic law. In most of the psychological realm, effects are rarely certain—at most they are probable.

The principle of influence assumes multideterminism and probabilistic causality. The dimensions of a principle of influence include the direction of the influence (toward what specific effect), the degree of probability of the effect, and the degree of the culture's dependence. In very exceptional cases, the probability of the effect is one, in which case the influence becomes a deterministic law. Figure 8 illustrates the difference between a law and a principle of influence.

LAW	PRINCIPLE OF INFLUENCE
$A \rightarrow B$ If A then B Ex.: Disorder in chromosome 21 produces Down's syndrome	$A \rightarrow Pr B$ If A then B is highly probable. Ex.: self-defeating self-instructions increases the probability that depressive feelings will occur.

Fig. 8.

The concept of principle of influence "humanizes" the principle of causality. Although it does not guarantee that an effect will occur, a principle of influence is more than just an influence; it implies that almost everyone will be influenced toward the same effect. In psychotherapy, a principle of influence can be intentionally used to achieve the objectives that the patient has proposed. Applying principles of influence, a therapist can be certain of influencing in the right direction, even when the effects are not yet observable.

Based on this integrative model, our team has defined over 70 principles of influence, each one tied to one of the model's six subsystems. Figure 9 illustrates some of these principles.

Predictive Contributions

We have seen that full prediction will always remain beyond the possibilities of any theory of complex phenomena. But we have also seen that the absence of prediction places us outside the framework of scientific explanations: "Scientific knowledge consists of discovering the causal regularities that can predict the future" (Grünbaum, 1979, p. 19). So, the best conceptual model would be the one that most enriches our predictive options.

What does the Integrative Model contribute in predictive terms? Using the model, we have attempted to predict the meanings that the self system will provide, i.e., to predict effective stimuli. We must remember that an effective stimulus is the result of an interaction between the self and the "external" stimulus. From this perspective, the predictive options will be enriched as the characteristics of the stimulus become known, e.g., whether it is subliminal or supraliminal, unconditional or conditional, etc. The predictive options will also be enriched as the characteristics of the person's self system become known: identity, ability to postpone impulses, perceptive accuracy, etc. Additionally, some stimuli require a more active participation

- | | |
|--|--|
| <p>1.- Biological Paradigm
 a) Restorative sleep influences by increasing the probability of lowering the homeostatic threshold.
 b) Systematic gymnastics influences by increasing the probability of relaxation.</p> | <p>4.- Affective Paradigm
 a) The patient's motivation for change influences by increasing the probability that the psychotherapy goals will be attained.
 b) The therapist's warmth influences by increasing the probability that the patient's psychological system will open up.</p> |
| <p>2.- Environmental/Behavioral Paradigm
 a) Active behavioral display influences by increasing the probability of reducing depressive feelings.
 b) Unemployment influences by increasing the probability of stress.</p> | <p>5.- Unconscious Paradigm
 a) The conscious acceptance of contents that were once pushed aside, influences by increasing the probability of relax within the system.
 b) The modification of rigid and/or despotic self-demands influences by increasing the probability of self-awareness.</p> |
| <p>3.- Cognitive Paradigm
 a) The patient's expectations of change influences by increasing the probability of change in psychotherapy.
 b) The "novel" character of the therapeutic message influences by increasing the probability of assimilating the therapeutic experience.</p> | <p>6.- Systemic Paradigm
 a) Reactance influences by increasing the probability that the psychological system will close down (morphostasis).
 b) The systemic context surrounding a symptom influences by increasing the probability of resistance to its modification.</p> |

Fig. 9. Principles of influence: An Illustration.

of the self and others are more automatic. Finally, predictive options will be enriched as the history of the person/stimulus interactions becomes known.

As we have seen, the construction of effective stimuli is also influenced from within the self system. The biological, cognitive, affective, and unconscious subsystems can also influence the construction of meanings by the self system. The self system and subsystems of one person will differ from that of the other, and in each experience, the subsystems will participate differentially. For example, some stimuli will contact many related emotions while others will contact fewer.

Occasionally one subsystem will dominate in determining the effective stimulus. For the most part, the effective stimulus will be determined by multiple sources from the stimuli, the self system, and its component systems. Because of individual differences, prediction is often difficult. Not even the presence of prominent personality traits ensures the prediction of effects. Thus, an aggressive person will not always act aggressively; a perfectionist will not always act in a perfectionist way.

In predictive terms, the Integrative Model provides some important advantages over other models with less paradigmatic integration. By using a variety of related paradigms, it enriches the opportunities for accurate prediction, while use of only one of these paradigms alone may not.

PROCESSES OF CHANGE AND INTEGRATIVE PSYCHOTHERAPY

If change in psychotherapy depended exclusively on nonspecific factors based only on the therapeutic relationship, the profession of psychotherapy would be in a very uncomfortable position. How can something be a specialty if the nonspecialists can do it as well or better? This point is very important and has drawn the attention of psychotherapists for some time. For example, Strupp and Hadley (1974) wrote,

Research in psychotherapy must address a central question: to what extent are therapeutic effects the result of specific techniques (such as suggestions, clarification, and interpretations), as opposed to so-called non specific factors inherent in any human relationship that affects the patient's expectations and hope? (p. 1125)

The results of the Vanderbilt I Psychotherapy Study showed that "Patients undergoing psychotherapy with college professors showed, on the average, quantitatively as much improvement as those patients treated by experienced professional psychotherapists" (Strupp & Hadley, 1979, p. 1134). These results provided clear support for a common factors position and suggested that professional training "might not contribute significantly to treatment outcome" (p. 431).

Research following the Vanderbilt I study has still not fully clarified the contribution of professional training. Using meta-analytical methods Hattie, Sharpley, and Rogers (1984) reanalyzed 39 studies and concluded that clients who seek help from paraprofessionals are more likely to achieve resolution of their problems than those who consult professionals. Additionally, Berman and Norton (1985) conducted a meta-analysis to examine the relative effectiveness of professional vs. paraprofessional therapists treating various disorders. Upon analyzing this study Arkowitz (1992) wrote, "The overall findings were quite clear: the experienced and professionally trained therapists were not significantly more effective than the relatively untrained paraprofessionals" (p. 411).

It is possible that the nonprofessionals get good results for certain types of problems and people, e.g., less severely disturbed patients and younger people. For example, Bergin and Garfield (1994) have suggested that "Greater severity may, however, test the limits of the common factors" (p. 823).

Nonetheless, it has still not been demonstrated that specific factors proposed by the different therapies are any more effective than common factors. Given this, it is not surprising that psychotherapists are advocating that we capitalize on these common factors (Arkowitz, 1992). In this con-

text, turning more seriously toward the common factors seems an interesting and attractive option.

The Integrative Model has attempted to address some of these issues. Using it, our institute has developed an integrative psychotherapy consistent with the model's postulates (Opazo, 1992, 1995). The model proposes that both specific and nonspecific factors are important in change in psychotherapy.

Patient, therapist, and relationship variables are all considered important in integrative psychotherapy. However, the task here is to specify the nonspecific variables as much as possible in order to optimize their clinical application. In the area of patient variables, our findings have emphasized the role of the expectations for change and motivation for change, among others. The therapist variables involving the capacity for empathy and the capacity to motivate are of particular importance. In the therapeutic relationship, integrative psychotherapy emphasizes the role of attaining unique relationships that "fit" each patient.

The principles of influence are intended to challenge the framework of common factors. Each one of the more than 70 principles of influence that we have identified involve specific forces of change, which can be subsumed under each of the six specific paradigms. In this way, the principles of influence become specific clinical strategies to help achieve specific therapeutic goals. These principles should be applied flexibly in an interpersonal context. The role of the patient's self system will be crucial in terms of the impact of many of the principles of influence on the construction of meanings.

From the perspective of the Supraparadigmatic Integrative Model, those specific techniques that have been supported by research (e.g., in vivo exposure, behavioral trials, etc.) are another set of options that go beyond common factors. Although the techniques are only applicable to certain symptomatic problems (Marks, 1987), they are powerful options of great help to patients.

Integrative psychotherapy, based on the Integrative Model, has been defined as a process that goes on in an interpersonal context. This process is deliberately designed as a means of influence, through the genesis of novel, corrective, and/or enriching cognitive, emotional, and behavioral experiences. The general purpose of the process of integrative psychotherapy is to attain objectives agreed upon between client and therapist. The process is guided by a specialist who bases his/her action on the Supraparadigmatic Integrative Model. The integrative psychotherapy is nourished on forces of change coming from the patient, from the therapist, and from the relationship. The therapist also uses specific forces of change from the biological, environmental/behavioral, cognitive, affective, unconscious, and

systemic paradigms. These are forces that have contributed to the explanation of the genesis of psychological maladjustments and to prediction and therapeutic change. These principles of influence, flexibly administered in an interpersonal context and with consideration of the patient's needs and objectives, supply the raw material that the patient's self system transforms into effective stimuli, i.e., into mobilizing experiences for change. When the clinical situation merits it, the integrative psychotherapist complements the changing action with specific techniques aimed at overcoming the patient's specific problems. Integrative psychotherapy is a creative process based on scientific principles (Opazo, 1995).

The Integrative Model suggests that, although the psychological system forms a whole, deciding where and when to intervene is very significant. Diagnosis in integrative therapy establishes the strengths and weaknesses of the self-system and each sub system. Such a diagnosis helps identify the best intervention strategies to expedite the diagnosis/treatment relationship. In this regard, we have developed an Integral Clinical Evaluation Chart (FECI), which is a self-report questionnaire that the patient fills out in the first session.

The Supraparadigmatic Integrative Model provides greater understanding of the meaning of symptoms. According to the model, a symptom is only occasionally the expression of an underlying unconscious conflict. It also could derive from a number of other sources including neurological disturbances, dysfunctional learning, or from difficulties in processing information. The model also predicts that a symptomatic change will "irradiate" through the self system and lead to a systemic adjustment, or a change in the system's point of homeostatic equilibrium. In these cases, symptom substitution is unlikely. Symptom substitution is also unlikely when relearning corrects prior experiences of dysfunctional learning.

The Integrative Model postulates that change can be initiated externally or internally. Therapeutic change can also involve changes in the environmental stimulation that the patient receives. Nevertheless, psychotherapeutic experience can promote mediational changes in the patient, which then generate changes in the way that the patient builds his/her effective stimuli. This is entirely consistent with Wachtel's suggestion (1987) of combining insight and action. No further expansion of the characteristics of integrative psychotherapy is possible here. Integrative psychotherapy provides important advantages for the patient because the therapist is open to a variety of theories and strategies, rather than being limited to only one perspective. In addition, the best validated concepts and clinical strategies will be utilized by the therapist in an understanding and nonreductionist way.

CONCLUDING COMMENTS

A number of objections or concerns may arise in reaction to the model presented in this paper. One objection might be that the model brings together those things that have already been proposed and does not contribute anything new. Nonetheless, the model contributes important assumptions, evaluation criteria, scientific evidence, and a set of integrated paradigms that provide guidelines for integrative therapy.

A second objection may be that the model is a theory in what Bergin and Garfield (1994) have called "an atheoretical era." Since theory has contributed very little to prediction and clinical practice, there are many today who are skeptical about theoretical contributions. Some defend technical eclecticism (Lazarus, 1989; Norcross & Napolitano, 1986) while others see hopeless obstacles to a theoretical integration. "The main problem here is that, upon close scrutiny, even theoretical tenets that seem to be interchangeable among different theories often turn out to be epistemologically and ontologically irreconcilable" (Lazarus, *et al.*, 1992, p. 13). Goldfried and Castonguay have a similar skepticism and have written the following:

Although integrative psychotherapy is unlikely to provide a grand theoretical synthesis, it nonetheless can help the field to achieve a consensus on integrative strategies for certain clinical problems, foster a dialogue in a theoretically neutral language, and encourage cross-fertilization in studying the process of change. (1992, p. 4)

This second objection is not easy to address. Since the epistemological and ontological problems are continuing, and even becoming more serious, if we wait for them to be resolved, there will never be an integrative model and we run the risk of becoming "eternal technocrats." The integrative model not only does not oppose technical integration, but it facilitates and focuses it. Nevertheless, it is hard to agree with just technical pragmatism, without any theoretical basis. In our clinical experience the integrative model has led to enhanced understanding of clinical problems and extremely useful guidelines that have empowered our clinical practice substantially.

A third objection that might be raised is that it is not possible to transfer theories and strategies from one semantic context to another, without considerable losses. In this view, a psychoanalytic concept cannot be separated from the global psychoanalytical theoretical framework, and accepting a behavioral clinical strategy would require accepting the entire behavioral theoretical framework. However, since no single paradigm has proven to be entirely adequate, such "contextual respect" does not seem so necessary. It may even be that clinical strategies can be enriched by importing them

into another conceptual framework. More may be gained than lost by such an integration.

There are some other limitations to the integrative model that need to be considered. The model rarely leads to precise and accurate predictions. The concept of their self system needs more precise definition and elaboration. The effectiveness of the principles of influence in clinical practice has not yet been well researched. Integrative psychotherapy itself, like any psychotherapy, runs into limiting forces derived from the person's biological structure and from his/her social environment.

Despite these and other objections, the Supraparadigmatic Integrative Model is a serious proposal that can potentially overcome the chaos in the current state of psychotherapy. It can potentially rescue the best contributions of people like Freud, Skinner, Rogers, Bandura, Bateson, and others. It also has great potential for improving clinical practice. A comprehensive integrative model can potentially lay the groundwork for future improvements in the field of psychotherapy.

REFERENCES

- Alexander, J., Holtzworth-Munroe, A., & Jameson, P. (1994). The process and outcome of marital and family therapy. Research review and evaluation. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 595-630). New York: John Wiley & Sons.
- Arkowitz, H. (1992). A common factors therapy for depression. In Norcross & M. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 402-431). New York: Basic Books.
- Baker, L. (1989, August). The paradox of happiness. *Psychology Today*, August.
- Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart & Winston.
- Bandura, A. (1977). Self-efficacy: Towards a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.
- Bandura, A. (1986). *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice-Hall.
- Barlow, D. (1988). *Anxiety and its disorders*. New York: Guilford Press.
- Bateson, G. (1972). *Steps toward an ecology of mind*. New York: Ballantine Books.
- Beck, A. T., Rush, A., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression*. New York: The Guilford Press.
- Bergin, A., & Garfield, S. (1994). Overview, trends and future issues. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 3-18). New York: John Wiley & Sons.
- Berman, J. S., & Norton, N. C. (1985). Does professional training make a therapist more effective? *Psychological Bulletin*, 98, 401-407.
- Beutler, L. E. (1983). *Eclectic psychotherapy: A systematic approach*. New York: Pergamon.
- Bouchard, T. (1984). Twins reared apart and together: What they tell us about human diversity. In S. Fox (Ed.), *The chemical and biological bases of individuality*. New York: Plenum.
- Bower, G. (1983). Affect and cognition. *Philosophical transactions of the Royal Society of London*, 302, 387-402.
- Bowers, K. S. (1966). Hypnotic behavior: The differentiation of trance and demand characteristic variables. *Journal of Abnormal Psychology*, 71, 42-51.

- Boyd, R., Gasper, P., & Trout, J. D. (1991). *The philosophy of science*. Cambridge, MA: The MIT Press.
- Buck, R. (1985). Prime theory: An integrated view of motivation and emotion. *Psychological Review*, 92, 389-413.
- Burns, D. (1980). *Feeling good*. New York: Morrow.
- Campbell, D. T. (1974). Evolutionary epistemology. In P. A. Schilpp (Ed.), *The philosophy of Karl Popper*, 14, (I & II), 413-463.
- Clarkin, J., & Carpenter, D. (1995). Family therapy in historical perspective. In B. Bongar & L. Beutler (Eds.), *Comprehensive textbook of psychotherapy*. New York: Oxford University Press.
- Coddou, F. (1992). Alcances epistemológicos y conceptuales en relación al enfoque sistémico. In R. Opazo (Ed.), *Integración en Psicoterapia*. Santiago, Chile: Ediciones CECIDEP.
- Coloma, J. (1989). Sobre el carácter científico del psicoanálisis. *Terapia Psicológica*, VIII, 7-18.
- Coyne, J. (1982). A critique of cognitions as causal entities with particular reference to depression. *Cognitive Therapy and Research*, 6, 3-14.
- Crits-Christoph (1992). The efficacy of brief dynamic psychotherapy: A meta-analysis. *The American Journal of Psychiatry*, 149, 151-158.
- Damasio, R. (1996). *El error de Descartes*. Editorial Andrés Bello.
- Davies, P. (1993). *The mind of God*. New York: Penguin Books.
- Davison, G. C., & Neale, J. M. (1980). *Psicología de la conducta anormal: Enfoque clínico experimental*. Limusa.
- De Broglie, L. (1963). *Por los senderos de la ciencia*. Madrid.
- Dell, P. (1982). Beyond homeostasis: Toward a concept of coherence. *Family Process*, 21.
- Dillthey, W. (1976). *Selected writings*. Cambridge University Press.
- Dobson, K., & Shaw, B. (1995). Cognitive therapies in practice. In B. Bongar & L. Beutler (Eds.), *Comprehensive textbook of psychotherapy*. New York: Oxford University Press.
- D'Zurilla, T. & Goldfried, M. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology*, 78, 107-126.
- Einstein, A. (1983). *Sobre la teoría de la relatividad*. Sarpe (Original, Amsterdam, 1934).
- Ellis, A. (1977). The basic clinical theory of Rational-Emotive Therapy. In A. Ellis & R. Grieger (Eds.), *Handbook of Rational-Emotive Therapy*. New York: Springer.
- Emmelkamp, P. (1994). Behavior therapy with adults. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change*. New York: John Wiley & Sons.
- Emmelkamp, P., Kuipers, A., & Eggerat, P. (1978). Cognitive modification versus prolonged exposure in vivo: A comparison with agoraphobics as subjects. *Behaviour Research and Therapy*, 16, 33-41.
- * Eysenck, H. J. (1990). Genetic and environmental contributions to individual differences: The three major dimensions of personality. *Journal of Personality*, 58, 245-261.
- Eysenck, H. J. (1994). The outcome problem in psychotherapy: What have we learned? *Behaviour Research and Therapy*, 32, 477-495.
- Fisher, L., Ransom, D., & Terry, H. (1993). The California Family Health Project. *Family Process*, 32.
- Flanagan, B., Goldiamond, I., & Azrin, N. H. (1959). Instatement of stuttering in normally fluent individuals through operant procedures. *Science*, 130, 979-981.
- Forgas, J. (1995). Mood and judgment: The affect infusion model. *Psychological Bulletin*, 117, 39-66.
- Frank, J. D. (1974). Therapeutic components of psychotherapy. A 25 year progress report of research. *The Journal of Nervous and Mental Disease*, 159, 325-342.
- Freud, S. (1948). *Obras completas, Vols. I and II*. Madrid: Editorial Biblioteca Nueva.
- Furth, H. G. (1987). *Knowledge as desire: An essay on Freud and Piaget*. New York: Columbia University Press.
- Garfield, S. (1992a). Eclectic psychotherapy: A common factors approach. In J. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 169-201). New York: Basic Books.

- Garfield, S. L. (1992b). Major issues in psychotherapy research. In D. K. Freedheim (Ed.), *History of psychotherapy: A century of change*, Washington, DC: American Psychological Association.
- Goldberg, C. (1986). *On being a psychotherapist*. New York: Gardner.
- Goldfried, M. R., & Castonguay, L.G. (1992). The future of psychotherapy integration. *Psychotherapy*, 29, 4-10.
- Golub, E. (1996). *Los límites de la medicina*. Editorial Andrés Bello.
- Goncalves, O. F., & Ivey, A. E. (1987). The effects of unconscious presentation of information on the therapist conceptualizations, interventions and responses. *Journal of Clinical Psychology*, 43, 237-245.
- Gorbman, A. (1983). *Comparative endocrinology*. New York: John Wiley & Sons.
- Greenberg, L., & Safran, J. (1984). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive Therapy and Research*, 8, 559-578.
- Greenberg, L., Elliot, R., & Lietaer, G. (1994). Research on humanistic and experiential psychotherapies. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change*. New York: John Wiley & Sons.
- Grossarth-Maticek, R., & Eysenck, H. J. (1990). Prophylactic affects of psychoanalysis on cancer-prone and coronary heart disease-prone probands, as compared with control groups and behavior therapy groups. *Journal of Behavioral Therapy and Experimental Psychiatry*, 21, 91-99.
- Grünbaum, A. (1979). La causalidad y la ciencia de la conducta humana. In R. Ulrich, T. Stachnik, & J. Mabry (Eds.), *Control de la conducta humana*. Trillas.
- Guidano, V. (1987). *Complexity of the self*. New York: Guilford Press.
- Guidano, V. F. (1988). A systems, process-oriented approach to cognitive therapy. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies*. (pp. Xx-xx). New York: Guilford Press.
- Guidano, V., & Liotti, G. (1983). *Cognitive processes and emotional disorders*. New York: Guilford Press.
- Gurman, A. S., & Kniskern, D. P. (1978). Research on marital and family therapy: Progress, perspective and prospect. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change*. New York: John Wiley & Sons.
- Hadley, M. E. (1984). *Endocrinology*. Englewood Cliffs, NJ: Prentice-Hall.
- Hayek, F. A. (1952a). *The counter-revolution of science*. Glencoe, IL: Free Press.
- Hayek, F. A. (1952b). *The sensory order*. Chicago: University of Chicago Press.
- Hayek, F. A. (1967). *Studies in philosophy, politics and economics*. University of Chicago Press.
- Hayek, F. A. (1978). *New studies in philosophy, politics, economics, and the history of ideas*. Chicago: University of Chicago Press.
- Haynes, S., Spain, H., & Oliveira, J. (1993). Identifying causal relationships in clinical assessment. *Psychological Assessment*, 3, 281-291.
- Hilgard, E. R. (1952). Experimental approaches to psychoanalysis. In E. Pumpian-Mindlin (Ed.), *Psychoanalysis as science*. New York: Basic Books.
- Hollon, S., & Beck, A. T. (1994). Cognitive and cognitive-behavioral therapies. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 428-466). New York: John Wiley & Sons.
- Husserl, E. (1931). *Ideas: General introduction to pure phenomenology*. London.
- Izard, C. E., Kagan, J., & Zajonc, R. B. (1984). *Emotion, cognition and behavior*. XX: Cambridge University Press.
- James, W. (1984). Absolution and empiricism. *Mind*, 281-286.
- Jaspers, K. (1963). *General psychopathology*. Chicago: University of Chicago Press.
- Kanfer, F., & Phillips, J. (1970). *Principios de aprendizaje en la terapia del comportamiento*. Trillas.
- Kanfer, F., & Saslow, G. (1965). Behavioral analysis: An alternative to diagnostic classification. *Archives of General Psychiatry*, 12, 529-538.
- Karasú, T. B. (1986). The specificity versus nonspecificity dilemma: toward identifying therapeutic change agents. *American Journal of Psychiatry*, 143, 687-695.

- Karon, B., & Widener, J. (1995). Psychodynamic therapies in historical perspective. In B. Bongar & L. Beutler (Eds.), *Comprehensive textbook of psychotherapy*. Oxford University Press.
- Kavanagh, D., & Bower, G. (1985). Mood and self-efficacy: Impact of joy and sadness on perceived capabilities. *Cognitive Therapy and Research*, 9, 507-525.
- Kegan, R. (1982). *The evolving self: Problem and process in human development*. Cambridge, MA: Harvard University Press.
- Kendler, K. S., & Robinette, C. D. (1983). Schizophrenia in the National Academy of Sciences—National Research Council Twin Registry: A 16-year update. *American Journal of Psychiatry*, 140, 1551-1563.
- Kennedy, R., & Craighead, E. (1982). *Recall of positive and negative feedback by depressed and non-depressed anxious university students*. Unpublished manuscript, Pennsylvania State University.
- Kernberg, O. (1989). An ego psychology object relations theory of the structure and treatment of pathologic narcissism: An overview. *Psychiatric Clinics of North America*, 12, 723-729.
- Kihlstrom, J. F. (1981). On personality and memory. In N. Cantor & J. F. Kihlstrom (Eds.), *Personality, cognition and social interaction*. Princeton, N.J.: Princeton University Press.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kruglanski, A. W. (1990). Lay epistemic theory in social-cognitive psychology. *Psychological Inquiry*, 1, 181-197.
- Kuhn, T. S. (1962) *The structure of scientific revolutions*. Chicago: University of Chicago Press.
- Lazarus, A. (1976). *Multimodal Behavior Therapy*. New York: Springer.
- Lazarus, A. (1989). *The practice of multimodal therapy*. New York: Springer.
- Lazarus, A., Beutler, L., & Norcross, J. C. (1992). The future of technical eclecticism. *Psychotherapy*, 29, 11-20.
- Lersch, P. (1962). La estructura de la personalidad. Editorial Scientia.
- Leuner, H. (1984). *Guided affective Imagery*. New York: Thieme-Straton.
- Leshner, A. (1978). An introduction to behavioral endocrinology. New York: Oxford University Press.
- LeDoux, J. E. (1986). The neurobiology of emotion. In J. E. LeDoux & W. Hirst (Eds.), *Mind and brain: Dialogues in cognitive neuroscience*. Cambridge University Press.
- Llinas, R. (1986). Alcances epistemológicos. In G. Klimovsky (Ed.), *Opiniones sobre la Psicología*. Ediciones ADIP.
- Lorenz, E. N. (1963). Deterministic non-periodic flows. *Journal of Atmospheric Science*, 20, 131-141.
- Madigan, R. J., & Bollenbach, A. K. (1986). The effects of induced mood on irrational thoughts and views of the world. *Cognitive Therapy and Research*, 10, 547-562.
- Mahoney, M. (1983). *Cognición y modificación de la conducta*. México: Editorial Trillas.
- Mahoney, M. (1991). *Human change processes*. New York: Basic Books.
- Marchetti, A. M. (1988). La re-estructuración afectiva en la práctica clínica. In R. Opazo (Ed.), *Los Afectos en la Práctica Clínica*. Santiago, Chile: Editorial Universitaria.
- Marks, I. (1987). *Fears, phobias and rituals*. New York: Oxford University Press.
- Markus, H. (1977). Self-schemata and processing information about the self. *Journal of Personality and Social Psychology*, 35, 63-78.
- Marx, M., & Hillix, W. (1969). *Sistemas y teorías psicológicas contemporáneos*. Paidós.
- Maruyama, M. (1963). The second cybernetics: Deviation-amplifying mutual causal processes. *American Scientist*, 51, 164-179.
- Maruyama, M. (1977). Heterogenistics: An epistemological restructuring of biological and social sciences. *Acta Biotheoretica*, 26, 120-136.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50.
- Maturana, H. (1990). *Biología de la cognición y epistemología*. Ediciones Universidad de la Frontera.
- Maturana, H. (1992). El hombre y la posibilidad del conocimiento objetivo. In R. Opazo (Ed.), *Integración en Psicoterapia*. Santiago, Chile: Ediciones CECIDEP.
- Maturana, H. and Varela, F. (1984). *El árbol del conocimiento*. Editorial Universitaria.
- McGinnies, E. (1949). Emotionality and perceptual defense. *Psychological Review*, 56, 244-251.

- Meichenbaum, D., & Gilmore, J. B. (1984). La naturaleza de los procesos inconcientes: Una perspectiva cognitivo-conductual. *Terapia Psicológica*, 4, 7-22.
- Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.
- Norcross, J. C., & Napolitano, G. (1986). Defining our journal and ourselves. *International Journal of Eclectic Psychotherapy*, 5, 249-255.
- Opazo, R. (1986). Terapia cognitivo-conductual en trastornos de personalidad. *Revista de Psiquiatría*, 10, 129-137.
- Opazo, R. (1988). Los afectos desde una perspectiva conductual-integral. In R. Opazo (Ed.), *Los afectos en la práctica clínica*. Santiago, Chile: Editorial Universitaria.
- Opazo, R. (1992a). Postulados básicos de una psicoterapia integrativa. *Revista Argentina de Clínica Psicológica*, Vol 1, No. 2.
- Opazo, R. (1992b). Fuerzas de cambio en psicoterapia: Un modelo integrativo. In R. Opazo (Ed.), *Integración en Psicoterapia*. Santiago, Chile: Ediciones CECIDER.
- Opazo, R. (1995). *Potenciando la efectividad de la psicoterapia*. Paper presented at XXV Congreso Interamericano de Psicología. San Juan, Puerto Rico.
- Ost, L., & Hughdall, X. (1981). Acquisition of phobias and anxiety response patterns in clinical patients. *Behaviour Research and Therapy*, 19, 439-447.
- Palmer, D. S. (1971). Is a scientific revolution taking place in psychology? *Science Studies*, 1, 135-155.
- Parkinson, L., & Rachman, R. (1980). Are intrusive thoughts subject to habituation? *Behaviour Research and Therapy*, 18, 409-418.
- Paul, G., Eriksen, C. W., & Humphries, L. G. (1962). Use of temperature stress with cool air reinforcement for human operant conditioning. *Journal of Experimental Psychology*, 64, 329-335.
- Perls, F. (1976). *Enfoque Gestáltico y testimonios de terapia*. Editorial Cuatro Vientos.
- Plomin, R. (1990). The role of inheritance in behavior. *Science*, 248, 183-188.
- Poincaré, H. (1929). *The foundations of science*. New York: Science House.
- Prigogine, I. (1980). *From being to becoming: Time and complexity in the physical science*. San Francisco: W. H. Freeman.
- Prochaska, J., & DiClemente, C. (1992). The transtheoretical approach. In J. Norcross, & M. Goldfried, (Eds.), *Handbook of psychotherapy integration* (pp. 300-334). New York: Basic Books.
- Reisenzein, R. (1983). The Schachter theory of emotion: Two decades later. *Psychological Bulletin*, 94, 239-264.
- Reiss, D., Plomin, R., & Hetherington, M. (1991). The separate social worlds of teenage siblings. In M. Hetherington, D. Reiss, & R. Plomin (Eds.), *The separate social worlds of siblings*. Hillsdale, N. J: Lawrence Erlbaum Associates.
- Rogers, C. R. (1966). *Psicoterapia centrada en el cliente: Práctica implicaciones y teoría*. Buenos Aires: Editorial Paidós.
- Rosenbaum, R., & Dyckman, J. (1995). Integrating self and system: An empty intersection? *Family Process*, 34.
- Rosenzweig, M., & Leiman, A. (1993). *Psicología fisiológica*. New York: McGraw-Hill.
- Rushton, P. (1989). Genetic similarity, human altruism, and group selection. *Behavioral and Brain Sciences*, 12, 503-559.
- Russell, B. (1948). *Human knowledge*. New York: Simon & Schuster.
- Sandler, J., & Davidson, R. (1977). *Psicopatología*. Trillas.
- Schulman, P., Keith, D., & Seligman, M. E. P. (1993). Is optimism heritable? A study of twins. *Behaviour Research and Therapy*, 31, 569-574.
- Shevrin, H. (1973). Brain wave correlates of subliminal stimulation, unconscious attention, primary and secondary process, thinking and repressiveness. *Psychological Issues*, 8, 56-87.
- Skinner, B. F. (1953). *Science and human behavior*. New York: Macmillan.
- Smith, M. B. (1978). Perspectives on selfhood. *American Psychologist*, 37, 526-532.
- Spearman, C. E. (1931). *The creative mind*. Appleton: New York.
- Spence, D. (1984). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: Norton.

- Strupp, H., & Hadley, S. W. (1979). Specific versus nonspecific factors in psychotherapy: A controlled study of outcome. *Archives of General Psychiatry*, 36, 1125-1136.
- Svarteg, M., & Stiles, T. C. (1991). Comparative effects of short-term psychodynamic psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 59, 704-714.
- Teasdale, J. D., & Bancroft, J. (1977). Manipulation of thought content as a determinant of mood and corrugator electromyographic activity in depressed patients. *Journal of Abnormal Psychology*, 86, 235-241.
- Tellegen, A., Lykken, D., Bouchard, T., Wilcox, K., Segal, N., & Rich, S. (1988). Personality similarity in twins reared apart and together. *Journal of Personality and Social Psychology*, 54, 1031-1039.
- Velten, E. (1968). A laboratory task for induction of mood states. *Behaviour Research and Therapy*, 6, 473-482.
- Von Glasersfeld, E. (1984). *An introduction to radical constructivism*. In P. Watzlawick (Ed.), *The invented reality*. New York: Norton.
- Wachtel, P. (1977). *Psychoanalysis and behavior therapy: Toward an integration*. New York: Basic Books.
- Wachtel, P. L. (1987). *Action and insight*. New York: Guilford Press.
- Watzlawick, P. (1979). *¿Es real la realidad?* Barcelona: Herder.
- Weinter, W. B. (1977). A conceptual framework for cognitive psychology: Motor theories of mind. In R. Shaw and J. Bransford (Eds.), *Perceiving, acting, and knowing*. Hillsdale, NJ: Erlbaum.
- Williamson, C. (1975). *The changer and the changed*. Olivia Record.
- Wolfe, B. E. (1995). Self pathology and psychotherapy integration. *Journal of Psychotherapy Integration*, 5, 293-312.
- Wolpe, J., & Rowan, V. (1989). Classical conditioning and panic disorder: Reply to Sanderson and Bock. *Behaviour Research and Therapy*, 27.
- Zajonc, R. B. (1980). Feeling and thinking: Preferences need no inferences. *American Psychologist*, 35, 151-175.
- Zajonc, R. B. (1984). On the primacy of affect. *American Psychologist*, 39, 117-123.