

# Behavior Therapy

*Iver Hand*

## I. Introduction

Behavior therapy (BT) has come of age for quite a while now. It has become an important treatment method in the health care systems in Europe and North America. Its acceptance is rising in Asian and South East Asian countries and in South America.

Since the 1950s, BT has gone through quite different developmental stages, generating a variety of "sub-schools". Yet, despite of their differences there are strong unifying boundaries, like: 1. Constant striving for empirical evaluation of theoretical and treatment concepts on the basis of experimental psychology as well as bio-social research; 2. Continuous development and evaluation of new treatment strategies and technologies for a growing number of psychiatric disorders ("evidence-based" practice).

In contrast to psychodynamic and psychoanalytic treatment schools, BT has not developed a "Menschenbild" (specific view of the human nature) of its own. This is an advantage from the point of view of some and a disadvantage for others. Regarding the transcultural acceptability of BT, on the first meeting of the Asia Pacific Association of Psychotherapists (1996 on Bali), several speakers emphasized, that BT can be much easier integrated into cultures with Islamic, Buddhist or Taoist religious tradition than psychoanalysis with its requirement to share specific views about the human nature which compete with religious views. In Europe and North America – particularly from the "humanistic" varieties of psychotherapy – BT sometimes has been accused of being a manipulative social technology because of its lack of a treatment-specific "Menschenbild".

Without an ideological position, one would assume, that any treatment tool – from the surgeon's knife via invasive diagnostic procedures via medication to psychotherapeutic interventions – can be expertly used for the benefit of a patient as well as it may be abused for purposes of the abuser. Therefore, some kind of social control needs to be exercised to protect patients from such an abuse.

It is hoped that the following brief account of the development, the current status and some future trends of and in BT will reduce misunderstandings and raise interest in a stimulating exchange of experience and opinions between psychotherapists of different orientation – in a positive sense of globalized psychotherapy!

## 2. Historical Development

Clinical behavior therapy started in the late 50s/early 60s in South Africa, England and the United States. The South African M.D.s. Wolpe and Marks and the psychologists Rachman, Lazarus, and Wilson soon became very influential in Great Britain and the USA respectively. Several of the early "fathers" of BT had originally received full or partial training in psychoanalytic therapies (e.g. Wolpe). This holds also true for some cognitive therapists who joined BT later (e.g. Beck, Ellis). BT was accepted quite early in prominent institutions of psychiatry and of psychology to an equal extent, whereas later on the impact on psychology exceeded by far that on psychiatry. Only lately, its integration into psychiatry is on the rise again, with an increase of BT-trained psychiatrists, and a growing number of psychologists working in psychiatric institutions. In the USA, post Second World War psychiatry was strongly influenced by psychodynamic and neo-analytic psychotherapies for at least two decades, then turning towards a predominant biological orientation. In the last decade in international psychiatry the strongest competition for the biological medication orientation has come from BT. More and more studies show, that in a large variety of psychiatric disorders, long term effects of BT treatment are much better than those of pure medication (e.g. in anxiety disorders, obsessive-compulsive disorder, depression etc.), and that medication effects over follow-up are much improved by additional BT (e.g. in schizophrenia). Thus, in many disorders BT shows a much better cost-effectiveness compared to drug treatment.

Competition between biological and behavioral treatments has led to the danger of exaggerated claims of success for each treatment, but has also led to very powerful bio-behavioral co-operation for disorders where this is essential for patients' maximum benefit (e.g. for schizophrenia in Liberman et al., 1998). Recently, the German journal "Verhaltenstherapie" devoted a whole issue to the discussion whether and when the individual or combined application of BT and drug treatment is indicated in schizophrenia, depression, anxiety disorders, and obsessive-compulsive disorder (Linden, 2001).

Early behavior therapy was mainly based on "classical conditioning", e.g. Systematic Desensitisation (Wolpe, 1954; using "reciprocal inhibition as the main basis of psychotherapeutic effects"), which finally led to his influential book on "psychotherapy by reciprocal inhibition" (1958). Essentially, it was hypothesized that anxiety-inducing stimuli lose their specific impact when repeatedly presented together with stimuli that inhibit the "anxiety response" (like relaxation, sexual responses and assertive responses). At approximately the same time, in London at the Maudsley Hospital / Institute of Psychiatry and at the Middlesex Hospital Rachman, Marks, Gelder, Mathews and Meyer developed an exposure treatment for anxiety disorders and obsessive compulsive disorder. This procedure was also derived from classical conditioning concepts, but postulated extinction as the result of continuous exposure to anxiety provoking stimuli. With regard to patients' anxiety, this was the opposite approach to that of Wolpe – deliberately inducing a high anxiety/panic state, which in Wolpe's procedure was to be avoided. Thus it was also an extremely emotion-oriented technique, a fact which only some 15 years later received adequate appraisal (review and discussion in Hand, 2000).

In the USA, the second influential school besides Wolpe was the "Skinnerian approach" (Skinner, 1974), an operant conditioning paradigm. Behavior was interpreted as a consequence of its positive or negative reinforcement by the (social) environment. An early clinical application occurred as "token economy" (money reward) system with chronic schizophrenic patients (Ayllon and Azrin, 1958).

The rise of BT in those years was partly supported by Eysenck (1952) with his strong and partly polemic condemnation of the other psychotherapies, because of the lack of scientific evidence for their effectiveness.

The first author who established the term "Behavioural Therapy" in a scientific journal was Lazarus (1958) in the South African Medical Journal. In the 1970s Lazarus became the father of multimodal behavior therapy, which up to now had the strongest influence on clinical BT. He claimed 7 treatment-relevant modes for an individual treatment design: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and biological factors (review of the development of his "school" by Lazarus, 2001).

This multimodal approach has been developed much further and into different directions. It is the main mode of BT in German speaking countries (e.g. Hand, 2002).

Another important influence in the development of BT came from "Self-Psychology". Authors like Bandura with his concept of "self-efficacy" (1977), Meichenbaum with his "self instruction-training" (1975) and Kanfer with "self-management" or "self-regulation" (1970) were prominent representatives of this approach within behavior therapy. Beck (1967) with his "Cognitive Therapy" (CT) and Ellis (1973) with his "Rational-Emotive Therapy" (RET) developed their techniques originally outside BT, out of dissatisfaction with their previous psychodynamic training. After a period of controversy, the incorporation of both, CT and RET, into BT made most people happy. Actually, these authors are often regarded the main initiators of the "cognitive revolution" in behavior therapy. This "cognitive revolution" was in one way necessary in order to draw more attention to cognitive processes for behavioral change, and on the other hand it was a severe backlash in the conceptualization of behavior therapy for quite some years. The early school of Cognitive Therapy (CT) and Cognitive Behavior Therapy (CBT) was as much guided by quasi-religious believes (the "cognitive church", Emmelkamp, 2001) as had been the case with "radical behaviourism" of the Skinnerian school. "Cognitivism" was as narrow a concept as behaviorism. For many clinical behavior therapists the rising popularity of CT came as a real surprise. The clinically much more adequate multimodal approach nevertheless grew continuously among clinical behavior therapists who were less interested in ideological debates. Currently, the vast majority of clinical behavior therapists agrees that behavioral, cognitive, physiological and emotional variables are equally important in behavior therapy. They claim (e.g. most of the 13 invited international authors in Pomini and Phillipot, 2001) that there are now no major differences between BT and CBT. Nevertheless, the most popular term for BT still is "Cognitive Behavior Therapy" (CBT). This is unfortunate, because in the meantime there has also been a strong trend towards increased consideration of emotions and emotional processing in the context of BT and CBT (e.g. Dobson, 1988; reviews in Pomini and Phillipot, 2001). Are we therefore now to label BT as "Cognitive-Behavioral-Emotional Behavior Therapy" (CBEBT) – and maybe in a couple of years, as changes continue to happen, add some

more adjectives? It might be more desirable to return to the original term of "Behavior Therapy", a name used by journals like "Behavior Therapy" or "Verhaltenstherapie", and recommended by associations like the Association for the Advancement of Behavior Therapy (AABT) in the USA. This could remain the quality label for a treatment approach that continuously modifies itself, regarding its strategy as well as its techniques, according to new empirical and research evidence.

Some prominent early behavior therapists now promote their new, "holistic" approaches under new names. Mahoney for instance (2000, 2001) claims that his "constructivism" is an "integrative approach that embraces the wisdom of the cognitive and behavioral approaches as well as that of existential-humanistic, biological, and psychodynamic perspectives". As for all such intellectually stimulating new panaceas, evidence for their effectiveness is lacking.

### 3. Current Status

Today, clinical behavior therapy mostly applies a multimodal diagnostic and treatment concept. It consists of a basic strategy as well as of a broad variety of disorder-specific techniques for individual, couple/family or group application.

According to the individual patients' needs, any or several of the following interventions will be applied:

- Biographical and motivational analyses with the patient and, wherever feasible, relatives or spouses.
- Behavioral analyses of the origin, the causes and the maintaining variables, as well as the current status of the disorder(s) to be treated, including a micro-analysis of the actual symptom behaviors.
- Assessment of the intraindividual and the interactional functions of symptom behaviors.
- Derivation of a causal – hierarchical order based on symptom behavior, comorbidity, "other problems in life" etc. to build a first clinical hypothesis. The multimodal treatment plan is derived from this hypothesis and not from DSM or ICD diagnoses.
- Symptom-directed techniques to reduce or eliminate maladaptive symptom behavior, like: exposure in-vivo and in fantasy for phobias, panic attacks, obsessive compulsive disorder (OCD); relaxation procedures; specific cognitive techniques to modify dysfunctional beliefs in depression, anxiety disorders, OCD etc.
- Deficits-directed techniques and procedures to increase skills, like: social skills training; problem solving training etc.
- Application of treatment techniques or symptom-specific strategies in disorder-specific group treatments like groups for: agoraphobia; panic disorder; OCD; specific phobias; social phobia/deficits, and the like. Most of these group programmes have been very well investigated. Additionally to these disorder-specific groups, there are those who emphasize interactional learning, like "interactional problem solving groups".

- Psychoeducational teaching for patients and relatives to reduce information deficits regarding the disorders to be treated, like: schizophrenia; eating disorders; OCD. Actually, a Psychoeducational introductory part is nowadays included in BT for most disorders.
- Assessment and, possibly, modification of motivation for change in patients and their immediate social surroundings (particularly important in behavioral excess disorders, that consist of an exaggeration of normal, every day behavior – like washing, eating, controlling, having sex etc.).

To illustrate the strategy of behavior therapy a little more, the following tabs. and graphs, deducted from our mode of multimodal BT (Strategic-Systemic Multimodal BT), may be useful (further details in Hand, 2002).

Basically, the principles of behavior therapy and behavior modification can be applied for:

- Prevention of disorders (“health education”)
- Reduction or even removal of disorders (incl. relapse prevention)
- Training of coping strategies for chronic psychiatric, psychosomatic, or somatic disorders.

The extend to which these are used depends on the individual patient’s condition and motivation for change.

A pragmatic operationalization of problem-areas, type of disturbance, type of intervention, and aim of intervention is shown in Tab. 1

The initial therapist-patient contact (intake interview) is usually characterised by three stages:

1. “Passive”-exploratory phase:  
Therapist listening, encouraging free, spontaneous, and self-exploratory talk of patient. Main verbal activity from patient, who “controls” information output.
2. “Active-directive” exploratory phase:  
First hypotheses from phase 1 are now systematically screened and evaluated by therapist. Directive information-gathering, therapist “controls” information output.
3. “Co-operative”, goal-oriented phase:  
Therapist and patient compare their problem hierarchies. Attempt to develop a mutually acceptable, initial hypotheses from which to derive a hierarchical, first treatment strategy.

These interviews may be conducted:

- only with patient
- also with relative / spouse
- together with patient and relative / spouse

Before a first treatment package (of interventions) is developed – with active participation of the patient – It is useful to check whether the following 10 decisive assessments have been possible:

Tab. 1. Problem-Areas, Kind of Disturbance and Interventions

Problem Areas	Kind of Disturbance	Intervention	Aim of Intervention
<i>Behavioral Disorders</i>	<i>Symptom Behaviors</i> Qualitatively new, "non-normal" behavior	<i>Reduction of Behavior</i>	Establishment of <i>Freedom for Action</i>
	<i>Excessive Behaviors</i> excessive "normal" behavior, c.f.: eating, cleaning, gambling		
<i>Behavioral Deficits</i>	<i>Deficits in Basic Behaviors</i> Primary or secondary deficits; c.f.: social competence; problem solving strategies; distress-coping	<i>Establishment of Behavior</i>	Establishment of <i>Competence for Action</i>
<i>Blockage of Perception</i>	<b>Paratactic Perception</b> Stereotype mis- perception of others	Historical orientation: <b>Induction of Transference-Neurosis</b>	Establishment of <i>Freedom for Perception</i>
	<i>Collusion</i> Complementary dyadic inter- dependence → "Interaction- Personality"	"Here and now" orientation: <b>Communication Training</b>	
<i>Blockage of Action</i>	<b>Conflict-Ambivalence</b> Partly subconscious "Intention" for illness rather than alternative behaviors. Common cause: conflict bet- ween emotional needs and rational beliefs	<ul style="list-style-type: none"> <li>• Interpretation (Analysis)</li> <li>• Systemic Functional Analysis (Behavior Therapy)</li> <li>• Paradoxical/Provocative Prescriptions (Family Therapy)</li> </ul>	Establishment of <i>Motivation for Action</i>

Tab. 2. Ten Decisive Assessments in Strategic-Systemic Behavior Therapy

<ul style="list-style-type: none"> <li>• Internal or external <i>motivation</i> for treatment and change</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Microanalysis of symptom-behaviors</i> (including test diagnostic assessments)</li> </ul>
<ul style="list-style-type: none"> <li>• Directly communicated or indirectly deducible <i>problem-areas other than the primary symptom</i> complaints</li> </ul>	<ul style="list-style-type: none"> <li>• Symptom-responses or other specific <i>responses in earlier bio-social</i> developmental stage (puberty, leaving parental household, leaving school, first intense dyadic relationship etc.)</li> </ul>
<ul style="list-style-type: none"> <li>• Differentiation of <i>causal and maintaining variables</i> for <i>symptom-behaviors</i> and problemareas, and their interactions in the past and at present time (biographical behavioral analyses)</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Social competence</i> (in groups as well as in dyadic relationships) and <i>emotional expressiveness</i> (c.f. actual patient-therapist interaction)</li> </ul>
<ul style="list-style-type: none"> <li>• Differentiation of <i>intraindividual and interpersonal functions</i> of the identified symptom-behaviors and problem-areas</li> <li>• <i>Consequences</i> to be expected from <i>reduction</i> (removal) of <i>symptoms</i> – patient's and therapist's account</li> </ul>	<ul style="list-style-type: none"> <li>• Intensity and quality of <i>self-induced "alter native" behaviors</i> (to illness-behavior) – in the past and at present</li> <li>• Similar assessments (as above) of <i>patient's most important other(s)</i>.</li> </ul>

For the individual treatment design, resulting from all these analyses, various BT approaches have been developed (see literature; some recent CBT textbooks are by Hawton et al., 1989 – 2<sup>nd</sup> edition in print; Needleman, 1999).

### 3.1 Reimbursement of Behavior Therapy by insurance companies

The most advanced and unfortunately also rather bureaucratic system with regard to reimbursement of psychotherapy and behavior therapy has been established in Germany. Up to 80 hours of BT may be paid by the insurance companies, provided: 1. The therapist has successfully completed a Government acknowledged training; 2. The therapist's report on treatment progress and further treatment goals has been approved by an external reviewer ("Gutachter"), after 25, 45, and 60 sessions of 50min. duration. Under certain conditions one or two sets of 20 sessions may be additionally approved.

In 1999 some 244000 patients received outpatient behavior therapy (short- or long term), provided by about 6900 behavior therapists (2/3 of those psychologists); (details on the quantitative development of behavior therapy in Germany compared to psychodynamic treatment in Hand, 2001). Another German speciality is the opportunity to receive behavior therapy or psychodynamic psychotherapy in specialised "psychosomatic clinics", spread all over the country. Here, the patient may get 3 to 12 weeks of specialised inpatient treatment, occasionally for an even longer period and sometimes on several occasions over their live span. Reimbursement will either be from the health insurance companies or the governmental pension funds. There is quite a controversial debate in Germany regarding

the usefulness of this system compared to the still underdeveloped outpatient services. More and more clinics have built up cost effectiveness research.

In contrast, in the USA and Canada most insurance companies will only reimburse 6–12 sessions of BT. Most American publications on treatment research in BT describe programmes that seem to be adjusted to the reimbursement rules, i.e. e. consisting of up to 12 sessions of BT spread over 8–12 weeks. This is also the standard in comparative research studies BT versus drug treatment. We cannot yet answer the question whether the North American system provides a (much) too short treatment opportunity for severely ill patients or whether the German system provides a treatment that is (much) too long (details regarding e.g. OCD research in Hand et al., 2001). Such studies would particularly need long term follow-ups, which in the US literature are the exception rather than the rule.

### 3.2 Therapists' training

Several national behavior therapy associations have long established training programmes for behavior therapists. These vary in content, intensity and costs quite substantially. It appears that training becomes more intense and time- and money-consuming, the more subsequent payment of therapists is Government regulated.

The European Association of Cognitive and Behavioral Therapies has established a "standing committee on training" that has published (in the Internet) "core training standards" as recommendation for a desirable minimum level of qualification. These include: 450h of theory (200 of those via personal teaching by a trainer); 200h of supervised assessment and therapy; a minimum of 8 patients, with at least three different disorders being treated under supervision. "Personal therapy/development" (Selbsterfahrung) is required in some European countries, but not (yet) in this list of minimum requirements. Qualification as supervisor is possible after more than 5 years of qualified practice and additional training. Continuous professional development after qualification is recommended.

In Germany, with the most comfortable reimbursement system for patients and therapists, training quite exceeds these minimum requirements:

Altogether, 4220h of training in 3 (full term) to 5 (part term) year courses for psychologists or MDs. 600h (400 in seminars) of theory; 600h of supervised treatment of at least 6 patients, plus 150h additional hours of supervision for these treatments. 120h of "self-development" (Selbsterfahrung). 950h preparation of treatment session, documentation etc. Direct costs for this training are around 1200 ff. Additionally to the above mentioned trainings, the "therapists in the make" have to spend 12.000h in a psychiatric hospital (usually for about 1 year) and 600h on an internship in a qualified behavior therapy practice. Exams have to be taken in the middle and at the end of this training course. Training institutes need government acknowledgement. For psychologists, since 1999 the law for psychological psychotherapists provides detailed rules for this training and for the qualification of the institutes. As a result, psychological psychotherapists gain a similar legal position as medical doctors (with the exception e.g. for prescribing drugs). Patients are allowed to contact

the psychologists for up to 5 hours, before being referred to an MD (by the psychologist) for a check-up of somatic risk factors for psychotherapy.

### 3.3 International Behavior Therapy Associations

- The Association for the Advancement of Behavior Therapy (AABT), the earliest BT Association, founded in 1996 in the USA (then labelled: Association for the Advancement of Behavioral Therapies). Contact via: [www.aabt.org](http://www.aabt.org).
- The European Association of Cognitive and Behavioral Therapies (EABCT) was founded in 1971 (then labelled: European Association of Behavior Therapy, EABT). It is a rather loose congregation of the national European Associations. The EABCT now represents 27 countries. Some of those are represented by 3 (like Germany) or 2 (like Austria Belgium, Finland, France, Greece, Iceland, and Italy) associations. Memberships are in the range from 25 to more than 3000. Main activities have been in the organisation of the European CBT conferences that have been held in most European countries. The 2003 European Conference will be in Prague: [www.pcp.lf3.cz/eabct](http://www.pcp.lf3.cz/eabct). Contact EABCT via: [www.eabct.com](http://www.eabct.com). The website of the EABCT also provides the internet addresses of its member-associations.

## 4. Future direction

Prediction of the future direction of BT (or any other treatment mode) is necessarily highly speculative. Nevertheless, there are a number of controversial issues to be resolved in the years to come:

- Which type of BT for which type of patient regarding: (multimodal) content; duration (hours to months or years); application in an out- or in-patient, individual or group-setting.
- The relative effectiveness of BT alone, drug treatment alone, and their combination in different disorders.
- Relevance of behavioral pharmacology (drug design according to receptor-affinity) as behavior specific rather than disorder specific drug approach for BT interventions.
- The trend for manualization of BT and psychotherapies for research purposes (comparative research with drug treatments), and in the training of therapists. Relative importance of standardised versus individualized treatment application.
- Improvement of treatment effectiveness for the more severe disorders. This includes thorough analyses of treatment failures (e. g. Foa and Emmelkamp, 1983).
- Adequate operationalization of "evidence" in "evidence-based" recommendations for specific interventions.
- Necessary amount of theory, supervision, and self-development in the training of behavior therapist.
- BT-specific training (general strategy of BT, including symptom directed techniques) – or: disorder-specific training (BT plus medication; currently popular in psychiatry, where it better fits the concepts of biological psychiatry and medication).

- Payment or reimbursement of BT by patients themselves, private insurance companies or government agencies. In Germany, where currently the most comfortable reimbursement system has been established, payment per hour by the insurance companies has recently dropped so much, that in several regions therapists cannot make their living from treatment only. Will BT/Psychotherapy remain a part of the medical care as it is in some countries, or will it in the long run become in most countries a private enterprise of the patient again.
- Unified versus diversified behavior/psychotherapy. Some professionals dream of one single, unified psychotherapy, comprising all effective ingredients from a variety of treatments schools. Yet, this development seems quite unlikely to succeed, as even within the existing "schools" there is a continuous strong trend for the creation of divergent "sub-schools". Desire for personal and professional promotion and expansion – besides gifted talent – seems to nourish this process indefinitely. Alternatively, all of the competitors would have to agree, that one of them is the "god-like" winner and inventor of the one mode of a unified psychotherapy which they all have been converted to. Billions of Dollars/Euros of research money would be needed to then demonstrate its superior effectiveness in "evidence-based psychotherapy". Realistically – and luckily so – we all will be challenged with new and pseudo-new approaches in our fields. May the exchange across boundaries further improve.

## 5. Literature

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# Globalized Psychotherapy



World Council of Psychotherapy

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