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Awareness Integration: A New Therapeutic Model

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ABSTRACT: *Awareness Integration (AI) is a new model in the field of psychotherapy which synthesizes numerous concepts from cognitive, behavioral, emotional, and body-mind theories. AI aims to enhance self-awareness, increase self-esteem, release past traumas and psychological blocks, reduce symptoms of anxiety and depression, and promote a clear, realistic, and positive attitude in order to learn and implement new skills for an effective, productive, and functional life. This model allows for release and then integration through flexibly structured questions and expansive interventions that connect core beliefs, emotions, locations in the body where emotions are stored and relevant/original memories. A pilot study indicated a 76% decrease in depression, a 60% decrease in anxiety, a 43% increase in self-esteem, and a 20% increase in self-efficacy after taking part in AI therapy.*

Key words: *Awareness; integration; depression; anxiety; self-esteem; self-efficacy; responsibility; accountability; result oriented; goal oriented; mental illness; mental health; psychology; counseling; psychology theory; psychology models; psychology interventions; cognitive therapy; emotion therapy; body and mind therapy.*

AWARENESS INTEGRATION: A NEW THERAPEUTIC MODEL

Awareness Integration (AI) is a multi-modality psychotherapeutic model that enhances self-awareness, releases past traumas and psychological blocks, and promotes clarity and positive attitudes. The AI model was created by synthesizing information and techniques from previous models such as Cognitive Behavioral Therapy (CBT), Existential Therapy, Person-Centered Therapy, Emotion-Focused Therapy (EFT), and Mind-Body Therapy (MBT), as well as Eye Movement Desensitization and Reprocessing (EMDR) and Hypnosis. The AI model incorporates various aspects of these treatments into one efficient, open-structured model that encompasses all aspects of the human experience in order to maximize its effectiveness and create enduring results.

Cognitive Behavioral Therapy understands psychological disorders in terms of mechanisms of learning and information processing (Hazlett-Stevens and Craske, 2002). CBT treats behavior as a function of internal and external conditions. It defines behavior as lawful, meaning it can be better understood once its function is known. The goal of CBT is to achieve change by means of new learning experiences that overpower prior maladaptive learning and information processing (Hazlett-Stevens and Craske, 2002). Schemas, or networks of information that dictate how people think about things and interpret the world, form in childhood and adolescence and can activate later in life. This may result in behavioral patterns in those with mental disorders (Neale and Davidson, 2001). Awareness Integration makes use of this theory of behavioral schemata to explain how people create patterns of maladaptive coping mechanisms out of perceptions; AI operates with the intention of challenging clients' beliefs and behaviors based on an understanding of how the client has developed schemata.

Awareness Integration also draws from Rational Emotive Behavior Therapy (REBT), a form of Cognitive Behavioral Therapy. One of the goals of REBT is to help clients understand their role in shaping and controlling their emotions and empowering them to lead a happier and more fulfilling life (Ellis, 2001). AI utilizes this essence of the ability to intensify or calm emotions, be in control, understand one's own rationale to set up a system of behavior to change existing patterns.

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Another form of psychotherapy that Awareness Integration draws from is Emotionally Focused Therapy (EFT). EFT is a brief therapy grounded in attachment theory (Palmer-Olsen, Gold and Woolley, 2011). EFT understands emotions as intrinsically important to an individual's self-experience, both in adaptive and maladaptive functioning and in therapeutic change. Awareness Integration combines the schematized model of the mind with EFT in that schemata in the psyche are not only cognitive, but emotional. AI uses both emotional and cognitive schemata to access source memories for non-functioning coping mechanisms, allowing clients to release and then integrate the blocked memory.

AI draws heavily from the holistic aspects of Humanistic Therapy (Rogers, 1951). A goal of Humanistic Therapy is to help clients achieve self-actualization by developing a stronger and healthier sense of self (Aanstoos, Serlin and Greening, 2000). Accordingly, human beings are aware and are aware of being aware – human beings are conscious beings. AI draws from this proactive view of humans, and understands people as intentional, responsible, future-oriented creatures who supersede the sum of their parts. Additionally, the goal of AI in fostering awareness in clients stems from the humanistic perspective.

Awareness Integration also draws from Existential Therapy. The philosophy of Existential Therapy is that although humans are inevitably alone, separate from the rest of the world, they still desire to be connected with others (Yalom, 1980). Norcross explains that there are eight themes in existential therapies: ontology, intentionality, freedom, choice/responsibility, phenomenology, individuality, authenticity, and potentiality (Norcross, 1987). Existential therapy deals with issues that are nearly universal across human beings, and Awareness Integration adopts this standpoint: AI explores topics from across a client's life.

Solution Focused Brief Therapy (SFBT) is another model that AI draws from. SFBT focuses on solutions rather than problem solving and explores current resources and future hopes rather than present problems and past causes (de Shazer, 1982). The therapy often involves observing how clients respond to a set of predetermined questions (de Shazer et al., 2007). SFBT focuses on identifying a solution to the client's problem and developing the skills discovering the resources to achieve that solution. Awareness Integration draws from the pragmatic aspects of this model of setting up a specific

action plan to achieve one's goals, developing the skills needed to lead a fulfilling life.

Awareness Integration also draws from hypnotic techniques to encourage one's ability to intensely focus on a particular thought, emotion, physical sensation, location in the body, and memories (Spiegel and Spiegel, 1978). In AI, this process is utilized to locate original memories that have been a source of negative core beliefs and to process memories toward a reintegration within the system as a whole.

The philosophy of Transactional Analysis and Inner Child Techniques are also applicable to AI. Transactional analysis understands the psyche as composed of different parts that have ongoing inner dialogues as one moves through life, and that the ability to conscious identify these dialogues is suppressed early in one's childhood (Berne, 1972). In AI, going back to original memories linked to negative core beliefs is pivotal. When healing those memories one needs to connect the accountable part of one's identity to the emotionally charged memories.

AI also uses the Sedona method for releasing memories. The Sedona Method is an accelerated way of releasing feelings such as anger, frustration, jealousy, anxiety, stress, and fear (Dwoskin, 2003). The method involves diving deep into an intense emotion or feeling and then releasing it. This released the charged up emotions that are tapped into.

Eye Movement Desensitization and Reprocessing (EMDR) is another model that Awareness Integration draws from. The model underlying EMDR hypothesizes the existence of an intrinsic neurologically based information processing system that functions to transform disturbing life experiences into narrative memories that are no longer disturbing (Forgash and Copeley, 2008). This information processing system connects a memory with a core belief, emotions that result from that core belief and the location in the body where that emotion can be felt. AI uses the same model of neural networking (core belief, emotion, body) to access original memories.

Some of these models focus on cognition, symptomology, and finding solutions; some on the unconscious, childhood experiences, and past traumas; some on effective and/or non-effective behaviors; some on emotions; and some on the body. Most of these theories handle just one or two aspects of the psyche, behavior, or emotion. AI brings all of these components together in a structured manner and creates a quick route for internal healing and reprocessing. As such, AI is both comprehensive and brief. The structure of AI allows therapists to follow a guide, but it is flexible enough that therapists can develop and use their own style within that structure. AI also has the benefit of extreme comprehension; through the process therapists will reach areas from across aspects of the clients' lives. Finally, AI is both process oriented and goal oriented; while AI helps individuals identify goals and develop the skills needed to reach those goals, it does not diminish the emphasis placed on the process of therapy and the time needed to heal.

PRINCIPLES OF THE AWARENESS INTEGRATION MODEL

The first principle of Awareness Integration is that reality is the experience of the observer. Every human being perceives and creates their own reality based on their state of being, beliefs, emotions, and behaviors. Human beings are the co-creators of reality. Siegel (1999) has explained that interpersonal experiences directly influence how we mentally construct reality. He also notes that experience can shape not only what information enters the mind, but the way in which the mind develops the ability to process that information. Our past dictates how we perceive the present as much as the present itself does. However, Stapp (2011) contends that "the observer does not create what is not potentially there, but does participate in the extraction from the mass of existing potentialities individual terms that have interest and meaning to the perceiving self." Thus, our minds will not extract impossible scenarios as the truth; improbable scenarios, however, while not usually extracted, can sometimes be found as 'true' by certain individuals. Thus, personal reality and consciousness is as much a product of emotions as it is of thought and rationality. Automatic emotion responses often precede or influence the conscious meaning of events; emotion and subjectivity rather than logic and objectivity most often determine what people see as 'true.'

The second principle of AI is that every human being has the capability and potential to learn the skills to have an enjoyable, happy, functional, and successful life. Siegel (1999) has explained that the brain is considered a living system that is open and dynamic, forever in a state of change. This open, dynamic system is one that is in continual exchange with a changing environment which then changes the state of its own activity. The fact that the brain is a dynamic system means that change is possible – and because change is possible, improvement is possible.

The third principle of AI is that the skills humans need to enjoy happy and successful lives are learned through physical and psychological development, one's own experiences, and mirroring parents, teachers, peers, media, and culture. Siegel (1999) explains that development is a product of the effect of experience on the unfolding genetic potential and that DNA transcription and genetic expression are directly influenced by experience. Thus, past experience actually changes how your genes are expressed and how your behavior is determined neurologically.

The fourth principle of AI is that the human mind perceives and creates meaning internally for all external stimuli, which results in a subjective reality that may vary from actual events and realities of others. Through the invented reality, one creates formulas, beliefs, and personal identities that relate to self, others, and the universe at large. According to Beck (1972; 1996) affective and behavioral responses to events are determined by cognitive appraisals of the situation and how the individual structures the experience. According to CBT, people tend to construct their beliefs, assumptions, attitudes, and values early in life (Beck, 1996). Thus, how one reacts to an experience is determined by cognition, and how one thinks is determined early in their life.

The fifth principle is that human beings store experiences cognitively, emotionally and somatically; un-integrated experiences awaiting integration. Shapiro (1995) states that the majority of pathology stems from earlier life experiences which that set in motion a continued pattern of affect, behavior, cognitions, and consequent identity structures. The pathological structure is intrinsic to insufficiently processed information stored at the time of the disturbing event. Negative core beliefs, including the emotions that are produced by them and the area of the body that experienced the emotions during the original incident, repeatedly resurface in automatic thinking. Siegel (1999) says that repeated patterns of neural activation may become engrained and more likely to be reactivated in the future. These negative core beliefs create a withholding and survival-based attitude. Triggered by an event, this attitude prohibits individuals from achieving optimal potential beyond survival, even when there is no real threat, holding them back from living a fulfilled life.

The sixth principle of Awareness Integration is that as the un-integrated belief-emotion-body state is attended to, released, and

integrated into the whole system, neutral and positive attitudes, beliefs, and emotions can be experienced. Siegel (1999) believes that small changes in perspective, beliefs or associations of particular forms of information processing can lead to large changes in state of mind and behavior. This is also a principle of EMDR, in that if the innate processing system in the mind is activated when a traumatic memory is accessed, an adaptive resolution may take place (Shapiro, 1995). This indicates that the mind can adapt to traumatic events and change undesirable behavior and cognition.

The seventh principle of AI is that through self-awareness, integration of one's experiences, and the creation of conscious choices regarding beliefs, emotions, and actions, one can choose a positive attitude for the creation of a new, positive reality. Horney (1937) states that the capacity for clear and conscious renunciation is rare because feelings and beliefs are muddled. Because AI allows for personal growth and awareness, the renunciation of one's previous beliefs in favor of new chosen beliefs is possible.

The eighth principle is that new skills can be learned and practiced in a neutral and positive environment to enhance one's capabilities, experiences, results, and relationships. AI is not primarily skill-based or goal-oriented, but does place an emphasis on teaching clients the skills they need in order to survive and be happy in the world.

The ninth and final principle is that conscious intentionality and envisioning of a desired result, in combination with effective planning and timely scheduled action plans, raise the probability of achieving one's desired results in all areas of life. Pinker (1997) defines intelligence as the ability to attain goals in the face of obstacles by means of decisions based on rational (truth-obeying) rules. Humans, as intelligent beings, are capable of reaching the goals they set for themselves, but sometimes they need therapeutic assistance to help them along.

AI MODEL PROCESS

The goal of this model is to foster awareness and to integrate all split parts of the self from the past into the present. The primary method of AI involves identifying clients' negative and/or irrational core beliefs, the formulas clients have created to operate within their lives, and the identities they have created, sustained and operated. AI allows for the release of emotional and somatic charges that remain from unintegrated experiences and memories and the dismantling of negative core beliefs. In therapy, clients are directed through the use of a structured set of questions in six phases. Each phase has its own set of questions and an intent specific to that phase. Clients are directed through all six phases and explore different areas of their lives including their careers, relationships, families, childhood, themselves, the universe, death, God and spirituality, and other significant areas especially related to the client. If a client presents a negative core belief and experiences high intensity of emotion whilst maintaining attachment to that belief, then the therapist will enact an intervention to connect the client's mind, body, and emotions and release their obstructing emotions, traumas, and associated negative beliefs.

Phase One is designed to induce awareness of the client's perceptions, emotion, and behaviors in relation to their external environment and how those constructs impact their lives. Questions in this phase include: What do you think of people? How do you feel about people? How do you behave towards people? How does the way you think, feel, and behave towards people affect your life? Generalized belief systems tend to become prominent during this phase of therapy.

Phase Two encompasses three functions: A) To create awareness of the client's projections of others' opinions and feelings about them; B) To enhance the client's ability to observe others' behavior towards them and to observe the meanings the client attributes to that behavior; C) To identify ways in which these constructs impact the client's life. This phase is only relevant to areas where one interacts with other people. Questions in this phase include: What do you think people think about you? How do you think people behave towards you? How does the way you think about people and behave around people affect your life? This phase is very impactful for people with high levels of anxiety. If there is no charged emotion in an area it is not necessary to focus on any area in particular to proceed onto the next phase.

Phase Three aims to foster awareness of clients' beliefs, emotions, and behaviors about themselves in relation to each area of life in consideration of the identity that interacts with and responds to various areas of life. This is the most important phase because this area is directed toward the client's awareness of their own identity and these questions in particular capture clients' core beliefs. Questions in this phase include: When you say "I'm bad," who says that about you? As you see yourself among people, looking at them while they're looking at you, what do you think about yourself? How do you feel about yourself? How do you behave towards yourself? Do you judge yourself? Are you compassionate? Are you ok?

In Phase Four, the client is assisted in simultaneously experiencing the connection between thoughts, formulas, and schemas with emotions and the body areas that maintain and reflect intense emotions. This process also links the associated memories to the belief system. Irrational thoughts, decision making, beliefs, formulas and schemas can be challenged, reframed, and replaced with realistic and positive thoughts and beliefs. In this process of integration, the client allows themselves to release negative core beliefs, hidden intentions, shadows, and emotions locked in the body. This process also allows clients to develop the ability to be with, tolerate, and manage emotions effectively. This phase is the most complicated area of AI because core beliefs may sometimes fit into a more complex formula. For example, the core belief of "I'm unlovable" may fit into a formula of "if I pretend that I'm sick my parents will pay attention to me, and therefore I am loved and special." In order to dismantle these unreasonable formulas and negative core beliefs, therapists use cognitive challenging and reality checks. Questions in this phase include: When you say [negative core belief] how to you feel about yourself? How do you feel when you say this to yourself? Where is the feeling in your body? What is the intensity on a scale from 1 to 10? This phase can be emotionally taxing on the client, so if they attempt to escape their inner conflict the therapist must insist they stay and focus, and reassure them that they will be unharmed. In such a case, the therapist will tell the client to focus on the body part where they feel the intensity and allow the feeling and associated emotion to take them to the first or other associated memories and then let the client explain the connection.

In Phase Five the therapist explores the client's chosen values with regards to areas of life they have previously touched on. Encouraging in the client a commitment to think, feel, and behave with an intention to actualize a chosen value system will bring forth a chosen attitude and a chosen identity to live by. From this new commitment, short and long term goals are identified and scheduled, and tangible action plans will be set toward a desired outcome. In this phase the therapist identifies which skills the client has already acquired and which skills need improvement. Questions in this phase are phrased and structured to explore each individual client's values and beliefs; for instance, if a client has previously been very aloof and angry with their mother, the therapist might ask them, "How do you choose to act towards your mother now?" If the client responds

that they choose to be "connected and loving," the therapist would follow up with "what specific actions do you have to do and commit to so that you can be connected and loving towards your mother?" This phase is both proactive and nuanced and should be tailored to individual clients.

In Phase Six, the client chooses an accumulation of values, situationally appropriate emotions, and behaviors to operate from and live by. The client then creates a symbolic external reminder to reinforce these values and self-programming. This reminder may be a collage, a painting, pictures, or anything else with a visual component to remind the client of who they chose to be and who they intend to be.

In order to assess the effectiveness of AI, a pilot study was conducted.

METHODS

Participants

Participants were selected from the clients who attended Personal Growth Institute, a non-profit organization that offers psychotherapy and counseling to a multicultural community. The model was offered randomly to clients who then decided whether to participate in the study.

Of the fourteen participants, there were 9 females and 5 males, ranging in age from 14 to 52. Self-identified ethnic backgrounds included: 2 Caucasians, 10 Iranians, 1 Armenian, and 1 Filipino. Education level varied from some high school to doctorate degree.

Procedure

Each participant completed an initial intake form. The first session was conducted to determine the presenting problem, gather history of the participant, conduct an assessment and formulate a diagnosis and treatment plan. During the second session, participants completed pre-testing and were explained how the model would be implemented in therapy. In consecutive sessions, participants completed all 6 phases of the model with all the areas of life relevant to their life. Depending on the participant's previous therapy experience and childhood trauma experience, this phase took between from 3 sessions for a person with extensive previous therapy, to 32 sessions for a participant with severe childhood physical abuse. Following completion of AI therapy, post-testing was conducted.

Measures

The Rosenberg self-esteem scale (RSES) (Rosenberg, 1965; Blascovich and Tomaka, 1993) is a ten-item scale with items answered on a four-point Likert scale, from strongly agree to strongly disagree. Five of the items have positively worded statements and five have negatively worded ones. The scale measures state self-esteem by asking the respondents to reflect on their current feelings. The Rosenberg self-esteem scale is considered a reliable (standard range 0.5 to 0.9) and valid quantitative tool for self-esteem assessment.

The Beck Depression Inventory BDI-II (Beck, Ward, Mendelson, et al., 1961) is a 21-question multiple-choice self-report inventory for measuring the severity of depression. This measure has been found to be a reliable (coefficient alpha = 0.92) and valid indicator of depression.

The General Self-Efficacy Scale (GSES) (Schwarzer & Jerusalem, 1995) measures the extent or strength of one's belief in one's own ability to complete tasks and reach goals. It is a 10 item measure that yields a composite score. Reliability measures vary between 0.76 and 0.90.

The Beck Anxiety Inventory (Beck, 1988; Beck and Steer, 1993) is a 21-question multiple-choice self-report inventory that is used for measuring the severity of an individual's anxiety. Reliability of the measures averages 0.75.

When a participant left an item on a measure blank, we substituted the average of other items. When a participant chose an item between two numbers (e.g. arrow between 2 and 3 or circled both 2 and 3) the larger of the two was selected. One participant did not complete the BAI and his scores on this measure were not included.

RESULTS

Due to the small sample size, pretest and post-test percent differences were initially assessed. BDI-II scores lowered 15.3 points, which was a 76% percent decrease in self-reported depression. BAI scores decreased 9.5 points, which was a 60% decreased in self-reported anxiety. Self-reported self-esteem scores increased 7.9 points which corresponds with a 43% increase in self-esteem. Self-efficacy scores increased 5.9 points, indication a 20% increase in self-reported self-efficacy. To further assess whether there were significant differences in pre and post test scores, t-tests were conducted. On the BDI-II, $t(13)=3.98$, $p<0.05$, with lower levels of depression on the post-test. On the BAI, $t(12)=3.12$, $p<0.05$, with lesser levels of depression reported post test. On the RSES, $t(13)=2.98$, $p<0.05$, with increased self-esteem on the post-test. On the GSES, $t(13)=2.01$ $p>0.05$, with higher levels of self-efficacy noted post-test. While changes in the self-efficacy measure were not statistically significant, it appears that there is a trend towards significance.

DISCUSSION

The advantage of Awareness Integration model over other psychotherapeutic models rests on the fact that it is a comprehensive model encompassing the cognitive, emotional, physical, and behavioral component while supporting the client in dealing with the past, present and the future toward the creation of one's fulfillment in life. The majority of existing therapeutic models only incorporate one or two of the above components. Until now, the theories and interventions that have worked with negative core beliefs have, at best, been able to challenge the beliefs and refocus on healthier coping mechanisms. The AI model seeks to dismantle the negative core beliefs so that they do not become a source of sub-conscious sabotage, nor remain as a burden of daily automatic thoughts that ignites intense displaced emotions.

Awareness Integration model seeks to bring depth into a brief and time efficient psychotherapeutic model. This model utilizes many interventions from evidence-based theories in an open structured procedure that allows a novice therapist to follow a direct and clear guideline toward a great therapeutic result, while also allowing a seasoned therapist to add their own unique style and orientation to the model.

It is hypothesized that the significant decrease in depression found is due to the challenging of negative core beliefs at the onset of creation in the past by taking what is excessively emotionally charged thought, form and behavior in the present, linking it to the emotion and the felt sensation, and gearing toward locating the original memory of the event that formed the negative core belief. This process allows for the clearing, healing and dismantling of the negative core belief, thus lessening depressive emotions. When this process is done in every area of life, the accessibility to all negative core beliefs and dissociated emotionally charged pockets becomes easier. This process integrates the past with the present moment,

and therefore the view of self, others and life in general becomes more realistic, objective, and holistic. The awareness toward the responsibility, ownership and accountability toward one's own thought, emotion, behavior and the impact of that experience on formulation of the negative core belief, irrational belief, and negative emotions creates clarity and empowerment. Therefore feeling of powerlessness and victimization that is a base emotion of depressive state dissipates. The goal setting toward a future with chosen values creates a proactive sense of self that is called toward a fulfilling actualized future.

The significant decrease in rate of anxiety is hypothesized to be due to the integration of the past with the present and visioning the future in a realistic and tangible way with an action plan that can be followed and measured. Skills are learned toward the implementation and sustainment of the future goals. So, rather than projections of a negative future from the negative experiences of the past, which produces anxiety, the AI model projects an intended positive and realistic future to move toward.

The changes found in self-esteem are believed to be due to the examination of identity that is acquired and lived upon in each area and phase of life. As the identity's belief systems, thoughts, emotions and behaviors toward the self are explored, the originating sources of these belief systems can be observed, challenged, and healed. This process allows a more nurturing and compassionate relation with self and assigning value to areas of strength while being caring toward the vulnerable parts of self.

In terms of the pattern of self-efficacy improvement, when using the AI model, self-efficacy is actualized due to learning and implementing sustainable skills that create and maintain results in all areas of life. Thus, self-efficacy at the completion of the therapy will rise as life skills are practiced daily and create long lasting results.

While initial results demonstrate support for the use of the AI model, there are certain limitations. Due to the small sample size, conclusions are deemed as preliminary. Additional research with a larger and more varied sample is recommended. Additionally, when utilizing the AI model, clients should have full or near full cognitive processing capabilities because of the need for awareness intrinsic to this model. As such, AI might not work with someone who has an active psychopathology, schizophrenia, dementia, or even severe developmental disabilities. Another limitation is in clients who have extreme ADHD because of the need for focusing on particular memories for extended periods of time. They may be aware but it is often the case that they are not able to recall memories long enough to completely release them. Additional research is needed in these areas.

The ability to be aware of self is a unique ability to humans. Awareness is the first step toward distinction and creation of choice. Most therapeutic interventions do not teach the client the mechanism of awareness, the distinctions between thought, emotion, behavior and the impact that these create in our life. The concept of being responsible and accountable for inner thoughts and emotions, externally oriented behavior allows for a powerful and pro-active stance toward co-creation of life with all that happens in life externally. The integration, clearing, healing, bringing forth the learning of the past to the present moment provides more accessibility for one's awareness. The ability to access all parts of self freely allows for more clarity in choosing more productive goals, actualizing and therefore being fulfilled with life.

REFERENCES

Aanstoos C, Serlin I, Greening, T (2000) *History of Division 32 (Humanistic Psychology) of the American Psychological Association.* In D. Dewsbury (Ed.), Unification through Division: Histories of the divisions of the American Psychological Association, Vol. V. Washington, DC: American Psychological Association.

Beck AT (1972) *Depression: Causes and treatment.* Philadelphia, PA: University of Philadelphia Press.

Beck AT (1996) Beyond belief: A theory of modes, personality, and psychopathology. In P.M. Salkovskis (Ed.), Frontiers of cognitive therapy. New York, NY: Guilford Press.

Beck AT, Steer RA (1993) *Beck Anxiety Inventory Manual*. San Antonio: Harcourt Brace and Company.

Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J (1961) An inventory for measuring depression. *Archives of General Psychiatry,* 4, 561-571.

Berne E (1972) *What do you say after you say hello?: The psychology of human destiny*. New York: Grove Press, Inc.

Blascovich J, Tomaka J (1993) Measures of Self-Esteem. In J.P. Robinson, P.R. Shaver & L.S. Wrightsman (Eds.), *Measures of Personality and Social Psychological Attitudes*. Third Edition. Ann Arbor: Institute for Social Research.

de Shazer SD (1982) *Patterns of brief family therapy: an ecosystemic approach*. New York: Guilford Press.

de Shazer S, Dolan Y, Korman H, Trepper T, McCollum E, Berg IK, et al. (2007) *More Than Miracles: the State of the Art of Solution-focused Brief Therapy.* New York: Routledge.

Dwoskin H (2003) *The Sedona method: your key to lasting happiness, success, peace and emotional well-being*. Sedona, AZ: Sedona Press.

Ellis A (2001) *Overcoming destructive beliefs, feelings, and behaviors: new directions for rational emotive behavior therapy*. Amherst, N.Y.: Prometheus Books.

Forgash C, Copeley M (2008) Introduction to EMDR. *Healing the heart of trauma and dissociation with EMDR and ego state therapy*. New York: Springer Pub.

Hazlett-Stevens H, Craske MG (2002) Brief Cognitive-Behavioral Therapy: Definition and Scientific Foundations. In Handbook of *Brief Cognitive Behaviour Therapy* (Eds F. W. Bond and W. Dryden), John Wiley & Sons Ltd, Chichester, UK.

Horney K (1937) *The neurotic personality of our time.* New York: Norton.

Neale JM, Davison GC (2001) *Abnormal psychology* (8th Ed.). New York: John Wiley & Sons.

Norcross, J.C. (1987) A Rational and Empirical Analysis of Existential Psychotherapy. *Journal of Humanistic Psychology*, *27*, 41-68.

Palmer-Olsen L, Gold LL, Woolley SR (2011) Supervising Emotionally Focused Therapists: A Systematic Research-Based Model. *Journal of Marital and Family Therapy*, *37*, 411-426.

Pinker S (1997) *How the mind works*. New York: Norton.

Rogers C R (1951) *Client-centered therapy: its current practice, implications, and theory.* Boston: Houghton Mifflin Co.

Rosenberg M (1965) *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Schwarzer R, Jerusalem M (1995) Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 35-37). Windsor, UK: NFER-NELSON.

Shapiro F (1995) *Eye movement desensitization and reprocessing: basic principles, protocols and procedures*. New York: Guilford Press.

Siegel DJ (1999) *The developing mind: toward a neurobiology of interpersonal experience.* New York: Guilford Press.

Spiegel H, Spiegel D (1978) *Trance and treatment: clinical uses of hypnosis*. New York: Basic Books.

Stapp HP (2011) *Mindful universe quantum mechanics and the participating observer* (2nd Ed.). Berlin: Springer.

Yalom ID (1980) *Existential psychotherapy*. New York: Basic Books.