CHAPTER 1

Navigating Rough Waters

Third-Wave Strategies for Complex Clinical Care

Brandon A. Gaudiano, Jessica L. Kingston,
and Mårten J. Tyrberg

KIMBERLY'S STORY

Kimberly is a 40-year-old mother of two who has faced multiple mental health challenges—depression, suicidal thoughts, trauma, and chronic pain—for more than 20 years. Despite trying various treatments, including medications, counseling, and even electroconvulsive therapy during periods of psychiatric hospitalization, she has seen little to no lasting results. Her medical records indicate that Kimberly is "treatment resistant." Her current therapist wonders: What can I do for Kimberly? What approach might I take to help this client move from merely managing symptoms to achieving a meaningful, stable life?

BE MINDFUL OF THE GAP!

Most clinicians have treated clients like Kimberly at some point, and her story is all too familiar to them. The last several decades have witnessed an unprecedented growth in the advancement of mental health treatments based on the emerging science of what works and what doesn't (Hollon & Teachman, 2019). Still, the methods we are understandably proud of frequently fall short of our own and our clients' expectations. This impeded treatment progress is not only a problem for our patients, but also for the therapists who treat them. Therapist burnout, emotional strain, and clinical demoralization are realities that all clinicians will face, at

least occasionally. Research backs this up, with reviews showing that up to 67% of mental health professionals experience high levels of burnout (Morse et al., 2012). Additionally, clinicians frequently report feelings of anger, helplessness, or anxiety during sessions with clients (Vivolo et al., 2017). Therapists' distress is likely rooted in the real-world challenges of clinical care. It is estimated that 50% of therapy clients will drop out of treatment prematurely (Barrett et al., 2008). Furthermore, 30–50% of clients do not make significant progress, at least early on, in their treatment (Lambert, 2010). The issue then becomes the following:

> How can we evolve the therapy process to address these inherent challenges faced by both therapists and their clients? How do we apply what we have learned to create a new path forward that better aligns with the conditions we find on the ground?

WHAT IS CLINICAL COMPLEXITY, ANYWAY?

The topic of clinical complexity is itself a complex one. Mezzich and Salloum (2008) note: "Clinical complexity is a protean term encompassing multiple levels and domains. Illustratively, a prominent concern in health care involves multiplicity of disorders and conditions experienced by a person along with their cross-sectional and longitudinal contexts" (p. 1). Surveying the literature and therapy lexicon, numerous terms have been used over the years to capture the "complexity" idea as depicted in Table 1.1.

Some of these terms are merely descriptive, whereas others imply a negative bias or even have an explicitly pejorative connotation. But what all these terms have in common is that they reflect a challenging clinical picture in which multiple, interacting factors require careful consideration and attention to achieve the desired treatment outcome. Historically, these conceptualizations of clinical complexity have overlooked the perspectives of the individuals being described—the ones with lived experience themselves. Rather than just defining complexity in terms of symptoms or syndromes, these service users describe the complex and evolving interactions among personal suffering, traumatic life events, identity, self-perception, interpersonal relationships, and their social environments (Slade, 2009).

Epidemiological research shows that 45% of patients exhibit comorbidity in the form of two or more concurrent diagnosable disorders (Kessler et al., 2005). In other words, mental health conditions are not distinct in practice and frequently overlap, such as in the case of depression and anxiety or personality dysfunction and trauma. Furthermore, therapists can attest that these experiences are typically embedded in the human condition itself, as well as normal evolutionary processes, including sadness, fear, and stress (Horwitz & Wakefield, 2007). Additionally, this

TABLE 1.1. Terms for Complex Clinical Presentations

Term	Definition/use
Treatment resistant/ nonresponsive	Lack of clinical response despite adequate treatment trials.
Comorbidity	Two or more co-occurring conditions.
Treatment refractory	Clinical nonresponse despite multiple adequate treatments.
Co-occurring problems	Multiple and overlapping clinical issues.
Multi-problem patient	Numerous clinical diagnoses along with social, interpersonal, and/or behavioral issues.
Difficult clients	Perceived as challenging to treat by therapists.
Dual diagnosis	The combination of mental health and drug/alcohol use disorders.
Severe and persistent mental illness (SPMI)	Major psychiatric conditions that are chronic and cause significant functional impairment.
Noncompliance	Treatment nonadherence or disengagement.
Therapy-interfering behaviors	Client behaviors that disrupt the therapy process.
Severe personality pathology	Enduring maladaptive personality traits causing distress or impairment.
Challenging clients	Broad label for clients who evoke strong countertransference in session.
Emotionally dysregulated	Extreme, labile emotional responses and difficulty managing affect.
High clinical acuity	Increased intensity/severity of symptoms requiring immediate or intensive care.

complexity does not reside solely in the individual; it also involves the intricate interplay among many biological, psychological, social, and cultural influences (Kazdin & Blase, 2011).

The current *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (American Psychiatric Association, 2022), only partially addresses the diverse foci of clinical intervention that clinicians encounter daily. Furthermore, various sociocultural and structural factors complicate diagnostic clarity and treatment access for all groups that experience disadvantages due to their personal or

cultural characteristics (Murthy, 2022). If we expand our conceptualization of clinical problem areas beyond the traditional diagnostic lens, we can identify a multitude of other vital domains that deserve our attention. To broaden our definition of clinical complexity, Table 1.2 depicts a multitude of perspectives for conceptualizing mental health treatment targets and processes.

There are many ways in which clinicians, researchers, and theorists have sought to understand the complexity of human beings' mental health suffering and address the unique problem areas that emerge based on differing conceptualizations of the issue. Clinical complexity is evident in multiple domains, and therefore, it is not surprising that our historical interventions have had difficulty addressing them adequately or comprehensively.

TABLE 1.2. Conceptual Perspectives on Psychopathology

Perspective	Description
Dimensional approaches	Symptoms exist along a continuum from normative to clinically impairing (Narrow & Kuhl, 2011).
Transdiagnostic symptoms	Certain symptoms (e.g., insomnia) cut across multiple diagnostic categories (Dolsen et al., 2014).
Psychosocial functioning	Considers quality of life, role functioning, and broader life satisfaction (Üstün & Kennedy, 2009).
Process-based models	Target core psychological processes (e.g., avoidance, cognition, attachment) that produce symptoms (Hayes et al., 1996).
Behavioral models	Emphasize learning history and reinforcement contingencies through idiographic functional analysis (Harvey et al., 2009).
Person-centered therapies	Center on the individual's subjective experience and personal perception of distress (Wong & Cloninger, 2010).
Cultural formulations	Highlight the influence of sociocultural context and ecological systems in shaping identity and distress (Gopalkrishnan, 2018).
Developmental perspectives	View symptoms as deviations from typical development, shaped by genes and environment over time (Rutter & Sroufe, 2000).
Biological models	Attribute mental health symptoms to brain structure, biochemistry, and genetic factors (Sullivan & Posthuma, 2015).
Existential models	Focuse on human concerns such as meaning, responsibility, freedom, and connection (Vos, 2023).

THE LIMITS OF TRADITIONAL THERAPY MODELS

A CLINICIAN'S DILEMMA

As a therapist in training, you might have been taught how to faithfully apply a standardized treatment protocol to a patient who met certain diagnostic criteria. Yet it quickly became apparent to you that the person's problems were far more intricate and dynamic than the diagnostic criteria or the manual could predict. Your initial assessment of the patient and early therapy sessions uncovered a multitude of overlapping struggles that basic techniques such as reflective listening or goal-setting seemed ill-suited to address alone. However, the evidence-based manuals often felt too constrictive and failed to meet the client where they were in session. You sought a method that, on one hand, grasped this complexity at a deeper level and, on the other, offered flexible tools to enable genuine and enduring change aligned with the client's desired goals. You thought to yourself, there must be a better path.

Historically, the field study of psychotherapy has attempted to apply a circumscribed treatment model to a specific problem or area of clinical focus, such as using Cognitive Therapy for reducing obsessive–compulsive symptoms or psychoanalysis for addressing intrapsychic conflicts. This general framework has led to the creation of hundreds, if not thousands, of unique psychotherapies that are applied to a plethora of distinct mental health problems (Herink & Herink, 2012). Each of these therapies has its own theoretical framework, techniques, and training procedures. During implementation, this practice is quite unwieldy.

The proliferation of various treatments has also plagued efforts to define and develop empirically supported psychotherapy lists and clinical practice guidelines that are designed to steer the selection and treatment of mental health conditions based on evidence-based principles (Rosen & Davison, 2003). The tendency to over-manualize or rigidly specify therapy protocols delivered in randomized controlled trials, and the success of researchers' grant funding being tied to their focus on specific DSM diagnoses, have further contributed to a burgeoning list of treatments that have evidence supporting their safety and efficacy (Truijens et al., 2019). However, evidence in support of a specific psychotherapy does not tell us much about when to use one treatment versus another, or for whom it will be most suitable or optimal. Depending on the treatment and condition, the efficacy of one therapy may not be significantly superior to an alternative credible therapy (Wampold, 2005). Nonetheless, clinicians need to make tailored treatment choices for the specific patient in front of them. Additionally, their challenge is amplified by the myopic focus of some evidence-based therapy models on symptom reduction rather than more holistic outcomes that encompass broader concepts such as

wellness, resilience, recovery, flourishing, satisfaction, quality of life, and psychosocial functioning (Bergström, 2023).

Finally, less attention has been paid to studying the mechanisms of change through which effective therapies work, specifically the causal processes by which an intervention produces its outcomes (Kazdin, 2009). This is important because, while there is ample evidence that psychotherapy has significant and enduring effects on a range of desired clinical outcomes, there is less reliable evidence indicating the necessary and sufficient processes through which effective treatments achieve their results.

THE EVOLUTION OF THIRD-WAVE AND PROCESSED-BASED THERAPIES

A THERAPEUTIC METAPHOR

Imagine you and your client are standing at the banks of a turbulent river, watching its roiling currents. Your client wants to learn how to navigate this formidable body of water safely, and you want to help. Traditional approaches often teach people how to overcome the current by growing stronger and trying to push past difficulties by powering through them. But consider a more creative and innovative solution—studying the currents, learning to float, and then using this strategy to propel you and your client in the direction you both want to go. Third-wave principles, such as mindfulness, acceptance, self-compassion, and values, offer more flexible navigation tools designed to facilitate a sustainable and workable approach for negotiating particular challenges.

The first wave focused on traditional behavioral therapies such as exposure-focused therapies for phobias, addressing overt behavior. Second-wave cognitive therapies expanded upon these methods by targeting change in thoughts by identifying and correcting biased information processing. So-called third-wave therapies were developed as an evolutionary step in addressing the overfocus on symptom reduction over functioning, therapy techniques over processes, and diagnostic categories versus transdiagnostic areas witnessed in the first and second waves (Hayes, 2004). Examples of third-wave therapies include interventions such as Mindfulness-Based Cognitive Therapy, Acceptance and Commitment Therapy, Radically Open Dialectical Behavior Therapy, Emotion Regulation Therapy, and Compassion-Focused Therapy, as illustrated in the following chapters in this book. Nonetheless, third-wave therapies should be viewed as transitional models that do not fully remedy all the challenges encountered when trying to develop and implement evidence-based psychotherapies.

From a process-based understanding, third-wave therapies emerged based on the distinctions between mindfulness-based processes and traditional cognitive and behavioral techniques. Whereas the latter emphasized changing the content of cognition to correct underlying information processing biases and change direct behavior, the former emphasized changing the relationship between the person and their cognition from a metacognitive perspective with an emphasis on functional behavior change (Herbert & Forman, 2011). This approach led to a different clinical focus in treatment process and strategy. Third-wave approaches incorporated mindfulness—present-focused, nonjudgmental awareness of experience (Bishop et al., 2004)—as well as related facilitators, such as psychological acceptance, self-compassion, and personal values. These processes are introduced and discussed in more detail in Chapter 2, and their application to different aspects of complexity is covered throughout the remaining chapters. Third-wave approaches are typically more flexible and transdiagnostic, emphasizing the function of behavior rather than its specific form. Instead of focusing on the superficial characteristics of the problem behavior, these approaches consider why the behavior occurs and how it functions for each person, viewing symptom profiles as less significant than the underlying dysfunctional processes that produce the symptoms. However, in contrast to other earlier approaches, such as psychodynamic therapies, there is still an emphasis on explicit behavior change and personal values-driven goals on the part of the client as characteristic of the first and second waves (Masuda & Rizvi, 2019).

While the term "third wave" is now widely accepted in clinical and research contexts, it actually refers to a diverse group of therapies that share some common features but also have significant differences. Nevertheless, these third-wave therapies experienced a rapid surge in popularity and uptake after the turn of the century (Gaudiano, 2008). This was largely due to their clinical appeal, coupled with strong evidence-based support that quickly accompanied them. Numerous meta-analyses and systematic reviews indicate that third-wave therapies are safe and effective for a wide range of mental health conditions, and their effect sizes appear to be at least on par with first- or second-wave approaches (Forman et al., 2021).

In addition to their research support, third-wave therapies align well with other mental health trends, such as recovery-oriented approaches (Davidson et al., 2016). These therapies also emphasize that improvement should not only focus on reducing symptoms but also, importantly, on enhancing individuals' long-term functioning and quality of life, enabling them to find personal satisfaction. Finally, third-wave approaches favor clinical adaptation, a personalized contextualization of problems, and flexibility in application in ways that focus more on targeting underlying processes of change and mechanisms of action to produce meaningful behavior change (Hayes et al., 2011).

Recently, third-wave therapies like Acceptance and Commitment Therapy (ACT) have begun to evolve further into what is now called "Process-Based Therapy" (PBT). Stemming from the collaboration between psychologists Steven Hayes, one of the creators of ACT, and Stefan Hofmann, a recognized leader in the field of Cognitive-Behavioral Therapy, PBT is designed to move the third-wave needle further in the direction of the individualized targeting of dynamic processes of change during treatment (Hayes & Hofmann, 2021). Recognizing the limitations of using only research-based nomothetic or group statistics to guide psychotherapy, Hayes and Hofmann prefer a ground-up, individual-based approach. PBT is more thoroughly explained in Chapter 13. Put briefly, it combines innovative new methods, such as network analysis and ecological momentary assessment, with personalized case conceptualization tied to functional analysis (Ong et al., 2022). It focuses on influencing the dynamic processes of change within individuals that drive desired behaviors by utilizing a range of proven therapeutic strategies. Research is still in its early stages, and questions remain about PBT's added value and practical utility compared to other methods. Nonetheless, PBT's ambitious effort to create a new science of personalized therapy, rooted in dynamic change processes, has the potential to unify various psychotherapy approaches used today. In this way, third-wave and newer process-based approaches seek to offer clinicians and researchers new tools and strategies for navigating the often complex and turbulent waters of clinical practice.

A GUIDE FOR READERS

Overview of Book Sections

This book aims to equip clinicians with practical tools by bringing together the creators of the latest iterations of third-wave therapies, including Mindfulness-Based Cognitive Therapy, Acceptance and Commitment Therapy, Radically Open Dialectical Behavior Therapy, Emotion Regulation Therapy, and Compassion-Focused Therapy. As the editors of this book, we gathered an international group of current innovators in therapy research and practice who are adapting and applying various third-wave treatments to tackle the complexities of the human condition. This book details how these therapies can be adapted for severe and chronic clinical presentations, including schizophrenia, bipolar disorder, suicidality, persistent depression, aggression, complex trauma, chronic pain, personality dysfunction, and neurodevelopmental disorders. In our work, we have frequently been posed this understandable question by our colleagues:

> "I personally find third-wave approaches helpful and incorporate them into my practice. However, I often worry about how to apply them safely and effectively

with clients experiencing severe and debilitating issues like psychosis, suicidality, and chronic depression."

If you've considered this in your work or are a learner aiming to work with individuals with these conditions, we created this book for you.

Part I of the book, "Foundations and Core Processes," offers the proverbial 30,000-foot view. It begins with a brief summary of the various third-wave processes featured in the subsequent chapters. This introductory overview equips you with the essential knowledge to delve into the other chapters, which detail the specific treatment strategies for different clinical complexities. Part II, "Applications to Complex Clinical Presentations," explores multiple challenging mental health conditions frequently seen in practice, demonstrating how specific third-wave therapies have been adapted for treatment. Moreover, the chapters emphasize a recurring transdiagnostic perspective and a focus on the underlying processes of change that are broadly compatible across third-wave approaches, which better reflect the challenges faced by clinicians in real-world settings.

This application section is divided into subsections on mood- and trauma-related disorders, transdiagnostic concerns like psychosis and suicidality, and personality and neurodevelopmental disorders. We designed these chapters to focus on practical tools and real-world applications of third-wave approaches. Each chapter focuses on a different third-wave therapy. However, we believe that you will notice more commonalities than differences and an inherent compatibility among these approaches, given their focus on process rather than content. Therefore, each chapter includes common elements to help readers compare and contrast the different approaches:

1. An overview of the target clinical population and their common complexities, including aspects of individual diversity.
2. A summary of the theoretical foundations and current empirical evidence related to each application.
3. An outline of key treatment techniques, strategies, and processes, with a real-world case example illustrating their application.
4. A detailed sidebar explaining a specific treatment strategy in-depth, with practical instructions.
5. A review of limitations, caveats, and future directions.
6. A concise resource list with articles, manuals, and websites for further learning.

Part III, "Synthesis and Future Directions," aims to identify the common thread running through the previous chapters and connect them to the evolving literature on Process-Based Therapy.

How to Use This Book

Our goal was to develop this book as a resource for clinicians at all levels of training. Whether you're an experienced professional wanting to stay abreast of the latest methods for treating complex conditions or a novice therapist aiming to learn advanced skills or enhance your work with the clinical populations covered here, this book highlights the importance of adaptability and innovation in clinical practice. It aims to go beyond just theory or empirical data on third-wave therapies, offering practical guidance on how these approaches are delivered in real therapy sessions with representative clients. We also view the application of third-wave therapies to complex clinical cases as an ongoing, evolving process. Thus, the book points out areas where further research and refinement are needed to further improve outcomes for affected individuals.

About Language

Throughout the chapters to come, when referring to a single nongendered subject, the pronouns "they" and "them" are used. Terms such as "therapist," "counselor," "clinician," and others are used interchangeably to refer to practitioners providing mental health services. Consumers of those services are referred to with terms such as "patient," "client," and "individual." The clients appearing in the illustrative examples are composites and fictionalized; no actual persons are depicted in these examples.

CONCLUSION

Let's revisit Kimberly, the client who spent years struggling with depression, suicidal thoughts, trauma, and chronic pain, illustrating the real-world complexity clinicians encounter daily. Her struggles lie at the core of this book and motivate us to write it. As fellow clinicians, we propose alternative pathways—shifting from rigid, fragmented care to a personalized treatment approach rooted in compassion for ourselves and our clients, while upholding scientific rigor and evidence-based practices. We believe that third-wave therapies and newer process-based methods have the potential to foster more meaningful, lasting change for vulnerable clients like Kimberly.

Overall, this volume offers trainees, practitioners, and supervisors a comprehensive overview of the latest research and clinical adaptations of third-wave therapies as applied to challenging clinical presentations, written by an international group of scholars. The book's contributors are committed to exploring novel approaches, especially for challenging issues where solutions have historically been

difficult to attain. We stress the importance of linking the best in scientific research with innovations in clinical practice, integrating evidence-based principles into patient care. It also is essential that we spread the word to fellow professionals and the general public that conditions like psychosis, neurodevelopmental disorders, and suicidality are treatable and that patients with these issues are fundamentally similar to those with more common problems. Furthermore, our experience underscores the need for greater attention to holistic, patient-centered care. Historically, there have been many instances of abusive and inhumane treatment of individuals with severe mental illnesses, and related social stigma has dissuaded people from seeking help. Psychotherapy needs to go beyond symptom reduction to promote resilience, well-being, and functional recovery in complex cases. We hope this book will also help address existing gaps in treatment access, acceptability, and effectiveness in complex clinical situations. Ultimately, we aim to stimulate further research to enhance these therapeutic methods and improve support for clients and society. We invite clinicians interested in tackling complex clinical conditions to join us in seeking solutions to these challenging issues and in making progress toward our shared goals.

REFERENCES

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Author.

Barrett, M. S., Chua, W.-J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training, 45*, 247–267.

Bergström, T. (2023). From treatment of mental disorders to the treatment of difficult life situations: A hypothesis and rationale. *Medical Hypotheses, 176*, 111099.

Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., et al. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice, 11*, 230.

Davidson, L., Tondora, J., O'Connell, M., Bellamy, C., Pelletier, J. F., DiLeo, P., & Rehmer, P. (2016). Recovery and recovery-oriented practice. In S. Jacobs & J. Steiner (Eds.), *Yale textbook of public psychiatry* (pp. 33–47). Oxford University Press.

Dolsen, M. R., Asarnow, L. D., & Harvey, A. G. (2014). Insomnia as a transdiagnostic process in psychiatric disorders. *Current Psychiatry Reports, 16*, 1–7.

Forman, E. M., Arch, J. J., Bricker, J. B., Gaudiano, B. A., Juarascio, A. S., Rizvi, S. L., et al. (2021). Mindfulness and acceptance-based treatments. In M. Barkham, W. Lutz & L. G. Castonguay (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change: 50th anniversary edition* (7th ed., pp. 507–538). Wiley.

Gaudiano, B. A. (2008). Cognitive-behavioural therapies: Achievements and challenges. *Evidence Based Mental Health, 11*, 5–7.

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health, 6*, 179.

Harvey, M. T., Luiselli, J. K., & Wong, S. E. (2009). Application of applied behavior analysis to mental health issues. *Psychological Services, 6*, 212–222.

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35*, 639–665.

Hayes, S. C., & Hofmann, S. G. (2021). "Third-wave" cognitive and behavioral therapies and the emergence of a process-based approach to intervention in psychiatry. *World Psychiatry, 20*, 363–375.

Hayes, S. C., Villatte, M., Levin, M., & Hildebrandt, M. (2011). Open, aware, and active: contextual approaches as an emerging trend in the behavioral and cognitive therapies. *Annual Review of Clinical Psychology, 7*, 141–168.

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152–1168.

Herbert, J. D., & Forman, E. M. (Eds.). (2011). The evolution of cognitive behavior therapy: The rise of psychological acceptance and mindfulness. In J. D. Herbert & E. M. Forman (Eds.), *Acceptance and mindfulness in cognitive behavior therapy: Understanding and applying the new therapies* (pp. 3–25). Wiley.

Herink, R., & Herink, P. R. (2012). *The psychotherapy guidebook*. Fideli.

Hollon, S. D., & Teachman, B. A. (2019). Advantages of developing clinical practice guidelines using international standards. *Psychotherapy, 56*, 340–346.

Horwitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19*, 418–428.

Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science, 6*, 21–37.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 617–627.

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. American Psychological Association.

Masuda, A., & Rizvi, S. L. (2019). Third wave cognitive behavioral based therapies. In S. B. Messer & N. J. Kaslow (Eds.), *Essential psychotherapies: Theory and practice* (pp. 183–217). Guilford Press.

Mezzich, J. E., & Salloum, I. M. (2008). Clinical complexity and person-centered integrative diagnosis. *World Psychiatry, 7*, 1–2.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research, 39*, 341–352.

Murthy, V. H. (2022). The mental health of minority and marginalized young people: An opportunity for action. *Public Health Reports, 137*, 613–616.

Narrow, W. E., & Kuhl, E. A. (2011). Dimensional approaches to psychiatric diagnosis in DSM-5. *Journal of Mental Health Policy and Economics, 14*, 197–200.

Ong, C. W., Hayes, S. C., & Hofmann, S. G. (2022). A process-based approach to cognitive behavioral therapy: A theory-based case illustration. *Frontiers in Psychology, 13*, 1002849.

Rosen, G. M., & Davison, G. C. (2003). Psychology should list empirically supported principles of change (ESPs) and not credential trademarked therapies or other treatment packages. *Behavior Modification, 27*, 300–312.

Rutter, M., & Sroufe, L. A. (2000). Developmental psychopathology: Concepts and challenges. *Development and Psychopathology, 12*(3), 265–296.

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge University Press.

Sullivan, P. F., & Posthuma, D. (2015). Biological pathways and networks implicated in psychiatric disorders. *Current Opinion in Behavioral Sciences, 2*, 58–68.

Truijens, F., Zühlke-van Hulzen, L., & Vanheule, S. (2019). To manualize, or not to manualize: Is that still the question? A systematic review of empirical evidence for manual superiority in psychological treatment. *Journal of Clinical Psychology, 75*, 329–343.

Üstün, B., & Kennedy, C. (2009). What is "functional impairment"? Disentangling disability from clinical significance. *World Psychiatry, 8*, 82.

Vivolo, M., Owen, J., & Fisher, P. (2024). Psychological therapists' experiences of burnout: A qualitative systematic review and meta-synthesis. *Mental Health & Prevention, 33*, 200253.

Vos, J. (2023). Existential psychological therapies: An overview of empirical research. *Pratiques Psychologiques, 29*, 211–229.

Wampold, B. E. (2005). Establishing specificity in psychotherapy scientifically: Design and evidence issues. *Clinical Psychology: Science and Practice, 12*, 194–197.

Wong, K. M., & Cloninger, C. R. (2010). A person-centered approach to clinical practice. *Focus, 8*, 199–215.