

**Handbook of  
Psychotherapy Integration,  
Second Edition**

*John C. Norcross  
Marvin R. Goldfried,  
Editors*

**OXFORD UNIVERSITY PRESS**

# HANDBOOK OF PSYCHOTHERAPY INTEGRATION

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*Handbook of Psychotherapy Integration, Second Edition*  
edited by John C. Norcross and Marvin R. Goldfried

# Handbook of Psychotherapy Integration

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Second Edition

*Edited by*  
John C. Norcross  
Marvin R. Goldfried

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# Preface

From its beginnings, psychotherapy integration has been characterized by a dissatisfaction with single-school approaches and the concomitant desire to look beyond school boundaries to see what can be learned—and how patients can benefit—from other forms of behavior change. Improving the efficacy, efficiency, and applicability of psychotherapy is the *raison d'être* of integration.

The 13 years between publication of the original edition of the *Handbook of Psychotherapy Integration* and this second edition was marked by memorable growth in psychotherapy integration. In 1992, psychotherapy integration was relatively new and novel, just entering its pre-teen years. Integration had only recently crystallized into a formal movement. Our original *Handbook* was the first compilation of the major integrative approaches and was hailed by one reviewer as “the bible of the integration movement.” Few empirical studies had yet been conducted on the comparative effectiveness of integrative or eclectic approaches to psychotherapy. The formal integration move-

ment was small and concentrated in the United States.

In 2005, psychotherapy integration has entered young adulthood, no longer an immature or novel approach to clinical work. *Eclecticism*—or the increasingly favored term, *integration*—is now well established as the modal orientation of psychotherapists, and this book is now only one of many volumes on the subject. Literally hundreds of books around the globe are now published with the term *integrative* in their titles. Empirical evidence attesting to the effectiveness of integrative psychotherapies is growing. Integration has grown into a mature and international movement.

For these and related reasons, the original edition of the *Handbook of Psychotherapy Integration* became dated and incomplete. It was time for a new edition.

## OUR AIM

What has not materially changed is the purpose of our book. The aim of this second edition

continues to be a state-of-the-art, comprehensive description of psychotherapy integration and its clinical practices by some of the leading proponents. Along with these integrative approaches, we feature the concepts, history, training, research, and future of psychotherapy integration as well.

The intended audiences are practitioners, students, and researchers. Psychotherapists of all persuasions and professions will be attracted to these premier integrative psychotherapies and integrative treatments. The first edition of the *Handbook* was widely adopted for courses and seminars on psychotherapy integration, and we anticipate that the second edition will again serve this purpose. The contributors' use of the chapter guidelines (see below) and our addition of a summary outline (next section) will facilitate a systematic and comparative analysis of the integrative approaches. We worked hard to maintain the delicate balance between authors' individual preferences and readers' desire for uniformity in chapter content and format. And researchers will find that each chapter summarizes the empirical evidence associated with that particular approach.

## CONTENT AND ORGANIZATION

The contents of this second edition reflect both the evolution of psychotherapy integration and the continuation of our original goals. We have deleted several dated chapters that appeared in the original edition, and all remaining chapters have been revised and updated. We added new chapters on outcome-informed clinical work, cognitive-analytic therapy, cognitive-behavioral analysis system of psychotherapy, integrative psychotherapy with culturally diverse clients, integrative problem-centered therapy, and blending spirituality with psychotherapy. An entirely new section (with two chapters) features assimilative integration. We have also tried to convey more about the process of integrative dialogue itself—the lively and dynamic exchanges that often occur in integrative meetings, particularly the annual conferences of the Society for the Exploration of

Psychotherapy Integration (SEPI). Within the constraints of a printed volume, we have tried to share some of that excitement by including an actual dialogue on psychotherapy integration between Paul Wachtel and Marvin Goldfried.

The *Handbook* is divided into five substantive parts. Part I presents the concepts (Norcross) and history (Goldfried, Pachankis, & Bell) of psychotherapy integration. Part II features exemplars of each of the movement's four predominant thrusts: common factors (Beitman, Soth, & Bumby; Miller, Duncan, & Hubble); technical eclecticism (Lazarus; Beutler, Consooli, & Lane); theoretical integration (Prochaska & DiClemente; Wachtel, Kruk, & McKinney; Ryle); and assimilative integration (Stricker & Gold; Castonguay, Newman, Borkovec, Holtforth, & Maramba). Part III presents integrative psychotherapies for specific disorders and populations—anxiety (Wolfe), chronic depression (McCullough), borderline personality disorder (Heard & Linehan), and culturally diverse clients (Ivey & Brooks-Harris). Part IV features integrative treatment modalities, specifically, differential therapeutics (Clarkin), combining therapy formats (Feldman & Feldman), integrative problem-centered therapy (Pinsof), integrating spirituality into psychotherapy (Sollod), and blending pharmacotherapy and psychotherapy (Beitman & Saveanu). Part V concludes the volume by addressing clinical training (Norcross & Halgin), outcome research (Schottenbauer, Glass, & Arnkoff), and future directions (Eubanks-Carter, Burchell, & Goldfried) in integration.

No single volume—even a hefty one like this—can canvass all important topics or clinical situations. One regrettable gap in our coverage is the absence of a chapter on integrative therapy with children and adolescents. We could not readily identify a conceptually advanced and empirically supported integrative therapy for children. Moreover, space considerations restricted us to four examples of integrative therapies for specific disorders and populations. In making the precarious choices of which material would receive coverage and which would be passed over, we opted to keep the book clinically useful and student accessible.

## CHAPTER GUIDELINES

Contributors to Part II (Integrative Psychotherapy Models) and Part III (Integrative Psychotherapies for Specific Disorders and Populations) were asked to address a list of central topics in their chapters. Chapter guidelines were designed to facilitate comparative analyses and to ensure comprehensiveness. As expected, the authors did not always use the suggested headings; all of the requested topics were addressed in the respective chapters, but we did not insist on identical formats.

### *The Integrative Approach*

Aim: To outline the historical development and guiding principles of the approach.

- What were the primary influences that contributed to the development of the approach (e.g., people, experiences, research, books, conferences)?
- What were the direct antecedents of the approach?
- What are the guiding principles and central tenets of your approach?
- Are some theoretical orientations more prominent contributors to your approach than others?
- What is the basis for selecting therapy interventions (e.g., proven efficacy, theoretical considerations, clinical experience)?

### *Assessment and Formulation*

Aim: To describe the methods used to understand patient functioning, to construct a case formulation, and to prioritize treatment goals.

- What are the formal and informal systems for diagnosing or typing patients?
- Do you employ tests or questionnaires in your assessment?
- What major client and/or environmental variables are assessed?
- At which levels (e.g., individual, dyadic, system) are the assessments made?
- How do you integrate assessment and treatment?
- What role does case formulation play in the approach?
- How do you select and prioritize treatment goals?

### *Applicability and Structure*

Aim: To describe those situations and patients for which the approach are particularly relevant.

- For which types of patients (e.g., diagnostic types, client characteristics) is the approach relevant?
- For which types of patients is the approach not appropriate or of uncertain relevance?
- For what situations (e.g., clinical settings, time limitations) is/is not the approach relevant?
- What are the clinical settings for the approach? Are there any contraindicated settings?
- What is the typical frequency and length of sessions?
- Is the therapy typically time-limited or unlimited? What is the typical duration of therapy (mean number and range of sessions)?
- Are combined therapy formats used (e.g., individual therapy plus family therapy)?
- Where does psychotropic medications fit into the approach?

### *Processes of Change*

Aim: To identify the mechanisms or processes that produce changes in therapy and to assess their relative impact.

- What is the role of insight and understanding in change, distinguishing between historical-genetic insight and interactional insight?
- What is the relative importance of insight/awareness, skill/action acquisition, transference analysis, and the therapeutic alliance in the approach?
- What are the relative contributions of “common” factors to outcome?
- Does the therapist’s personality and psychological health play an important role?
- What other therapist factors influence the course and outcome of therapy?
- Which patient variables enhance or limit the probability of successful treatment?

### *Therapy Relationship*

Aim: To depict the therapeutic relationship



valued in the approach and the therapist behaviors contributing to it.

- How do you view the therapeutic relationship (e.g., as a precondition of change, as a mechanism of change, as content to be changed)?
- What are the most important ingredients of the therapy relationship in the approach?
- On what grounds is the therapy relationship adjusted or tailored to the individual patient?
- Does the therapist's role change as therapy progresses?

### *Methods and Techniques*

Aim: To delineate the methods and techniques frequently employed in the approach.

- What are some of the interventions used to engage patients?
- What is the therapist's work in treatment? What is the client's work in treatment?
- What therapy methods are typically employed? Which would typically not be used?
- How do you deal with resistances and blocks in treatment?
- What are the most common and the most serious technical errors a therapist can make when operating within your approach?
- How active and directive is the therapist in the approach?
- How are maintenance sessions and relapse prevention addressed in the approach?

### *Case Example*

Aim: To illustrate the initiation, process, and outcome of the integrative approach with a single case example.

- To maintain comparability among the examples, the cases in Part II should deal with the treatment of a client with general anxiety and unipolar depression (psychological distress). The case example should illustrate and discuss the initiation of treatment, patient assessment, case formulation, treatment methods, therapy relationship, termination, and outcome.

Cases in Part III will pertain, of course, to the specific disorder discussed in the respective chapters.

### *Empirical Research*

Aim: To summarize the empirical research on the approach.

- What research has been conducted on the conceptual framework of the approach?
- What empirical evidence exists for the efficacy and effectiveness of the approach?
- What are the percentages of dropouts and negative outcomes?

### *Future Directions*

Aim: To explicate the future directions and needs of the approach.

- What further work (clinical, research, theoretical, training) is required to advance your approach?
- In what directions is your approach heading in the next decade?

## ACKNOWLEDGMENTS

A large and integrative volume of this nature requires considerable collaboration. Our efforts have been aided immeasurably by our families and our SEPI colleagues; the former giving us time and inspiration, the latter providing intellectual stimulation and professional affirmation.

We are truly indebted to the contributors. Most of them are SEPI members, and all are eminent psychotherapists in their own right. They are "beyond category"—a phrase that Duke Ellington used as a high form of praise for artists who transcend the normal theoretical boundaries. We are pleased to be in their company and to privilege their integrative work.

Finally, we reciprocally acknowledge each other for the pleasure and success of our editorial collaboration. We have a long history of collaborating on various projects and consider ourselves fortunate to continue to do so.

John C. Norcross  
Clarks Summit, PA

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Stony Brook, NY

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## Summary Outline (for Parts II and III)

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## About the Editors

JOHN C. NORCROSS, Ph.D., is Professor of Psychology and Distinguished University Fellow at the University of Scranton and a clinical psychologist in part-time practice. Author of more than 200 scholarly publications, Dr. Norcross has co-written or edited fourteen books, including *Psychotherapy Relationships That Work*, *Psychologists' Desk Reference* (with Gerald P. Koocher and Sam S. Hill), *Authoritative Guide to Self-Help Resources in Mental Health*, and *Systems of Psychotherapy: A Transtheoretical Analysis* (with James O. Prochaska). He is President of the International Society of Clinical Psychology, past-President of the APA Division of Psychotherapy, and Council Representative of the American Psychological Association (APA). Dr. Norcross is also editor of *Journal of Clinical Psychology: In Session* and has been on the editorial boards of a dozen journals. His professional awards include the Pennsylvania Professor of the Year from the Carnegie Foundation, APA's Distinguished Contributions to Education and Training Award, the Rosalee Weiss Award from the American Psychological Foundation, and election to the National Academies of Practice.

MARVIN R. GOLDFRIED, Ph.D., is Distinguished Professor of Psychology and Professor of Psychiatry at the State University of New York at Stony Brook. In addition to his teaching, clinical supervision, and research, he maintains a limited practice of psychotherapy in New York City. Dr. Goldfried is the recipient of the American Psychological Association (APA) Distinguished Psychologist Award for Contributions to Knowledge. He received Distinguished Psychologist awards from APA's divisions of clinical psychology; general psychology; lesbian, gay, and bisexual issues; and psychotherapy. He also received the Award for Clinical Contributions from the Association for Advancement of Behavior Therapy. He is past-President of the Society for Psychotherapy Research; founder of the journal *In Session: Psychotherapy in Practice*; and author or editor of several books, including *Clinical Behavior Therapy* (with Gerald C. Davison), *Converging Themes in Psychotherapy: From Cognitive-Behavior Therapy to Psychotherapy Integration*, and *How Therapists Change*. Dr. Goldfried is cofounder of the Society for the Exploration of Psychotherapy Integration (SEPI) and founder of AFFIRM: Psychologists Affirming Their Gay, Lesbian, and Bisexual Family.



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## **PART I**

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# Conceptual and Historical Perspectives

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# 1

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## A Primer on Psychotherapy Integration

JOHN C. NORCROSS

Rivalry among theoretical orientations has a long and undistinguished history in psychotherapy, dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affection in a “dogma eat dogma” environment (Larson, 1980). Clinicians traditionally operated from within their own particular theoretical frameworks, often to the point of being blind to alternative conceptualizations and potentially superior interventions. Mutual antipathy and exchange of puerile insults between adherents of rival orientations were very much the order of the day.

This ideological cold war may have been a necessary developmental stage toward sophisticated attempts at rapprochement. Kuhn (1970) has described this period as a pre-paradigmatic crisis. Feyerabend (1970, p. 209), another philosopher of science, concluded that “the interplay between tenacity and proliferation is an essential feature in the actual development of science. It seems that it is not the puzzle-solving activity that is responsible for the

growth of our knowledge, but the active interplay of various tenaciously held views.”

As the field of psychotherapy has matured, integration, or eclecticism, has become a therapeutic mainstay. Since the early 1990s, we have witnessed both a general decline in ideological struggle and the movement toward rapprochement. Psychotherapists now acknowledge the inadequacies of any one theoretical system and the potential value of others. What is distinctive of the present era is tolerance for and assimilation of formulations that were once viewed as deviant. Indeed, many young students of psychotherapy express surprise when apprised of the ideological cold war of the preceding generations.

Psychotherapy integration has crystallized into a formal movement or, more dramatically, a “revolution” (Lebow, 1997) and a “metamorphosis” in mental health (London, 1988; Moultrup, 1986). Although various labels are applied to this movement—eclecticism, integration, rapprochement—the goals are similar. Psycho-



therapy integration is characterized by dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy.

A number of indicators attest to the maturity of psychotherapy integration. *Eclecticism*, or the more favored term *integration*, is the modal theoretical orientation of English-speaking psychotherapists. Leading psychotherapy textbooks routinely identify their theoretical persuasion as eclectic, and an integrative or eclectic chapter is regularly included in compendia of treatment approaches. The publication of books that synthesize various therapeutic concepts and methods continues unabated, now numbering in the hundreds. Handbooks on integration, such as this one, have been published in at least six countries. Reflecting and engendering the movement have been the establishment of interdisciplinary organizations devoted to integration, notably the Society for the Exploration of Psychotherapy Integration (SEPI), and of international publications, including SEPI's *Journal of Psychotherapy Integration*. And the integrative fervor will apparently persist well into the 2000s: A recent panel of psychotherapy experts did portend its escalating popularity into the new millennium (Norcross, Hedges, & Prochaska, 2002).

Although psychotherapy integration has indeed come of age, we have not yet attained consensus or convergence. As Lazarus (this volume) notes, the field of psychotherapy is still replete with cult members; devoted followers of a particular school of thought. High priests of psychological health are still engaged in competitive strife and internecine battles. These battles have receded but not extinguished, particularly in countries outside North America and Western Europe.

A consensus has been achieved, however, in support of the idea that neither traditional fragmentation nor premature unification will wisely serve the field of psychotherapy or its clients. We are in no position to determine conclusively which single theory, single treatment, or

single unification scheme is best. Although it might be more satisfying and elegant if the psychotherapy world were not a multiverse but rather a universe, the pluralists assure us that this quest will not be realized, at least not soon (Messer, 1992). In the meantime, psychotherapy is progressing toward integration in the *zeitgeist* of informed pluralism.

## PLAN OF THE CHAPTER

This chapter explicates the broad context of psychotherapy integration and sets the stage for the subsequent chapters in the volume. As the chapter title indicates, I offer a primer on integration: in the dual sense of a *primer* (soft *i*) as a small introduction to the subject and of a *primer* (hard *i*) as a basecoat or undercoat for the following applications. This chapter begins by describing the converging reasons for the growth of psychotherapy integration, after which I review four predominant routes to integration. This segues into a brief consideration of the varieties of integration, which includes summaries of recent studies on the prevalence and subtypes of eclectic/integrative therapies. The chapter concludes with a discussion of recurrent obstacles to psychotherapy integration.

## WHY INTEGRATION NOW?

Integration as a point of view has probably existed as long as philosophy and psychotherapy. In philosophy, the third-century biographer Diogenes Laertius referred to an eclectic school that flourished in Alexandria in the second century A.D. (Lunde, 1974). In psychotherapy, Freud consciously struggled with the selection and integration of diverse methods (Frances, 1988).

More formal ideas on synthesizing the psychotherapies appeared in the literature as early as the 1930s (Goldfried, Pachankis, & Bell, this volume). For example, Thomas French (1933) stood before the 1932 meeting of the American Psychiatric Association and drew parallels between certain concepts of Freud and Pavlov; in 1936, Sol Rosenzweig published an article that

extracted commonalities among various systems of psychotherapy. Until recently, however, integration has appeared only as a latent theme (if not conspiratorially ignored altogether) in a field organized around discrete theoretical orientations. Although psychotherapists secretly recognized that their orientations did not adequately assist them in all they encountered in practice, a host of political, social, and economic forces—such as professional organizations, training institutes, and referral networks—kept them penned within their own theoretical school yards and typically led them to avoid clinical contributions from alternative orientations.

It has only been within the past 20 years that integration has developed into a clearly delineated area of interest. Indeed, the temporal course of interest in psychotherapy integration, as indexed by both the number of publications (Arkowitz, 1992) and development of organizations and journals (Goldfried et al., this volume), reveals occasional stirrings before 1970, a growing interest during the 1970s, and rapidly accelerating interest from 1980 to the present.

The rapid increase in integrative psychotherapies of late leads one to inquire, “Why now?” What conditions encouraged the field to give specific attention and credence of late to an elusive goal that has been around for more than half a century? At least eight interacting, mutually reinforcing factors have fostered the development of integration in the past two decades:

1. Proliferation of therapies
2. Inadequacy of single theories and treatments
3. External socioeconomic contingencies
4. Ascendancy of short-term, problem-focused treatments
5. Opportunity to observe various treatments, particularly for difficult disorders
6. Recognition that therapeutic commonalities heavily contribute to outcome
7. Identification of specific therapy effects and evidence-based treatments
8. Development of a professional network for integration

The sheer proliferation of diverse schools has been one important reason for the surge of integration. The field of psychotherapy has been staggered by over-choice and fragmented by future shock. Which of 400-plus therapies should be studied, taught, or bought? Conflicting and untested theories are advanced almost daily, and no single theory has been able to corner the market on utility. The hyperinflation of brand-name therapies has produced narcissistic fatigue: “With so many brand names around that no one can recognize, let alone remember, and so many competitors doing psychotherapy, it is becoming too arduous to launch still another new brand” (London, 1988, pp. 5–6). This might also be called the “exhaustion theory” of integration: Peace among warring schools is the last resort.

A related and second factor is the growing awareness that no one approach is clinically adequate for all patients and situations. The proliferation of theories is both a cause and symptom of the problem—neither the theories nor the techniques are adequate to deal with the complexity of psychological problems (Beutler, 1983). Surveys of self-designated eclectic and integrative clinicians reveal that their alignment is motivated in part by disillusionment with single-therapy systems (Garfield & Kurtz, 1977; Norcross, Karpik, & Lister, 2004). Kazdin (1984, p. 139) writes that underlying the ecumenical spirit is the “stark realization” that narrow conceptual positions and simple answers to major questions do not begin to explain current evidence in many areas of psychotherapy. Clinical realities have come to demand a more flexible, if not integrative, perspective.

No therapy or therapist is immune to failure. It is at such times that experienced clinicians often wonder if the clinical methods from orientations other than their own might more appropriately have been included in the treatment—if another orientation’s strength in dealing with the particular therapeutic problems might complement the therapist’s own orientational weakness. This premise is the basis of Pinosof’s (1995, this volume) Integrative Problem-Centered Therapy, which rests upon the twin assumptions that each orientation has

its particular domain of expertise and that these domains can be interrelated to minimize their deficits.

The proliferation of therapies and the inadequacies of single models were in part precipitated by a matrix of economic and social pressures. In the 1970s and 1980s, integration was spurred along by such occurrences as the advent of legal accreditation of psychotherapists, with a resultant surge in professional practice and growth of psychological trade schools; the destigmatization of psychotherapy, spurred by the human-potential movement; the onset of federal financial support for clinical training; and insurance companies' financing of psychological treatment (London, 1983). Psychotherapy also experienced mounting pressures from such not easily disregarded sources as government policymakers, informed consumers, and national health insurance planners who started to demand crisp and informative answers regarding the effectiveness of psychosocial treatments. More broadly, the culture of the 1970s and 1980s created an intellectual and sociopolitical climate for psychotherapists in which experimentation and heterodoxy could flower more easily than at other times (Gold, 1990).

In the 1990s, the field was subjected to another set of forces that weakened rigid theoretical boundaries. Consumer groups and insurance companies were pressuring psychotherapists to demonstrate the efficacy of their methods. Biologically oriented psychiatrists questioned the psychosocial paradigm of psychotherapists. The failure of research findings to demonstrate a consistent superiority of any one school over another and the shifting focus to specific clinical problems (often requiring the expertise of different professions and orientations) led an increasing number of clinicians to search seriously for solutions outside their own particular paradigm.

Attacks from outside the mental health professions have started to propel them together. Without some drastic changes (not the least of which is integration), psychotherapists stand to lose prestige, customers, and money. As Mahoney (1984) put it (paraphrasing Benjamin Franklin), there is something to be said for hav-

ing the different therapies "hang together," rather than "hang separately."

The same time period also witnessed the rising interest in short-term, problem-focused psychotherapies. Treatment reviews, tightening insurance reimbursement, and mandated brief treatment began to startle clinical practitioners out of their complacency with long-term treatment. With 90% of all patients covered by some variant of managed care, short-term therapy has become the *de facto* treatment.

Short-term therapy invariably means more problem-focused therapy. The brief, problem focus has brought formerly different therapies closer together and has created variations of therapies that are more compatible with each other. Integration, particularly in the form of technical eclecticism, responds to the pragmatic time-limited injunction of "whatever therapy works better—and quicker—for this patient with this problem." In one early study of 294 health maintenance organization (HMO) therapists, for instance, the prevalence of eclecticism/integration as a theoretical orientation nearly doubled as a function of their employment in HMOs favoring brief, problem-focused psychotherapy (Austad et al., 1991).

A fifth factor in the promotion of psychotherapy integration has been clinicians of diverse orientations observing and experimenting with diverse treatments (Arkowitz, 1992). The establishment of specialized clinics for the treatment of specific disorders have afforded exposure to other theories and therapies. These clinics are often staffed by professionals of different orientations and disciplines, with greater emphasis on their expertise about the clinical problem than on their theoretical orientation *per se*. These clinics focus on treating patients and disorders that have not historically responded favorably to pure-form psychotherapies: personality disorders, eating disorders, substance abuse, post-traumatic stress disorders (PTSD), obsessive-compulsive disorders (OCD), and the chronically mentally ill, to name a few.

Moreover, the publication of detailed treatment manuals and the release of numerous videotapes of actual psychotherapy have permitted more accurate comparisons and con-

trasts among the therapies. Many clinicians reading manuals or watching videotapes are surprised by the immense commonality among practitioners of diverse orientations, in spite of their differing vocabulary. Even when actual differences remain, in behavioral terms, observing practices of different orientations may have induced an informal version of “theoretical exposure”: previously feared and unknown therapies were approached gradually, anxiety dissipated, and the previously feared therapies were integrated into the clinical repertoire.

At the same time, controlled research has revealed surprisingly few significant differences in outcome among different therapies. Luborsky and associates (1975), borrowing a phrase from the Dodo bird in *Alice in Wonderland*, wryly observe that “everybody has won and all must have prizes.” Or, in the words of London (1988, p. 7), “Meta-analytic research shows charity for all treatments and malice towards none.” Though there are many possible interpretations of such findings (Norcross, 1995a; Stiles, Shapiro, & Elliot, 1986), the two most common responses seem to be a specification of factors common to successful treatments and a synthesis of useful concepts and methods from disparate therapeutic traditions.

The recognition that the so-called common factors play major roles in determining therapy effectiveness served as another contributor to the rise of integration. The common factors most frequently proposed are the development of a therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviors, and clients’ positive expectancies (Grencavage & Norcross, 1990; Tracey et al., 2003). Empirically speaking, therapy outcome can best be predicted by the properties of the patient and the therapy relationship (see Norcross [2003] for reviews); only 10% to 15% of outcome variance is generally accounted for by the particular technique.

Nonetheless, more than commonalities are evident across the therapies—there are unique or specific factors attributable to different therapies as well. Psychotherapy research has demonstrated the differential effectiveness of a few therapies with specific disorders for example,

behavior therapy for child conduct disorders, conjoint therapy for marital conflict, cognitive-behavior therapy for panic disorder and demonstrated the differential effectiveness of therapy relationships with specific types of patients for example, less directive therapies for highly resistant patients, and insight-oriented therapies for people in the contemplation stage of change. We can now selectively prescribe different treatments, or combination of treatments, for some clients and problems.

Practitioners have learned to emphasize those factors common across therapies while capitalizing on the contributions of specific or unique techniques. The proper use of common *and* specific factors in therapy will probably be most effective for clients and most congenial to practitioners (Garfield, 1992). We integrate by combining fundamental similarities and useful differences across the schools.

The identification of specific or unique effects in psychotherapy relates closely to the recent promulgation of empirically supported, or evidence-based, treatments in mental health. These tend to be manualized, single-theory treatments for specific disorders that are supported by controlled research in clinical trials. At first blush, the compilation of single-theory or pure-form treatments would seem antithetical to the integration movement (Glass & Arnkoff, 1996). The promotion of such compilations might lead to training programs teaching only the listed pure-form therapies, insurance companies funding only these, and practitioners conducting only these.

Yet, the emergence of evidence-based treatments in mental health has, paradoxically, furthered the breakdown of traditional schools and the escalation of informed pluralism. The particular decision rules for what qualifies as evidence remain controversial, but the emerging evidence-based lists reveal a pragmatic flare for “what works for whom.” The clear emphasis is on “what” works, not on “what theory” applies. The evidence-based movement is compatible with theoretical integration and essential to technical eclecticism (Shoham & Rohrbaugh, 1996). In fact, several commentators believe that evidence-based compilations her-

ald the final dismantling of traditional theoretical categories and will yield a new metatheory of therapy (Smith, 1999).

Finally, the development of a professional network has been both a consequence and cause of interest in psychotherapy integration. In 1983, the interdisciplinary Society for the Exploration of Psychotherapy Integration (SEPI) was formed to bring together those who were intrigued by the various routes to rapprochement among the psychotherapies. SEPI promotes the integrative spirit throughout the therapeutic community through annual conferences, regional networks, a quarterly journal, and professional networking. Integrationists and eclectics now have a professional home.

#### FOUR ROUTES TO INTEGRATION

There are numerous pathways toward the integration of the psychotherapies; many roads lead to Rome. The four most popular routes are technical eclecticism, theoretical integration, common factors, and assimilative integration. Recent research (Norcross, Karpiak, & Lister, 2004) reveals that each of the four are embraced by considerable proportions of self-identified eclectics and integrationists (19% to 28% each). All four routes are characterized by a general desire to increase therapeutic efficacy, efficiency, and applicability by looking beyond the confines of single theories and the restricted techniques traditionally associated with those theories. However, they do so in different ways and at different levels.

##### Technical Eclecticism

Eclecticism is the least theoretical of the four routes but should not be construed as either atheoretical or antitheoretical (Lazarus, Beutler, & Norcross, 1992). Technical eclectics seek to improve our ability to select the best treatment for the person and the problem. This search is guided primarily by data on what has worked best for others in the past with similar problems and similar characteristics. Eclecticism focuses on predicting for whom interven-

tions will work: the foundation is actuarial rather than theoretical. The multimodal therapy of Lazarus (1989, 1997, this volume) and the systematic treatment selection (STS) of Beutler (1983; Beutler & Clarkin, 1990; Beutler & Consoli, this volume) are exemplars of technical eclecticism.

Proponents of technical eclecticism use procedures drawn from different sources without necessarily subscribing to the theories that spawned them, whereas the theoretical integrationist draws from diverse systems that may be epistemologically or ontologically incompatible. For technical eclectics, no necessary connection exists between metabeliefs and techniques. "To attempt a theoretical rapprochement is as futile as trying to picture the edge of the universe. But to read through the vast amount of literature on psychotherapy, *in search of techniques*, can be clinically enriching and therapeutically rewarding" (Lazarus, 1967, p. 416).

##### Theoretical Integration

In this form of synthesis, two or more therapies are integrated in the hope that the result will be better than the constituent therapies alone. As the name implies, there is an emphasis on integrating the underlying *theories* of psychotherapy ("theory smushing") along with the integration of therapy techniques from each ("technique melding"). Proposals to integrate psychoanalytic and behavioral theories illustrate this direction, most notably the cyclical psychodynamics of Wachtel (1977, 1987; Wachtel, Kruk, & McKinney, this volume), as do efforts to blend cognitive and psychoanalytic therapies, notably Ryle's (1990, this volume) cognitive-analytic therapy. Grander schemes have been advanced to meld most of the major systems of psychotherapy, for example, the transtheoretical approach of Prochaska and DiClemente (1984, this volume).

Theoretical integration involves a commitment to a conceptual or theoretical creation beyond a technical blend of methods. The goal is to create a conceptual framework that synthesizes the best elements of two or more approaches to therapy. Integration aspires to more

TABLE 1.1 Eclecticism versus Integration

Eclecticism	Integration
Technical	Theoretical
Divergent (differences)	Convergent (commonalities)
Choosing from many	Combining many
Applying what is	Creating something new
Collection	Blend
Applying the parts	Unifying the parts
Atheoretical but empirical	More theoretical than empirical
Sum of parts	More than sum of parts
Realistic	Idealistic

than a simple combination; it seeks an emergent theory that is more than the sum of its parts and that leads to new directions for practice and research.

The preponderance of professional contention resides in the distinction between theoretical integration and technical eclecticism. How do they differ? Which is the more fruitful strategy for knowledge acquisition and clinical practice? A National Institute of Mental Health (NIMH) workshop on integration (Wolfe & Goldfried, 1988) and several studies (e.g., Norcross & Napolitano, 1986; Norcross & Prochaska, 1988; Norcross, Karpiak, & Lister, 2004) have clarified these questions. Table 1.1 summarizes the consensual distinctions between integration and eclecticism.

The primary distinction is that between empirical pragmatism and theoretical flexibility. Integration refers to a commitment to a conceptual or theoretical creation beyond eclecticism's pragmatic blending of procedures; or, to take a culinary metaphor (cited in Norcross & Napolitano, 1986, p. 253): "The eclectic selects among several dishes to constitute a meal, the integrationist creates new dishes by combining different ingredients." A corollary to this distinction, rooted in the theoretical integration's earlier stage of development, is that current practice is largely eclectic; theory integration represents a promissory note for the future. In the words of Wachtel (1991, p. 44):

The habits and boundaries associated with the various schools are hard to eclipse, and for most of us integration remains more a goal than a

daily reality. Eclecticism in practice and integration in aspiration is an accurate description of what most of us in the integrative movement do much of the time.

### Common Factors

The common factors approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on those commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy success than the unique factors that differentiate among them. The long considered "noise" in psychotherapy research is being reconsidered by some as the main "signal" elements of treatment (Omer & London, 1988). The work of Frank (1973; Frank & Frank, 1993), Garfield (1980, 1992), and Miller, Duncan, and Hubble (this volume; Hubble, Duncan, & Miller, 1999) have been among the most important contributions to this approach.

In his classic *Persuasion and Healing*, Frank (1973) posited that all psychotherapeutic methods are elaborations and variations of age-old procedures of psychological healing. The features that distinguish psychotherapies from each other, however, receive special emphasis in the pluralistic, competitive American society. Because the prestige and financial security of psychotherapists hinge on their ability to show that their particular approach is more successful than that of their rivals, little glory has traditionally been accorded the identification of shared or common components.

One way of determining common therapeutic principles is by focusing on a level of abstraction somewhere between theory and technique. This intermediate level of abstraction, known as a clinical strategy or a change process, may be thought of as a heuristic that implicitly guides the efforts of experienced therapists. Goldfried (1980, p. 996, italics in original) argues:

*To the extent that clinicians of varying orientations are able to arrive at a common set of strate-*

*gies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases.*

In specifying what is common across disparate orientations, we may also be selecting what works best among them.

### Assimilative Integration

This form of integration entails a firm grounding in one system of psychotherapy but with a willingness to selectively incorporate (assimilate) practices and views from other systems (Messer, 1992). In doing so, assimilative integration combines the advantages of a single, coherent theoretical system with the flexibility of a broader range of technical interventions from multiple systems. A behavior therapist, for example, might use the Gestalt two-chair dialogue in an otherwise behavioral course of treatment. In addition to Messer's (1992, 2001) original explication of it, exemplars of assimilative integration are Gold and Stricker's assimilative psychodynamic therapy (this volume; Stricker & Gold, 1996), Castonguay and associates' (2004, this volume) cognitive-behavioral assimilative therapy, and Safran's (1998; Safran & Segal, 1990) interpersonal and cognitive assimilative therapies.

To its proponents, assimilative integration is a realistic way station to a sophisticated integration; to its detractors, it is more of a waste station of people unwilling to commit to a full evidence-based eclecticism. Both camps agree that assimilation is a tentative step toward full integration: Most therapists have been and continue to be trained in a single approach, and most therapists gradually incorporate parts and methods of other approaches once they discover the limitations of their original approach. The odysseys of seasoned psychotherapists (see, e.g., Goldfried, 2001; Dryden & Spurling, 1989) suggest this is how therapists modify their clinical practice and expand their clinical repertoire. Therapists do not discard original ideas and practices but rather rework them, augment them, and cast them all in new form. They gradually, inevitably integrate new

methods into their home theory (and life experiences) to formulate the most effective approach to the needs of patients.

In clinical work, the distinctions among these four routes to psychotherapy integration are not so apparent. The distinctions may largely be semantic and conceptual, not particularly functional, in practice. Few clients experiencing an "integrative" therapy would be able to distinguish among them (Norcross & Arkowitz, 1992).

Moreover, these integrative strategies are not mutually exclusive. No technical eclectic can totally disregard theory, and no theoretical integrationist can ignore technique. Without some commonalities among different schools of therapy, theoretical integration would be impossible. Assimilative integrationists and technical eclectics both believe that synthesis should occur at the level of practice, as opposed to theory, by incorporating therapeutic procedures from multiple schools. And even the most ardent proponent of common factors cannot practice "nonspecifically" or "commonly"; specific techniques must be applied.

### Defining the Parameters of Integration

By common decree, technical eclecticism, common factors, theoretical integration, and assimilative integration are all assuredly part of the integration movement. However, where are the lines to be drawn, if drawn at all, concerning the boundaries of psychotherapy integration?

What about the combination of therapy formats—individual, couples, family, group—and the combination of medication and psychotherapy? In both cases, a strong majority of clinicians—80% plus—consider these to be within the legitimate boundaries of integration (Norcross & Napolitano, 1986). Of course, the inclusion of psychopharmacology enlarges the scope to integrative treatment, rather than integrative psychotherapy per se. Integrative treatments now habitually address the combinations of pharmacotherapy and psychotherapy (Beitman & Saveanu, this volume) and com-

bined therapy formats (Clarkin, this volume; Feldman & Feldman, this volume).

Two recent thrusts proposed as parts of psychotherapy integration are the infusion of multicultural theory and spirituality/religion into clinical practice. These are receiving increased attention in the literature and in this *Handbook* (see Ivey & Brooks-Harris, this volume; Sollod, this volume). However, in a 2004 study of eclectic and integrative psychologists, we found very few of them incorporating multicultural or spiritual concerns into their practices (Norcross, Karpiak, & Lister, 2004). It routinely takes several years for new developments in the literature to be widely practiced in the field.

Psychotherapy integration, like other maturing movements, is frequently characterized in a multitude of confusing manners. One routinely encounters references in the literature and in the classroom to integrating self-help and psychotherapy, integrating research and practice, integrating Occidental and Oriental perspectives, integrating social advocacy with psychotherapy, and so on. All are indeed laudable pursuits, but we restrict ourselves in this volume to the traditional meaning of integration as the blending of diverse theoretical orientations and treatment formats.

## VARIETIES OF INTEGRATIVE EXPERIENCE

Integration, as is now clear, comes in many guises and manifestations. It is clearly neither a monolithic entity nor a single operationalized system; to refer to *the* integrative approach to therapy is to fall prey to the “uniformity myth” (Kiesler, 1966). The twin goals of this section are to explicate the immense heterogeneity in the psychotherapy integration movement and to review studies on self-identified integrative and eclectic therapists.

### Prevalence of Integration

Approximately one-quarter to one-half of contemporary American clinicians disavow an affiliation with a particular school of therapy and

prefer instead the label of *eclectic* or *integrative*. Some variant of eclecticism or integration is routinely the modal orientation of responding psychotherapists. Reviewing 25 studies performed in the United States between 1953 and 1990, Jensen, Bergin, and Greaves (1990) reported a range from 19% to 68%, the latter figure being their own finding. It is difficult to explain these variations in percentages, but differences in the organizations sampled and in the methodology used to assess theoretical orientations account for some of the variability (see Poznanski & McLennan, 1995; Arnkoff, 1995).

More recent studies confirm and extend these results. Table 1.2 summarizes the prevalence of eclecticism/integration found in studies published during the past decade. Although theoretical orientation was measured in disparate ways, eclecticism/integration was the most common orientation in the United States. Cognitive/cognitive-behavioral therapy (CBT), however, is rapidly challenging eclecticism/integration for the modal theory, at least in the United States. CBT lags only 2 to 4 percentage points behind eclecticism/integration or actually supercedes it in several studies. As also shown in Table 1.1, eclecticism/integration receives robust but lower endorsement outside of the United States and Western Europe. The column titled *modal orientation* in Table 1.2 reveals that eclecticism/integration is typically the modal orientation in the United States but not in other countries around the world.

Nor is eclecticism restricted to members of general psychotherapy organizations. Older surveys of dues-paying members of orientation-specific organizations—both behavioral (Association for Advancement of Behavior Therapy) and humanistic (APA Division of Humanistic Psychology) associations—reveal sizable proportions who endorse an eclectic orientation; 42% in the former and 31% in the latter (Norcross & Wogan, 1983; Swan, 1979).

The prevalence of integration can be ascertained directly by psychotherapist endorsement of a discrete integrative or eclectic orientation. It can also be gleaned indirectly by psychotherapist endorsement of multiple orientations. For example, in a study of Great Britain



TABLE 1.2 Summary of Recent Studies Assessing the Prevalence of Eclecticism/Integration

Psychotherapists	Country	Sample size	Response rate (%)	Percentage eclectic or integrative	Modal orientation	Citation
Clinical psychologists	USA	694	46	29	Yes	Norcross, Karpiak, & Santoro (2004)
Counseling psychologists	USA	439	25	29	Yes	Bechtoldt et al. (2001)
Counseling psychologists	Australia	178	44	7	No	Poznanski & McLennan (1998)
Counselors	Britain	309	56	42	No	Hollanders & McLeod (1999)
Couples therapists	USA	186	37	28	Yes	Whisman, Dixon, & Johnson (1997)
Pediatric psychologists	USA	377	54	16	No	Mullins et al. (2003)
Psychologists	Ireland	111	44	33	Yes	Carr (1995)
Psychologists	New Zealand	247	62	31	No	Kazantzis & Deane (1998)
Psychologists	Spain	—	—	23	No	Santolaya, Berdullas, & Fernandez (2000)
Psychotherapists	USA	538	57	36	Yes	Norcross, Hedges, & Castle (2002)
Psychotherapists	Portugal	161	34	13	No	Vasco, Garcia-Marques, & Dryden (1994)

counselors, 85% to 87% did not take a pure-form approach to psychotherapy (Hollanders & McLeod, 1999). In our recent study of clinical psychologists in the United States, for another example, fully 90% of psychologists embraced several orientations (Norcross, Karpiak, & Lister, 2004). In a study of New Zealand psychologists, for a final example, 86% indicated that they used multiple theoretical orientations in the practice of psychotherapy (Kazantzis & Deane, 1998). Indeed, very few therapists adhere tenaciously to a single therapeutic tradition

The results of the massive collaborative study of the Society of Psychotherapy Research (SPR) bear this out dramatically (Orlinsky et al., 1999). Nearly 3,000 psychotherapists from 20 countries completed a detailed questionnaire, including questions on theoretical orientations. Orientations were assessed from therapist responses to the question “How much is your current therapeutic practice guided by each of the following theoretical frameworks?” Responses were made to six orientations on a 0 to 5 scale. Twelve percent of the psychotherapists

were uncommitted in that they rated no orientations as 4 or 5; 46% were focally committed to a single orientation (rating of 4 or 5); 26% were jointly committed; and 15% were broadly committed, operationally defined as three or more orientations rated 4 or 5. The commitment toward integration is even clearer when one considers that 54% were not wed to a single orientation. As the authors conclude (Orlinsky et al., 1999, p. 140), “While there is a substantial group whose theoretical orientations are relatively pure, they are a minority in the present data base.”

Although relatively easy to ascertain self-reported prevalence of eclecticism, it is much more difficult to determine what “integrative” practice precisely entails. Far more process research is needed on the conduct of eclectic or integrative psychotherapies. Such investigations will probably need to make audio, video, and transcript recordings of the therapy offered in order to clarify the nature of therapeutic interventions. Until greater precision is attained in descriptions and practices, the crucial question of whether outcomes are enhanced by in-

egrative methods will remain unanswered. “Thus the many efforts to understand the diversity in therapist orientations will have been wasted unless it can be shown that specific combinations of techniques produce superior outcomes with given disorders” (Jensen, Ber- gin, & Greaves, 1990, p. 129).

## Integrative Therapists

With such large proportions of psychotherapists embracing integration/eclecticism, it would be informative to identify distinctive characteristics or attitudes of eclectics as compared to noneclectics. Demographically, there do not appear to be any consistent differences between the two groups, with the exception of clinical experience in several older studies (Norcross & Prochaska, 1982; Norcross & Wogan, 1983; Smith, 1982; Walton, 1978). Clinicians ascribing to eclecticism tended to be older and, concomitantly, more experienced. Inexperienced therapists are more likely to endorse exclusive theoretical orientations. Several empirical studies have suggested that reliance on one theory and a few techniques may be the product of inexperience or, conversely, that with experience comes diversity and resourcefulness (see reviews by Auerbach & Johnson, 1977; Beutler, Machado, & Neufeldt, 1994). In more recent studies (e.g., Mullins et al., 2003; Norcross, Karpik, & Lister, 2004), the age and experience differential of eclectics has disappeared, probably owing to the fact that a greater percentage of psychotherapists are being explicitly trained as eclectics or integrationists in graduate school.

Attitudinally, eclectic clinicians differ from their noneclectic colleagues in at least two respects. First, eclectics report greater dissatisfaction with their current conceptual frameworks and technical procedures (Norcross & Prochaska, 1983; Norcross & Wogan, 1983; Vasco, Garcia-Marques, & Dryden, 1992). This increased dissatisfaction may serve as an impetus to create an integrative approach, or it may have resulted from the elevated expectations that integration has engendered. Second, practitioners seem to embrace eclecticism/integration more frequently than academic and train-

ing faculty (Friedling, Goldfried, & Stricker, 1984; Norcross et al., 2004; Tyler & Clark, 1987). Eclectics/integrationists are more involved in conducting psychotherapy than their pure-form colleagues.

From a personal-historical perspective, Robertson (1979) identifies six factors that may facilitate the choice of eclecticism. The first is the lack of pressures in training and professional environments to bend to a doctrinaire position. Also included here would be the absence of a charismatic figure to emulate. A second factor, which we have already discussed, is length of clinical experience. As therapists encounter heterogeneous clients and problems over time, they may be more likely to reject a single theory. A third factor is the extent to which doing psychotherapy is making a living or making a philosophy of life; Robertson asserts that eclecticism is more likely to follow the former, consistent with the research reviewed above. In the words of several distinguished scientist-practitioners (Ricks, Wandersman, & Poppen, 1976, p. 401):

So long as we stay out of the day to day work of psychotherapy, in the quiet of the study or library, it is easy to think of psychotherapists as exponents of competing schools. When we actually participate in psychotherapy, or observe its complexities, it loses this specious simplicity.

The remaining three factors are personality variables: an obsessive-compulsive drive to pull together all the interventions of the therapeutic universe; a maverick temperament to move beyond some theoretical camp; and a skeptical attitude toward the status quo. Although these factors require further confirmation, they are supported by our training experiences and the personal histories of prominent clinicians represented in this volume and elsewhere (see chapters 3–15; Goldfried, 2001).

## Survey Glimpses

Definitions of psychotherapy integration do not tell us what individual psychotherapists actually do or what it means to be an eclectic or integrative therapist. Several studies, however, have attempted to do just that.

In an early survey of eclectic psychologists in the United States, Garfield and Kurtz (1977) discerned 32 different theoretical combinations used by 145 eclectic clinicians. The most popular two-orientation combinations, in descending order of frequency, were psychoanalytic and learning theory; neo-Freudian and learning theory; neo-Freudian and Rogerian theory; learning theory and humanistic theory; and Rogerian and learning theory. Most combinations were blended and employed in an idiosyncratic fashion. The investigators concluded that the designation of eclectic covers a wide range of views, some of which are quite distinct from others.

Replications of the seminal Garfield and Kurtz study in 1988 and again in 2004 enlarged and updated the findings. In the most recent study (Norcross, Karpiak, & Lister, 2004), exactly one-half of the 187 self-identified eclectic/integrative psychologists adhered to a specific theoretical orientation before becoming eclectics or integrationists. This 50% is similar to the two previous studies in which 58% (Norcross & Prochaska, 1988) and 49% (Garfield & Kurtz, 1977) had previously adhered to a single orientation. The previous theoretical orientations were varied but were principally psychodynamic (41%), cognitive (19%), and behavioral (11%). Thus, as with the earlier findings and other studies (e.g., Jayaratne, 1982; Jensen, Bergin, & Greaves, 1990), the largest shift continues to occur from the psychodynamic and psychoanalytic persuasions and the next largest from the cognitive and behavioral traditions.

Eclectic psychologists rated the frequency of the use of six major theories (behavioral, cognitive, humanistic, interpersonal, psychoanalytic, systems, and other) in their eclectic/integrative practice. To permit historical comparisons with the earlier studies, we examined the individual ratings to determine the most widely used combinations of two theories. The most frequent combinations of theoretical orientations constituting eclectic/integrative practice are summarized in Table 1.3. All 15 possible combinations of the six theories presented were endorsed by at least one self-identified

eclectic/integrationist. As seen in the table, cognitive therapy predominates; in combination with another therapy system, it occupies the first 5 of the 15 combinations and accounts for 42% of the combinations. Put differently, cognitive therapy is the most frequently and most heavily used contributor to an eclectic or integrative practice, at least in the United States.

Over time, the behavioral and psychoanalytic combination as well as the behavioral and humanistic combination have slipped considerably. They have gradually dropped from the first and third most frequently combined theories in 1977 to the ninth and fourth in 1988 and now to thirteenth and fourteenth in 2004. The behavioral and psychoanalytic hybrid—accounting for 25% of the combinations in the 1970s and only 1% on the 2000s—has firmly been replaced by cognitive hybrids.

This study and other research demonstrate an emerging preference for both the term *integration* and the practice of theoretical or assimilative integration, as opposed to technical eclecticism. Fully 59% preferred the term *integrative* compared to 20% who favored *eclecticism*. Fully 54% embraced theoretical integration or assimilative integration compared to the 19% who embraced technical eclecticism. This preference for integration over eclecticism represents a historical shift. There seems to have been a theoretical progression analogous to social progression: one that proceeds from segregation to desegregation to integration. Eclecticism represented desegregation, in which ideas, methods, and people from diverse theoretical backgrounds mix and intermingle. We have now transitioned from desegregation to integration, with increasing efforts directed at discovering viable integrative principles for assimilating and accommodating the best that different systems have to offer.

The integrative/eclectic orientation consistently remains the most popular orientation in the United States (Bechtoldt et al., 2001), but its constituent parts and even its label continue to evolve. Since the earlier studies, three principal changes are evident: A clear preference for the term and process of *integration* as op-

TABLE 1.3 Most Frequent Combinations of Theoretical Orientations Among Eclectic Psychologists in the United States

Combination	1976		1985		2004	
	Percentage (%)	Rank	Percentage (%)	Rank	Percentage (%)	Rank
Behavioral & cognitive	5	4	12	1	16	1
Cognitive & humanistic	NR		11	2	7	2 (Tie)
Cognitive & psychoanalytic	NR		10	3	7	2 (Tie)
Cognitive & interpersonal	NR		<4	12	6	4 (Tie)
Cognitive & systems	NR		<4	14	6	4 (Tie)
Humanistic & interpersonal	3	6	8	4 (Tie)	5	6
Interpersonal & systems	NR		5	7 (Tie)	4	7
Psychoanalytic & systems	NR		4	9 (Tie)	3	8 (Tie)
Interpersonal & psychoanalytic	NR		<4	15	3	8 (Tie)
Behavioral & interpersonal	NR		<4	13	2	10
Behavioral & systems	NR		5	7 (Tie)	2	11 (Tie)
Humanistic & psychoanalytic	NR		<4	12	2	11 (Tie)
Behavioral & humanistic	11	3	8	4 (Tie)	1	13 (Tie)
Behavioral & psychoanalytic	25	1	4	9 (Tie)	>1	14 (Tie)
Humanistic & systems	NR		6	6	>1	14 (Tie)

Note. NR, not reported

\*Percentages and ranks were not reported for all combinations in the 1976 study (Garfield & Kurtz, 1977).

posed to *eclecticism*; the definite emergence of assimilative integration as another path to integration; and the encroaching dominance of cognitive therapy in eclectic/integrative practice.

Sophisticated integrative practice obviously is more complex than these brief survey glimpses can provide. To echo the authors of the original study, “Some value psychodynamic views more than others, some favor Rogerian and humanistic views, others clearly value learning theory, and various combinations of these are used in apparently different situations by different clinicians” (Garfield & Kurtz, 1977, p. 83). However, eclecticism has gradually lost some of its negative definition as a nondescript brand name for those dissatisfied with orthodox schoolism. Instead, these clinicians actively and positively endorsed eclecticism/integration as much as for what it offers as for what it avoids. When asked if they considered eclecticism/integration the absence of a theoretical orientation or the endorsement of a broader one in its own right (or both), the vast majority of eclectics—85%—conceptualized it as the endorsement of a broader orientation (Norcross, Karpiak, & Lister, 2004). In

other words, integration “by design” is steadily replacing eclecticism “by default.”

### Eclecticism versus Syncretism

The term *eclecticism* has acquired an emotionally ambivalent, if not negative, connotation for some clinicians due to its alleged disorganized and indecisive nature. In some corners, eclecticism connotes undisciplined subjectivity, “muddle-headedness,” the “last refuge for mediocrity, the seal of incompetency,” or a “classic case of professional anomie” (quoted in Robertson, 1979). Many of these psychotherapists wander around in a daze of professional nihilism experimenting with new fad methods indiscriminately. Indeed, it is surprising that so many clinicians admit to being eclectic in their work, given the negative valence the term has acquired.

But much of the opposition to eclecticism should properly be redirected to *syncretism*—uncritical and unsystematic combinations (Norcross, 1990; Patterson, 1990). This haphazard “eclecticism” is primarily an outgrowth of pet techniques and inadequate training, an arbi-

trary, if not capricious, blend of methods by default. They have been called grab-bag feckless eclectics (Smith, 1999). Eysenck (1970, p. 145) characterized this indiscriminate smorgasbord as a “mish-mash of theories, a huggemugger of procedures, a gallimaufry of therapies,” having no proper rationale or empirical verification. This muddle of idiosyncratic and ineffable clinical creations is the antithesis of effective and efficient psychotherapy.

Systematic eclecticism, by contrast, is the product of years of painstaking clinical research and experience. It is truly eclecticism by design; that is, clinicians competent in several therapeutic systems who systematically select interventions based on comparative outcome research and a given patient’s need. The strengths of systematic integration lie in its ability to be taught, replicated, and evaluated. Years ago, Rotter (1954, p. 14) summarized the matter as follows: “All systematic thinking involves the synthesis of pre-existing points of views. It is not a question of whether or not to be eclectic but of whether or not to be consistent and systematic.”

### Three Stages

Werner’s (1948; Werner & Kaplan, 1963) organismic-developmental theory is instructive for conceptualizing psychotherapists’ development of a sophisticated integrative stance. In the first of three developmental stages, one perceives or experiences a global whole, with no clear distinctions among component parts. Unsophisticated laypersons and undergraduates probably fall into this category.

In the second stage, one perceives or experiences differentiation of the whole into parts, with a more precise and distinct perspective of components within the whole. However, one no longer has a perspective on the whole and subsequently loses the big picture. Most psychotherapy courses, textbooks, and clinically inexperienced practitioners fall into this category.

In the third stage, the differentiated parts are organized and integrated into the whole at a higher level. Here, the unity *and* complexity of psychotherapy are appreciated. It is to this

level, we believe, that psychotherapy should aspire.

### Role of Pure-Form Therapies

Conspicuously absent from this primer on integration has been acknowledgment of the conventional, “pure-form” (or brand name) therapy systems, such as psychoanalytic, behavioral, experiential, and systems. Although it may not be immediately apparent, pure-form therapies are part and parcel of the integration movement. In fact, integration could not occur without the constituent elements provided by the respective therapies—their theoretical systems and clinical methods.

In a narrow sense, pure-form or single-theory therapies do not contribute to the integration movement because they have not generated paradigms for synthesizing various interventions and conceptualizations. But in broader and more important ways, they add to our therapeutic armamentarium, enrich our understanding of the clinical process, and produce the process and outcome research from which integration draws. One cannot integrate what one does not know.

In this respect, we should be reminded that the so-called “pure-form” psychotherapies are themselves “second-generation” integrations. In factor analytic terms, virtually all neo-Freudian approaches would be labeled “second order” constructs—a superordinate result of analyzing and combining the original components (therapies). Just as Freud necessarily incorporated methods and concepts of his time into psychoanalysis (Frances, 1988), so do newer therapies. All psychotherapies may, therefore, be viewed as products of an inevitable historical integration—an oscillating process of assimilation and accommodation (Sollod, 1988).

An appreciation of this historical process can temper the judgmental flavor frequently expressed toward those who may be antagonistic toward psychotherapy integration. These antagonistic characterizations—“rigid,” “invertebrate,” “narrow,” “close-minded,” for instance—are likely to result in a win-lose, zero-sum encounter, in which the integrative “good guys” seek victory over the separatistic “bad guys.”

Such an attitude will do little to promote a welcoming attitude toward integration on the part of the “opposition” and even less to build on the documented successes of pure-form therapies. The objective of the integration movement, as I have repeatedly emphasized, is to improve the effectiveness of psychotherapy. To obtain this end, the valuable contributions of pure-form therapies must be collegially acknowledged and their respective strengths collaboratively enlisted.

## OBSTACLES TO INTEGRATION

Enthusiasts of psychotherapy integration have not always seriously considered their potential obstacles and trade-offs. If we are to avoid uncritical growth or fleeting interest in eclectic/integrative psychotherapy, then some honest recognition of the barriers we are likely to encounter is sorely needed. Caught up in the excitement and possibilities of the movement, we have neglected the problems—the “X-rated topics” of integration. Healthy maturation, be it for individuals or for movements, requires self-awareness and constructive criticism.

What is stopping psychotherapy integration from progressing? Survey research of prominent integrationists (Norcross & Thomas, 1988) and special journal sections (Norcross & Goldfried, *in press*) converge in highlighting several obstacles.

Probably the most severe obstruction centers on the partisan zealotry and territorial interests of “pure” systems psychotherapists. Representative responses in the survey research (Norcross & Thomas, 1988) were “ego-centric, self-centered colleagues,” “the institutionalization of schools,” and “ideological warfare, factional rivalry.” Unfortunately, professional reputations are made by emphasizing the new and different, not the basic and similar. Careers are “made by making history, not knowing it” (Goldfried, 2001, p. xx). In the field of psychotherapy, as well as in other scientific disciplines, the ownership of ideas secures far too much emphasis. Although the idea of naturally occurring, cooperative efforts among professionals is engaging, their behavior, realistically,

may be expected to reflect the competition so characteristic of our society at large (Goldfried, 1980).

Inadequate training in eclectic/integrative therapy is another recurrent impediment. Training students to competence in multiple theories and interventions is unprecedented in the history of psychotherapy. Understandable in light of its exacting nature, the acquisition of integrative perspectives has occurred quite idiosyncratically and perhaps serendipitously to date (see Chapter 21). Designing an integrative training program is a massive task; gathering support for such a program from all of the faculty members is probably even more intimidating.

A third obstacle concerns differences in ontological and epistemological issues. These entail basic and sometimes contradictory assumptions about human nature, determinants of personality development, and the origins of psychopathology (Messer, 1992). For instance, are people innately good, evil, both, neither? Do phobias represent learned maladaptive habits or intrapsychic conflicts? Is the primary purpose of psychotherapy to facilitate insight, restructure relationships, modify overt behavior, or promote self-actualization? Interestingly enough, it may precisely be these diverse world views that make psychotherapy integration interesting, in that it brings together the individual strengths of these complementary orientations. Profound epistemological and ontological differences impede rapid or wholesale integration (Allport, 1968). But even here, most antagonists believe the movement “deserves a fair hearing and a substantial trial” (Messer, 1983, p. 132).

Another obstacle to a consensually supported integration—widely discussed in the 1990s but not lately—is the absence of a common language. Each psychotherapeutic tradition has its own jargon, clinical shorthand among its adherents, which widens the precipice across differing orientations. The “language problem,” as it has become known, confounds understanding and, in some cases, leads to active avoidance of each other’s constructs. Many a behaviorist’s mind has wandered when case discussions turn to “transference issues”

and “warded off conflicts.” Similarly, psychodynamic therapists typically tune out buzzwords like “conditioning procedures” and “discriminative stimuli.” Isolated language systems encourage clinicians to wrap themselves in semantic cocoons from which they cannot escape and which others cannot penetrate.

Before an agreement or a disagreement can be reached on a given matter, it is necessary to ensure that the same phenomenon is, in fact, being discussed. Punitive superego, negative self-statements, and poor self-image may indeed be similar phenomena, but that cannot be known with certainty until the constructs are defined operationally and consensually. Without a common language, the field resembles a Tower of Babel (Messer, 1987).

In the short run, using the vernacular—descriptive, ordinary natural language—might suffice (Driscoll, 1987). One metaphor for a common metalanguage is the *lingua franca* that grows up in marketplaces, where communication among people of many cultures and languages is honed down to the essentials needed for transacting essential business (Andrews, 1989). In the long run, the field of psychotherapy ultimately needs a language system that is tied to a database. Such an evidence-based common language may hail from cognitive psychology or interpersonal psychology. In the meantime, while the field decides whether and how it will implement a common language, Messer (1992) reminds us that there is much to be learned by becoming fluent in a number of current theoretical languages. He argues that “. . . this way, we can better appreciate the concepts, ideology, and terms of other viewpoints. This will surely lead to the permeation of ideas from one theory to another. . . .” (p. 198).

A final obstacle to be addressed here is the challenge of continually expanding integrative therapies to incorporate newer elements. Early integrative and eclectic therapies needed to be revamped to include family systems, feminist, cognitive therapies, and, in some cases, narrative or constructivist therapies. A contemporary case in point is the multicultural/cross-cultural element. For too long, we have treated patients, disorders, and their goals outside the

context of their culture (Ivey & Brooks-Harris, this volume). Yet, integrative therapies have been slow in incorporating a multicultural dimension. If the integration movement ignores these key additions, the end point will be insulated, albeit newly packaged versions of psychotherapy that do not challenge the narrow traditions and that do not address the needs of the populations we serve (Rigazio-Digilio, Gonçalves, & Ivey, 1996).

## CONCLUDING COMMENTS

Psychotherapy integration, as presented in this *Handbook*, is a vibrant, maturing, and international movement that has made encouraging contributions to the field. Integrative perspectives have been catalytic in the search for new ways of conceptualizing and conducting psychotherapy that go beyond the confines of single schools. They have encouraged practitioners and researchers to examine what other therapies have to offer, particularly when confronted with difficult cases and therapeutic failures. Rival systems are increasingly viewed not as adversaries, but as a welcome diversity (Landsman, 1974); not as contradictory, but as complementary. Transtheoretical dialogue and cross-fertilization fostered by the integrative spirit are very much the order of the day. Whether considered a revolutionary paradigm shift or merely a theme that cuts across theoretical orientations, psychotherapy integration will most certainly be a therapeutic mainstay of the twenty-first century.

The success of the integration movement, however, raises two crucial questions for its future. The first question is whether there will be sufficient empirical evidence in support of integrative and eclectic treatments to compel educators and practitioners to embrace them. In recent years, the empirical outcome literature on integrative treatments has grown considerably (Schottenbauer, Glass, & Arnkoff, this volume), and controlled research has been undertaken on many of the integrative therapies presented in this *Handbook*. Nevertheless, much work is left to be done, and most integrative treatments continue to be promulgated in

the absence of any rigorous outcome research (Kazdin, 1996; Norcross, 1995b). The call for rapprochement is intellectually and clinically appealing, but in an era of accountability and evidence-based treatments, such an appeal will fall short of the mark unless accompanied by compelling research attesting to the effectiveness, efficiency, and applicability of integrative psychotherapies.

The second question for the future: Will there be competition and proliferation of various schools of integrative therapy, just as there has been intense competition among “pure-form” schools? Partisanship and competition among developing integrative models would simply be repeating the same old historical mistakes of psychotherapy. Integrative therapies could, ironically, become the rigid and institutionalized perspectives that psychotherapy integration attempted to counter in the first place. Rather, my view of—and hope for—psychotherapy integration is that it will engender an open system of informed pluralism, deepening rapprochement, and evidence-based practice, one that leads to improved effectiveness of psychosocial treatments. The tell-tale sign of the success of a movement is not how long it lasts, but what it leaves.

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## A History of Psychotherapy Integration

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Alas, our theory is too poor for experience.

—Albert Einstein

No, no! Experience is too rich for our theory.

—Niels Bohr

The idea of being able to integrate the psychotherapies has intrigued mental health professionals since the early part of the twentieth century. It is only since the 1980s, however, that psychotherapy integration has developed into a clearly delineated area of interest. Prior to that, it was more of a latent theme that ran through the literature.

As is the case with any attempt to trace the historical origins of contemporary thought, one never knows for certain the influence that earlier contributions have made to later thinking. More often than not, innovative ideas and findings are initially ignored, only to become assimilated into the mainstream at a later point in time (Barber, 1961). It is possible that the ultimate contribution of an idea lies in its consciousness-raising function. Thus, quite apart from their specific merits, new ideas sensitize us to otherwise neglected areas of thought. With regard to psychotherapy, some notions have continued to live on over the years, whereas others have failed to pass the test of time. Still others disappear after their introduc-

tion only to reappear at a later time when the *zeitgeist* has become more hospitable. As observed by Boring (1950) in his historical analysis of psychology, “an idea too strange or preposterous to be thought in one period . . . may [later] be readily accepted as true” (p. 3). The marked interest in developing a rapprochement across the psychotherapies dramatically illustrates this phenomenon.

In this chapter, we begin with a historical review of past efforts at psychotherapy integration, covering the work that has been done through the end of the twentieth century. Finally, we describe the development of a professional reference group whose purpose is to support continued work in this area.

### EARLY ATTEMPTS AT INTEGRATION

In what represented one of the earliest attempts at integrating the psychotherapies, French delivered an address at the 1932 meeting of the American Psychiatric Association in which he

drew certain parallels between psychoanalysis and Pavlovian conditioning (e.g., the similarities between repression and extinction). The following year, the text of French's presentation was published, together with comments by members of the original audience (French, 1933). As one might expect, French's presentation resulted in very mixed audience reaction. As one of the most unabashedly negative responses by a member of the audience, Myerson acknowledged:

I was tempted to call for a bell-boy and ask him to page John B. Watson, Ivan Pavlov, and Sigmund Freud, while Dr. French was reading his paper. I think Pavlov would have exploded; and what would have happened to Watson is scandalous to contemplate, since the whole of his behavioristic school is founded on the condition reflex . . . Freud . . . would be scandalized by such a rapprochement made by one of his pupils, reading a paper of this kind. (in French, 1933, p. 1201)

Adolph Meyer was not nearly as unsympathetic. Although he stated that the field should encourage separate lines of inquiry and should not attempt to substitute any one for another too prematurely, Meyer nonetheless suggested that one should "enjoy the convergences which show in such discussions as we have had this morning" (French, 1933, p. 1201). Gregory Zilboorg, who was also in the audience at the time, took an even more favorable stand, noting:

I do not believe that these two lines of investigation could be passed over very lightly. . . . There is here an attempt to point out, regardless of structure and gross pathology, that while dealing with extremely complex functional units both in the physiological laboratory and in the clinic, we can yet reduce them to comparatively simple phenomena. (French, 1933, pp. 1198–1199)

In an extension of French's attempts, Kubie (1934) maintained that certain aspects of psychoanalytic technique itself could be explained in terms of the conditioned reflex. Noting that Pavlov hypothesized that certain associations might exist outside of an individual's awareness because they took place under a state of inhibition, Kubie suggested that free association

might serve to remove the inhibition and allow such unconscious association to emerge.

In 1936, Rosenzweig published a brief article in which he argued that the effectiveness of various therapeutic approaches probably had more to do with their common elements than with the theoretical explanations on which they were based. In this article, which had as its subtitle, "At last the Dodo said, 'Everybody has won and all must have prizes,'" Rosenzweig suggested three common factors: (a) Therapist's personality has much to do with the effectiveness of the change process, as it may function to inspire hope in patients or clients. (b) Interpretations are helpful because they provide alternative and perhaps more plausible ways of understanding a particular problem. (c) Even though varying theoretical orientations may focus on different aspects of human functioning, they can all be effective because of the synergistic effects that one area of functioning may have on another.

At the 1940 meeting of the American Orthopsychiatric Association (Watson, 1940), a small group of therapists got together to discuss areas of agreement in psychotherapy. Commenting on the points of commonality (e.g., the importance of the therapeutic interaction), Watson astutely observed that "if we were to apply to our colleagues the distinction, so important with patients, between what they tell us and what they do, we might find that agreement is greater in practice than in theory" (p. 708).

In his book *Active Psychotherapy*, Herzberg (1945) described how systematically prescribed "homework" assignments might be used within the context of psychodynamic therapy. Anticipating an important behavioral contribution to the field by more than a decade, Herzberg proposed the use of graded tasks, particularly in those cases where the clients' avoidance behavior was based on anxiety.

Woodworth's 1948 text, *Contemporary Schools of Psychology*, explored the development and substantive content of the then existing schools of psychological thought, such as behaviorism, gestalt psychology, and the psychoanalytic schools. He recognized that although each school had made gains in its own respective chosen direction, "no one [school] is good

enough” (p. 255). Observing that psychology was advancing in many different directions, Woodworth wondered “whether synthesis of the different lines of advance [might] not sometime prove to be possible” (p. 10).

Close on the heels of this thesis was a landmark work in the history of psychotherapy integration, namely, Dollard and Miller’s classic book, *Personality and Psychotherapy*, published in 1950 and dedicated to “Freud and Pavlov and their students.” The importance of Dollard and Miller’s work in the history of psychotherapy can be attested to by the fact that this book has remained in print for more than 50 years. Although behavior therapists have argued that Dollard and Miller’s thinking had little impact on the development of behavior therapy, the fact that the work is continually referenced suggests that it has widely been read. In their work, Dollard and Miller described in detail how such psychoanalytic concepts as regression, anxiety, repression, and displacement may be understood within the framework of learning theory. For the most part, Dollard and Miller merely translated one language system into another. Nonetheless, they did point to certain factors that may very well be common to all therapeutic approaches, such as the need for the therapist to support an individual’s attempt at changing by expressing empathy, interest, and approval for such attempts.

Even though Dollard and Miller (1950) stayed fairly close to the interventions associated with psychoanalytic therapy, they made continual reference to principles and procedures on which contemporary behavior therapy is based. Thus, Dollard and Miller suggest: the value of modeling procedures (e.g., “watching a demonstration of the correct response may enable the student to perform perfectly on the first trial,” pp. 37–38); the use of hierarchically arranged tasks (e.g., “the ideal of the therapist is to set up a series of graded situations where the patient can learn,” p. 350); reinforcement of gradual approximations toward a goal (e.g., “if a long and complex habit must be learned, the therapist should reward the subunits of the habit as they occur,” p. 350); the principle of reciprocal inhibition (e.g., “like any other response, fear apparently can

be inhibited by responses that are incompatible with it,” p. 74); the significance of the reinforcing characteristic of the therapist (e.g., “the therapist uses approval to reward good effort on the part of the patient,” p. 395); the importance of teaching the individual self-control or coping skills to be used after therapy (e.g., “it is theoretically possible that special practice in self-study might be given during the latter part of a course of therapeutic interviews. The patient might be asked to practice solving particular problems . . . [under conditions] as similar as possible to those to be used after therapy,” p. 438); the treatment of orgasmic dysfunctions via masturbation (e.g., “at one point in a therapeutic sequence, the therapist might have to reward masturbation so that the patients may experience the sexual orgasm for the first time” p. 350); and the importance of environmental contingencies for maintaining behavior change (e.g., “the conditions of real life must be favorable if new responses are to become strong habits,” p. 427).

Unlike Dollard and Miller (1950), whose primary emphasis was on the integration of two theoretical orientations, Frederick Thorne (1950) was interested in pursuing therapeutic integration on the basis of what we know empirically about how people function and change. From the time that he was a medical student, Thorne was struck by the fact that medicine was not divided up into different schools of thought, but rather that basic principles of bodily functioning were what guided clinical practice.

Like Thorne, Garfield has long been interested in an empirically based approach to therapy, and in 1957 he outlined what appeared to be common points among the psychotherapies. In an introductory clinical psychology text, Garfield noted such universal factors as an understanding and supportive therapist, the opportunity for emotional catharsis, and the provision of self-understanding.

Glad’s (1959) *Operational Values in Psychotherapy* took issue with the relative inflexibility of psychotherapy when practiced, to the letter, according to any given theoretical persuasion. He thought that the value systems instilled by doctrinaire approaches posed major limitations, and therefore recommended that the

practicing therapist be exposed to (if not specifically trained in) systematic operations of psychotherapists from the major theoretical approaches of the time.

### MORE RECENT TRENDS TOWARD RAPPROCHEMENT

The topic of therapeutic rapprochement was seriously addressed by only a handful of writers in the 1950s, due, no doubt, to the fact that no single approach to psychotherapy had yet gained enough momentum to challenge psychoanalytic therapy. Perhaps it was also the conservative social and political climate of the 1950s that served to discourage therapists from questioning their paradigms. The 1960s, along with the broad array of societal challenges that came with them, brought a sharp increase in the number of books and articles dealing with rapprochement.

#### The 1960s

The most significant contribution to the integration of psychotherapies made in the early 1960s was Jerome Frank's (1961) *Persuasion and Healing*. This book addressed itself to commonalities cutting across varying attempts at personal influence and healing in general. Similar change processes, Frank observed, can be seen in such diverse methods as religious conversion, primitive healing, brainwashing, and the placebo effects that occur in the practice of medicine. When distressed individuals are placed in any of these contexts, an expectancy for improvement and an arousal of hope result in a concomitant increase in self-esteem and improved functioning. It should be pointed out that although Frank continued, in his later writings, to stress common factors across the psychotherapies, in one of his later reviews of the field (Frank, 1979), he acknowledged that certain clinical problems (e.g., fears, phobias, compulsive rituals) may effectively be dealt with by methods that go beyond the general nature of the therapeutic interaction.

Thirty years after the publication of French's landmark article, a colleague of his, Alexander

(1963), suggested that psychoanalytic therapy might profitably be understood in terms of learning theory. Based on an analysis of tape recordings of psychoanalytic therapy sessions, Alexander concluded that many of the therapeutic changes that occurred "can best be understood in terms of learning theory. Particularly the principle of reward and punishment and also the influence of repetitive experiences can be clearly recognized" (p. 446). A therapist who was dedicated throughout his career to the advancement of the field, Alexander suggested that "we are witnessing the beginnings of a most promising integration of psychoanalytic theory with learning theory, which may lead to unpredictable advances in the theory and practice of the psychotherapies" (p. 448). A year later, Marmor, involved in the same program of psychotherapy research, described in detail the learning principles that he believed to underlie psychoanalytic therapy (Marmor, 1964).

About this time, Carl Rogers (1963) published an article dealing with the current status of psychotherapy. He noted that the field was "in a mess," but that the theoretical orientations within which therapists had typically functioned were starting to break down. He stated that the field was now ready to shed itself of the limitations inherent in specific orientations—including client-centered therapy—and that it was essential to observe more directly exactly what goes on during the course of psychotherapy.

London (1964), in a short but insightful book entitled *The Modes and Morals of Psychotherapy*, pointed to the inherent limitations associated with both the psychodynamic and behavioral orientations. He suggested:

There is a quiet blending of techniques by artful therapists of either school: a blending that takes account of the fact that people are considerably simpler than the Insight schools give them credit for, but that they are also more complicated than the Action therapists would like to believe. (p. 39)

Marks and Gelder (1966) also compared behavior therapy and psychodynamic procedures. Although acknowledging that there was probably common ground between the two ap-



proaches, Marks and Gelder also underscored certain differences. They further suggested that the two approaches should be viewed as potentially contributing to each other, rather than necessarily being antagonistic in nature. Arguing for the integration of learning theory with psychoanalysis, Wolf (1966) suggested that “their integration is sooner or later inevitable, however passionately some or many of us may choose to resist it” (p. 535).

The very important concept of “technical eclecticism” was introduced in 1967 by Arnold Lazarus, who maintained that clinicians could use techniques from various therapeutic systems without necessarily accepting the theoretical underpinnings associated with these methods. Starting from this pragmatic point of view, Lazarus maintained that the ultimate standard of utility should rest on empirical, not theoretical grounds. His views were eventually expanded and revised into the development of multimodal therapy (Lazarus, 1989). Appearing in that same year as Lazarus’ landmark paper was an article by Patterson (1967) on divergent and convergent elements across the psychotherapies; a paper by Whitehouse (1967) on the generic principles underlying a variety of therapeutic interventions; and a discussion by Weitzman (1967) of how systematic desensitization may profitably be used within a psychoanalytic context.

Brady (1968), responding to the practical demands of doing actual clinical work, argued that behavioral and psychodynamic approaches were not necessarily contradictory in nature but could, in certain cases, be used in combination. He described the treatment of a preorgasmic woman with systematic desensitization and short-term psychodynamic therapy focusing on the woman’s relationship with her husband. In a similar vein, Leventhal (1968) described a case of a woman experiencing anxiety over sexuality who was successfully treated with combined behavioral and insight-oriented interventions.

Developing this line of reasoning, Bergin (1968) asserted that systematic desensitization could be made into an even more powerful treatment procedure if accompanied by therapist warmth, empathy, and moderate interpre-

tation. Bergin reasoned that such extrabehavioral activities were important because they elicited cognitive and emotional responses that are intimately tied to the behavioral situations addressed in the desensitization hierarchies. He maintained that a theory of therapy that addressed a more universal set of psychological events would be less likely to lead therapists to conceptual dead-ends in the face of particularly complex cases. Along these same lines, in an article offering a rationale for “psychobehavioral therapy,” Woody (1968) observed that the integration of behavior therapy and psychodynamic therapy was particularly relevant for cases that were unresponsive to treatment.

In the following year, Kraft (1969) presented clinical evidence that systematic desensitization could help patients gain insight into a wealth of unconscious material through both imagery and relaxation in the face of previously feared objects or situations. In a theoretical paper examining the similarities among psychoanalytic, behavioral, and client-centered therapy, Sloane (1969) maintained that common factors ran through all three orientations, and that the underlying process of therapeutic change probably involved principles of learning. Commenting on Sloane’s paper, Marmor (1969) agreed that all therapies involve some application of learning principles, either directly or unwittingly, but argued that the simple S-R model could not explain some of the more complex aspects of human functioning. Moreover, like London (1964), Marks and Gelder (1966), Lazarus (1967), Brady (1968), Bergin (1968), and others, Marmor concluded that behavioral and psychodynamic therapies are probably best viewed as complementary in nature, with neither model being totally applicable to all cases. Cautioning against a haphazard piecing together of techniques from different orientations, Brammer (1969) maintained that what was needed was an eclecticism based on research findings about the effectiveness of various treatment procedures.

## The 1970s

The year 1970 marked the inauguration of a new journal, *Behavior Therapy*. Interestingly

enough, editors and contributors devoted serious attention to theory and therapy that were not strictly “behavioral.” Thus, Birk (1970) described two clinical cases to illustrate the potential integration of behavior therapy with psychodynamic theory. Bergin (1970a) followed his earlier treatise on nonbehavioral “adjuncts” to systematic desensitization with an article that went so far as to claim that desensitization proper was, in fact, much more than a simple counterconditioning process, drawing heavily upon cognitive and relationship variables. Bergin (1970b, p. 207), in applauding the recent introduction of cognitive methods into behavior therapy, observed that:

The sociological and historical importance of the movement should not be underestimated for it has three important consequences. It significantly reduces barriers to progress due to narrow school allegiances, it brings the energies of a highly talented and experimentally sophisticated group to bear upon the intricate and often baffling problems of objectifying and managing the subjective, and it underscores the notion that a pure behavior therapy does not exist.

As it turned out, Bergin’s observations were very much on the mark; many of the behavior therapists who became involved in the development of cognitive procedures (e.g., Davison, Goldfried, Lazarus, Mahoney, Meichenbaum) later moved on to an interest in therapeutic integration.

In a consideration of the importance of the therapeutic relationship within a behavioral approach, Truax and Mitchell (1971) noted that the successful procedures of behavior therapy were not being delivered in an interpersonal vacuum. Although they lamented the evident difficulties involved in conducting research on the therapy interaction, they suggested—as Rosenzweig (1936) had done some 35 years earlier—that there existed important therapist characteristics that contributed to the change process, regardless of therapeutic orientation.

Marmor published an article on therapeutic integration in that same year (Marmor, 1971, p. 26), in which he suggested:

The research on the nature of the psychotherapeutic process in which I participated with Franz Alexander, beginning in 1958, has convinced me that all psychotherapy, regardless of the techniques used, is a learning process. . . . Dynamic psychotherapies and behavior therapies simply represent different teaching techniques, and their differences are based in part on differences in their goals and in part on their assumptions of the nature of psychopathology.

Most contemporary behavior therapists probably would now agree with Marmor’s clinical observation that not only simple conditioning but also cognitive learning occurs during the course of therapy.

In a scholarly review of the psychotherapy outcome literature, Bergin (1971) recognized the important empirical contributions that behavior therapy had begun to make. Nonetheless, he concluded that the field needed to remain open to the “many fertile leads yet to be extracted from traditional therapy” (p. 254). Responding to Bergin’s observations that behavior therapy alone was not always effective clinically, Lazarus (1971) described in *Behavior Therapy and Beyond* a wide array of both behavioral and nonbehavioral techniques that may be employed by broad-spectrum behavior therapists. In the same year, Woody (1971) also published a book integrating behavioral and insight-oriented procedures; Woody suggesting that the practicing clinician is capable of selecting and integrating procedures from varying sources based purely on pragmatic grounds. Marks (1971, p. 69) similarly noted the beginning trends toward rapprochement, observing that therapists “are growing less reluctant to adopt methods with pedigrees outside their own theoretical systems.”

Houts and Serber’s (1972) edited book, *After the Turn On, What?*, described the experiences of seven researchers and practitioners who spent a weekend together in an encounter group. Ranging from radical behaviorism to cognitive learning in orientation, the participants described what they saw to be both assets and liabilities of their group experience. As a part of a larger project to try to determine the future course of psychotherapy research, Bergin and Strupp (1972) reported on their con-

tacts with researchers throughout the country. Among those interviewed was Neal Miller, who predicted that as behavior therapy began to become involved with more complicated types of cases, and as psychodynamic therapy focused more on ego mechanisms and the working-through process, the two therapeutic approaches would eventually start to converge in some interesting ways.

In a provocative article on the “end of ideology” in behavior therapy, London (1972) asked his behavioral colleagues to declare a truce in their strife with other orientations and to look more realistically and pragmatically at what we are able to do clinically. Very much the pragmatist, London cautioned against becoming overly enamored with theories, noting that “the first issue, scientifically as well as clinically, is the factual one—do they work? On whom? When? The how and why come later” (p. 919).

Other efforts at therapeutic integration that appeared in 1972 included a book by Martin that attempted to integrate learning theory with client-centered therapy; a description of universal healing processes as seen among psychotherapists and witchdoctors alike (Torrey, 1972); and a set of papers dealing with the theoretical and clinical aspects of the integration of psychodynamic and behavior therapies (Feather & Rhoads, 1972a, 1972b). Feather and Rhoads (1972a) argued that in psychology, as in medicine, the existence of many treatments for a given disorder probably signaled a poor understanding of the disorder, and that none of the separate individual treatments was likely to be adequate.

Commenting on one of Feather and Rhoads’ articles appearing in the previous year, Birk (1973) noted that one area of complementarity between the behavioral and psychodynamic approaches was that the former dealt more with external stimuli, whereas the latter tended to focus on stimuli that are more internal in nature. Strupp (1973), stressing the common elements underlying all psychotherapies, underscored the therapeutic relationship as a vehicle for change, providing the patient with a corrective learning experience. Thoresen (1973) suggested that many of the philosophical underpinnings of behaviorism and humanism

were in agreement, and that it was possible to view a behavioral approach as providing the technology by which certain humanistic goals might be achieved. Appearing in that same year was a report of two cases of sexual deviance (Woody, 1973), in which successful treatment was accomplished by aversion therapy and short-term psychodynamic therapy, administered concurrently by separate therapists.

A fair number of articles appeared in 1974 on the issue of therapeutic rapprochement. In an intriguing discussion of behavioral and psychodynamic approaches as “complementary” rather than mutually exclusive, Ferster (1974)—a well-known Skinnerian—described what he considered to be some of the merits of psychoanalytic therapy. The complementary nature of different approaches was demonstrated by Lambley (1974) in the treatment of an obsessive-compulsive disorder. Birk and Brinkley-Birk (1974) provided a conceptual integration of psychoanalysis and behavior therapy, suggesting that insight can set the stage for change, whereas behavior therapy provides some of the actual procedures by which the change process may be brought about. Birk (1974) also illustrated how intensive group therapy might be implemented by combining behavioral and psychoanalytic principles, and Rhoads and Feather (1974) described cases treated with desensitization procedures that were modified along psychodynamic lines.

Kaplan (1974), in her book *The New Sex Therapy*, outlined how a psychodynamic approach to therapy may be integrated with performance-based methods, and Sollod’s (1975) article expounded on the merits of this structured and synergistic integrative approach to sex therapy. In a report of the Menninger Foundation Psychotherapy Research Project, Horwitz (1974, 1976) noted that inasmuch as supportive treatment was just as effective as insight-oriented therapy, the psychodynamic approach needed to consider alternative methods of producing therapeutic change that might not readily fit into its usual conceptual model. Similarly, Silverman (1974) made suggestions to his psychoanalytic colleagues that there is much to learn from “other approaches that can make (unmodified) psychoanalytic treatment

more effective" (p. 305). In a paper delivered at the 1974 meeting of the American Psychological Association, Landsman (1974) urged his humanistically oriented colleagues to attend to some of the contributions of behavior therapy, such as "attention to specifics, to details, careful quantification, modesty in claims, demonstrable results" (p. 15).

In his incisive book, *Misunderstandings of the Self*, Raimy (1975), like Frank (1961), suggested that various approaches to therapy all seem to be directed toward changing clients' misconceptions of themselves and of others. All therapies are alike in that they "present evidence" to assist individuals in changing these misconceptions; the type of evidence and the way it is presented, however, vary across different therapeutic orientations. An article by the German psychologist Bastine (1975), amplified upon a few years later (Bastine, 1978), likewise outlined common strategies together with the techniques by which they may be implemented. In his clinically oriented book on the therapeutic change process, Egan (1975) modified his original humanistic orientation to acknowledge that although the contributions of Rogers (1963) and others are essential for establishing the type of therapeutic relationship in which change can take place, behavior therapy offers methods to implement specific action programs. Also in 1975, Sloane, Staples, Cristol, Yorkston, and Whipple published their findings on psychodynamic and behavior therapists' activities, showing that therapists from both orientations demonstrated comparable degrees of warmth and positive regard, and that patients of both types of therapists exhibited the same depth of self-exploration.

On a theoretical level, Sheckman (1975) suggested that behavioral principles might provide psychoanalysis with a more adequate theory of learning. Paul Wachtel (1975), in the first of his many writings on therapy integration, cited the contributions made to psychodynamic therapy by Alexander, Horney, and Sullivan as evidence that behavioral approaches, which attempt to deal directly with problematic behaviors, could readily be incorporated into a psychodynamic framework. This is a two-way street, argued Wachtel, in that many

instances of relapse following behavior therapy might possibly be linked to the client's maladaptive patterns that might more readily be identified when viewed from within a psychodynamic framework. Wachtel (1977) went on to explore such integration at greater length in his well-known and challenging book, *Psychoanalysis and Behavior Therapy*, in which he maintained that the convergence of clinical procedures from each orientation would likely enhance the effectiveness of our intervention attempts.

In 1976, a number of articles and books touched on therapeutic integration. Hans Strupp (1976) criticized psychoanalytic therapy for not keeping up with the times, using therapeutic procedures more on the basis of faith than data. In a commentary on Strupp's article, Grinker (1976) underscored the need for a therapeutic approach based on research findings and noted that with added clinical experience, even the most orthodox of psychoanalysts learn that other methods are needed to help facilitate change. As a practicing psychoanalyst with personal experience in the human potential movement, Appelbaum (1976) suggested that some gestalt therapy methods may complement more traditional psychoanalytic techniques. Appelbaum's excursion into more humanistically oriented activities were described in fascinating detail in a later book (Appelbaum, 1979).

Wandersman, Poppen, and Ricks' (1976) *Humanism and Behaviorism* offered discussions by members of each orientation, which attempted to acknowledge points of potential integration. In Burton's (1976) edited volume, *What Makes Behavior Change Possible?*, 16 representatives of diverse orientations addressed themselves to some of the basic questions about the essential ingredients of therapeutic change. Noting that behavior therapy was a useful framework for dealing with clinical cases but still incomplete in and of itself, Hunt (1976) argued that there exists no single orientations that can deal with all clinical material.

In their book *Clinical Behavior Therapy*, Goldfried and Davison (1976) maintained that behavior therapy need no longer assume an antagonistic stance *vis-à-vis* other orientations.

Acknowledging that there is much that clinicians of different orientations have to say to each other, they suggested: "It is time for behavior therapists to stop regarding themselves as an outgroup and instead to enter into serious and hopefully mutually fruitful dialogues with their nonbehavioral colleagues" (p. 15). That many clinicians were in effect already doing this was reflected in Garfield and Kurtz's (1976) findings that approximately 55% of clinical psychologists in the United States considered themselves eclectic. Most frequently used in combination were the psychodynamic and learning orientations, a combination that was based on the pragmatics of doing clinical work (Garfield & Kurtz, 1977).

Integration at a clinical level was dealt with in several articles (Lambley, 1976; Levay, Weissberg, & Blaustein, 1976; Murray, 1976; Segraves & Smith, 1976). Also, Lazarus's (1976) book, *Multimodal Behavior Therapy*, extended and refined his broad-spectrum approach to behavior therapy so as to systematically take into account the individual's behaviors, affects, sensations, images, cognitions, interpersonal relationships, and drugs/physiological states.

In the following year, Lazarus (1977), then having practiced behavior therapy for approximately 20 years, questioned whether behavior therapy, as a delimited school of thought, had "outlived its usefulness." He recognized the need to "transcend the constraints of factionalism, where cloistered adherents of rival schools, movements, and systems each cling to their separate illusions" (p. 11). An editorial comment appearing in the *Journal of Humanistic Psychology* (Greening, 1978) applauded Lazarus's 1977 paper and urged readers of the journal to be open to such suggestions for rapprochement.

Commenting on the gap that frequently exists between theory and practice, Davison (1978) delivered a talk at the Association for Advancement of Behavior Therapy (AABT) convention in which he suggested that behavior therapists consider the possibility of using certain experiential procedures in their clinical work. Krasner (1978) outlined the history of both behaviorism and humanism, noting that the two orientations shared some common view of human

functioning (e.g., importance of situational factors, the uniqueness of the individual). He looked forward to the time when representatives in "both camps will decrease mutual battling and recriminations."

Gurman (1978) challenged the usefulness of approaching a psychological problem through the eyes of one theory. Underscoring what we all too often forget, Gurman went on to suggest that "Therapy is not viewed as a reified set of procedures, but as an evolving science" (p. 131). Diamond, Havens, and Jones (1978) independently came to the same conclusion, stressing the need for an eclectic approach to therapy that would be tied to research and theory yet flexible enough to provide highly individualized treatment. In that same year, Fischer (1978) outlined an eclectic approach to social casework, and O'Leary and Turkewitz (1978) described how a communications analysis of marital interaction might be used within the context of behavioral marital therapy. Some of the points of overlap between behavior therapy and Zen Buddhism were outlined by Mikulas (1978) and Shapiro (1978).

A symposium on the compatibility and incompatibility of behavior therapy and psychoanalysis, chaired by Arkowitz (1978), was held at the 1978 AABT Convention. In a subsequently published 1978 convention paper entitled "Are Psychoanalytic Therapists Beginning to Practice Cognitive Behavior Therapy or is Behavior Therapy Turning Psychoanalytic?," Strupp (1983) commented on some of the converging trends that seem to be occurring within each of these orientations. In a reanalysis of agoraphobia, Goldstein and Chambless (1978) described some of the complicating features in dealing with this problem clinically, outlining a comprehensive treatment plan that went beyond the straightforward methods typically associated with a behavioral approach. Also in the same year, Brown (1978) presented case material reflecting the integration of psychodynamic and behavior therapies, and Ryle (1978) suggested that experimental cognitive psychology might provide a common language for the psychotherapies.

Prochaska (1979), in a textbook describing the diverse systems of psychotherapy, concluded

with a chapter that made the case for ultimately developing a transtheoretical orientation that would encompass what may have been found to be effective across different approaches to psychotherapy. In that same year, Knobloch and Knobloch (1979) presented their approach to integrated psychotherapy.

Presenting some interesting parallels between cognitive therapy and psychodynamic therapy, Sarason (1979) suggested that experimental cognitive psychology may provide a conceptual system for understanding both orientations. Goldfried (1979) proposed that cognitive-behavior therapy might be construed as often dealing with an individual's implicit meaning structures, and that use of association techniques from experimental cognitive psychology to study such phenomena should be equally acceptable to clinicians and theorists of a psychodynamic orientation. It is interesting to note that Sarason and Goldfried drew their conclusions independently and without any apparent knowledge of Ryle's (1978) very similar conclusion the year before.

Robertson (1979) speculated on some of the reasons for the existence of eclecticism, such as lack of pressures, in one's training or professional setting, to take a given viewpoint; and a therapeutic orientation reaching a point where "the bloom is off the rose." Related to this last point are the results of Mahoney's (1979) survey of leading cognitive and noncognitive behavior therapists. Among the several questions asked of the respondents was: "I feel satisfied with the adequacy of my current understanding of human behavior." Using a 7-point scale, Mahoney found that the average rating of satisfaction was *less than 2!*

### The 1980s

During the 1980s, psychotherapy integration made a significant advance as a defined area of interest—indeed, a movement. There was a geometric increase in the number of publications and presentations on the topic, making it unwieldy and impractical for us to offer an adequate description of the hundreds of publications that appeared during this decade and the one that followed.

Noting past attempts to find commonalities across psychotherapies, Goldfried (1980) argued that a fruitful level of abstraction at which such a comparative analysis might take place would be somewhere between the specific technique and theoretical explanation for the potential effectiveness of that technique. He maintained that it is at this intermediate level of abstraction—at the level of clinical strategy—that potential points of overlap may exist. One clinical strategy that may very well cut across orientations entails providing the client/patient with "corrective experiences," particularly with regard to fear-related activities. For example, Fenichel (1941, p. 83), on the topic of fear reduction, noted that:

when a person is afraid but experiences a situation in which what was feared occurs without any harm resulting, he will not immediately trust the outcome of his new experience; however, the second time he will have a little less fear, the third time still less.

This very same conclusion was reached by Bandura (1969, p. 414), who observed:

Extinction of avoidance behavior is achieved by repeated exposure to subjectively threatening stimuli under conditions designed to ensure that neither the avoidance responses nor the anticipated adverse consequences occur.

Relevant to this general theme was Nielsen's (1980) description of how certain psychoanalytic concepts are reflected in the practice of gestalt therapy.

In a 1980 special issue of *Cognitive Therapy and Research*, therapists of various orientations answered a set of questions about what they believed to be the most effective ingredients in therapeutic change (Brady et al., 1980). At the 1980 AABT Convention, Goldfried and Strupp (1980) held a dialogue on the issue of rapprochement in which they agreed that in the final analysis, any attempt at finding points of commonality must be based on what clinicians do, rather than what they say they do. Dryden (1980) discussed the differences in therapeutic styles across orientations, particularly as they relate to the concept of transference, Bastine

(1980) observed that a problem-oriented approach to intervention is likely to facilitate psychotherapy integration, and Linsenhoff, Bastine, and Kommer (1980) emphasized that the field of psychotherapy could benefit most from an integration that would be both theoretical and practical.

Messer and Winokur (1980), in an article examining the potential benefits and pitfalls of psychotherapy integration, suggested that both action-oriented and insight-oriented approaches may be used in combination to help patients to translate their insights into action. Mahoney (1980) noted that behaviorists had begun not only to adopt a position that accepted a person's thoughts as useful data, but also to pay attention to "implicit" cognitions. In this manner, cognitive-behavioral theorists and therapists were beginning to examine "unconscious" events.

Marmor and Woods' (1980) edited book, *The Interface Between the Psychodynamic and Behavioral Therapies*, illustrated the theme that no single approach to therapy can deal with all of human functioning. This general theme was reflected in a case report by Cohen and Pope (1980), in which a single client was significantly helped by two cooperating therapists, one behavioral and the other analytic. A survey by Larson (1980) found that although therapists typically used a single orientation as their primary reference point, 65% acknowledged that their clinical work included contributions from a number of other therapeutic approaches. Ryle (1980) reported the findings of a series of case histories, in which an integrated, cognitive-dynamic intervention was found to be clinically effective. Garfield (1980), drawing on different therapeutic orientations in his *Psychotherapy: An Eclectic Approach*, described an empirically oriented view of psychotherapy. Like Bergin before him, he viewed the introduction of cognitive variables into behavior therapy as a particularly important advance.

In 1981, a number of writers furthered the argument that each distinct orientation presents different strengths that can be combined into a more broad-based and useful approach. For example, Arnkoff (1981) reported combining cognitive therapy with the Gestalt empty-chair

technique in order to increase affect and to elicit meaningful cognitions from the patient. The multimodal therapy of Lazarus (1981) essentially maintained that the therapist's choice of therapy techniques must be data-driven, not theory driven.

Schwartz (1981) reported that group psychotherapists who led groups in psychotherapy were moving toward "technical and theoretical eclecticism" in increasing numbers. Addressing the issue of integrative conceptual models, Landau and Goldfried (1981) described in detail how certain concepts from experimental cognitive psychology (e.g., schema, scripts) can offer the field a consistent framework within which cognitive, behavioral, and psychodynamic assessment may fit. Also appearing in 1981 was an article by Rhoads (1981) outlining and illustrating the clinical integration of behavior therapy and psychoanalytic therapy; a chapter by Gurman (1981) that described how different therapeutic orientations may be fitted into a multifaceted empirical approach to marital therapy; and a convention presentation by Sears (1981) relating his own personal observations of the early attempts to link behavior theory with psychoanalytic therapy.

As the discussion of therapeutic integration was becoming increasingly widespread, it became desirable for concerned professionals to arrange meetings to facilitate a more efficient and meaningful exchange of views. For example, in 1981, a small group of clinicians and clinical researchers (Garfield, Goldfried, Horowitz, Imber, Kendall, Strupp, Wachtel, & Wolfe) held an informal, two-day conference to determine whether clinicians of different orientations could communicate with each other about actual clinical material. This group did not attempt to generate any particular product; their primary objective was to have the opportunity to initiate a dialogue with each other.

Communication between psychotherapy practitioners and researchers of diverse orientations became a worldwide phenomenon in the following years. For example, in 1982, the Adler Society for Individual Psychology dedicated their World Congress (held in Vienna) to the exchange of views between representatives of many of the major therapy models. The follow-

ing year, an International Congress in Bogota, Columbia, led by Augusto Perez Gomez, focused on the prospects for the convergence of psychotherapies and a cross-fertilization of ideas. As a way of illustrating how such rapprochement might be implemented, Anchin (1982) described an integration of interpersonal and cognitive-behavioral constructs, Bohart (1982) discussed the points of overlap between cognitive and humanistic therapy, Dryden (1982) indicated how rational-emotive therapy had selected techniques from other orientations, and Mahoney and Wachtel (1982) presented a day-long dialogue and discussion of actual clinical material.

Goldfried and Padawer (1982) argued that the activities of psychotherapists of differing theoretical orientations are highly similar, even though their conceptualizations of cases may be articulated quite differently. Their review of the literature revealed a number of strategies that seem to guide the efforts of most therapists. Focusing on the process of therapeutic change that occurs between sessions, Kazdin and Mascitelli (1982) noted that the study of "extra-therapy practice" might be a fruitful area in which to find commonalities across orientations.

In 1982, the issue of theoretical integration acquired still greater visibility through the publication of a number of books on the topic, authored by clinicians and researchers from diverse backgrounds. In *Converging Themes in Psychotherapy*, Goldfried (1982a) provided a compendium of articles dealing with the issue of rapprochement, together with an overview of the current status and future directions in psychotherapy integration. In *Resistance*, Wachtel (1982b) elicited the views of experienced and well-known therapists in an attempt to explore the possibility that a synthesis of the psychodynamic and behavioral approaches might shed light on resistance to therapeutic change. In *Psychotherapy: A Cognitive Integration of Theory and Practice*, Ryle (1982) assimilated theories and methods of a heterogeneous set of orientations into a common language system—cognitive psychology. In *Marital Therapy*, Segraves (1982), like Ryle, attempted to integrate elements of seemingly disparate theoretical sys-

tems by translating them into the language of cognitive social psychology. The utility of his cognitive-social psychology terminology is exemplified by the persuasive presentation of the concept of "interpersonal schemas," analogous to the analytic concept of "transference," to explain the influence of early-life significant relationships on a person's perceptions of his/her spouse.

In 1983, the frequently asked question of "what therapy activities are most appropriate for what type of problem, by which therapist, for what kind of client/patient?" was addressed by Beutler in his book, *Eclectic Psychotherapy*. This volume suggested ways of maximizing therapeutic effectiveness by reviewing what is known about the optimal matching of patients to therapists and techniques. Fensterheim and Glazer (1983), in *Behavioral Psychotherapy*, highlighted the complementarity of psychoanalytic and behavioral treatment methods. Also appearing in this year was a book on psychotherapy integration in German (Textor, 1983), reflecting the growth of the movement on an international level.

Evidence of a rapprochement between biological and psychological approaches to therapy appeared in the work of Gevins (1983), and in the theme of the 1983 meeting of the Society of Biological Psychiatry—"The Biology of Information Processing." The following year, Beck (1984) and Beitman and Klerman (1984) presented guidelines for the integration of psychotherapies and pharmacotherapy.

A number of authors began to suggest that the field of psychotherapy needed to develop a new, higher-order theory that would help us to better understand the connections between cognitive, affective, and behavioral systems (Beck, 1984; Greenberg & Safran, 1984; Mahoney, 1984; Ryle, 1984; Safran, 1984). These writers maintained that attempts to answer the question of how affective, behavioral, and cognitive systems interact would move the field toward the development of a more adequate, unified paradigm.

Another framework for organizing and integrating various approaches to psychotherapy was presented by Driscoll (1984) in *Pragmatic Psychotherapy*. Substituting the vernacular for



theoretical jargon, Driscoll presents a method (the pragmatic “survey”) by which any given psychological problem can be elucidated and conceptualized in a diversity of ways.

In Arkowitz and Messer’s (1984) edited volume, *Psychoanalytic Therapy and Behavior Therapy: Is Integration Possible?* they, along with 10 contributing authors, explore the clinical, theoretical, and empirical issues of a serious attempt at rapprochement. Although there was no clear consensus on such matters, Arkowitz and Messer provided an invaluable opportunity for the generation and exchange of fruitful philosophical and practical ideas toward the advancement of the field as a whole.

In addition to the aforementioned books, numerous others on therapeutic integration appeared at this time in the 1980s (e.g., Guidano & Liotti, 1983; Hart, 1983; Meyer, 1982; Palmer, 1980; Papajohn, 1982; Prochaska & DiClemente, 1984; Wittman, 1981). Moreover, journals started to feature discussions on this topic. A special 1982 issue of *Behavior Therapy* contained a series of articles examining the potential benefits and drawbacks of complementing a behavioral approach with those of other orientations (Garfield, 1982; Goldfried, 1982b; Kendall, 1982; Wachtel, 1982a), and a 1983 issue of the *British Journal of Clinical Psychology* presented spirited “point-counterpoint” commentary between Yates (1983a, 1983b), Davis (1983), Messer (1983), Murray (1983), and Wachtel (1983) on the subject of the plausibility of psychotherapy integration.

A particularly significant event in the history of psychotherapy integration was the formation of an international organization devoted specifically to this endeavor. Formed in 1983, the Society for the Exploration of Psychotherapy Integration (SEPI) was established as a way of bringing together the growing number of professionals interested in this area. An interdisciplinary organization that has grown to be international in scope, SEPI holds yearly conferences at which many of the most active clinicians and researchers present their current work, and where attendees are provided with the opportunity to discuss and exchange ideas. We shall have more to say about SEPI later in this chapter.

In the mid to late 1980s, it became apparent that the movement toward psychotherapy integration had succeeded in reaching an ever-broadening and receptive audience. There was a significant increase in the number of authors who became active in contributing to the advancement of the field. In order to provide forums for these many voices, new journals appeared that directly addressed clinical and research issues pertinent to integration. One such journal was the *International Journal of Eclectic Psychotherapy*, later renamed the *Journal of Integrative and Eclectic Psychotherapy* in 1987. Also started in 1987 was the *Journal of Cognitive Psychotherapy: An International Quarterly*, which openly invited papers that discuss and explicate the integration of cognitive psychotherapy with other models of treatment.

In 1985, Mahoney cast a critical eye on the sociopolitics of academia, saying in effect that current systems foster and reward conformity and static viewpoints. He vehemently argued that knowledge would best be advanced when there would be an openness to views that went beyond mainstream thinking. The movement toward psychotherapy integration was presented as an important new area of exploration that the field would do well to support.

In the following year, Messer (1986) drew a comparison between psychoanalytic and behavioral approaches to treatment, using various clinical choice points to highlight where they were similar and where they differed. Thus, when dealing with a patient’s distorted view of the world, the psychodynamic therapist would place more of a focus on the nature of the distortion, whereas the behavior therapist would be quicker to help the patient to incorporate the reality. Which of these two strategies is more effective clinically remains to be demonstrated empirically. Dealing with the psychotherapy research findings to date, Stiles, Shapiro, and Elliott (1986) concluded that the failure to find consistent superiority of any one approach over another should lead us to carry out more work on studying the process of change. This point was similarly made by Goldfried and Safran (1986), who pointed to future research directions in psychotherapy integra-

tion. Acknowledging that the change process with certain complex clinical disorders requires a comprehensive intervention, Chambless, Goldstein, Gallagher, and Bright (1986) outlined and provided some preliminary evidence for an integrative program to treat agoraphobia.

If the movement toward psychotherapy integration is to help the field as a whole to progress, it becomes vital to define clearly the parameters of such a therapeutic approach and to suggest methods and modes of teaching the therapy to trainees (Halgin, 1985). An important edited volume by Norcross (1986) made valuable headway in this regard. Contributing authors spelled out their conceptualizations of eclectic psychotherapy and shared their views on how to teach students the vast amount of information needed to understand and integrate various models. Also in 1986, a special issue of the *International Journal of Eclectic Psychotherapy* was devoted to a discussion of the training and supervision of integrative/eclectic psychotherapists (Norcross et al., 1986). It was clear that this would be a formidable task with which to grapple, and that ongoing development would be necessary in order to begin to approach satisfactory answers. Therefore, later issues of the same publication, the newly named *Journal of Integrative and Eclectic Psychotherapy*, would carry on the dialogue on training and supervision (Beutler et al., 1987; Halgin, 1988; Norcross, 1988).

A glance at some of the major books on integration in 1987 reminds us that interest in this area had become worldwide. From Italy, we had Guidano's (1987) *Complexity of the self: A developmental approach to psychotherapy and theory*. From English-speaking Canada, Greenberg and Safran (1987) published *Emotion in Psychotherapy*; from French-speaking Canada, we see LeCompte and Castonguay's (1987) edited work, *Rapprochement et Integration en Psychotherapie*. From the United States came Wachtel's (1987) *Insight and Action*, Beitman's (1987) *The Structure of Individual Psychotherapy*, and Norcross' (1987) *Casebook of Eclectic Psychotherapy*. Wachtel (1987) presented a therapeutic method that meshed the goals of greater self-awareness and subjective

relief with objective therapeutic changes in observable behavior, Beitman (1987) presented a four-stage model of therapy that cut across orientations and used a common language, and Orlinksy and Howard (1987) described a generic model of therapy on the basis of their review of therapy research.

A 1987 issue of the *Journal of Integrative and Eclectic Psychotherapy* addressed the problem of overcoming the theoretical language barrier that would otherwise impede communication and collaborative study between clinicians and researchers of differing theoretical training backgrounds (Messer, 1987). A number of writers expounded on the merits of such language systems as the vernacular (Driscoll, 1987), experimental cognitive psychology and social cognition (Goldfried, 1987; Ryle, 1987), and interpersonal theory (Strong, 1987).

Elaborating on the theme that diverse therapeutic orientations are needed for a multidimensional method of intervention, Bergin (1988) pointed out that nobody attempting to understand the workings of the human body would ever try to invoke a single set of rules. For example, principles of fluid mechanics are needed to understand how the heart operates, whereas electrochemical principles are needed for an understanding of neural transmission. A true rapprochement across the psychotherapies is needed, suggested Bergin, if we are to deal effectively with those complex human problems requiring psychotherapeutic intervention.

In 1988, Norcross and Prochaska revisited and updated Garfield and Kurtz's 1977 study on eclectic views. The results demonstrated that the majority now preferred the label of integrative over eclectic in describing their theoretical orientation. Although the integrative/eclectic orientation continued to be the modal orientation among American psychotherapists, the frequency of theoretical contributions was changing. Whereas the most frequent combination in the 1970s was psychoanalytic and behavioral, the most common combinations were cognitive and behavioral and then humanistic and cognitive in the 1980s. The authors observed that "integration by design is steadily replacing eclecticism by default" (p. 173).

Another series of articles on the subject of psychotherapy integration appeared in *Psychiatric Annals* in 1988: Rhoads' (1988) contribution addressed the dual use of psychotherapy and psychotropic medication; Babcock (1988) and Powell (1988) independently pointed out that many behavioral interventions will provoke clinically meaningful emotional and cognitive insights; London and Palmer (1988) argued that cognitive therapies represent viable integrative therapies in and of themselves; and Birk (1988) reminded us of the need to explore the integration of individual psychotherapy with marital and family therapy.

The integration of therapeutic modalities, such as individual and family therapy, was typified by the work of Allen (1988), Beach and O'Leary (1986), Duhl and Duhl (1980), Feldman (1979, 1989), Feldman and Pinsof (1982), Friedman (1980a,b 1981), Grebstein (1986), Gurman (1981), Hatcher (1978), Lebow (1984), Pinsof (1983), Rosenberg (1978), Segraves (1982), Steinfeld (1980), and Wachtel and Wachtel (1986). A common phenomenon these authors discussed was the vicious cycle that results when a member of an interpersonal system expects and assumes the worst about a significant other, resulting in acting in such a way to provoke the very negative reactions from the significant other that "confirm" the original dysfunctional belief. As testimony to the momentum the above works have gathered, a special interest group within the American Family Therapy Association was organized to support these integrative efforts.

Toward the end of the 1980s, the call for the development of an empirical methodology for the study of psychotherapy integration became quite pronounced (e.g., Goldfried & Safran, 1986; Norcross & Grencavage, 1989; Norcross & Thomas, 1988; Safran, Greenberg, & Rice, 1988; Wolfe & Goldfried, 1988), whereas others (Messer, Sass, & Woolfolk, 1988) underscored the benefits of alternate epistemological approaches to understanding the therapy process. Safran, Greenberg, and Rice (1988) posited that psychotherapists ultimately would learn more about the process of therapy via the intensive study of successful

and unsuccessful cases rather than through the extensive study of groups of clients categorized by broad diagnostic labels. Cashdan (1988) described the role of the therapeutic relationship within an object relations framework, Andrews (1988, 1989) offered a model of change that emphasized the importance of self-confirming feedback cycles, Glass and Arnkoff (1988) found evidence for common as well as specific factors in clients' explanations for change, and Omer and London (1988) concluded that the nonspecific variables in therapy were no longer "noise" but have achieved the status of "signal."

Wolfe and Goldfried (1988), reporting on a National Institute of Mental Health (NIMH) research conference dealing with psychotherapy integration, stated that the establishment and growth of an accessible archive of tapes and transcripts would be a major boon to empirical studies relevant to integration. Another subtheme related to the need for integration to be based in empirical findings was the call for a better, more unified understanding of psychopathology (Arkowitz, 1989; Guidano, 1987; Wolfe, 1989; Wolfe & Goldfried, 1988).

One of the first research programs specifically designed to develop a new methodology for the advancement of psychotherapy integration began to emerge from the work of Goldfried and his associates (e.g., Castonguay, Goldfried, Hayes, & Kerr, 1989; Goldfried, Newman, & Hayes, 1989; Goldsamt, Goldfried, Hayes, & Kerr, 1989; Kerr, Goldfried, Hayes, & Goldsamt, 1989). These authors developed a coding system, composed in the language of the vernacular, to compare and contrast the feedback that cognitive-behavioral and psychodynamic therapists give their patients. Their database comprised transcripts and audiotapes of actual therapy sessions, thus facilitating the study of what the therapists actually do in session (Goldfried & Newman, 1986).

Another issue that gained momentum in the late 1980s was the examination of the narrowing gap between cognitive-behavioral and psychodynamic viewpoints on the nature of the therapeutic relationship. For example, Linehan's (1987; Heard & Linehan, 2005) Dialectical Behavior Therapy for borderline personal-

ity disorder characterized the therapeutic relationship as being central to the success of the treatment. Westen's (1988) intriguing article conceptualized the transference phenomenon in terms of information processing while acknowledging its vital emotional component. Goldfried and Hayes (1989) argued that—even in behavior therapy—the therapeutic relationship frequently elicits a sample of the client's most clinically relevant thoughts, emotions, and behaviors as they pertain to the self and others. Newman (1989) authored a treatise on the phenomenon of countertransference as experienced and conceptualized from the perspective of the cognitive-behavioral therapist.

In 1989, Lazarus published a revision of his influential book, *The Practice of Multimodal Therapy*. Simek-Downing's (1989) *International Psychotherapy*, a book that took cross-cultural factors into account in examining the process of therapy, addressed elements of successful interpersonal helping that appear to be universal. Mahrer's *The Integration of Psychotherapies* (1989) expressed the sentiment that "... integrationists are dealing with many of the crucial questions for our field" and spelled out his recommended responsibilities for the integrative therapist, teacher, supervisor, and researcher. Beitman, Goldfried, and Norcross' (1989) overview article on psychotherapy integration in the *American Journal of Psychiatry* underscored the importance of research findings on this topic so that "prescriptive treatment [could be] based primarily on patient need and empirical evidence rather than on theoretical predisposition" (p. 141). Beginning work in this area came from Sheffield, England (Barkham, Shapiro, & Firth-Cozens, 1989), where it was found that a combined intervention that went from psychodynamic to cognitive-behavior therapy worked better than one in which the sequence was reversed.

Although not originally intended to be an integrative text, the *Comprehensive Handbook of Cognitive Therapy* (Freeman, Simon, Beutler, & Arkowitz, 1989) nonetheless comprised many chapters that seemed to create conceptual and technical bridges between cognitive therapy and other approaches (e.g., experien-

tial therapy, Piagetian theory, behavior therapy, psychodynamic therapy, Gestalt imagery, marital therapy, and pharmacotherapy).

### The 1990s

If the 1980s witnessed the establishment of integration as a movement, then the 1990s saw the ideas of this movement become generally recognized and adopted by a wide variety of researchers and clinicians alike. Indeed, integrative themes became part of the prevailing *zeitgeist* and were increasingly incorporated into mainstream writing. Moreover, Jensen, Bergin, and Greaves (1990) surveyed psychotherapists and found that a majority of them subscribed to eclectic/integrative forms of therapy.

*Interpersonal Process in Cognitive Therapy* by Safran and Segal (1990) outlined how the clinical effectiveness of cognitive therapy could be enhanced by incorporating principles and techniques associated with interpersonal theory. In their edited volume, *Eclecticism and Integration in Counseling and Psychotherapy*, Dryden and Norcross (1990) included a consideration of potential obstacles to integration as well as emerging themes that could potentially lead to contention among those in the field, noting that since integration and eclecticism were still in their early stages of development, different authorities have had different views. In another edited book, *Client-Centered and Experiential Psychotherapy in the Nineties* (Lietaer, Rombauts, & VanBalen, 1990), Bohart contributed a chapter in which he brought an integrative approach to client-centered therapy, describing the common underlying factors in psychotherapy and how these are related to client-centered therapy. In their review of the burgeoning common-factors literature, Gren-cavage and Norcross (1990) suggested that the factors could be classified according to client characteristics, therapist attributes, change processes, treatment structure, and therapy relationship.

Duncan, Parks, and Rusk (1990) noted that although theoretical integration may offer "the greatest intellectual appeal," technical eclecticism may be the more practical solution, al-

lowing the clinician to avoid having to find a connection between techniques and metabeliefs or theoretical underpinnings. Beutler and Clarkin (1990) proposed a systematic eclectic therapy that allows for the selection of a treatment approach based on client predisposing variables, treatment context, relationship variables, therapeutic strategies, and techniques. Discussing their identification as a technical eclectic and a common factors integrationist, respectively, Lazurus (1990) and Beitman (1990) debated their differing stances. Expanding on work begun in the 1980s, Ryle (1990) discusses how cognitive-analytic therapy integrates aspects of cognitive, psychodynamic, and behavior therapies. Also in 1990, Lazarus urged integrationists to avoid training students in one particular approach to therapy and instead to present them with various options in an unbiased manner so that they can learn to recognize the values of each approach.

Two landmark books appeared in 1991. One (Frank & Frank, 1991) was a revision of the classic *Persuasion and Healing* by Frank that was published three decades earlier (Frank, 1961) and the other a comprehensive analysis by Mahoney (1991) on the process of change.

Also of particular significance in 1991, the Society for the Exploration of Psychotherapy Integration (SEPI) began publishing its own journal, the *Journal of Psychotherapy Integration*. The goal of the journal was to offer a forum for articles that moved beyond the confines of single-school or single-theory approaches to psychotherapy and behavior. Much of the work in the area of integration throughout the 1990s was published in this journal.

The first articles published in the *Journal of Psychotherapy Integration* dealt with the current state and trends of psychotherapy integration. In a dialogue between Lazarus and Messer (1991), Lazarus lamented the fragmentation that exists among psychotherapies and called for “fewer theories and more facts” (p. 146), arguing for a data-based technical eclecticism rather than an integration that is informed solely by theory. Messer countered this argument by noting that all data are informed by theory but also acknowledged that imported

techniques must be tried out in their new contexts and be validated through use and experimentation. Writing about multicultural counseling and therapy, Ramirez (1991) observed the regular use of contributions from different orientations. Alford (1991) called for integrationists to find the various systems that are worthy of integration, noting a continued lack of consensus regarding criteria for the selection and incorporation of elements from various therapies. Horowitz (1991) proposed “deep” formulations such as emotionality, relationships, self-control, and development that may potentially offer an entry to integration. Wachtel (1991) similarly proposed moving beyond simply combining elements, suggesting that we try to achieve a more seamless psychotherapeutic integration. He also pointed out that instances of true synthesis do occur sometimes and that it is important to take special note of them.

Goldfried (1991) proposed a research enterprise that would examine such instances. He discusses his “desegregation” research across pure-form treatment modalities, which involves a comparative analysis of the change process. He proposed that by focusing on clinical principles that are common across orientations, research would have a greater likelihood of focusing on the most important mechanisms of change. Commenting on this article, Shoham-Salomon (1991) added that only therapies that are different from each other in clearly identifiable ways can be integrated.

Writing in 1991, Schacht suggested that the manner in which clinicians learn therapy will influence their ability to employ integrative concepts in therapy, observing that integration has different meanings for beginning therapists than for expert therapists. He proposed that those who train students in integrative approaches need to take note of the developmental path that therapists follow as they move from novice to expert therapists. In the same year, Mahoney and Craine reported on a survey of 177 members of SEPI and the Society for Psychotherapy Research (SPR) regarding optimal therapeutic practice. The only difference found among theoretical orientations was

that behaviorists rated psychological change as less difficult than non-behaviorists. Of particular interest is the finding that most respondents exhibited considerable belief change over the course of their careers.

In 1992, Goldfried and Castonguay noted that despite the popularity of integrative approaches, the three major therapeutic schools were most likely here to stay. However, just two years later, Castonguay and Goldfried (1994) highlighted several instances of rapprochement that have led to the refinement of the existing schools.

In an edited volume, *History of Psychotherapy: A Century of Change* (Freedheim & Frenzenberger, 1992), Arkowitz presented a chapter that traced the development of psychotherapy integration across the twentieth century. Apart from the content that Arkowitz offered, what is particularly significant is the reality that including such a chapter was regarded as essential for a complete portrayal of the last 100 years of psychotherapy. In the same volume, Arnkoff and Glass (1992) devoted a substantial portion of their chapter on cognitive therapy to psychotherapy integration, noting that the development of cognitive therapy sparked interest in eclectic and integrative approaches to therapy.

Integration was met with receptivity in the early 1990s. As an example, Duncan (1992) offered the use of integrative techniques for ameliorating the criticisms of strategic family therapy, suggesting ways for improving strategic therapy that are clearly integrative in nature. Writing in the same year, Norcross and Newman (1992) discussed the factors that contributed to the growing interest in psychotherapy integration: (1) the proliferation of different schools of thought within psychotherapy, which led to increasing fragmentation and confusion; (2) the realization that no theoretical orientation was sufficient to handle all clinical issues; (3) the rise of managed health care and the consequent pressure for accountability and consensus; (4) the growing focus on specific clinical problems and practical ways of dealing with them; (5) increasing opportunities to observe and experiment with clinical approaches other than one's own; (6) the interest in common

factors that cuts across all forms of treatment; and (7) SEPI, which provides an educational, clinical, and scientific forum in which to consider integration.

Commensurate with its maturation, psychotherapy integration began to differentiate more clearly into separate paths or subtypes: common factors, theoretical integration, and technical eclecticism (Arkowitz, 1992). Lazarus, Beutler, and Norcross (1992) discussed the future of technical eclecticism. In the early 1990s, eclecticism became a more deliberate combination of interventions stemming from more appropriate training in various orientations, a systematic assessment of client needs, and a use of outcome research.

The first edition of the *Handbook of Psychotherapy Integration*, edited by Norcross and Goldfried (1992), offered a comprehensive examination of the theory and practice of integrative psychotherapy, including a conceptual and historical perspective, models of psychotherapy integration, approaches to specific clinical problems, different modalities of intervention, and issues related to training, research, and future directions. Norcross and Goldfried concluded that it is unlikely that the psychotherapy integration movement will provide the field with a grand, overarching theoretical orientation. Instead, they proposed that integrative efforts can lead to increased consensus on the interventions that are indicated for certain clinical problems. They called for process and outcome studies of both pure form and integrative interventions to be complemented by research findings on the determinants of specific clinical disorders. In the same year, Dryden (1992) edited a volume on clinical and research contributions to integration in the United Kingdom, and included a valuable bibliography of relevant articles appearing in British journals between 1966 and 1990.

During the next year, Stricker and Gold (1993) published their *Comprehensive Handbook of Psychotherapy Integration*, which included contributions on a variety of topics such as individual approaches to integration, the integration of traditional and nontraditional approaches, psychotherapy integration for spe-

cific disorders and specific populations, teaching psychotherapy integration, and a review of relevant research.

That same year, the *Journal of Psychotherapy Integration* featured a roundtable discussion by prominent scientist-practitioners (Norcross, 1993). The panelists (Glass, Arnkoff, Lambert, Shoham, Stiles, Shapiro, Barkham, and Strupp) dealt with the two central influences in the current integration movement: common factors and technical eclecticism. They covered the empirical investigation of therapeutic commonalities, the value of research programs determining “treatments of choice,” and alternatives to comparative designs. They concluded by proposing additional research directions to advance integration. One such study was conducted by Jones and Pulos (1993), who reported on both the similarities and differences in therapy methods between cognitive-behavioral and psychodynamic therapy. Other studies compared these same two orientations with regard to the working alliance (Raue, Castonguay, & Goldfried, 1993) and client emotional experiencing (Wiser & Goldfried, 1993). Greenberg and Korman (1993) discussed the utility in involving an empirical measure of emotional processing in the therapeutic process—clearly integrative. Castonguay (1993) called attention to the tendency to equate “nonspecific” factors with “common” factors, pointing out that the former refers to unspecified relational contributions, whereas the latter refers to techniques (e.g., reinforcement) or strategies (i.e., facilitating corrective experiences) that are shared by different orientations.

Mahoney, also writing in 1993a, maintained that the goal of integration is not to eliminate differences among the various approaches to therapy, but to consolidate the unique aspects of each school of therapy. Given the complexity of human nature, he suggested that it is necessary and, in fact, unavoidable to establish an integrative movement that can allow for both a common factors approach as well as a more dialectical integration.

In a separate article that same year, Mahoney (1993b) traced the theoretical developments in cognitive psychology since the 1950s.

As others had indicated before him, he noted the large involvement of cognitive therapists in the integration movement. Schwartz (1993) considered his work on social cognition and cognitive-affective balance in the development of psychopathology as an integrative construct. He discussed how balance is an ideal central construct for an integrative cognitive-dynamic therapy and noted that Linehan’s dialectical behavior therapy (see Heard and Linehan, 2005) attempts such balance in teaching clients to transcend artificial polarities through the dialectical process. It was also in 1993 that Linehan published her landmark book on dialectical behavior therapy, in which she describes in detail how this approach can be implemented clinically.

In the edited book *Beyond Carl Rogers* (Brazier, 1993), Hutterer discussed the frequent move toward eclecticism by therapists trained in a client-centered model and noted that clinicians trained in an “anti-dogmatic” approach such as Rogers’ may naturally seek out integration in order to buttress the effectiveness of their therapy. Goldfried and Castonguay (1993) suggested that this openness also characterized practicing behavior therapists who have been shown to complement behavioral methods with contributions from other orientations.

In an article for a special issue of the *Journal of Psychotherapy Integration*, Goldfried (1993) suggested that psychopathology research can inform integrative therapy by uncovering potentially relevant determinants associated with various disorders. The clinician can then use these determinants to understand the core issues that need to be addressed in therapy. Writing about the feasibility of integrative approaches to the study of personality, Millon, Everly, and Davis (1993) suggested that psychotherapy integration is a sign of a mature clinical science that allows for a coherent taxonomy of personality disorders. Along with Gaston (1995), the authors call for such an integrative model of personality.

Dutch psychologists Lemmens, deRidder, and vanLieshout (1994) discussed empirical, conceptual, and linguistic strategies of psychotherapeutic integration. They propose that these strategies offer ways to approach integra-

tion from a neutral stance. The empirical strategy seeks to find common factors through research, the conceptual strategy attempts to develop superordinate constructs, and the linguistic strategy is rooted in the notion that a common language must exist across orientations in order to better understand psychotherapy.

Jacobson (1994) discussed the potential for integration inherent in contemporary behaviorism and offered examples of some integrative therapies derived from a behavioral orientation—Acceptance and Commitment Therapy (ACT; Robinson & Hayes, 1997), Dialectical Behavior Therapy (DBT; Linehan, 1992), and Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991). In this regard, Goldfried and Davison's (1976) integration-friendly *Clinical Behavior Therapy* was reissued in an expanded edition (Goldfried & Davison, 1994).

Sechrest and Smith (1994) called for the integration of psychotherapy into the science of psychology. They noted that behavior therapy is a fitting example of the successful integration of a psychotherapeutic approach into mainstream psychology. They go on to say that the successful integration of psychotherapy into the broader field of psychology would address the conceptual and scientific limits of psychotherapy.

In that year, Beitman called for a change in SEPI's mission as he argued that clinicians and researchers interested in integration must stop exploring and start defining the principles of psychotherapy integration. Also in that year, Castonguay and Goldfried (1994) noted that a major obstacle to achieving that goal was the lack of common language that exists for clinicians to use in order to communicate across the various therapeutic schools.

Poznanski and McLennan (1995a) described their attempts to assess theoretical orientation of practicing counselors and concluded that it is best measured on two polar dimensions: analytic versus experiential and subjective versus objective. Yet, as Arnkoff (1995) noted, this may not offer an adequate framework for integrative theories. She offered Wachtel's (1977, 1987) theory, which integrates psychodynamic and behavioral constructs, as an example of the

difficulty involved in mapping integrative theories onto such a plane. In a reply to Arnkoff, Poznanski and McLennan (1995b) concurred that theoretical orientation is more multifaceted than was originally conceptualized and is best conceived of as being composed of four elements: (1) the therapist's theoretical affiliation, (2) the therapist's espoused theory, (3) the theory inferred from observations of therapy sessions, and (4) the therapist's personal therapeutic belief system.

In the *Comprehensive Textbook of Psychotherapy* (Bongar & Beutler, 1995), Beutler, Consoli, and Williams (1995) offer strategies for designing effective treatment plans from the vantage point of systematic eclectic psychotherapy. These include: (1) patient characteristics, (2) treatment context, (3) patient-therapist relationship qualities, and (4) selection of clinical strategies depending on problem complexity/severity, motivation, coping style, and resistance potential.

Weinberger (1995) criticized technical eclecticism as lacking a theoretical base, which Beutler (1995) countered by stating that the absence of a single theory of psychopathology and therapeutic change is indeed a strength, not a weakness. He also stated that traditional theories do not adequately address mechanisms of change and that individual theories within a larger theoretical framework vary too much. Also in response to Weinberger, Gaston (1995) noted that theoretical (not technical) eclecticism has the ability to "fuel conceptual creativity" by encouraging therapists to learn all major theoretical approaches.

In his volume on rational-emotive behavior therapy, Dryden (1995) discussed the issues that rational-emotive therapists consider when choosing to undertake more integrative approaches to therapy. With regard to Gestalt therapy, Resnick (1995) maintained that integration is intrinsic to the approach. Greenberg (1995) pointed out that Wolfe's (1995) self-psychopathology can serve as a potential basis for psychotherapy integration in that it contains a set of integrative treatment principles for repairing various forms of pathologies that are conceptualized as being rooted in issues involving the self (see Wolfe, 2005). Safren and



Inck (1995) made explicit integrative contributions to the treatment of depression, discussing the decision rules for combining tasks and goals from different approaches. Acknowledging the importance of promoting integration at the training level, Robertson (1995) published a text designed to assist those who are involved in training clinicians within a theoretically and pedagogically integrative framework.

Goldfried's (1995) book *From Cognitive-Behavior Therapy to Psychotherapy Integration: An Evolving View* traced the development of cognitive behavior approaches and its eventual implications for therapy integration. Davison (1995), an important figure in the history of cognitive-behavior therapy, similarly offered a personal and professional account of the past 20 years of his career. He elaborated on the therapeutic benefits of taking a broader therapeutic approach and discussed how his early cases may have had better outcomes if such a perspective had been taken.

An important contribution to the psychotherapy integration literature was McCullough's (1995) manual for his Cognitive Behavioral Analytic System of Psychotherapy (CBASP), an intervention developed to treat chronic depression. It comprises a clinically sophisticated integration of cognitive, behavioral, and interpersonal approaches and has subsequently been published in book form (McCullough, 2000) together with its empirical support. Still another important contribution in 1995 was the publication of Pinsof's *Integrative Problem-Centered Therapy*, in which he describes an approach for integrating different theoretical approaches associated with individual, family, and biological interventions.

In the mid-1990s, there is evidence that psychiatry continued to take notice of the psychotherapy integration movement. Albeniz and Holmes (1996) noted in the *British Journal of Psychiatry* that integration at the level of practice is common and desirable and called for more clarification of integrative principles at the level of theory. He concluded by noting that the different orientations should work closely together while retaining their separate identities.

Stricker (1996) and Goldfried and Wolfe (1996) discussed the implications of manual-based, theoretically pure treatments for integration and noted that integration may be difficult for clinicians working from a manual. Fensterheim and Raw (1996) similarly argued that empirically supported treatments that used such manuals have the potential to obstruct the integration movement. All of these authors suggested that because empirically supported treatments have little to do with actual clinical practice, the flexibility (and potentially integrative stance) of the clinician is undermined by such treatments.

Rigazio-Digilio, Goncalves, and Ivey (1996) elaborated upon Goldfried and Castonguay's (1992) analysis of the future directions of integration. Of interest is Rigazio-Digilio and colleagues' mention of the need for the integration movement to include cultural and interdisciplinary domains (see Ivey & Brooks-Harris, 2005). Historically, individuals interested in psychotherapy integration have failed to address such issues, and the authors, together with Perez (1999), suggested that this constitutes an important next step for the movement.

Books with integrative themes continued to appear in 1996, such as Gold's (1996) review of key concepts on psychotherapy integration and Gilbert and Shmukler's (1996) volume on how humanistic, psychodynamic, and behavioral contributions may be used in couples therapy. In addition, the topic of psychotherapy integration became increasingly salient in books on psychotherapy theory and technique (e.g., Patterson & Watkins, 1996).

In a survey of 268 members of SEPI, Figure and Norcross (1996) reported that respondents ranked the provision of a forum for the systematic investigation and discussion of integrative themes as the central priority of SEPI. In addition to continuing as is, the most frequent recommendations for SEPI were to increase its membership, advocate for integration, offer training, and produce more research. Overall, the results revealed that although different benefits of SEPI were endorsed, members were largely satisfied with both SEPI and its journal.

In 1997, Safran and Messer discussed trends in the integration movement from the perspective of pluralism and contextualism. They noted that because therapeutic approaches are rooted in a particular framework, these concepts might not make sense once they are removed from their context. Thus, they propose that the proper goal of integration is to maintain an ongoing dialogue among the proponents of the various orientations while allowing for the discussion and clarification of differences.

Patterson (1997) argued for the use of an integrative approach to ameliorate the divisiveness that characterizes family therapy. Specifically, he uses integrative concepts to establish a substrate upon which various techniques can be added in a coherent fashion. He suggested that doing so can allow the public and third-party insurers to understand family therapy more clearly.

Stricker (1997) discussed the integration of science and practice, maintaining that the psychotherapy integration model is a step toward the reduction in the incommensurability of science and practice. Yet, Norcross, writing that same year (Norcross, 1997), reported that although integration or eclecticism is the most common theoretical orientation among psychotherapists, it continues to lack practical coherence. He underscored the need for outcome research to establish the effectiveness of integrative treatments, for training programs that ensured competence in integrative approaches, and for a clearer delineation of the integration movement's mission and goals.

Also writing in 1997, Millon and Davis stated that eclectic therapies fall short of adequately addressing the needs of personality disordered clients because "personality is integrative and cohesive, while eclecticism need not be" (p. 386). They added that personality disorders are pervasive and long-standing and have complex diagnostic patterns that may not lend themselves to brief or manualized types of treatment.

Lewis (1997) emphasized interpersonal and experiential aspects in his discussion of integrated psychodynamic therapy with children. He noted that the use of nonpsychodynamic methods does not minimize the psychody-

amic theme but instead enhances it. Alford and Beck (1997) provided an entire volume on cognitive therapy as an integrative paradigm for psychotherapy, maintaining that it has evolved into a multidimensional approach that incorporates interpersonal, behavioral, and psychodynamic techniques.

In Wachtel's (1997) update of his original book, *Psychoanalysis and Behavior Therapy*, he offered an integrative construct, cyclical psychodynamics, which addresses fundamentals of both psychoanalytic and behavioral orientations (see Wachtel, Kruk, & McKinney, 2005). The book, *Psychoanalysis, Behavior Therapy, and the Relational World*, deals with how behavior therapy may usefully complement the intrapersonal and interpersonal contributions of psychoanalytic therapy.

Into the later part of the decade, the call for more research continued with relatively little evidence that it was being undertaken. Glass, Arnkoff, and Rodriquez (1998) noted that empirical research in psychotherapy integration seriously lags behind the widespread clinical and theoretical interest that it has received. They observed that even though some of the theoretically integrative treatments are based on research, the effectiveness of the therapeutic models remains, for the most part, unsubstantiated by empirical investigation. They included mention of four promising integrative approaches that have received initial empirical support: Prochaska and DiClemente's (1984) transtheoretical approach, Ryle's (1990) cognitive analytic therapy, Greenberg's process-experiential approach (Greenberg, Rice, & Elliott, 1993), and Shapiro's (1995) eye-movement desensitization and reprocessing. However, just a few years later, Schottenbauer, Glass, and Arnkoff (2005) note that there has more recently been a dramatic increase in outcome research on psychotherapy integration.

In a commentary on a special section on psychotherapy integration with children in the *Journal of Clinical Child Psychology*, Goldfried (1998) lamented the fact that integrationist work did not always reflect a broader historical and conceptual perspective, thereby at times "rediscovering the wheel." Still, the significance that an entire issue of such a journal was

devoted to integrative approaches is noteworthy.

Toward the end of the 1990s, integrative themes continued to take root internationally. For instance, Hollanders and McLeod (1999) found that roughly 87% of counselors in Great Britain do not take a pure-forms approach to therapy. Trijsburg, Colijn, Collumbien, and Lietaer (1998), writing from The Netherlands, Eagle (1998), writing from South Africa, Carere-Comes (1999) and Giusti, Montanari, and Montanarella (1995), writing from Italy, Christoph-Lemke (1999), writing from Germany, and Caro (1998), writing from Spain, all proffered integrative perspectives from an international perspective.

In 1999, Jacobson presented an outsider's perspective on psychotherapy integration. Some integrationists took umbrage at Jacobson's article (Cullari, 1999; Goldfried, 1999), noting that his perspective was tainted with a pessimistic view of the potential for human change and contained a misunderstanding of the goal of integration. He suggested that by taking note of the social psychology of psychotherapy and integration, integrationists might find that they have heretofore been exaggerating the progress of integration.

Smith (1999) noted that the growing emphasis placed on evidenced-based treatments might paradoxically lead to a breakdown of traditional theoretical approaches. He stated that this could have the advantage of yielding a new kind of "meta-theory" of therapy, which will increase the applicability of clinical research. Beitman and Yue (1999) presented such a data-based approach to therapy in a training manual.

Also writing in 1999 in the *International Journal of Psychotherapy*, Slunecko took an epistemological approach toward his discussion of integration. He noted that psychologists must engage in a nonjudgmental, structured dialogue with one another in order to become aware of the differences that exist among different orientations.

There is evidence that integrative concepts continued to expand into diverse modalities during the latter part of the 1990s. Budman (1999) discussed time-effective couples' ther-

apy, which integrates aspects of psychoanalytic, behavioral, solution-oriented, and cognitive approaches. Also, Shirk (1999) drew from the empirical literature to propose the utility of integrative child therapy.

We noted at the outset of this chapter that our historical review ends with the twentieth century. This is an arbitrary, but convenient point at which to stop; the history of psychotherapy integration continues beyond that point. Advances continue to be made in the twenty-first century, as reflected in the milestone inclusion of an entire volume on integration in the four-volume *Comprehensive Handbook of Psychotherapy* (Lebow, 2002). The remaining chapters that follow in the current edition of the *Handbook of Psychotherapy Integration* provide a sampling of these advances.

#### THE DEVELOPMENT OF A PROFESSIONAL NETWORK AND INTEGRATIVE OUTLETS

Recognizing the need to provide a reference group oriented toward rapprochement among the therapies, Goldfried and Strupp, in 1979, compiled a list of professionals who were likely to be interested in efforts toward therapeutic integration and wrote to all of these individuals, inviting them to add their names to an informal "professional network." Little was done with this list until 1982, when Wachtel and Goldfried decided to poll those included in the network about potential directions. Taking the existing network list and expanding it on the basis of their personal contacts, they mailed a questionnaire. A total of 162 individuals completed the survey. The respondents expressed their continued interest in rapprochement and offered their views on what should be done next; namely, the establishment of a newsletter and the formation of an organization.

In the summer of 1983, an organizing committee, consisting of Lee Birk, Marvin Goldfried, Jeanne Phillips, George Stricker, Paul Wachtel, and Barry Wolfe, met to discuss the results of the questionnaire. It was immediately apparent to all six that the time was ripe to do something with this rapidly growing network,

and it was agreed that a newsletter was in order. The group discussed the advisability of creating an organization, especially in light of some of the comments on the questionnaire expressing reservations about formalizing something that might best be dealt with informally. It finally was decided that without the existence of an organization, it would be difficult to maintain any sense of continuity. As later noted by Goldfried and Wachtel (1983, p. 3), "It was concluded that we needed to achieve a delicate balance: a formal organization that would facilitate informal contacts among the members." Hence, the Society for the Exploration of Psychotherapy Integration (SEPI) was formed.

SEPI members represent diverse orientations and interests. Some are professionals who clearly identify themselves with a particular theoretical framework but openly acknowledge that other schools have something to offer; some are people who are interested in finding commonalities among the therapies; some would like to find a way to integrate existing approaches; some would like eventually to develop a totally new approach based on research findings; and some are professionals who have gradually drifted away from their original orientation and are interested in developing clearer guidelines that are more consistent with their clinical experience. A common thread that runs through this diversity is a respect for research evidence and an openness to procedures found to be clinically effective.

An interdisciplinary organization that has grown international in scope, SEPI holds annual conferences at which many of the most active clinicians and researchers present their current work, and at which attendees are provided with the opportunity to discuss and exchange ideas. As of 1991, it began publication of its official journal, the *Journal of Psychotherapy Integration*. More recently, it has created a Web site, which can be found at: [www.cyberpsych.org/sepi](http://www.cyberpsych.org/sepi).

Although the notion of lowering the boundaries that have existed among different schools of thought has been a latent theme for some 50 years, the formation of SEPI provided the impetus for psychotherapy integration to be-

come established as a definite and visible movement. It is no longer novel to hear mental health professionals acknowledge the importance of psychotherapy integration. Indeed, books have routinely been published in the past decade or two with the term "integration" in their title. Many of these have been noted in our historical overview. Other publication outlets in the integrative tradition consist of journals dedicated to that purpose. In addition to the *Journal of Psychotherapy Integration*, there is *Integrative Psychiatry* and *In Session*, which appears quarterly as part of the *Journal of Clinical Psychology*. *In Session* offers a state-of-the-art overview of research and clinical advances on various topics (e.g., PTSD, anger, coping with infertility, panic disorder, resistance, therapeutic alliance). A particularly unique feature is that it not only describes and illustrates, without the use of theoretical jargon, different approaches to a given clinical problem or issue, but also summarizes the available research findings for use by the practicing clinician.

The hope is that SEPI and the several publication outlets dedicated to psychotherapy integration will raise our consciousness about the field's need for a more comprehensive model of therapeutic intervention and will encourage the clinical and research efforts of an increasing number of professionals interested in pursuing this goal. The *zeitgeist* is more receptive to integrative efforts than it has ever been before; psychotherapy integration is no longer an idea that is "too strange or preposterous" to consider (cf. Boring, 1950). It is our hope that within this hospitable context, significant advances will be made.

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## **PART II**

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# Integrative Psychotherapy Models

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## *A. Common Factors*

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# 3

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## The Future as an Integrating Force Through the Schools of Psychotherapy

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### THE INTEGRATIVE APPROACH

Like Diogenes in the darkness, I (B. B.) have held the lamp to each passing claimant in the search of the one element common to the bewildering array of psychotherapies. Illuminated, a unifying theme emerges: the client's future. All brand names of talking psychotherapies, from the venerated traditions such as psychoanalysis and cognitive-behavioral, to solution focused approaches and the latest West Coast high-fee seminars, direct themselves to this integrating component. Although the past and present are often explored, the real impetus of psychotherapy revolves around how a client will feel, think, and behave in the future (Anchin, 2003).

In earlier books and chapters, I conceptualized psychotherapy integration as an interpersonal relationship that moves through the stages of engagement, pattern search, change (giving up the old pattern, beginning and maintain-

ing a new pattern), and termination (Beitman, 1987). The teaching application of this template, as offered in *Learning Psychotherapy* (Beitman & Yue, 1999), emphasized the processes common to psychotherapy, such as verbal response modes, intentions, active listening skills, establishment of a therapeutic alliance, resistance, transference, and management of countertransference. Although the text was widely used in psychiatric residency training programs and by several psychology graduate training programs, a crucial element seemed nevertheless missing. Though the abstract lenses and methods of each camp are different on the surface, they also shape a strong underlying and intersecting theme: a psychotherapeutic emphasis on clients' futures.

Clinicians invariably help clients change the way in which they perceive and understand the future (Melges, 1982). This professional thrust assists in clients reworking their images of the future to alter problematic expectations,

anticipations, and intentions. Therapy, in other words, helps clients think-do-feel something different *after* they leave the clinical office.

The rationale for a future orientation in psychotherapy is based on the recognition that human behavior is controlled by its consequences: "A person's processes are psychologically channelized by the way in which he anticipated events" (Kelly, 1955, p. 46). People are drawn to act by images of the future, which are composed by reassembling memories from the past; in this sense, *the future is remembered*. Individuals, however, vary in their tendencies to visualize, use language, and experience emotions in creating ideas of the future, whereas biology and culture act to co-create general expectations throughout the human life cycle.

### Expectations and Experience

Human behavior, thought, and emotion are strongly influenced by anticipated consequences. When faced with a crisis, individuals with a positive vision of the future reckon much better than those without such a vision (Markus & Nurius, 1986). People who cope successfully with difficult circumstances (e.g., the loss of a child, severe illness) set priorities, actively seek information, maintain hope, plan for alternative ways to approach problems, and rehearse actions well in advance. They use a flexible collection of strategies for handling future stresses and believe that their own actions determine their fate (Madsen, 1999), whereas those who do not cope successfully tend to believe that their lives are externally controlled (Melges, 1982). The sense that life problems are opportunities to learn and develop is central not only to successful personal coping but also to psychotherapy.

Culture and genetics shape human views of the future. The human mind recognizes what is wrong, deviant from expectations, and anomalous. Survival depends on anticipating threats in order to neutralize and defuse them. When survival is relatively assured, humans seek security, acceptance, love, and respect. Conditions that appear to imperil these goals trigger a variety of emotions, such as anger, anxiety, fear,

guilt, and shame, which mobilize individuals to oppose the plausible threat.

### Mismatches Between Expectations and Experience Often Cause Distress

When the outcome of plans meets anticipated goals, positive emotions usually emerge. However, when plans appear inadequate or when outcomes do not match desired goals, negative emotions emerge, such as misery, unhappiness, and disappointment. For example, grief is linked with loss of a future, regret is often correlated with "what might have been will not be," anger is associated with "what should be is not or will not be," and guilt is marked by, "I should not have done it. I should be punished."

Such unwanted emotions are associated with discrepant anticipated futures or a disconnection between expectations and experience. For illustration, J. S., a 62-year-old pharmacy technician, sought psychotherapy for excessive anxiety. She had expected to retire at age 60, but decided to keep working, as her drug-addicted daughter, unable to work, needed financial help to survive. J. S.'s sister suffered from major depression and also needed J. S.'s support. Her husband subsidized his parents' income with money J. S. thought they did not need, instead of taking J. S. on a planned trip to Hawaii. J. S. saw herself as having been a "major giver" to her children, her sister, and her parents, and had predicted to now have a life for herself. Her anxiety hid her rage at the disparity between her expectations and her reality.

There are five common forms of such future mismatches: foreshortened futures, catastrophic futures, interpersonal disappointments, interpersonal conflicts, and failures in developmental expectations.

The sense of a *foreshortened future* is experienced when one sees no or very limited future possibilities. The individual feels no control over their future and perceives no opportunities to activate goals. No matter what is done, there is a sense of futility in influencing any positive outcome; the future seems an imperceptible void. Individuals affected in this manner lack plans, expectations, and hopes, and do

not expect themselves or loved ones to live long, productive lives. Emotional experiences are blunted. Clients who perceive foreshortened futures are often depressed or suffering from posttraumatic stress syndrome, living day-to-day without extended plans or goals.

A *catastrophic future*, often seen in people with anxiety disorders, imposes a constant sense that something terrible will happen, wherein the individual not only feels unable to prevent such devastation, but may also believe him or herself to be the cause of this fearsome fate. Anxiety fills the mind, limiting development of future plans or methods of response to the anticipated calamity, and conceptualization of any possible alternative future is overcome by persistent worry.

An *interpersonal mismatch* is characterized by individuals preoccupied with fears of being controlled, subjugated, rejected, or abandoned. In order to maintain the relationship, persons tend to appease (becoming what they believe others expect of them) and, in doing so, lose their own independent personalities and futures; or, they may try to control the spouse or partner and attempt to maintain the relationship. Fear of disapproval may lead to fears of rejection and abandonment, stimulating obsessive efforts to satisfy the other person. On the other hand, fear of losing control to the other leads to loss of identity. The resulting high anxiety may lead to fears of being involved at all.

*Conflicting interpersonal expectations*, on the other hand, involves multiple conflicting expectations operating competitively at the same time; in close relationships, numerous expectations can lead people to become angry, needy, loving, and fearful simultaneously, each emotion at odds with the others. A young woman entering a new heterosexual relationship might experience several concurrent expectations: (1) Marriage and children, (2) He will leave me for another woman, (3) He will die as so many other young men in my life have, (4) He will dominate me the way my father dominated my mother, (5) It is safer for me to grow old alone.

Incongruities of a *developmental mismatch* revolve around the failure to meet expected developmental norms. A 21-year-old college stu-

dent, for example, might drink heavily, fails her junior year, becomes pregnant, and move back in with her parents. When individuals do not pass developmental milestones, disconnection is experienced between one's sense of anticipated maturity level and his or her reality.

Most psychotherapeutic work is directed toward relieving the intrusiveness of these mismatches and reducing the emotional pain they cause. The disparity between personal expectations and the actual experiences of life offer the possibility of a reformulation with the help of the therapist to co-imagine an alternative future. The plan for the future, for how the client will think, feel, and act subsequent to the controlled rehearsals of the therapy experience, is always the focus of the psychotherapeutic process.

### Observing Self

Buddhist meditation and mindfulness emphasize the self-awareness potential of each person. This process, globally known as mindfulness, is also known by a legion of synonyms: decentering, detachment, autonoetic consciousness, metacognition, observing ego, and observing self. Defined as a "state of *psychological freedom* that occurs when attention remains quiet and limber, without attachment to any point of view" (Martin, 1999, pp. 291–292), mindfulness refers to the necessity of self-reflective capabilities of clients, as well as therapists. Most psychotherapy requires clients to "step back" to observe and describe the landscapes of their minds. This ability provides a sense of agency, an "I," observing, planning, deciding, and evolving toward a future goal.

The capacity for self-awareness is essential to reflection upon the self in relation to reality. Acting as co-imaginators of the client's future, therapists try to help clients gain a nonmyopic image of him or her *self*. Because the capacity for self-observation varies significantly among individuals, therapists pace, modulate, and adjust attempts to expand client self-awareness to the client's abilities. Freud described the process whereby, "the treatment is begun by the patient being required to put himself in the position of an attentive and dispassionate self-



observer. . . . we instruct the patient to himself into a state of quiet, unreflecting self-observation, and to report to us whatever internal perceptions he is able to make—feelings, thoughts, memories—in the order in which they occur to him . . .” (quoted in Deikman, 1982, p. 97).

The theme of the observing self is discernible in most contemporary psychotherapeutic writings. More recently, cognitive therapists have consciously been integrating self-awareness into their treatment protocol with the recognition that many clients are uncontrollably caught up in anxious, guilty, emotionally laden thoughts (hot cognitions) and have difficulty “stepping back” from such states (Segal, Williams, & Teasdale, 2002). Mindfulness training can provide the needed distance and liberation from these internal states, as patients learn “I am not my thoughts,” allowing freedom and space to inspect other significant domains.

### Major Schools of Psychotherapy: Future Orientation

Each of the various schools of psychotherapy implicitly emphasizes the future through differing premises, constructs, methodology, and change mechanisms. The basic psychotherapeutic script consists of engagement, pattern search, change, and termination. Within these four stages, therapists across orientations help their clients change by providing experiences in the clinical setting that lead to improvements in how the client deals with experiences in the world at large. Although not overtly stated, these changes are intended to alter the client’s view of his or her own personal future. The major schools of psychotherapy, directly or indirectly, reflect the integrated feature of a future orientation.

Within a humanistic approach, psychological disturbance is conceptualized as one’s internalization of the attitudes, evaluations, and criticism of early significant others, particularly parental figures. Given the human need for positive regard and approval from others, a negative self-concept established from early interactions can perpetuate behaviors that cyclically reinforce images of worthlessness. A Rogerian (1951) approach helps to change negative self-

*expectations* by avoiding reaffirmation of worthlessness and substituting genuine acceptance and positive regard.

The psychodynamic approach, in seeking an underlying motive for psychological symptoms, examines the past for patterns that are likely to be repeated in the present and, indirectly, the future. Client motives are conceptualized as projections of the future: intentions, wishes, and fears (e.g., Oedipal complex). According to Freud, the goals of therapy are for a patient “to love and to work.” Listed below are major psychodynamic principles with illustrations suggesting how each incorporates the concept of the future:

Reenactment of past to present: “The past is passed. You no longer need to act as if it is the same. Recognize that the present and the future are different from the past and not determined by it.”

Unconscious conflicts: “You have at least two futures in mind. Clarify the intentions of each and negotiate between the two.”

Super-ego versus id: “Your strict rule-bound self is predicting punishment, while your self-indulgent side is seeking enjoyment or release.”

Maladaptive defense mechanisms: “You once learned valuable ways to protect yourself, but they are no longer useful. You are defending yourself against imagined rather than real threats.”

Interpersonal therapists also believe that early interpersonal transactions with significant others shape the internal representation of one’s self-concept. Children, with instinctual motivations for love and acceptance, must receive a sense of self-worth from parental figures; when these conditions are not met, a child alters his or her interpersonal behavior to achieve a compromise between needs and reality. These strategies may result in interpersonal deficits and excesses, such as an extreme need to please or pathological narcissism. Such ill-formed interpersonal functioning re-creates old patterns through ongoing and future interactions with others. One may believe, for instance, “When

I meet someone new, they will not like me,” “My significant other will break off our relationship if I say something wrong,” or “If I go to the party, no one will talk to me.” These ideas, illustrative of images of the future, reveal how problematic expectations may be created through maladaptive patterns. Other interpersonal principals (Klerman, Weissman, Rounsaville, & Chevron, 1984) also implicitly include the significance of the future:

Role transition: “You need to give up the old expectations of your role and define the new ones.”

Role conflicts: “You see one future, the other person sees another. How incompatible are they?”

Unresolved grief: “Grieving requires letting go of a future you once thought you had with someone else and now no longer have.”

Behavioral therapists propose that behavior is conditioned by its anticipated consequences. In classical conditioning, a stimulus may be paired with a given response; under operant conditioning, a rewarding outcome increases one’s propensity to repeat that behavior, and a noxious response diminishes one’s willingness to replicate a behavior. Social learning theory (Bandura, 1977), in suggesting a template for imitation of others, describes a clear basis for expectations. By observing models of imperfect behavior precipitating reactions, patients learn to see themselves in others and practice planning new futures for themselves.

Through a cognitive-behavioral orientation, psychological symptoms are viewed as resulting core cognitions that are activated by stressful life events. These dysfunctional core beliefs or schemas shape the lens through which clients anticipate future interactions and events. An individual may tell himself, “I can’t make good choices,” “No one will ever love me,” or “If I am assertive, I will drive others away,” and proceed to validate his or her own predictions. Beck, in fact, asserted, “The role of anticipation in influencing feelings and actions is far more dominant than is generally recognized. The meaning of a person’s experiences is very

much determined by his expectations of their immediate and ultimate consequences” (Beck, 1976, pp. 40–41). Future-oriented concepts of cognitive-behavioral therapy include:

Automatic thoughts: “Your automatic thoughts are predicting negative consequences. Examining these thoughts for accuracy may produce a different outcome.”

Cognitive schemas: “You are interpreting the events of your day in ways that suggest that the future will be horrible. If you examine these beliefs and behave differently, the outcome may be different and you may feel better about it.”

From an existential perspective, individuals’ difficulties and concerns are rooted in conflicts about death, isolation, freedom, and meaninglessness (Yalom, 1995). In reflecting a client’s tendency to extend fears of existence into the future, problematic expectations emerge:

Fear of freedom and responsibility: “Clarify what you fear about being in charge of your own life instead of being directed by others.”

Fear of death: “In the core of each human being is knowledge of his/her own death. That knowledge can be either imprisoning or liberating. Your choice.”

Fear of isolation: “We are all interdependent. We seek love, respect, and acceptance from others. What do you fear when you think about being alone?”

Meaninglessness: “Each of us needs a purpose in life. Whether it is discovered, given or invented, we do not know.”

Although sometimes only obliquely addressed, each school of psychotherapy informs how clients think of the future. A futuristic approach is the common thread across all the psychotherapeutic paradigms.

## ASSESSMENT AND FORMULATION

Formulation should be distinguished from assessment and from diagnosis. Assessment refers

to processes of data-gathering, though the function is influenced by the conceptual grid of formulation when therapists look for ways to frame a client's information within the structure of a predetermined theoretical pattern to which the therapist is partial. Diagnosis, on the other hand, is the process of gathering specific types of assessment data and identifying their points of convergence with empirically based criteria. Assessment with diagnosis transforms symptoms and problems into testable hypotheses about which treatment methods have been effective in similar clinical presentations.

The two phases of formulation are analogous to the middle stages of psychotherapy: definition of the problem(s) in ways that suggest solution(s) (the pattern definition stage) and development of strategies and techniques for change (the stage of change) (Beitman, 1987). These two aspects of formulation tend to influence one another throughout the course of psychotherapy: clarifying a dysfunctional pattern will lead to the selection of treatment strategies. Changed patterns can make other maladaptive patterns more obvious.

The biphasal formulation process (pattern definition and change strategies) creates tension between theory and change techniques. Theory tends to define "causes" of psychological dysfunction; technique seeks an active solution to the problem. Theories of psychopathology, normal development, and normal functioning each influence the formulation of problematic patterns. Theories based on intrapsychic conflict, for example, will direct the therapeutic focus to somewhat different problematic patterns than theories based on systems concepts. Variations in conceptualizations of psychological distress may also emerge from successful techniques. Empathic reflections, for example, preceded the development of theories of psychopathology and normal functioning. Such conceptual and stylistic distinctions, or "schools" of psychotherapeutic thought, can be more easily understood by studying from the perspective of how each incorporates the future in its diagnostic and therapeutic models.

Clients often find relief in learning that there is invariably a connection between presenting distress (symptoms, unpleasant emo-

tions, undesirable behaviors) and triggering events. Client-oriented formulation may thus be considered a "reformulation" of the client's preexisting explanation of the distress that brings him or her to care. To illustrate, a newly diagnosed diabetic woman with remarkable memory abilities is puzzled by the intense anxiety generated by the finger-stick she must perform several times a day to measure blood glucose. She notes, "I should not react with this much anxiety, sweating and trembling. I make quilts and often stick my fingers. What is going on?" During therapy, she is reminded of being forced as a child to receive penicillin shots in her thigh for recurrent earaches; these injections were painful and terrifying for her. The client's daily glucose testing had mobilized emotional resonances of these hated childhood experiences and caused her to react as she had then to a similar but much more painful therapeutic regimen.

With the therapist acting as a co-imaginer through facilitating client "reformulation," the woman was encouraged to construct a new expectation for her future. By engaging techniques to dissociate the diabetic finger-stick from the old penicillin shots, the therapist and client were able to coproduce a new, more satisfactory expectation. The new set of images including seeing herself calmly and nearly painlessly pricking her finger to measure her glucose, monitoring her diet and medication, improving her self-care, and feeling appreciably better than she had before her diabetes had been diagnosed and treated.

## APPLICABILITY AND STRUCTURE

Five content variables can be woven into the reformulation and reconstruction of personal futures: precipitant/trigger, developmental challenges, client's formulation and reformulation, diagnosis, and expectations of significant others from the therapeutic encounter.

### Precipitant/Trigger for Seeking Help

Most psychotherapists evaluate the client's stated reason for seeking care as an indicator of the

underlying problem. The event that mobilized the client to come for treatment often encapsulates problematic patterns of expectations that should be addressed in the course of therapy. For instance, a 45-year-old woman experienced psychotic episodes while visiting her mother, terrified that she might encounter her divorced father who had abused and threatened her when she was young. She was afraid that this man would assault her again. Psychotherapy should be directed toward helping this woman to reframe this trigger mechanism and recognize that the father was long-gone from her mother's home and does not represent a realistic threat to her anymore.

### Developmental Challenges

Each stage of human development marks the confluence of physical changes and cultural norms. When an individual finds that one or more of these developmental expectations has not been met, psychological symptoms may arise. Children may expect that, "No matter what I do, everything should come easily to me. I expect the world to be fair and adults to be perfect." Adolescents may think, "I won't die and my friends are more important than anything. I have to make them like me." Young adults might anticipate, "I need to find a partner in life, and the work I find must be rewarding financially and personally." Middle-aged adults may believe, "I must be a good parent. Is this all there is to life? I expected much more." Elders often presume, "I will not be able to do the things I used to do, and I am losing my place in the world. I do not want to die in pain. I want to leave a legacy."

### Client Formulation and Reformulation

As mentioned earlier, clients usually bring their own ideas about what is wrong and how to fix it in the therapeutic encounter. Therapists, however, vary in how directly they use these predispositions toward the future. The elementary questions that define the client's formulation include:

What is the problem?

What caused it?

What is the desirable outcome(s)? Or: How will we know when we are finished?

What are the desirable roles of both client and therapist?

What are the client's preferred methods of psychological change?

What is stopping the client from changing?

The therapist collaborates with the client on *reformulating* his or her original formulation by not only conceptualizing client patterns but also incorporating points about future expectations.

### Diagnosis

Diagnoses offer ideas about a client's potential sense of a distorted future. Depression, for instance, often contains the "the depressive triad": negative views of the self, the world, and the future (Beck, 1976). Depressed clients are typically unable to reach desired future goals. These goals may be excessively difficult to reach (e.g., an idealized relationship, career role, or social position), or the client may not have the means to achieve even modest goals (e.g., secondary to low energy, ineffective strategies, inadequate prerequisites). Depressed clients often struggle with two strong contradictory expectations: feeling powerless to affect anything good, ("whatever I try to do, it never works out") and taking responsibility for everything bad ("all the bad things that have happened are my fault").

Anxious people, frightened by potential catastrophic outcomes, often produce the outcomes they most fear. With Generalized Anxiety Disorder, any new difficulty is experienced as the precursor of total personal ruin, and even non-problematic events appear threatening. People with social phobia, fearing rejection and abandonment, isolate themselves. Panic sufferers, feeling threatened by impending death, insanity, or annihilation, may hold any or all of the four following expectations: abandonment leading to isolation, "intense" anger, activation of traumatic or unresolved grief memories, and odd bodily sensations, like chest pain. People

with panic disorder may actually precipitate the onset of heart disease by refraining from exercise (which scares them by raising their heart rates) and thereby contributing to deterioration of their physical condition. With Posttraumatic Stress Disorder (PTSD), typical thoughts revolve around, "I must do everything I can to avoid having to remember those terrible things because I will be overwhelmed by terrible feelings. I have lost trust in people, in the world, and in any Higher Power. Nothing turns out right. I am not safe." By withdrawing from the world and numbing their feelings, individuals with PTSD can alienate themselves from social interaction and confirm their own sense of joyless existence. Other future expectations associated with diagnoses include:

Hypochondriasis: "I am falling apart and no one is willing to help me."

Mania: "I feel very powerful. If I imagine something, I can accomplish it."

Alcohol abuse: "With alcohol I do not have to feel awful emotions. I cut off a painful future possibility. Getting drunk is more reliable than people at making me feel good."

Anorexia: "I judge myself by my weight and body shape. My life, especially my eating habits, must be completely controlled. I seek a perfect balance between hunger and fullness, so I do not have to think about it anymore. I will look better if I do not eat."

Paranoid personality: "If I trust anyone, I will be hurt. Others will take advantage of me."

Borderline personality: "My feelings control me; I must escape them by running away or hurting myself. Eventually I will be abandoned" (Freeman, Simon, Beutler, & Arkowitz, 1989).

## PROCESSES OF CHANGE

The future-oriented process of therapeutic change stresses a sequential four-step model that underlies but is less prominent in the schools of psychotherapy. The steps include (1) identify-

ing problematic responses, (2) activating the observing self, (3) identifying mismatches between expectation and experience, and (4) changing either expectations or external reality to realign them with one another. Stage one of this process defines the emotions, behaviors, and symptoms that are in need of change. During the second stage, a therapist uses the identified problem responses to guide the client toward an objective view (the observing self) of his or her interior states, thoughts, desires, images, and emotions. Consciously observing the self leads to step three: recognizing mismatches between one's experience and one's expectations. Stage four concentrates upon resolving these disconnections in such a way that desired future expectations are realized rather than not. The various schools, along with specific future-oriented strategies, employ diverse strategies in addressing this incongruence, such as resolving unconscious fears, cognitive restructuring, or providing facilitating therapeutic conditions.

## THERAPY RELATIONSHIP

The psychotherapist should consider several key variables early in each therapeutic encounter: client suitability for psychotherapy, client role preference, client level of self-awareness, positive or negative influences in the client's environment, therapist role preference, therapist confidence in his or her capacity to help in this situation, and potential outcome predictors. Each of these elements helps to orient both the client and therapist to the range of future possibilities within and outside the therapeutic relationship. Their answers are predictive of the course of therapy and provide the foundation of the interpersonal script that is the therapeutic relationship itself.

### Client Suitability for Psychotherapy

Not every individual who comes to a see a therapist is well suited for psychotherapy, and not every problem is susceptible to its ministrations. Some clients may have medical problems that resemble psychological ones, and some others may require psychoactive medica-

tions only. Acutely suicidal patients will need hospitalization first; psychotic clients, medication; some drug seekers may require referral for withdrawal or detoxification. A client might also need social support, money, food, clothing, shelter, friends, or familial affection that a therapist cannot provide. The client's appropriateness for therapy is thus a crucial consideration for any effective therapeutic change of the future.

### Client Role Preference

Offering clients relational and technical interventions that meet their expectations seems clearly practical, at least until the client becomes acculturated to each therapist's individual approach. Help in selecting the best initial role relationship model for a new client may be found in a review of any prior psychotherapy relationships. A 35-year-old woman reported that each of her three previous therapists saw her as a victim of sexual abuse who deserved pity. She did make it clear that she did not like to be put in a "poor me" role; instead, she preferred to be empowered and focus on what she could do to correct her current interpersonal difficulties.

A client's preferred relationship, however, can sometimes obstruct a positive outcome. If, for example, a client is overly submissive toward the therapist, this relationship pattern may validate and perpetuate rather than resolve the presenting symptoms. Significant research suggests that those clients who clearly understand their roles in the therapeutic process remain in psychotherapy longer (Beitman, 1987; Beitman & Yue, 2004).

People tend to cope with adversity along a continuum of internalizing–externalizing. The internalizing end is characterized by turning inward regarding emotions, thoughts, and behaviors and avoidance of psychological and interpersonal conflict. Internalizers are often preoccupied by issues of interpersonal *relatedness*, such as trust, caring, intimacy, and sexuality, and tend to form dependent relationships. Externalizers, on the other end of the continuum, are assertive, gregarious, and seek help and support from others in times of stress. They are

most concerned with maintaining a viable *self*, a sense of separateness, autonomy, and control. Rather than blaming themselves for problems, externalizers see the source of their difficulties outside themselves. These clients are likely to respond better to behaviorally focused relationships, whereas internalizers are more receptive to insight-oriented approaches (Norcross & Beutler, 1997).

### Client Ability to Be Self-Aware

Psychotherapy asks clients to psychologically "step back" to a vantage point from which to observe and report their inner emotional, cognitive, and visual experiences (Deikman, 1982). Some clients are unable to engage in this process, whereas others become enraptured by it and tend to be overly descriptive. Without a well-functioning self-observer, articulation of expectations and experiences is likely to limit the therapeutic task; at the other extreme, self-observation with excessive detail, patterns can be lost in extraneous verbosity. The ability to enter the theater of oneself and achieve self-reflection must be developed to master and change one's faulty expectations. Such self-awareness is also correlated with resilience in response to stress (Fonagy, Steele, Steele, Higgitt, & Target, 1994), responsiveness to cognitive therapy in schizophrenia (Rector, 1999), and receptiveness to psychotherapy in depression (J. Perry, personal communication, July 15, 1998).

### Positive and/or Negative Influences in the Client's Environment

Individuals in the client's social network can help or impede changes. Pretreatment nurturance and encouragement by friends and family to engage in psychotherapy is associated with a cohesive therapeutic bond and better commitment to therapy (Bankoff & Howard, 1992). On the other hand, clients who feel pressured to enter therapy tend to be defensive throughout treatment and do not develop strong therapeutic relationships. Family conflict and poor family support predict poorer therapeutic outcomes. Clients with a close confidant and less

family conflict show better outcomes with brief therapy. Long-term therapy is better suited for patients with significant family conflict and no access to a close support figure (Moos, 1990). The degree of client social support and investment in social attachments appears to predict the value of interpersonally focused and family therapies (Sotsky et al., 1991).

### Therapist Role Preference

The therapist's personal experiences inevitably influence his or her understanding of client problems and solutions. History with clients, successful as well as failing, also guide how therapists think about people who subsequently seek their care. Therapists continue to evolve their own styles and ideas about how to conduct the psychotherapeutic relationship as their clients teach them how to be better therapists.

### Therapist's Belief in Ability to Help Client

Sometimes therapists find themselves frustrated with individual clients, feeling helpless, personal distaste, or bafflement. The experience typically introduces countertransference issues into the therapeutic relationship. Directly addressing this issue can provide a dose of realism leading to consultation, client transfer, referral, or clarification of the problem. Psychotherapy requires realistic optimism; a therapist must believe change is possible. As suggested by Bandura's (1977) concept of self-efficacy, if a clinician believes that he or she can help clients in co-imagining futures that are more satisfactory than present reality, it is more likely that this goal will be achieved. Therapists need faith in their abilities to help clients discover "a way out," coupled with a willingness to face the often disturbing facts of clients' painful situations. These twin interacting perspectives allow therapists to search for clues for better client futures.

### Potential Outcome Predictors

Research findings on the process and outcome of psychotherapy can also be used to assist in

shaping clients' treatment. In major depression, for instance, the following variables have been shown to result in poorer treatment outcomes:

- Younger age at first episode of depression
- Presence of chronic intermittent or minor (double) depression
- Longer duration of first episode of Major Depressive Disorder
- High levels of perfectionism
- Cohabitation with a criticizing partner
- Self-perceived parent-child conflict
- Higher severity of depression at baseline measurement
- Inability to use psychotherapy relationship
- Higher levels of social and cognitive dysfunction
- Lack of positive expectations of improvement
- Personality disorders (each Axis II cluster predicted similarly poor outcomes)

(Birmaher et al., 2000; Janowsky, 2000; Leff et al., 2000; Shea, Elkin, & Sotsky, 1999).

## METHODS AND TECHNIQUES

Our approach to integration uses many methods drawn from diverse systems of psychotherapy and supplements them with specialized future-oriented strategies. This section addresses psychotherapy change methods with a future orientation.

### Activating the Observing Self

Psychotherapists help clients activate their self-awareness to identify problematic expectations and generate new visions of the future. The therapist becomes an alternate observer of the client's self. With the therapist co-observing the landscape of a client's mind, the client is able to see his or her *self* through a different perspective; such attention to subjective experiences helps guide self-awareness, assessment, visualization of opportunities, and choice about what to change. This cognizance of self, or mindfulness, may be activated by any of several techniques.

In describing the basic therapeutic techniques of psychoanalysis, Freud (1962) instructed his clients to “act as though, for instance, you were a traveler sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside.” A practitioner of the interpersonal school emphasizes the therapeutic relationship as a source of therapeutic change and calls attention to the here-and-now of the interaction. The client usually responds with an activated self-awareness, “stepping back” in order to examine inner representations of role expectations and projections. Through a cognitive-behavioral model, the Cognitive Thought Record is employed to activate awareness; in recording and analyzing self-talk statements, clients acquire a deeper sense of their inner psychological states. In the behavioral school, the monitoring of actions and situations enhances client recognition of personal patterns. A Rogerian perspective uses the therapeutic conditions to create the possibilities of change; this mode of relational restructuring may act as a catalyst for increased self-awareness of not only negative evaluations in the past, but also consequential future expectations through gaining the perspective of a caring other (therapist).

### Expectation Videos

In order to examine potential futures, individuals often visualize possibilities. Some may be only dimly aware of their future images, whereas others may generate sharp, precise images. Some focus on the future primarily through words, others do so predominantly with emotion. Taken together, these plans and images form videos of future possibilities. These Expectation Videos may range over the time continuum from immediate to near future to long term (Madsen, 1999; O’Hanlon & Beadle, 1994). Expectation Videos may be considered the targets of psychotherapeutic change.

These mental “movies” are composed of speech, thoughts, emotions, plans, and goals and are structured through scripts, actors, setting, and action. The brain has programmed into memory not only the sum of an individ-

ual’s experience but also rehearsed ways of thinking–feeling–doing–living; this “procedural memory” is the foundation of Expectation Videos. Though Expectation Videos screen themselves seemingly automatically in the mind, these images may be also stimulated through active consciousness (self-awareness) for examination and redevelopment. Expectation Videos thus imply that a client has a sharpened sense of responsibility of being not only an actor but also a writer of his or her own life dramas. Expectation Videos are produced, directed, photographed, and edited by “I,” starring “Me,” for the improvement and edification of “Myself.”

### Identifying Problematic Expectation Videos

For many clients seeking psychotherapy, faulty images of the future can lead to undesired results, including problematic emotions, undesirable behavioral patterns, and self-fulfilling prophecies. Examining such problematic outcomes can point toward the underlying expectation videos; this recognition is necessary for reconstructing a new vision of the future. Psychotherapists of all orientations seek targets for change by working backward from signals of distress, and forward from situations, in order to define the intervening psychological variables connecting the stimulus (triggers) with response (symptoms). These intervening variables have been divided into several overlapping categories, including wishes/fears of conflict (psychodynamic), cognitive distortions, faulty schemas, dysfunctional automatic thoughts (cognitive-behavioral), and maladaptive interpersonal schemas (interpersonal). Expectation Videos incorporate all these primarily linguistic descriptions and distinctions. Primary concepts from each of the schools of therapy can be transformed from word–based emphases to a word-image based focus.

### Modifying Problematic Expectation Videos

Modifying Expectation Videos begins with the recognition that something must be changed. In order to facilitate this change, the client’s



mind must first be cleared of unwanted videos and new ones then developed. Some of the well-known school-based strategies indirectly help to erase problem videos without providing sufficient guidance in developing the new ones that will replace them.

Psychoanalytic insight, for example, teaches clients to examine and put aside role expectations through interpretations. If, for example, a husband accuses his wife of having an affair when the evidence is clear that she is not, it may be possible to help the client understand that he is projecting an inaccurate movie of his own emotions and thoughts. His infidelity fantasy is actually an expression of the neglect he feels because she spends so much time with her own family, makes “excuses” to do extra work, and lacks sexual desire. The accusation of infidelity is a reflection of his effort to make sense of her behavior without having to directly tell her how rejected and hurt he feels. As he comes to accept the interpretation, the “video screen” in his mind clears. He can begin to create a new video to replace the old one he was projecting.

Psychoanalytic interpretations do not usually provide much help in developing new Expectation Videos. The school-based approaches most directly tuned to create new videos are the skill training packages that teach individuals assertiveness, anger management, and basic interpersonal skills. Through such experiences, clients learn new ways of acting, thereby training their brains to function differently by reprogramming their procedural memories to produce new Expectation Videos. Systematic desensitization, by imagining feared circumstances in a slow, progressive manner, also helps to create new movies in place of old, anxiety-provoking ones. Instead of turning away from the dreaded situation, for example, a client is encouraged to envision taking one step closer, thus creating a new Expectation Video. Moreover, when the gradual approximations are applied to a real situation, the client gains a memory of the experience, which becomes the basis for still another video displaying mastery and success to which he or she can refer to for support when next confronted by anxieties.

In addition to the strategies offered by the

schools of psychotherapy and skill training to alter problematic Expectation Videos, there are potentially useful explicit future-oriented methods and strategies:

1. Giving it up, letting it go. Letting go is the most direct way of clearing a movie screen. Letting go of something that is intensely desired clears the screen for new videos. For example, a person is threatened by a loss of working position. This strategy suggests accepting the worst of the worst outcomes; by accepting the terrible, the video screen becomes clearer. The paralyzing anxiety gives way to new plans and the machinery of the mind, once rusted by corrosive anxiety, is then freed to consider new possibilities.

2. Forgiving. Forgiveness of self and of others requires the dissolution of Expectation Videos of punishment, regret, and revenge in order to clear one’s screen and create space for new Expectation Videos. Without letting go of angry videos, there is no room for the development of new ones.

3. Practicing “next day imagining” to make positive events occur. By visualizing small success experiences, one is more likely to actualize the desired scenario (as with the behavioral hierarchy, an agoraphobic may imagine the small steps required to go into a store before he or she makes the actual attempt to climb them). This not only fine-tunes one’s expectation machinery, but also reinforces the ability to imagine successfully.

4. Collecting effective, satisfactory videos to repeat. With the recognition that one possesses resiliency and has gained knowledge from previous negative experiences, one’s strengths can be mobilized to compensate for shortcomings. For example, an ex-basketball star knew that his success was dependent on the abilities of his teammates. When he became the leader of a subunit of his organization, he used some of the same ideas with his colleagues wherein he supported them and their success helped him to succeed.

5. Acting as if what is desired is already happening. By living as if a decision had been made or a goal accomplished, a dynamic is established that reinforces the new role. For example, as an interim academic department

chairman applying for the permanent position, a professor conducted her business as if she were the permanent chair. People responded by acknowledging her suitability for the role, and she was awarded the permanent position.

6. Visualizing a future as if nothing has changed. A woman is uncertain about whether to stay with her lover and is asked to imagine being married to him 10 years later. What would their life together be like?

7. Visualizing ahead 6 months. Imagine your future autobiography (Melges, 1982). If you achieved everything you want, how would things be different? Project 6 months ahead. What would your life look like? Pick a time, place, and person and describe it. Who is there? What are they doing? What are you doing? Fill in the details. Make it just what you want it to be.

8. Looking back at now from 10 years ahead. Would you be satisfied with the decisions you made or did not make? The 10-year time span is almost unimaginable, and in being so distant provides a broad, panoramic look at what is, might be, could be, and what would have been. Most clients do not have the luxury of imagining from this perspective, because they are usually inundated with complications and problems of the near present.

Changing personal perspectives on the future can be exhausting, consuming both time and emotional energy. One's old tapes are well ingrained and automatic: "I am who I have been." A person familiar with ignoring successes and discounting compliments will tend to keep the "I am incompetent" script going by casting actors to speak the necessary derogatory lines and editing out positive words and/or actions. Similar to the physics principle of inertia, expectation videos continue to run until sufficient psychological force knocks them out of their video players to be replaced by new ones.

### Co-Imagining New Expectation Videos

Therapists help in co-constructing patient's visions of the future. Each school of psychotherapy employs unique techniques to help in this co-constructing. For example, a therapist using

a cognitive-behavioral perspective with Carla, an anxious young woman, may record the following in her thought record:

Situation: Drying dishes in boyfriend's apartment

Emotion: Anxiety, panic attack

Thought: I am going to die; I have to get out of here

This woman's past included an overcontrolling father, who, by criticizing her mother's successful professional life, ultimately coerced her into becoming a housewife. Recently, when Carla's father asked her to stay longer than planned during a visit home, even at the cost of jeopardizing her job, she became fearful that she might end up like her mother: surrendering her dreams to satisfy her father. The dish-drying domestic scene triggered Carla's expectation video of losing her identity and becoming the housewife of an overcontrolling man. The therapist helped Carla imagine a different future by encouraging her to describe her old videos to her new boyfriend. The therapist and Carla discussed her fears of intimacy (including anxiety upon sexual penetration) and her need to have her own apartment to be able to retreat to its safety when she felt the need. Carla begins to construct a video of her new romantic relationship, with the therapist acting as a movie consultant. With the boyfriend's willing compliance, he and Carla can construct a life together that gradually brings her closer to him and the possibility of being in an extended relationship while maintaining her personal independence. Her new interpersonal Expectation Video balanced Carla's need to feel self-sufficient with her need to be involved without threatening her loss of personal identity.

### CONSTRAINTS

Many people have trouble clearing the video screens of their minds and imaging better futures. What are some of their difficulties? Psychotherapists try to help clients imagine a positive, realistic future. If this general solution to

problems is so simple, why do clients need therapists? The answer lies within forces, both internal and external, which constrain individuals from being able to imagine. Being able to recognize, accept, and work with interferences to change distinguish professional listeners, like psychotherapists, from friends, clergy, and sympathetic bartenders. The psychodynamic terms “defense” and “resistance” carry more pessimistic connotations about the possibility of a better future, whereas the term “constraints” implies that the patient’s major aim is change rather than maintenance of an unsatisfactory status quo (Madsen, 1999). The following section describes some of the general categories of constraints.

### Demoralization

Persons entering psychotherapy often present with feelings of helplessness, hopelessness, and isolation, resulting from persistent failures to cope with routine internal or external stressors. The instillation of hope constitutes a primary intent of all psychotherapies (Frank, 1976). Hope is the canvas upon which a positive future can be sketched. Depressed and traumatized people develop foreshortened futures, trying to live “day-to-day” without long-term goals and associated plans. Without a sense of purpose, meaning, or direction in life, many people become demoralized and lose hope and the ability to project new possibilities on their mind-screens.

### Forces Maintaining Problems

There are many potential internal and external influences impeding the individual’s progress toward a better future. Substance abuse, for instance, is maintained not only by chemical reinforcement but also by continuing relationships with other drug users. The craving for the drug forces the video “Gotta get my high” on the marquee of the Mind Theater. In addition, terminating drug use requires severing drug-related associations, which can provoke frightening movies of isolation and loneliness.

Almost any change in behavior threatens the stability of important relationships. The

emerging assertiveness of a passive person may be dampened by family and friends who are uncertain about how to respond to this newly acquired trait. Significant others may even prevent the emergence of new behaviors. They may subtly or overtly try to prevent the emergence of new behaviors to keep the person in a role to which they have become accustomed. A young man may not believe he makes good decisions, for example. He makes a decision that results in a poor outcome, tells his mother, and is told, as so often before, “I have been telling you all your life that you can’t make good decisions.” He believes her again and continues to rely on her to make his decisions. In other situations, a significant other does not even have to be present to exert influence: a father warned his daughter to avoid feeling sensitive to the needs of others and especially not to express her needs to anyone. Although he died when she was 27, as a 38-year-old woman she continues to follow his rule, despite the havoc it causes in her marriage. She did not want to change this part of her relationship with her father. She continues to follow Daddy’s wishes and feel as if she is Daddy’s “Good Little Girl.”

### Self-Fulfilling Prophecies

The expectations of responses by others can be fulfilled by one’s own behavior. Humans create problems by being unaware of the ways in which we induce others to respond. A high-level administrator may not believe he deserves the title and respect he has achieved. Unaware, he creates political rivals, who threaten his position. When they attack him, he quietly believes that they are correct in their rationale and meekly surrenders his hard-won gains. A shy but very intelligent young woman has immense trouble making friends. She believes that others think she is stupid. When she talks with others, she becomes intensely anxious about their opinion of her. Her anxiety causes her to speak haltingly and disjointedly, causing her acquaintances to believe that she is indeed of low intelligence and thus display no interest in establishing a friendly relationship with her. She remains isolated and unhappy.

## Mechanical Problems

### *Insufficient Self-Observation*

Expectations are based on past experiences. Rigidly held beliefs generated by past experiences have to be studied before they can be changed, but some people are unable or unwilling to scrutinize these images, emotions, and thoughts. Therapists can help form a client's foundation of self-awareness by acting as dispassionate observers and supporting the client's own self-observational abilities.

### *Conflicting Expectation Videos*

Individuals have multiple selves. We are a symphony orchestra of many parts each trying to blend harmoniously with the others. Sometimes people deteriorate into internal conflict. Perhaps the most common conflict emerges between the self that wants, the self that feels, and the rule-bound self-critic. Objectively, each self is striving to maintain and develop itself for the betterment of the whole organism. Therapists may help clients find the intentions behind each self; usually the differing goals reflect parts of the long-term goals and may be balanced and blended into the overall desired intentions.

### *Insufficient Experience in Developing Achievable Goals and Practical Strategies*

Effective images of the future require setting achievable goals by using practical strategies. Some patients may not have had sufficient experience in estimating realistic goals or may not have accumulated a toolbox of effective strategies (perhaps for lack of coaching or practice) with which to build their desired results.

### *Repeated Experiences of Imagining Future Goals and Having Each of Them Subverted*

The experience of repeated failure, of defeat and disappointment by conditions beyond personal control, is acutely discouraging and

chronically demoralizing. People who have known constant defeat come to expect consistent defeat and no longer direct their actions toward features that typically contribute to happy, satisfying lives. Young people who have known too many deaths among those they have depended on, for instance, surrender their sense of a fair and ordered world in which particular behaviors create agreeable responses. They withdraw emotionally to avoid the pain of losses they know are inevitable, thereby depriving themselves of any opportunity for the human warmth and security they really crave.

### *Inability to Prioritize Sequence of Goals*

Many individuals see several problems to be settled all at once. The challenge of simultaneous stressors overwhelms their ability to pragmatically sequence selected goals. These people confront multiple Expectation Videos, with different demands and goals, and experience them all as requiring immediate attention: "I must do my income tax, call my brother, complete a project at work, plan for a staff meeting, worry about my mother's new symptoms, take my child to the doctor, and figure out why my spouse is acting strangely." Longer term goals for this individual might include changing jobs, moving to be closer to relatives, becoming more attentive and empathic toward a spouse, changing financial investment strategies, and planning for the children's college. These futures accumulate at the door of the mind's theater, each demanding an immediate audience. Activity on the stage becomes so hectic that the theater closes and no Expectation Videos are run.

### *Negative Beliefs About Self*

"I don't deserve to change." "I am afraid to change." "I can never change." "I can't learn how to change." "I don't want to change." Such people may be unable to permit themselves the luxury of imagining themselves in a better situation. Their continuous self-condemnation locks the door to the Expectation Video sound stage. The video camera gets put away.

Not uncommonly, people who genuinely try to change the things about themselves and their environment that torment them are simultaneously working to defeat their own efforts. Their secret sense of shame, fear, anxiety, or unworthiness causes them to quietly resist the corrections that will relieve them of these emotions and otherwise let them enjoy their lives more fully. Imagine Becky, forced to see a psychiatrist by her husband after many visits to emergency rooms because of recurrent chest pain. She is 28 years old, and a cardiac workup showed no anatomical defect. After reluctantly agreeing to a psychiatric evaluation, she is diagnosed with panic disorder. Becky has terrible side effects with almost every antidepressant the psychiatrist prescribes, until one finally seems to work without creating more misery than it relieves. After 10 years of psychotherapy and antidepressant medication, Becky becomes clearer about the processes that seem to have prevented her from changing:

1. She did not believe in a psychological explanation for her chest pain. She expected that a medical explanation would be found.
2. Multiple antidepressants were ineffective for Becky. She believed this meant she did not have a psychiatric problem.
3. Afraid her therapist would reject her, Becky did not tell him about her persistent suicidal ideation.
4. Becky was terrified that any psychological intervention would force her to talk about traumatic events of her childhood and resurrect the pain they caused her.
5. She did not believe that she could master her own intense emotions. If the emotions were released, she saw herself “falling apart.”
6. Her husband was terrified that she would leave him if she became more independent, like other women had before. When she started to be more self-sufficient, he sought psychotherapy himself. She knew that he was afraid of her improving, and she did not want to lose him. Each partner thought that if they resolved their

own pathology they would lose the love of the other.

This entanglement of destructive Expectation Videos created intense complications in the psychotherapy of this patient.

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### CASE EXAMPLE

Maria, a 25-year-old part-time college student, presented for psychotherapy with a history of depression. She reported first becoming depressed for a period of 6 months at age 15; she had sought no treatment at that time. During pregnancy at age 24, Maria again started feeling depressed; postpartum, these symptoms rapidly worsened, accompanied by anxiety and an inability to sleep. In her initial psychiatric session, Maria was prescribed Zyprexa, 5 mg, which sedated her. She was then in combination switched to Risperdal, 1 mg, and Zoloft, 75 mg.

Maria's presenting concerns revolved around guilt of neglecting Cameron, her 18-month-old son. She reported she did not want to feed him, play with him, or even hold him, but she hated herself for not mothering him the way she should. In the four-step stage model, the identification of these problematic responses is step 1. Maria described her own childhood as violent, with an alcoholic father who was physically abusive and constantly critical toward her mother, her brother, and herself. After each such episode, however, the family acted as though nothing had happened. Maria could not understand how her mother allowed her father to abuse herself and her children. Maria was using her self-observational abilities, psychotherapy step 2, to start locating the mismatches between her expectations and actual experiences.

Maria's psychotherapist eventually hypothesized that perhaps Maria was jealous of Cameron because he had a better mother than Maria had. Maria brightened and replied, “Hey, that's just what my mother-in-law said.” This crucial therapeutic exchange further expanded the range of Maria's observing self: with the therapist co-observing and highlighting the landscape of Ma-

ria's subjective experiences, she was able to see a pair of Expectation Videos playing almost simultaneously. One video played out her ideal form of mothering, while another projected her own childhood experiences. Upon observing these two, Maria subconsciously withdrew in a jealous fit to an "in-between" mode of neglectful mothering. Maria then fairly quickly completed step 3, the clear identification of the mismatch between her expectations and actual experiences that produced her "neglectful mother video." Once aware of this process, she recognized that these images were problematic, unfairly coloring her interactions with her son. Maria discovered, "the problem is with my mother, not Cameron. I've got to do something about my anger at her." Step 4 of the future-oriented psychotherapy process leads to an alteration of either expectations or experience. Maria clearly saw that she had to change her own internal expectations about her son.

At a later session, the therapist worked with Maria to modify her problematic Expectation Videos and create new ones for a more satisfying relationship with her son.

MARIA: Even though I now realize that I am irrationally basing my interactions with Cameron on my past, I can't stop feeling like I don't want to be a good mother to him. It is so frustrating. I just want to scream at myself, "Why can't you stop feeling what you felt as a child?"

THERAPIST: (Intending to slow Maria down and have her listen to her own statements.) Your sentence uses a verbal order to yourself about a feeling in the present triggered by activating an old movie of yours. "Stop" is the command-word, "feeling" connects past and present, and "as a child" activates the video from which your feelings emerge.

MARIA: Yes. I don't know how to stop running that picture in my mind. I just have so much trouble nurturing him when I see that he has everything. I think it would be easier for me to embrace someone who has had a bad childhood. Also, my husband had a great upbringing and I feel different from both of them. If I had a child who was more like me, it would be bad, but I think it may be easier for me to love him.

THERAPIST: May we imagine together any other way you might act with Cameron?

MARIA: I'll try . . . but this is hard because I don't know any other way to be. I only know how I was raised.

THERAPIST: Okay, well, visualize ahead 6 months. If you could have what you wanted with Cameron, what might that be like?

MARIA: (Silence)

THERAPIST: How would it be different from now?

MARIA: Umm . . . I guess I would be able to put Cameron "over there," by saying to myself, "just because I had a bad childhood does not mean he is a bad person or that he has to have a bad childhood for me to love him."

THERAPIST: If we were to put that statement into a movie, what would it look like?

MARIA: Well, I guess I would have the starring role as a mother. I would love Cameron completely for who he is, putting aside his pampered lifestyle and my past. As a mother, I would enjoy raising him, loving, cuddling, reading, and playing with him. He would grow to know that his mother truly cared for him deeply.

THERAPIST: When you put him aside you put him into a different video, different from the "jealous of him" version. By putting him "over there" you are able to build a new and better movie around him.

MARIA: Yes, I need to look at the situation in a different way. I am not happy with all that he has, but I need to take pride in this, take pride in myself as a caregiver.

THERAPIST: By running that video, you will have a different set of expectations for your relationship with Cameron.

At a later session:

THERAPIST: How are you doing with Cameron?

MARIA: Well, I still occasionally have the feeling that I wish I would have had what he has, but after recognizing that I was projecting onto him my own experiences with my mother, I don't look at him in a negative way anymore. We are doing much better . . .

I do, however, have something new that is

bothering me. At the university, in my program, my professor seems really critical of my work. I feel like he is more critical of me than any of the other students. It has gotten to the point where I just want to leave school.

THERAPIST: How much of this is the old movie of your father criticizing you, which usually led to his physically abusing you, and how much of this is genuine?

MARIA: Hmm . . . well, I guess I had not really thought of it like that . . . (long pause). But, yes, like with Cameron, maybe I am hearing my father when my professor speaks. Maybe I am interpreting his intentions incorrectly.

THERAPIST: If this is the case, how might you see your professor differently? How might we construct a new movie for you to run?

MARIA: Well, now that I know how this works, I guess I would see my professor as someone who is trying to help me, not hurt me. And maybe try to listen to the content of his words more, rather than only seeing it as attacks on me.

Maria was able to understand how her mind generates movies. She learned how to separate problematic videos from reality and recognize how many of her expectations root and link back to abuse she suffered as a child from her father. By co-imagining new Expectation Videos with her psychotherapist, Maria became able to identify old, maladaptive Expectation Videos and co-imagine new ones for a more satisfying future.

During termination, after eight sessions, Maria reviewed what she had learned. Due to her changes in therapy, Maria's medication was in sequence reduced to Risperdal, 0.5 mg, and Zoloft, 50 mg. Maria described herself as overall much happier and a better mother. She enjoyed her ability to take a situation that was bothering her and then "run the videos." When she came to crucial choice points (should I do this, should I do that?), she found that she could screen the videos to check the potential outcomes of each decision: "I can avoid a lot of problems doing this."

## EMPIRICAL RESEARCH

After Melges' (1982) seminal work on how time varies by diagnostic category, there is very

little new empirical research on how future orientation is the unifying thread across the schools of therapy. There is no controlled research on the effectiveness of a future-oriented approach to psychotherapy. Additional work will clarify and develop the change methods proposed in this chapter and amplify how each school of psychotherapy strives, using different concepts, methods, and terminology, to help patients change their personal futures. Specifically, additional research will prognosticate the particular types of clients for whom future-oriented treatments will be most effective. New studies will broaden our understanding of the constraints and barriers that must be negotiated in helping clients to envision better futures.

## FUTURE DIRECTIONS

This chapter contains what we believe to be the fundamental, superordinate concepts that form the basis of psychotherapy: stages, relationship, self-awareness, and changing personal futures. Through holding fast to the basic constructs and exploring more fully the incorporation of a future-orientation psychotherapy, we will continue to evolve with the unpredictable variations that will continue to enrich our theory and practice.

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# 4

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## Outcome-Informed Clinical Work

SCOTT D. MILLER, BARRY L. DUNCAN,  
AND MARK A. HUBBLE

The proof of the pudding is in the eating.  
—Cervantes, *Don Quixote*

Throughout much of the 1800s and the century that followed, the railroad industry was *the* most successful business in America. Various companies raced to lay track from city to city and across the continent, speeding up the pace of life and making a mountain of money in the process. By the 1960s, however, this once great stalwart of American commerce was in serious decline—in truth, dying. When asked about the cause, business executives usually answered that the need was being filled in other ways (i.e., cars, trucks, airplanes, and new technologies like the telephone). It was hard to argue with such logic. Where transportation was concerned, consumers were seeking faster, easier, more flexible, and individualized alternatives.

For Harvard business professor Theodore Levitt, the conventionally held wisdom made no sense at all and, in fact, begged the question. The industry, Levitt (1975) argued, was not in trouble “because the need was filled by others . . . but because it was *not* filled by the railroads themselves” (p. 19). Why did the in-

dustry not diversify when it had the chance? Because, as it turns out, railroad executives had come to believe they were in the *train* rather than *transportation* business. Consequently, trucking and air-freight industries flourished while the old iron horse rusted away on the back lots of abandoned railroad yards.

In what has become one of the most cited articles in the business literature, Levitt (1975) showed how various industries, including everything from the railroads to Hollywood, suffered dramatic reversals in fortune when they became “product-oriented instead of customer-oriented” (p. 19). Movie moguls, for instance, were caught totally off guard by the television industry because they wrongly thought themselves in the movie rather than entertainment business. And thus famed director and studio executive Darryl F. Zanuck boldly asserted, “Television won’t be able to hold onto any market it captures after the first six months. People will soon get tired of staring at a plywood box every night” (Lee, 2000). Such ex-

traordinary lack of foresight eventually forced the closure of once powerful studios and bankrupted numerous high rollers in the trade. The empire never recovered its once and former greatness.

Applying Levitt's thesis to the field of psychotherapy suggests that the long-standing debate between this or that model of therapy, specific versus common factors, integration versus eclecticism, misses the point in a major way. Put bluntly, it has proceeded as though the field were in the therapy business rather than the business of change. "The illusion," according to Levitt, is "that continued growth is a matter of continued product innovation and improvement" (p. 27). For their part, consumers (and payers) care little about how change comes about—they simply want it. As such, the field's exclusive focus on the means of producing change (i.e., models, techniques, therapeutic process) has been and continues to be on the wrong track. Like their counterparts in the railroad and movie business, therapists are in danger of losing their customer base.

Consider the results of focus groups conducted by the American Psychological Association (APA, 1998). When asked, 76% of potential consumers of psychotherapy identified low confidence in the outcome of therapy as *the* major reason for *not* seeking treatment, far eclipsing variables traditionally thought to deter people from seeing a therapist (e.g., stigma, 53%; length of treatment, 59%; lack of knowledge, 47%). Such a "no confidence" vote is especially difficult to accept given decades of research showing that the average treated client is better off than 80% of the untreated sample in most studies (Asay & Lambert, 1999; Wampold, 2001). Yet, like it or not, this is the perception of consumers.

According to Levitt (1975), industries that thrive *start* with the customer's needs and work *backwards*, "first concerning itself with the . . . delivery of customer satisfactions. Then it moves back further to creating the things by which these satisfactions are in part achieved" (p. 27). Less time and resources are spent controlling the means of production and more effort is expended in staying in touch with customer de-

sires. Doing otherwise, he warns, risks "defining an industry, or a product, or a cluster of know-how so narrowly as to guarantee its premature senescence" (p. 20).

Consistent with the perspective presented by Levitt, the outcome-informed approach described in this chapter is less concerned with the elements of effective clinical practice—integrated, eclectic, or otherwise—and more focused on whether consumers experience the changes they desire, *whatever the means*. Instead of assuming that the right process leads to favorable results, ongoing feedback from consumers regarding both the process and outcome of care is used to construct and guide therapeutic interaction as well as inspire innovation.

## THE APPROACH

For a field as intent on identifying and codifying the methods of treatment as psychotherapy is, abandoning process in favor of outcome may seem radical indeed. Nevertheless, an entire tradition of using outcome to inform process exists. We begin by exploring the empirical antecedents of an outcome-informed approach to clinical practice. After this review, the development of our own work and perspective is presented.

### Empirical Antecedents of Outcome-Informed Work

Outcome research indicates that the general trajectory of change in successful psychotherapy is highly predictable, with most change occurring earlier rather than later in the treatment process (Brown, Dreis, & Nace, 1999; Hansen & Lambert 2003). In their now classic article on the dose-effect relationship, Howard, Kopte, Krause, and Orlinsky (1986) found that between 60% and 65% of people experienced significant symptomatic relief within one to seven visits—figures that increased to 70%–75% after 6 months and to 85% at 1 year. These same findings further showed "a course of diminishing returns with more and more ef-

fort required to achieve just noticeable differences in patient improvement” as time in treatment lengthened (Howard, Kopte, Krause, & Orlinsky, 1986, p. 361).

More recently, researchers have been using early improvement—specifically, the *client’s* subjective experience of meaningful change in the first few visits—to predict whether a given pairing of client and therapist or treatment system will result in a successful outcome (Haas, Hill, Lambert, & Morrell, 2002; Lambert et al., 2001). To illustrate, Howard, Lueger, Maling, and Martinovich (1993) not only confirmed that most change took place earlier than later, but also found that an absence of early improvement in the client’s subjective sense of well-being significantly decreased the chances of achieving symptomatic relief and healthier life functioning by the end of treatment. Similarly, in a study of more than 2000 therapists and thousands of clients, Brown, Dreis, and Nace (1999) found that therapeutic relationships in which no improvement occurred by the third visit did not on average result in improvement over the entire course of treatment. This study further showed that clients who worsened by the third visit were twice as likely to drop out than those reporting progress. More telling, variables such as diagnosis, severity, family support, and type of therapy were, “not . . . as important [in predicting eventual outcome] as knowing whether or not the treatment being provided [was] actually working” (p. 404).

In the mid-1990s, several researchers began using data generated *during* treatment to improve the quality and outcome of care. In 1996, Howard, Moras, Brill, Martinovich, and Lutz showed how measures of client progress could be used to “determine the appropriateness of the current treatment . . . the need for further treatment . . . [and] prompt a clinical consultation for patients who [were] not progressing at expected rates” (p. 1063). That same year, Lambert and Brown (1996) made a similar argument using a shorter, and hence more feasible, outcome tool. Other researchers had already found that clients’ early ratings of the alliance, like progress, were “significant predic-

tors of final treatment outcome” (Bachelor & Horvath, 1999, p. 139). Building on this, Johnson and Shaha (1996, 1997; Johnson, 1995) were among the first to document the impact of outcome *and* process tools on the quality and outcome of psychotherapy as well as demonstrate how such data could foster a cooperative, accountable relationship with payers.

With regard to clinical practice, the conclusion to be drawn from the foregoing research is clear: feedback and input from clients improves success. As for treatment method, the diverse number of approaches encompassed in such data clearly hints that the particular brand of therapy employed is of less importance. From an outcome-informed perspective, such data indicate that therapists do not need to know what approach to use, but whether the current relationship is a good fit and, if not, to be able to adjust and accommodate early enough in order to maximize the chances of success. Said another way, assessment is not something that precedes and dictates intervention. It is a vital, ongoing part of the therapeutic relationship—essential for change (Duncan & Miller, 2000).

### The Heart and Soul of Change Project

Our interest in an outcome-informed approach to clinical practice began following a chance meeting at a professional conference in 1993. Concerned about the rapid proliferation of therapeutic models and resulting division along theoretical, technical, and disciplinary lines, our initial efforts focused on developing a “unifying language of psychotherapy practice” that would enable the field to “set aside [its] many apparent differences and find a way to talk, to join together, and to share what . . . works” (Miller, Duncan, & Hubble, 1997, p. xi; Miller, Hubble, & Duncan, 1995). Research and writing on the common factors—dating back to Rosenzweig’s (1936) and Frank’s (1961) publications and forward to Lambert’s (1986, 1992) scholarly reviews of the literature—provided the foundation for the basic vocabulary of that language.

Of the various factors identified, the data indicated that two, the client and the therapeutic alliance, accounted for the majority of the variance in treatment outcome (Miller, Duncan, & Hubble, 1997). Lambert (1986, 1992), for example, suggested that 40% was attributable to the client/extratherapeutic factors and 30% to the therapeutic relationship. By comparison, model and technique factors and placebo were thought to contribute 15% each. Later meta-analytic research by Wampold (2001) confirmed and extended these findings, documenting larger roles for client/extratherapeutic, alliance, and placebo factors but a weaker contribution from models and techniques.

Such data, when combined with “the observed superior value, across numerous studies, of clients’ assessment of the relationship in predicting the outcome” (Bachelor & Horvath, 1999, p. 140) made a strong empirical case for putting the client in the “driver’s seat” of therapy. Successful treatment, we argued, was a matter of tapping into client resources and ensuring a positive experience of the alliance (Hubble, Duncan, & Miller, 1999). To these two elements a third aspect was added; namely, the client’s frame of reference regarding the presenting problem, its causes, and potential remedies—what we termed the client’s theory of change (Duncan, Hubble, & Miller, 1997; Duncan & Miller, 2000).

Adopting the *client’s* frame of reference as the defining “theory” for the therapy fit with several major findings from the extant, process-outcome literature. For example, in 1994 researchers Orlinsky, Grawe, and Parks (1994, p. 361) reported that, “the quality of the client’s participation in treatment stands out as the most important determinant of outcome.” What better way to enlist clients’ partnership, we reasoned, than by accommodating their preexisting beliefs about the problem and the change process? Other data provided further support. For example, follow-up research from the landmark Treatment of Depression Collaborative Research Project showed that although outcome did not vary between treatments, congruence between a person’s beliefs about the causes of his or her problems and the treat-

ment approach offered resulted in stronger therapeutic alliances, increased duration, and improved rates of success (Elkin et al., 1999).

To explain the basic components of a *client-directed* approach, we used an analogy of a three-legged stool (see Figure 4.1). Set against a backdrop of client strengths and resources, each leg of the stool stood for one of the core ingredients of the therapeutic alliance as identified in the research literature: (1) shared goals; (2) consensus on means, methods, or tasks of treatment; and (3) an emotional bond (Bachelor & Horvath, 1999; Bordin, 1979; Horvath & Bedi, 2002). Holding everything together was the client’s theory of change. Consistent with the metaphor, goals, methods, and a bond that were congruent with the client’s theory were likely to keep people comfortably seated (i.e., engaged) in treatment. Similarly, any disagreement between various components destabilized the alliance, either making the stool uncomfortable or toppling it completely.

As much empirical and clinical sense as these ideas may have made, however, they were still out of step with the cold, hard facts from the psychotherapy outcome literature. Yes, at first blush, tapping into client resources, ensuring the client’s positive experience of the alliance, and accommodating treatment to the client’s frame of reference appeared to capitalize on the two largest contributors to success. At the same time, no matter how abstractly the ideas might be presented, whether defined as

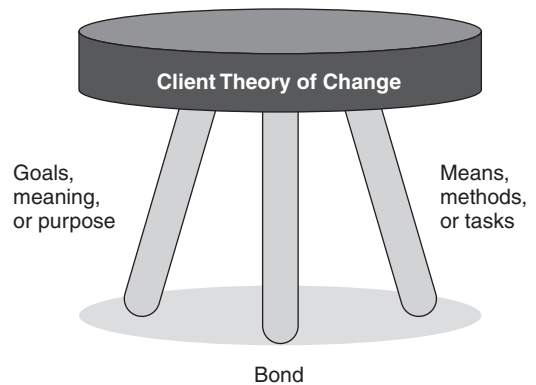


FIGURE 4.1 The Therapeutic Alliance

principles rather than mandates, closer examination made clear that any operationalization merely led to the creation of another model for how to do therapy. On this point, the research was clear: models mattered comparatively little in terms of outcome (Hubble, Duncan, & Miller, 1999; Wampold, 2001). What's more, research on the alliance showed that neither training nor experience had a strong relationship with either the quality of the alliance or outcome of treatment (Horvath, 2001; Horvath & Bedi, 2002).

On further examination, we concluded that that our own efforts, albeit unintentionally, had subtly but surely continued to privilege the therapist's role and perspective regarding treatment process. As had been true throughout much of the history of psychotherapy, the therapist was still "in charge"—in this case, finding client strengths, determining the status of the alliance, understanding the nature of the client's theory, and choosing which, if any methods, might be congruent with that theory. To remedy this problem and give clients the voice in treatment that the research literature said they deserved, we began encouraging therapists to "check in" with clients on an ongoing yet informal basis regarding both the nature of and progress in treatment (Miller & Duncan, 2000a).

In early 1998, a research project was initiated to investigate the impact of seeking client feedback on treatment outcome (Duncan & Miller, 2000). Several conditions were included. In one, therapists were supposed to seek client input in an informal manner (i.e., using the questions described above). In another, building on the work of Lambert (Lambert & Brown, 1996; Lambert, Okiishi, Finch, & Johnson, 1998) and Johnson (1995; Johnson & Shaha, 1996), results from standardized, client-completed outcome and alliance measures were fed back to the therapists during treatment. Treatment-as-usual served as a third, control group.

As reported by Duncan and Miller (2000), initial results of the study "point[ed] to an advantage for the feedback conditions" (p. 183). Ultimately, however, the entire project had to be abandoned. First of all, a review of the vid-

eotapes showed that the therapists in the first condition routinely failed to ask clients for their input—even though, when asked, the clinicians frequently maintained they *had* sought feedback. At the same time, 75% of the therapists in the formal feedback condition dropped out of the study, citing both the length and cumbersome nature of the measures as reasons for their departure.

Therapists, the study showed, had difficulty appreciating client feedback unless a *formal* and *feasible* process for bringing the client's view into treatment was in place. Toward that end, we began working to develop a set of clinical tools that were user-friendly and both valid and reliable (Duncan, Miller, & Sparks, 2004). Two measures emerged from this effort.

The first, the Session Rating Scale 3.0 (SRS; Johnson, Miller, & Duncan, 2000), is a brief, four-item measure of the therapeutic alliance completed by the client and discussed with the therapist at the end of each session. The scale takes less than a minute to complete and score and is available in both written and oral forms in several different languages. Research to date has shown the measure to have sound psychometric qualities (Duncan et al., in press). The second measure, the Outcome Rating Scale (ORS; Miller & Duncan, 2000b), also a brief, four-item measure of change, is completed by the client and discussed with the therapist at the beginning of each visit. As with the SRS, this scale takes less than a minute to administer and score, is available in both written and oral forms in several languages, and possesses good psychometric qualities (Miller, Duncan, Brown, Sparks, & Claud, 2003).

Presently, the SRS and ORS have been employed in diverse clinical settings with positive effect. For example, given the brief, clinician- and client-friendly nature of the scales, the number of complaints regarding the use of the tools has plummeted and compliance rates have soared (Miller, Duncan, Brown, Sparks, & Claud, 2003). Providing feedback to therapists regarding clients' experience of the alliance and progress in treatment via the SRS and ORS has also been shown to result in significant improvements in both client retention and outcome. For example, Miller, Duncan,

Brown, Sorrel, and Chalk (in press) found that clients of therapists who opted out of completing the SRS were twice as likely to drop out of treatment and three to four times more likely to have a negative or null outcome. In the same study, the average effect size of services at the agency where both measures were employed shifted from .5 to .8—a 60% increase (see Figure 4.2). A detailed analysis of the cases included in the sample showed that this improvement was due to a combination of decreasing negative outcomes, increasing positive outcomes, and an overall positive shift in the outcome for therapists working at the clinic.

The positive results are entirely consistent with findings from other researchers. For example, in a meta-analysis of three studies, Lambert et al. (2003) reported that those therapeutic relationships at risk for a negative or null outcome that received formal feedback were, at the conclusion of therapy, better off than 65% of those without access to the information regarding treatment progress (Average ES = .39). In yet another study, Whipple et al. (2003) found that clients whose therapists had access to outcome *and* alliance information were less likely to deteriorate, more likely to stay longer, and *twice as likely* to achieve a clinically significant change.

Notably, the results of our own research as well as that of Lambert and colleagues were obtained without any attempt to organize, systematize, or otherwise control treatment pro-

cess. Neither were the therapists in these studies trained in any new therapeutic modalities, treatment techniques, or diagnostic procedures. Rather, the individual clinicians were completely free to engage their individual clients in the manner they saw fit. Availability of formal client feedback provided the only constant in an otherwise diverse treatment environment.

Such findings, when taken in combination with the field's continuing failure to discover and systematize therapeutic process in a manner that reliably improves success, have led us to conclude that the best hope for integration of the field will be found in outcome. The time has come for the field to move beyond efforts aimed at seeking consensus on how therapy is to be conducted. Clinicians, researchers, and consumers believe what they will believe—and for good reason, recent meta-analyses indicate that allegiance effects account for approximately four times as much of the variance in treatment outcome as models (Wampold, 2001). Nevertheless, no matter the many, varied, and often contradictory beliefs regarding effective psychotherapy, nearly everyone agrees on the ultimate goal: change.

In the pages that follow, the elements of our outcome-informed approach to clinical practice are spelled out and illustrated with case material. We have fit the material into the process-oriented structure used in this part of the *Handbook*, with one exception. Empirical research on the approach has been incorporated

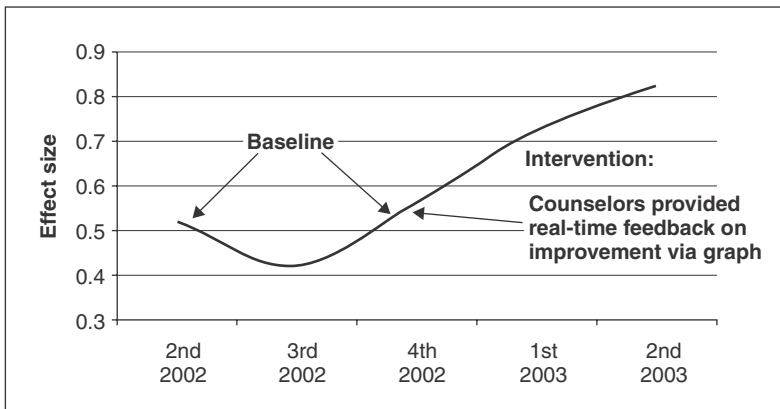


FIGURE 4.2 Improvements in Effect Size After Process and Outcome Feedback

into each of the relevant sections that follow rather than being discussed separately.

## ASSESSMENT AND FORMULATION

Though the practice of psychotherapy usually begins with diagnosis and selection of treatment, the outcome-informed approach to clinical practice described in this chapter starts with finding measures of process and outcome that are valid, reliable, and feasible for the context in which the tools will be employed (Duncan & Miller, 2000, Duncan, Miller, & Sparks, 2004). Despite widespread use of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the diagnosis a person receives at the outset of treatment bears little or no relationship to the outcome of that care (Brown et al., 1999; Duncan, Miller, & Sparks, 2004; Wampold, 2001). For example, the research of Howard and colleagues (1986, 1996) suggests that clients with an Axis II diagnosis may require longer and more intensive treatment in order to realize gains. However, our own research (Miller, Duncan, Brown, Sorrell, & Chalk, in press) and that of Lambert et al. (2003; personal communication, July 3, 2003) suggests no relationship. Among the reasons accounting for this poor correlation, the lack of specific curative factors in psychological therapies and questionable validity and reliability of the diagnostic categories figure prominently (Duncan, Miller, & Sparks, 2004; Wampold, 2001).

Of course, there is no such thing as a “perfect” measure. Finding the right set of tools for a particular setting means working to strike a balance between the competing demands of validity, reliability, and feasibility. A simple, brief, and therefore highly feasible measure, for example, is likely to be less reliable. At the same time, any gains in reliability and validity associated with a longer and more complicated measure are likely to be offset by decreases in feasibility.

In our own research, the SRS was chosen because of the strong empirical support for the role of the client’s view of the therapeutic alliance in predicting retention in and outcome of treatment. Similarly, the ORS was adopted

both because it measured the outcomes most likely to result from the treatment offered at the settings in which we worked and was a more feasible alternative to the longer measure employed in our original research (Duncan & Miller, 2000; Lambert & Hill, 1994; Miller, Duncan, Brown, Sparks, & Claud, 2003). The ORS has further proven to be sensitive to change in those undergoing treatment while being stable in a nontreated population—a crucial issue in selecting a valid measure of psychotherapy outcome (Miller, Duncan, Brown, Sparks, & Claud, 2003). As for reliability, research on the SRS and ORS has returned solid estimates of internal consistency and test–retest reliability (.88 and .93, and .74 and .66, respectively).

## APPLICABILITY AND STRUCTURE

While there is little theoretical reason to suspect that the outcome-informed perspective as a whole might be limited to particular contexts, treatment populations, or modes of service delivery, research to date has largely focused on mental health services delivered to adults in outpatient settings or via the telephone. At least one study, for example, questions the applicability of an outcome-informed approach in children’s services (Salzer, Bickman, & Lambert, 1999). Though two later studies found otherwise (Angold, Costello, Burns, Erkanli, & Farmer, 2000; Asay, Lambert, Gregersen, & Goates, 2002), projects aimed at determining the degree to which the approach applies across modes of service delivery, consumer groups, and presenting complaints are currently underway.

With regard to the length, organization, and content of treatment sessions, therapists are free to work in whatever fashion fits and benefits the client. When outcome-informed, a clinician is limited only by practical and ethical considerations and their creativity. Of course, research on the common factors may serve as guiding principles for interacting with clients. The specifics, however, can only be derived from client feedback regarding process and outcome. As such, no direct attempt is made

to structure therapeutic process. Given the superiority of both client ratings and allegiance factors (e.g., therapist belief) over adherence to a particular model in accounting for treatment outcome, such process freedom can only work to enhance therapeutic benefits.

One area where our outcome-informed approach can exert significant influence on therapeutic process is in the scheduling and duration of treatment. With regard to frequency of visits, for example, the research suggests meeting clients on a more regular basis in the beginning of treatment when the slope of change is steep and then tapering contact as the pace of change lessens (cf., Howard et al., 1986). Other outcome data strongly suggest that every effort be made to minimize the amount of time between scheduling and the first appointment. Multiple studies (e.g., Howard et al., 1986; Lambert, Shapiro, & Bergin, 1986; Lawson, 1994; Weiner-Davis, de Shazer, & Gingerich, 1987) have documented the significant percentage of clients that improve prior to the formal initiation of treatment (15%, 40%, 60%, and 66%, respectively). The longer the interim, the greater the likelihood that the expected outcome will have reached a point of diminishing returns, thereby decreasing client motivation for attending treatment. Because available evidence indicates that therapy increases both the magnitude and durability of such pretreatment change, client drop-out while waiting for services—in spite of any measured improvement in functioning—is a missed opportunity (Lambert & Ogles, 2004).

Other outcome indices can inform decisions regarding treatment intensity (e.g., outpatient vs. inpatient, treatment vs. education or supportive care). For example, Brown et al. (1999) and Miller, Duncan, Brown, Sorrell, and Chalk (in press) found that as many as one-third of clients entering treatment started with a score on the outcome tool that exceeded the clinical cutoff. Such clients, it turns out, are at significant risk for worsening rather than improving during the course of treatment. Encouraging therapists to adopt a strengths-based or problem-solving approach in lieu of depth-oriented or other intensive treatment strategies can serve to maximize engagement while min-

imizing the risk of client deterioration. Similarly, when a mandated or involuntary client scores above the clinical cut off, the client's view of the referral source's rating of them on the outcome scale can be used to guide decisions regarding scheduling and intensity of treatment (Duncan, Miller, & Sparks, 2004). In such cases, the client and therapist would technically be working together to resolve the problem that the referent has with the client.

## METHODS AND TECHNIQUES

An outcome-informed approach to clinical work contains no fixed techniques, invariant patterns in therapeutic process, definitive prescriptions to produce good treatment outcome, and no causal theory regarding the concerns that bring people into treatment. Literally any interaction with a client can be outcome-informed in nature. This comes about when therapists purposefully use valid and reliable assessments of the client's experience of process and outcome to guide treatment.

Using feedback from outcome and process tools can be as simple as scoring and discussing results together with clients at each session or as complex as an automated, computer-based data entry, scoring, and interpretation software program. Of course, the choice of approach will depend on the needs, aims, and resources of the user. In general, the outcome scale is given at the start of each session. As detailed in the case example, the process begins by explaining the measures and inviting client participation. Meetings then conclude with a review of the client's scores on the alliance tool.

As to interpretation of the results, a single-subject case design will suffice for most practitioners. On the SRS, for example, scores of 36 or below are ordinarily considered cause for concern as they fall at the 25th percentile of those who complete the measure. Because research indicates that clients frequently drop out of treatment *before* discussing problems in the alliance, a therapist would want to use the opportunity provided by the scale to open discussion and remedy whatever problems exist (Bachelor & Horvath, 1999).



In terms of using outcome scores to inform practice, the research literature shows that an absence of improvement in the first handful of visits could serve as a warning to the therapist, signaling the need for opening a dialogue with the client regarding the nature of treatment. Lebow (1997), for example, using the work of Howard and colleagues as a guide, recommends a change of therapists whenever a client deteriorates in the initial stages of treatment or “is responding poorly to treatment by the eighth session” (p. 87).

Though a single-subject design offers ease and simplicity of use, it suffers in terms of precision and reliability. The broad guidelines for evaluating progress are based on data pooled over a large number of clients. Because the amount and speed of change in treatment varies depending on how an client scores at the first session, such suggestions are likely to underestimate the amount of change necessary for some cases (i.e., those starting treatment with a lower score on the outcome measure) while overestimating it in others (i.e., those with a higher initial score).

A simple linear regression model offers a more precise method for predicting the score at the end of treatment (or at any intermediate point in treatment) based on the score at intake. Using the slope and an intercept, a regression formula can be calculated for all clients in a given sample. Once completed, the formula can be used to calculate the expected outcome for any new client based on the intake score.

Miller, Duncan, Brown, Sorrell, and Chalk (in press) employed this method as part of a computerized feedback system employed in a large health care organization. Figure 4.3 depicts the outcome of treatment derived from an ORS administered at the beginning of each session of therapy with a sample client. The dotted line represents the expected trajectory of change for clients at this clinic whose total score is 4 at the initial visit. In contrast, the solid line plots the client’s actual score from session to session. As can be seen in this case example, the two lines are divergent, with this client reporting significantly less progress than

average. In fact, scores falling in the solid dark area represent the 10th percentile of responders. As a result, the therapist receives a “red” signal, warning of the potential for premature drop-out or negative outcome should therapy continue unchanged. An option button provides suggestions including talking with the client about problems in the alliance or the type and amount of treatment being offered, as well as suggesting that the therapist seek consultation or supervision.

Client responses on the SRS were plotted in a similar fashion at the end of each visit. Scores falling below the 25th and 10th percentiles triggered a yellow and red signal, respectively. The program further encouraged therapists to check in with their client, express concern about their work together, and explore options for changing the interaction *before* ending the session.

## PROCESSES OF CHANGE

The history of psychotherapy can be characterized as the search for the specific mechanisms or processes that reliably produce change. Few would debate the success of this perspective in medicine where an organized knowledge base, coupled with improvements in diagnosis and pathology, and the development of treatments containing *specific* therapeutic ingredients, have led to the near extinction of a number of once-fatal diseases. Unfortunately, for all the claims and counterclaims, and thousands of research studies, psychotherapy in general and the integrative movement in particular cannot boast of the development of treatments containing specific therapeutic ingredients.

Reliable predictors of treatment outcome do exist but do not fit nicely within a medical conceptualization of psychotherapy. For example, research indicates, that “who” the therapist is much more important in terms of success than “what” treatment approach is employed—accounting for six to nine times more variance in outcome (Lambert, 1989; Luborsky et al., 1986; Luborsky, McLellan, Diguier, Woody, & Seligman, 1997; Wampold, 2001). Similar

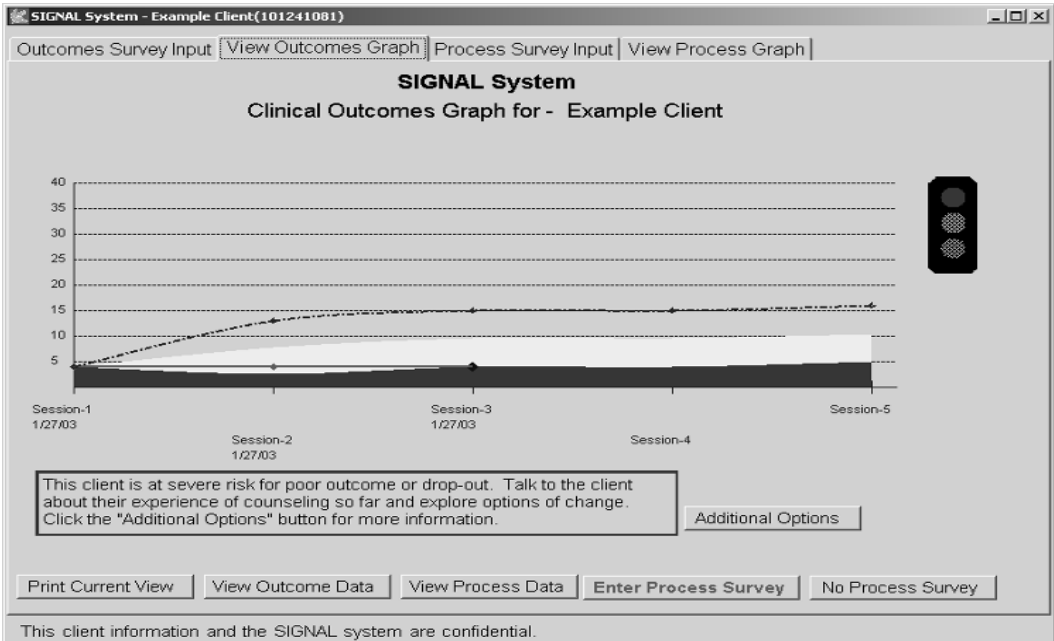


FIGURE 4.3 Outcome Feedback Screen

variations in results have been found between different treatment sites within studies employing the same approach (Miller, Duncan, & Hubble, 2002).

Such findings strongly suggest that the field would be better served by identifying effective therapists and treatment settings than underlying processes of change. To this end, Miller, Duncan, Brown, Sorrell, and Chalk (in press) reported data from 22 therapists that had at least 30 completed cases of treatment. Figure 4.4 shows the range of outcomes for each clinician in the sample. A therapist is statistically "above average" at a 90% confidence interval when the bottom end of that range falls above the average effect size for the agency.

Naturally, the identification of reliable differences between providers and treatment settings invariably leads to the question of "why?" and a resumption of the search for specific processes of change. Several research projects the authors have underway attempting to identify differences in practice between the effective and ineffective providers and treatment settings that might serve to inform therapy in the fu-

ture. Though having documented tremendous improvements in cases at risk for a negative or null outcome, Lambert (personal communication, July 3, 2003) has not found that the overall effectiveness of individual therapists improves with time and feedback.

Studies documenting a small but consistent advantage in outcome for experienced therapists—especially with complicated cases—may indicate that therapy is an activity that can be learned but not taught (Atkins & Christensen, 2001; Bergin & Lambert, 1978; Lambert & Bergin, 1994; Weisz, Weiss, Alicke, & Klotz, 1987). If confirmed, however, such findings, when taken in combination with the weak historical link between training and outcome in psychotherapy (Lambert & Ogles, 2004), further underscore the need to shift away from process and toward an outcome-informed approach to clinical practice. As Lambert et al. (2003) note, "therapists' confidence in their own clinical judgment stands as a barrier to . . . modify[ing] their practices and . . . long held beliefs about the nature of psychopathology and psychotherapy" (p. 299).

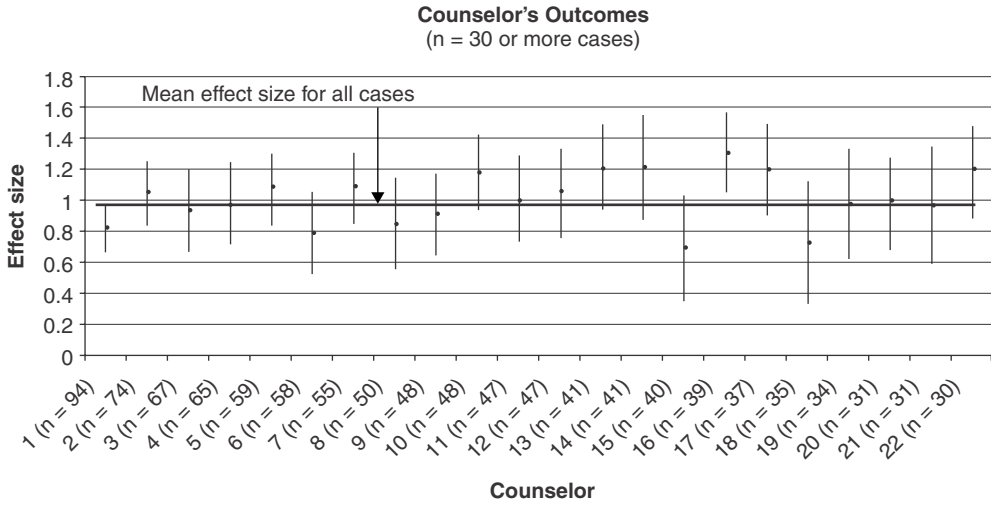


FIGURE 4.4 Range of Counselor Effectiveness

### THERAPY RELATIONSHIP

Clearly, the therapeutic relationship is a pivotal ingredient in successful psychotherapy. Research on the power of the alliance is reflected in more than 1,000 findings (Orlinsky, Grawe, & Parks, 1994). Lambert (1986, 1992) estimated that as much as 30% of client improvement is attributable to variables inherent in a good relationship (e.g., empathy, warmth). Based on a review of the empirical literature, Horvath (2001, p. 366) suggests, “a little over half of the beneficial effects of psychotherapy . . . are linked to the quality of the alliance.”

The same body of research documenting the importance of the alliance also shows that (1) clients and therapists differ in their perception of the alliance (Gurman, 1977; Horvath & Marx, 1990); (2) clients ratings of the relationship have a higher correlation with outcome than therapists (Bachelor & Horvath, 1999; Horvath & Symonds, 1991; Lambert & Bergin, 1994); (3) a therapist’s ability to develop productive alliances is not a “simple function of training or experience” (Horvath, 2001, p. 370); (4) there is no single, invariably facilitative type of relationship as clients differ significantly in how they wish to relate and be related to (Duncan & Miller, 2000); and finally, (5) clients rarely report problems with

the relationship until they have already decided to terminate (Bachelor & Horvath, 1999).

Taken together, such findings point to the importance of routinely and systematically assessing the client’s experience of the therapeutic relationship. As was the case with methods and techniques, and processes of change, the approach described in this chapter offers no invariant patterns for or definitions of the therapeutic relationship. Rather, from an outcome-informed perspective, soliciting and responding to client feedback regarding the alliance is the pivotal component—much more important than any a priori notions a given therapist or the field may have.

In many ways, therapists must simply begin and then ask, on an ongoing and formal basis, “Can the client relate?” If the answer is yes, and the client is improving, then the work can continue unaltered. If, on the other hand, the answer is no, then every effort should be made to accommodate the client. And finally, whether good or not, termination and transfer should be made when alliances evince little or no evidence of improvement in the time period established by the norms for a particular context.

Recall, we found that clients of therapists who failed to measure the quality of the relationship were twice as likely to drop out of treatment and three to four times more likely

to have a negative or null outcome (Miller, Duncan, Brown, Sorrell, & Chalk, in press). In that same study, further improvement in outcomes was realized when decisions about whether to change or maintain a particular pairing of client and therapist were informed by formal client feedback. Logically, clients that were already improving did significantly better when encouraged to continue meeting with (75th percentile) rather than change therapists (25th percentile).

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### CASE EXAMPLE

Robyn was a 35-year-old, self-described “agoraphobic” brought to treatment by her partner because she was too frightened to come to the session alone. Once an outgoing and energetic person making steady progress up the career ladder, Robyn had during the last several years grown progressively more anxious and fearful. “I’ve always been a nervous kind of person,” she said during her first visit, “Now, I can hardly get out of my house.” She added that she had been to see a couple of therapists and tried several medications. “It’s not like these things *haven’t* helped,” she said, “it’s just that it never goes away, completely. Last year, I spent a couple of days in the hospital.”

In a brief telephone call prior to the first session, the philosophy of our outcome-informed approach to clinical practice had been described to Robyn and her partner, Gwen. As requested, the two arrived a few minutes early for the appointment, completing the necessary intake and consent forms, as well as the outcome measure in the reception area while waiting to meet the therapist. The intake forms requested basic information required by the state in which services were offered. The outcome measure used was the ORS (Miller & Duncan, 2000b). In this practice, the entire process takes about 5 minutes to complete.

One attractive feature of an outcome-informed approach is an immediate decrease in the process-oriented paperwork and external management schemes that govern modern clinical practice. The number of forms, authorizations, and

other oversight procedures has exploded in recent years, consuming an ever-increasing amount of time and resources. Where a single HCFA 1500 form once sufficed, clinicians now have to contend with a “paper curtain” made up of pre-treatment authorization, intake interviews, treatment plans, and ongoing quality assurance reviews—procedures that add an estimated \$200 to \$500 to the cost of each case (Johnson & Shaha, 1997). The addition of all this paperwork presumably is based on the premise that controlling treatment process will enhance outcomes. On a positive note, two large behavioral health care organizations have recently eliminated virtually all paperwork and automated the treatment authorization process based on the submission of outcome and process tools (Hubble & Miller, 2004).

Returning to the case, the therapist met Robyn and Gwen in the waiting area. Following some brief introductions, the three moved to the consulting room where the therapist began scoring the outcome measure.

THERAPIST: You remember that I told you on the phone that we are dedicated to helping our clients achieve the outcome they desire from treatment?

ROBYN: Yes.

T: And that the research indicates that if I’m going to be helpful to you, we should see signs of that sooner rather than later?

R: Uh huh.

T: Now, that doesn’t mean that the minute you start feeling better, I’m going to say “*hasta la vista, baby*” . . .

R AND GWEN: (laughing). Uh huh.

T: It just means your feedback is essential. It will tell us if our work together is on track, or whether we need to change something about the treatment, or, in the event that I’m not helpful, when we need to consider referring you to someone or someplace else in order to help you get what you want.

R: (nods).

T: Does that make sense to you?

R: Yes.

Once completed, scores from the ORS were entered into a simple computer program running

on a PDA. The results were then discussed with the couple.

T: Let me show you what these look like. Um, basically this just kind of gives us a snapshot of how things are overall.

R: Uh huh.

T: . . . this graph tells us how things are overall in your life. And, uh, if a score falls below this dotted line . . .

R: Uh huh.

T: Then it means that the scores are more like people who are in therapy and who are saying that there are some things they'd like to change or feel better about . . .

R: Uh huh.

T: . . . and if it goes above this dotted line, that indicates more the person saying, you know, "I'm doing pretty well right now."

R: Uh huh.

T: And you can see that overall it seems like you're saying you're feeling like there are parts of your life you'd like to change, feel better about . . .

R: Yes, definitely.

T: (setting the graph aside and returning to the ORS form). Now, it looks like interpersonally, things are pretty good . . .

R: Uh huh. I don't know how I would have made it . . . without Gwen. She's my rock . . .

T: Okay, great. Now, individually and socially, you can see . . .

R AND G: (leaning forward).

T: . . . that, uh, here you score lower . . .

Both Robyn and Gwen confirmed the presence of significant impairment in individual and social functioning by citing examples from their daily life together. At this point in the visit, Robyn indicated that she was feeling comfortable with the process. Gwen exited the room as the pair had planned beforehand and the session continued for another 40 minutes.

As the end of the hour approached, Robyn was asked to complete the SRS.

T: This is the last piece . . . as I mentioned, your feedback about the work we're doing is very important to me . . . and this little scale . . . it works

in the same way as the first one . . . (pointing at the individual items) with low marks to the left to high to the right . . . rating in these different areas . . .

R: (leaning forward). Uh huh.

T: It kind of takes the temperature of the visit, how we worked today . . . if it felt right . . . working on what you wanted to work on, feeling understood . . .

R: All right, okay (taking the measure, completing it, and then handing it back to the therapist). (A brief moment of silence while the therapist scores the instrument)

T: Okay . . . you see, just like with the first one, I put my little metric ruler on these lines . . . and measure . . . and from your marks that you placed, the total score is 38 . . . and that means that you felt like things were okay today . . .

R: Uh huh.

T: That we were on the right track . . . talking about what you wanted to talk about . . .

R: Yes, definitely.

T: Good.

R: I felt very comfortable.

T: Great . . . I'm glad to hear that . . . at the same time, I want you to know that you can tell me if things don't go well . . .

R: Okay.

T: I can take it . . .

R: Oh, I'd tell you . . .

T: You would, eh?

R: (laughing). Yeah . . . just ask Gwen . . .

In consultation with Robyn, an appointment was scheduled for the following week. In that session and the handful of visits that followed, the therapist worked with Robyn alone and, on a couple of occasions, with her partner present, to develop and implement a plan for dealing with her anxiety. Recall that from an outcome-informed perspective, the particulars of the plan are not important. Rather, the client's early subjective experience of the alliance and improvement whatever the process.

Though Robyn's fear was palpable during the visits, she nonetheless gave the therapy the high-

est ratings on the SRS. Unfortunately, her scores on the outcome measure evinced little evidence of improvement. By the fourth session, the computerized feedback system was warning that the therapy with Robyn was “at risk” for a negative or null outcome.

The warning led the therapist and Robyn to review her responses to each item on the SRS at the end of the fourth visit. Such reviews are not only helpful in ensuring that the treatment contains the elements necessary for a successful outcome but also provide another opportunity for identifying and dealing with problems in the therapeutic relationship that were either missed or went unreported. In this case, however, nothing new emerged. Indeed, Robyn indicated that her high marks matched her experience of the visits.

T: I’m just wanting to check in with you . . .

R: Uh huh . . . .

T: . . . and make sure that we’re on the right track . . . .

R: Yeah . . . uh huh . . . okay . . . .

T: And, you know, looking back over the times we’ve met . . . at your marks on the scale . . . about the work we’re doing . . . the scores indicate that you are feeling, you know, comfortable with the approach we’re taking . . . .

R: Absolutely . . . .

T: That it’s a good fit for you . . . .

R: Yes . . . .

T: I just want to sort of check in with you . . . and ask, uh, if there’s anything, do you feel . . . or have you felt between our visits . . . even on occasion . . . that something is missing . . . .

R: Hmm.

T: That I’m not quite “getting it.”

R: Yeah . . . (shaking head from left to right). No . . . I’ve really felt like we’re doing . . . that . . . this is good . . . this is right, the right thing for me.

In spite of the process being “right,” both the therapist and Robyn were concerned about the lack of any measurable progress. Knowing that more of the same approach could only lead to more of the same results, the two agreed to organize a reflecting team for a brainstorm session. Briefly, this process is based on the pioneering

clinical work of Anderson (1991) and is often useful for generating possibilities and alternatives. As Friedman and Fanger (1991, p. 252) summarize:

The views offered are not meant to be judgments, diagnostic formulations, or interpretations. No attempt is made to arrive at a team consensus or even to come to any agreement. Comments are shared within a positive framework and are presented as tentative offerings.

As frequently happens, Robyn found one team member’s ideas particularly intriguing. Here again, the particular idea offered is unimportant. Rather, client engagement is the issue. When the suggested change in approach had not resulted in any measurable improvement by the eighth visit, the computerized feedback system indicated that a change of therapists was probably warranted. Indeed, given the norms for this particular setting, the system indicated that there was precious little chance that this relationship would result in success.

Clients vary in their response to an open and frank discussion regarding a lack of progress in treatment. Some terminate prior to identifying an alternative, while others ask for or accept a referral to another therapist or treatment setting. If the client chooses, the therapist may continue in a supportive fashion until other arrangements can be made. Rarely, however, is there justification for continuing to work *therapeutically* with clients who have not achieved reliable change in a period typical for the majority of cases seen by a particular therapist or treatment agency. In essence, clinical outcome must hold therapeutic process “on a leash.”

In the discussions with the therapist, Robyn shared her desire for a more intensive treatment approach. She mentioned having read about an out-of-state residential treatment center that specialized in her particular problem. When her insurance company refused to cover the cost of the treatment, Robyn and her partner put their only car up for sale to cover the expense. In an interesting twist, Robyn’s parents, from whom she had been estranged for several years, agreed to cover the cost of the treatment when they learned she was selling her car.

Six weeks later, Robyn contacted the therapist. She reported having made significant progress

during her stay, as well as reconciling with her family. Prior to concluding the call, she asked whether it would be possible to schedule one more visit. When asked why, she replied, "I'd want to take that ORS one more time!" Needless to say, the scores confirmed her verbal report. In effect, the therapist had managed to "fail" successfully.

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## FUTURE DIRECTIONS

Health care policy has undergone tremendous change during the last two decades. Among the differences is an increasing emphasis on outcome that is not specific to any particular professional discipline (e.g., mental health vs. medicine) or type of payment system (e.g., managed care vs. indemnity-type insurance or out-of-pocket payment). Rather, it is part of a worldwide trend (Andrews, 1995; Humphreys, 1996; Lambert, Okiishi, Finch, & Johnson, 1998; Sanderson, Riley, & Eshun, 1997). The shift toward outcome is so significant that Brown et al. (1999, p. 393) argued, "In the emerging environment, the *outcome* of the service *rather than the service itself* is the product that providers have to market and sell. Those unable to systematically evaluate the outcome of treatment will have nothing to sell to purchasers of health care services."

Currently, the most popular approach for addressing calls for accountable treatment practice has been to focus on organizing and systematizing therapeutic process, molding the practice of psychotherapy into the "medical model." By contrast, the approach described in this chapter involves shifting away from process and toward outcome. Evidence for this perspective dates back 18 years, beginning with the pioneering work of Howard, Kopte, Krause, & Orlinsky (1986) and extending forward to Lambert, Shapiro, & Bergin (1996, 1998, 2003), Johnson & Shaha (1996, 1997; Johnson, 1995), and our own studies (Miller, Duncan, Brown, Sorrell, & Chalk, in press). The approach is simple, straightforward, unifies the field around the common goal of change, and, unlike the process-oriented efforts employed

thus far, results in significant improvements in outcome.

Such results notwithstanding, more work remains to be done. As noted previously, research to date has focused largely on mental health services delivered to adults in outpatient settings or via the telephone. Currently, work is being done to determine the extent to which the measures and results generalize to other treatment populations and settings. For example, studies on services delivered in group, via case management, with child- and family-related problems, and in residential treatment settings are underway. At the same time, efforts are being made to expand and enhance the technological interface. Given the importance of the client's view of and engagement in the feedback process—an aspect missing in the research thus far—the feasibility and impact of Web and e-mail based data-entry and retrieval are being studied.

Though we are skeptical, several projects are underway to determine whether there are any consistent qualities of reliably superior therapists and treatment settings. Should any be found, subsequent studies would examine the impact of transferring the findings to others. Presently, the weak relationship between professional training and outcome in psychotherapy raises serious questions about professional specialization, training and certification, reimbursement for clinical services, and, above all, the public welfare (Berman & Norton, 1985; Christensen & Jacobsen, 1994; Clement, 1994; Garb, 1989; Hattie, Sharpley, & Rogers, 1984; Lambert et al., 2003; Lambert & Ogles, 2004; Stein & Lambert, 1984).

Of course, we believe that becoming outcome-informed would go a long way toward correcting these problems, at the same time offering the first "real-time" protection to consumers and payers. Instead of empirically supported *therapies*, consumers would have access to empirically validated *therapists*. Rather than evidence-based practice, therapists would tailor their work to the individual client via practice-based evidence. With that end in mind, we are spending a significant amount of time and effort studying how best to communicate the advantages of an outcome-informed perspective

to therapists, third-party payers, and certifying bodies. As Lambert et al. (2003) point out, “those advocating the use of empirically supported psychotherapies do so on the basis of much smaller treatment effects” (p. 296).

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## *B. Technical Eclecticism*

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# 5

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## Multimodal Therapy

ARNOLD A. LAZARUS

At the time when rival factions were dominating the field of psychotherapy, I was prompted to write a brief note, “In Support of Technical Eclecticism” (Lazarus, 1967). Specific schools of thought were actively competing for dominance and prominence—each claiming their own superiority over all others. It seemed obvious that no one school could have all the answers and that many approaches had something worthwhile to offer. I was influenced by London’s (1964) observation that techniques, not theories are actually used on people, and that the “study of the effects of psychotherapy, therefore, is always the study of the effectiveness of techniques” (p. 33). Thus, I recommended that we cull effective techniques from many orientations without subscribing to the theories that spawned them. I argued that to combine different theories in the hope of creating more robust methods would only furnish a *mélange* of diverse and incompatible notions, whereas technical (not theoretical) eclecticism would permit one to import and apply a broad

range of potent strategies. Subsequently, in addition to developing the multimodal approach to assessment and therapy (which will be explicated in this chapter), I contributed chapters to books on eclectic psychotherapy and wrote at length about the pros of technical eclecticism and the cons of theoretical integration (Lazarus, 1986, 1987, 1989, 1992, 1995, 1996; Lazarus & Lazarus, 1987; Lazarus, Beutler, & Norcross, 1992; Lazarus & Beutler, 1993).

In 1983, the Society for the Exploration of Psychotherapy Integration (SEPI) was founded, held annual international conferences, and launched the *Journal of Psychotherapy Integration*. It is my view that the much-needed emphasis on eclecticism and integration has served a useful purpose but that it is now *passé*. The narrow and self-limiting consequences of adhering to one particular school of thought are now self-evident to most. It seems that the current emphases on empirically supported methods and the use of manuals in psychotherapy

research and practice (Wilson, 1998) have much to commend them.

As I will now underscore, the multimodal approach provides a framework that facilitates systematic treatment selection in a broad-based, comprehensive, and yet highly focused manner. It respects science and data-driven findings, and it endeavors to use empirically supported methods when possible. Nevertheless, it recognizes that many issues still fall into the gray area in which artistry and subjective judgment are necessary and tries to fill the void by offering methods that have strong clinical support.

### HISTORY OF THE MULTIMODAL THERAPY (MMT) APPROACH

My undergraduate and graduate training exposed me to several schools of psychotherapeutic thought—Freudian, Rogerian, Sullivanian, Adlerian, and behavioral—but for several reasons, I became a strong advocate for behavior therapy (Wolpe & Lazarus, 1966). Most of my conclusions about the conduct of therapy were derived from careful outcome and follow-up inquiries. Twice a year I have made a point of studying my treatment outcomes. I ask, in essence, “Which clients have derived benefit? Why did they apparently profit from my ministrations? Which clients did not derive benefit? Why did this occur, and what could be done to rectify matters?”

Follow-up investigations have been especially pertinent. They led to the development of my broad-spectrum outlook because, to my chagrin, I found that about one-third of my clients who had attained their therapeutic goals after receiving traditional behavior therapy tended to backslide or relapse. Further examination led to the obvious conclusion that *the more people learn in therapy, the less likely they are to relapse*. There is obviously a point of diminishing returns. In principle, one can never learn enough; there is always more knowledge and skills to acquire, but for practical purposes, an end point is imperative. So what are people best advised to learn to augment the likelihood of having minimal emotional problems?

Clearly there are essential behaviors to be acquired—acts and actions that are necessary for coping with life’s demands. The control and expression of one’s emotions are also imperative for adaptive living—it is important to correct inappropriate affective responses that undermine success in many spheres. Untoward sensations (e.g., the ravages of tension), intrusive images (e.g., pictures of personal failure and ridicule from others), and faulty cognitions (e.g., toxic ideas and irrational beliefs) also play a significant role in diminishing the quality of life. Each of the foregoing areas must be addressed in an endeavor to remedy significant excesses and deficits. Moreover, the quality of one’s interpersonal relationships is a key ingredient of happiness and success, and without the requisite social skills, one is likely to be shortchanged in life.

The aforementioned considerations led to the development of what I initially termed *multimodal behavior therapy* (Lazarus, 1973, 1976), which was soon changed to *multimodal therapy* (see Lazarus, 1981, 1986, 1997, 2000a, 2000b). Emphasis was placed on the fact that, at base, we are biological organisms (neurophysiological/biochemical entities) who *behave* (act and react), *emote* (experience affective responses), *sense* (respond to tactile, olfactory, gustatory, visual, and auditory stimuli), *imagine* (conjure up sights, sounds, and other events in our mind’s eye), *think* (entertain beliefs, opinions, values, and attitudes), and *interact* with one another (enjoy, tolerate, or suffer various interpersonal relationships). By referring to these seven discrete but interactive dimensions or modalities as behavior, affect, sensation, imagery, cognition, interpersonal, drugs/biologicals, the convenient acronym BASIC I.D. emerges from the first letter of each one.

### THEORETICAL BASIS

The BASIC I.D. or multimodal framework rests on a broad social and cognitive learning theory (e.g., Bandura, 1977, 1986; Rotter, 1954) because its tenets are open to verification or disproof. Instead of postulating putative

complexes and unconscious forces, social learning theory rests upon testable developmental factors (e.g., modeling, observational and enactive learning, the acquisition of expectancies, operant and respondent conditioning, and various self-regulatory mechanisms). It must be emphasized again that while drawing on effective methods from any discipline, the multimodal therapist does not embrace divergent theories but remains consistently within social-cognitive learning theory. As mentioned at the start of this chapter, the virtues of *technical eclecticism* (Lazarus, 1967, 1992; Lazarus, Beutler, & Norcross, 1992) over the dangers of *theoretical integration* have been emphasized in several publications (e.g., Lazarus, 1989, 1995; Lazarus & Beutler, 1993). The major criticism of theoretical integration is that it inevitably tries to blend incompatible notions and only breeds confusion.

The polar opposite of the multimodal approach is the Rogerian or Person-Centered orientation, which is entirely conversational and virtually unimodal. Though, in general, the relationship between therapist and client is highly significant and sometimes “necessary and sufficient,” in most instances, the doctor-patient relationship is but the soil that enables the techniques to take root. A good relationship, adequate rapport, and a constructive working alliance are “usually necessary but often insufficient” (Fay & Lazarus, 1993; Lazarus & Lazarus, 1991a).

Many psychotherapeutic approaches are trimodal, addressing affect, behavior, and cognition—ABC. The multimodal approach provides clinicians with a comprehensive template. By separating sensations from emotions, distinguishing between images and cognitions, emphasizing both intraindividual and interpersonal behaviors, and underscoring the biological substrate, the multimodal orientation is most far-reaching. By assessing a client’s BASIC I.D., one endeavors to “leave no stone unturned.”

## ASSESSMENT AND FORMULATION

The elements of a through assessment involve the following range of questions:

**B:** What is this individual doing that is getting in the way of his or her happiness of personal fulfillment (self-defeating actions, maladaptive behaviors)? What does the client need to increase and decrease? What should he or she stop doing and start doing?

**A:** What emotions (affective reactions) are predominant? Are we dealing with anger, anxiety, depression, combinations thereof, and to what extent (e.g., irritation vs. rage; sadness vs. profound melancholy)? What appears to generate these negative affects—certain cognitions, images, interpersonal conflicts? And how does the person respond (behave) when feeling a certain way? It is important to look for interactive processes—what impact does various behaviors have on the person’s affect and vice versa? How does this influence each of the other modalities?

**S:** Are there specific sensory complaints (e.g., tension, chronic pain, tremors)? What feelings, thoughts, and behaviors are connected to these negative sensations? What positive sensations (e.g., visual, auditory, tactile, olfactory, and gustatory delights) does the person report? This includes the individual as a sensual and sexual being. When called for, the enhancement or cultivation of erotic pleasure is a viable therapeutic goal. The importance of the specific senses is often glossed over or even bypassed by many clinical approaches.

**I:** What fantasies and images are predominant? What is the person’s “self-image”? Are there specific success or failure images? Are there negative or intrusive images (e.g., flashbacks to unhappy or traumatic experiences)? And how are these images connected to ongoing cognitions, behaviors, affective reactions, and the like?

**C:** Can we determine the individual’s main attitudes, values, beliefs, and opinions? What are this person’s predominant shoulds, oughts, and musts? Are there any definite dysfunctional beliefs or irrational ideas? Can we detect any untoward automatic thoughts that undermine his or her functioning?

**I.:** Interpersonally, who are the significant others in this individual’s life? What does he or she want, desire, expect, and receive from them, and what does he or she, in turn, give to



and do for them? What relationships give him or her particular pleasures and pains?

**D.:** Is this person biologically healthy and health conscious? Does he or she have any medical complaints or concerns? What relevant details pertain to diet, weight, sleep, exercise, alcohol, and drug use?

The foregoing are some of the main issues that multimodal clinicians traverse while assessing the client's BASIC I.D. A more comprehensive problem identification sequence is derived from asking most clients to complete a Multimodal Life History Inventory (MLHI) (Lazarus & Lazarus, 1991b). This 15-page questionnaire facilitates treatment when conscientiously completed by clients as a homework assignment, usually after the initial session. Seriously disturbed clients will obviously not be expected to comply, but most psychiatric outpatients who are reasonably literate will find the exercise useful for speeding up routine history taking and readily provide the therapist with a BASIC I.D. analysis.

In addition, there are three other important assessment procedures employed in MMT: Second-Order BASIC I.D. Assessments, a method called Bridging, and another called Tracking.

### Second-Order BASIC I.D. Assessments

If and when treatment impasses arise, a more detailed inquiry into associated behaviors, affective responses, sensory reactions, images, cognitions, interpersonal factors, and possible biological considerations may shed light on the situation. For example, a client was making almost no progress with assertiveness training procedures. He was asked to picture himself as a truly assertive person and was then asked to recount how his behavior would differ in general, what affective reactions he might anticipate, and so forth, across the BASIC I.D. This brought a central cognitive schema to light that had eluded all other avenues of inquiry: "I am not entitled to be happy." Therapy was then aimed directly at addressing this maladaptive cognition before assertiveness training was resumed.

### Bridging

Let's say a therapist is interested in a client's emotional responses to an event. "How did you feel when you first discovered that your wife was seeing another man?" Instead of discussing his feelings, the client responds with defensive and irrelevant intellectualizations. "My wife was always looking for affirmation. It stemmed from the fact that her parents were less than forthcoming with praise or affection." It is often counterproductive to confront the client and point out that he is evading the question and seems reluctant to face his true feelings. In situations of this kind, *bridging* is usually effective. First, the therapist deliberately tunes into the client's preferred modality—in this case, the cognitive domain. Thus, the therapist explores the cognitive content. "So you see it as a consequence of your wife's own lack of self-confidence and her excessive need for love and approval. Please tell me more." In this way, after perhaps a 5- to 10-minute discourse, the therapist endeavors to branch off into other directions that seem more productive. "Tell me, while we have been discussing these matters, have you noticed any sensations anywhere in your body?" This sudden switch from Cognition to Sensation may begin to elicit more pertinent information (given the assumption that in this instance, Sensory inputs are probably less threatening than Affective material). The client may refer to some sensations of tension or bodily discomfort at which point the therapist may ask him to focus on them, often with an hypnotic overlay. "Will you please close your eyes, and now feel that neck tension. (Pause). Now relax deeply for a few moments, breathe easily and gently, in and out, in and out, just letting yourself feel calm and peaceful." The feelings of tension, their associated images and cognitions may then be examined. One may then venture to bridge into Affect. "Beneath the sensations, can you find any strong feelings or emotions? Perhaps they are lurking in the background." At this juncture, it is not unusual for clients to give voice to their feelings. "I am in touch with anger and with sadness. I feel betrayed." By starting *where the*

*client* is and then bridging into a different modality, most clients then seem to be willing to traverse the more emotionally charged areas they had been avoiding.

### Tracking the Firing Order

A fairly reliable pattern may be discerned in the way that many people generate negative affect. Some dwell first on unpleasant sensations (palpitations, shortness of breath, tremors), followed by aversive images (pictures of disastrous events), to which they attach negative cognitions (ideas about catastrophic illness), leading to maladaptive behavior (withdrawal and avoidance). This S-I-C-B firing order (Sensation, Imagery, Cognition, Behavior) may require a different treatment strategy from that employed with say a C-I-S-B sequence, a I-C-B-S, or yet a different firing order. Clinical findings suggest that it is often best to apply treatment techniques in accordance with a client's specific chain reaction. A rapid way of determining someone's firing order is to have him or her in an altered state of consciousness—deeply relaxed with eyes closed—contemplating untoward events and then describing their reactions. This tracking procedure can also have an immediate positive effect.

Thus, a 67-year-old woman who had responded well to a course of cognitive restructuring for depression nevertheless complained that she was prone to what she termed “panic attacks.” As she explained it, “I am inclined to feel somewhat nervous and jittery at times, but for no reason at all, this often develops into a massive sense of anxiety. I have no idea where this comes from.” She was asked to identify, if possible, the thoughts that preceded and accompanied her next attack, and to jot them down.

Subsequently, she outlined the following sequence: “I was waiting at home for my friend Betty to come over. I really like her and was looking forward to her visit. Suddenly, I noticed that my nervous feeling was coming on. I did what you said and asked myself what I was thinking, and how I was bringing it on. But I drew a blank. I then became aware that

my heart was beating rather fast and took my pulse—it was over 90 beats per minute. Then I started feeling over heated, as if I had a temperature. But when I took it, my thermometer showed that my temperature was below normal—98.3 degrees. Then I noticed that my right knee was throbbing and felt painful, so I started massaging it. Because I was scrutinizing and following my thoughts as you had recommended, I immediately realized that I was picturing myself in the rehab center right after my knee replacement surgery, and dwelling on how I had developed an infection that almost killed me. Ever since then I know I have been panicky whenever I have a fever or whenever my knee hurts. So I told myself not to be stupid because my temperature was in fact below normal, I had no fever, and I was actually creating fear out of nothing, and this calmed me down.”

This woman's firing order appeared to follow a Sensory (becomes aware of nervous reaction, develops tachycardia, feels overheated), Behavioral (measures her temperature), Sensory (pain in her knee), Behavioral (massages her knee), Imagery (recalling her life-threatening postoperative infection), Cognition (turns to rational, self-calming thoughts). Many clients have reported that using this “tracking” procedure tends to furnish them with a useful self-control device.

Another client who reported having panic attacks “for no apparent reason” was able to put together the following string of events.

She had initially become aware that her heart was beating faster than usual. This brought to mind an episode where she had passed out after imbibing too much alcohol at a party. This memory or image still occasioned a strong sense of shame. She started thinking that she was going to pass out again, and as she dwelled on her sensations, this cognition only intensified and culminated in her feelings of panic. Thus, she exhibited an S-I-C-S-C-A pattern (Sensation, Imagery, Cognition, Sensation, Cognition, Affect). Thereafter, she was asked to take careful note whether any subsequent anxiety or panic attacks followed a similar “firing order.” She subsequently confirmed that her two “trigger points” were usually Sensation and

Imagery. This alerted the therapist to focus on sensory training techniques (e.g., diaphragmatic breathing and deep muscle relaxation) followed immediately by Imagery training (e.g., the use of coping imagery and the selection of mental pictures that evoked profound feelings of serenity).

A *Structural Profile Inventory* (SPI) has been developed and tested. This 35-item survey provides a quantitative rating of the extent to which clients favor specific BASIC I.D. areas. The instrument measures action-oriented proclivities (Behavior), the degree of emotionality (Affect), the value attached to various sensory experiences (Sensation), the amount of time devoted to fantasy, daydreaming, and “thinking in pictures” (Imagery), analytical and problem-solving propensities (Cognition), the importance attached to interacting with other people (Interpersonal), and the extent to which health-conscious habits are observed (Drugs/Biology). The reliability and validity of this instrument has been borne out by research (Herman, 1992; Landes, 1991). Herman (1991, 1994, 1998) showed that when clients and therapists have wide differences on the SPI, therapeutic outcomes tend to be adversely affected.

In multimodal assessment, the BASIC I.D. serves as a template to remind therapists to examine each of the seven modalities and their interactive effects. It implies that we are social beings who move, feel, sense, imagine, and think, and that at base we are biochemical–neurophysiological entities. Students and colleagues frequently inquire whether any particular areas are more significant, more heavily weighted, than the others. For thoroughness, all seven require careful attention, but perhaps the biological and interpersonal modalities are especially significant.

The biological modality wields a profound influence on all the other modalities. Unpleasant sensory reactions can signal a host of medical illnesses; excessive emotional reactions (anxiety, depression, and rage) may all have biological determinants; faulty thinking, and images of gloom, doom, and terror may derive entirely from chemical imbalances; and untoward personal and interpersonal behaviors may

stem from many somatic reactions ranging from toxins (e.g., drugs or alcohol) to intracranial lesions. Hence, when any doubts arise about the probable involvement of biological factors, it is imperative to have them fully investigated. A person who has no untoward medical/physical problems and enjoys warm, meaningful, and loving relationships is apt to find life personally and interpersonally fulfilling. Hence, the biological modality serves as the base and the interpersonal modality is perhaps the apex. The seven modalities are by no means static or linear but exist in a state of reciprocal transaction.

A question often raised is whether a “spiritual” dimension should be added. In the interests of parsimony, I point out that when someone refers to having had a “spiritual” or a “transcendental” experience, typically their reactions point to, and can be captured by, the interplay among powerful cognitions, images, sensations, and affective responses.

A patient requesting therapy may point to any of the seven modalities as his or her entry point. Affect: “I suffer from anxiety and depression.” Behavior: “My skin picking habit and nail biting are getting to me.” Interpersonal: “My husband and I are not getting along.” Sensory: “I have these tension headaches and pains in my shoulders.” Imagery: “I can’t get the picture of my mother’s funeral out of my mind, and I often have disturbing dreams.” Cognitive: “I know I set unrealistic goals for myself and expect too much from others, but I can’t seem to help it.” Biological: “I need to remember to take my medication, and I should start exercising and eating less junk.”

It is more usual, however, for people to enter therapy with explicit problems in two or more modalities—“I have headaches that my doctor tells me are due to tension. I also worry too much, and I feel frustrated a lot of the time. And I’m very angry with my brother.” Initially, it is usually advisable to engage the patient by focusing on the issues, modalities, or areas of concern that he or she presents. To deflect the emphasis too soon onto other matters that may seem more important is only inclined to make the patient feel discounted.

Once rapport has been established, however, it is usually easy to shift to more significant problems.

Thus, any good clinician will first address and investigate the presenting issues. "Please tell me more about the aches and pains you are experiencing." "Do you feel tense in any specific areas of your body?" "You mentioned worries and feelings of frustration. Can you please elaborate on them for me?" "What are some of the specific clash points between you and your brother?" Any competent therapist would flesh out the details. However, a multimodal therapist goes farther. She or he will carefully note the specific modalities across the BASIC I.D. that are being discussed and which ones are omitted or glossed over. The latter (i.e., the areas that are overlooked or neglected) often yield important data when specific elaborations are requested. And when examining a particular issue, the BASIC I.D. will be rapidly but carefully traversed.

There is a lot more to the multimodal methods of inquiry and treatment, and the interested reader is referred to some of my other publications that spell out the details (e.g., Lazarus, 1989, 1997, 2000a, 2001a, 2001b, 2002). In general, it seems to me that narrow school adherents are receding into the minority and that competent clinicians are all broadening their base of operations. The BASIC I.D. spectrum has continued to serve as a most expedient template or compass.

## APPLICABILITY AND STRUCTURE

One cannot point to specific diagnostic categories for which the MMT orientation is especially suited. MMT offers practitioners a broad-based template, several unique assessment procedures, and a technically eclectic armamentarium that permits the selection of effective interventions from any sources whatsoever. Yet, given the emphasis placed on established treatments of choice for specific disorders and the weight attached to using empirically supported methods, in most instances, MMT typically draws on methods employed by most cognitive-behavior

therapists. The cognitive-behavioral literature has documented various treatments of choice for a wide range of afflictions including maladaptive habits, fears and phobias, stress-related difficulties, sexual dysfunctions, depression, eating disorders, obsessive-compulsive disorders, and posttraumatic stress disorders. We can also include psychoactive substance abuse, somatization disorder, borderline personality disorders, psychophysiological disorders, and pain management. There are relatively few empirically supported treatments outside the area of cognitive-behavior therapy.

Thus, Cognitive-Behavior Therapy (CBT), more than any other approach, has provided research-based data matching particular methods to explicit problems. Most clinicians of any persuasion are likely to report that Axis I clinical disorders are more responsive than Axis II personality disturbances. Like any other approach, MMT can point to many individual successes with patients diagnosed as schizophrenic or with those who suffered from mood disorders, anxiety disorders, sexual disorders, eating disorders, sleep disorders, sexual disorders, and the various adjustment disorders. But there is no syndrome or symptoms that stand out as being most strongly indicated for a multimodal approach. Instead, MMT practitioners will endeavor to mitigate any clinical problems that they encounter, drawing on the scientific and clinical literature that shows the best way to manage matters. But they will also traverse the BASIC I.D. spectrum in an attempt to leave no stone unturned. Moreover, they may refer out to an expert, a resource better qualified to treat the problematic disorder.

To reiterate, MMT is not a unitary or closed system. It is basically a clinical *approach* that rests on a social and cognitive learning theory and uses technical eclectic and empirically supported procedures in an individualistic manner. The overriding question is mainly, "Who and what is best for this client?" Obviously, no one therapist can be well versed in the entire gamut of methods and procedures that exist. Some clinicians are excellent with children, whereas others have a talent for working with geriatric populations. Some practitioners have

specialized in specific disorders (e.g., eating disorders, sexual dysfunctions, PTSD, panic, depression, substance abuse, or schizophrenia). Those who employ multimodal therapy will bring their talents to bear on their areas of special proficiency and employ the BASIC I.D. as per the foregoing discussions and, by so doing, possibly enhance their clinical impact. If a problem or a specific client falls outside their sphere of expertise, they will endeavor to effect a referral to an appropriate resource. Thus, there are no problems or populations per se that are excluded. The main drawbacks and exclusionary criteria are those that pertain to the limitations of individual therapists.

It cannot be overstated that MMT is predicated on the twin assumptions that most psychological problems are multifaceted, multidetermined, and multilayered, and that therefore comprehensive therapy calls for a careful assessment of seven parameters or “modalities”—Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships and Biological processes. The most common biological intervention is the use of psychotropic *drugs*. The first letters from the seven modalities yield the convenient acronym BASIC I.D.—although it must be remembered that the “D” modality represents the entire panoply of medical and biological factors.

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## TWO CASE EXAMPLES

### CASE #1

Matt, 26, a single White male, was in an executive training program with a large corporation. He was raised in an affluent suburb, did well at school, graduated from college, but tended to be rather obsessive-compulsive, prone to bouts of depression, and conflicted about his career options. After an initial session that consisted of the usual exploration of the client’s current situation, some background information, and an inquiry into antecedent events and their consequences, Matt was asked to complete a Multimodal Life History Questionnaire (Lazarus & Lazarus, 1991b)

and bring it with him to the next session. Clients who comply tend to facilitate their treatment trajectory because the questionnaire enables the therapist rapidly to determine the salient issues across the client’s BASIC I.D.

### A Step-By-Step Inquiry

**B:** What is Matt doing that is getting in the way of his or her happiness or personal fulfillment (self-defeating actions, maladaptive behaviors)? What does he need to increase and decrease? What should he stop doing and start doing?

**A:** What emotions (affective reactions) are predominant? Are we dealing with anger, anxiety, depression, combinations thereof, and to what extent (e.g., irritation vs. rage; sadness vs. profound melancholy)? What appears to generate these negative affects—certain cognitions, images, interpersonal conflicts? And how does Matt respond (behave) when feeling a certain way? We discussed what impact various behaviors had on his affect and vice versa and how this influenced each of the other modalities.

**S:** We discussed Matt’s specific sensory complaints (e.g., tension, chronic lower back discomfort) as well as the feelings, thoughts, and behaviors that were connected to these negative sensations. Matt was also asked to comment on positive sensations (e.g., visual, auditory, tactile, olfactory, and gustatory delights). This included sensual and sexual elements.

**I:** Matt was asked to describe some of his main fantasies. He was asked to describe his self-image? (It became evident that he harbored several images of failure.)

**C:** We explored Matt’s main attitudes, values, beliefs, and opinions and looked into his predominant shoulds, oughts, and musts. It was clear that he was too hard on himself and embraced a perfectionistic viewpoint that was bound to prove frustrating and disappointing.

**I.:** Interpersonally, we discussed his significant others, what he wanted, desired, and expected to receive from them, and what he, in turn, gave to them. (He was inclined to avoid confrontations and often felt shortchanged and resentful.)

**D.:** Despite his minor aches and pains, Matt appeared to be in good health and was health

conscious. There were no untoward issues pertaining to his diet, weight, sleep, exercise, or to alcohol and drug use.

The foregoing pointed immediately to three issues that called for correction: (1) His images of failure had to be altered to images of coping and succeeding. (2) His perfectionism needed to be changed to a generalized antiperfectionistic philosophy of life. (3) His interpersonal reticence called for an assertive *modus vivendi* wherein he would easily discuss his feelings and not harbor resentments. To achieve these ends, the techniques selected were standard methods—positive and coping imagery exercises, disputing irrational cognitions, and assertiveness training.

This straightforward case has been presented to demonstrate how the Multimodal Therapy approach provided a template (the BASIC I.D.) that pointed to three discrete but interrelated components that became the main treatment foci. In a sense, the term “Multimodal Therapy” is a misnomer because while the assessment is multimodal, the treatment is cognitive-behavioral and draws, whenever possible, on empirically supported methods. The main claim is that by assessing clients across the BASIC I.D., one is less apt to overlook subtle but important problems that call for correction, and the overall problem identification process is significantly expedited.

## CASE #2

The case of Ed will now be discussed to underscore that flexibility is the sine qua non of effective therapy.

When 72-year-old Ed arrived for his first session, he looked like a zombie. His eyes were half closed, half focused on his shoes, his hands hung listlessly at his side. He exuded an aura of gloom, despondency, and despair. When he spoke, his voice was soft and devoid of inflection. “All of this is my own fault. I’ve got nobody to blame but myself for this fix I’m in.”

I asked: “What is it that you did that is supposedly so horrific that you deserve to be punished in such a profound way?”

“It’s my wife,” he croaked in a hoarse voice. “I just couldn’t take care of her the way she

needed to be. I’m just so selfish that I couldn’t make her happy.”

Out poured Ed’s miserable tale of being such a terrible, worthless, incompetent, unfeeling husband that he not only deserved to have his wife leave him but that he should burn in hell ever after because of his marital sins.

“And what is it exactly that you did to your wife? Did you beat her?”

Ed shook his head.

“Marital affairs then? You’ve been sleeping with other women?”

Ed looked horrified. “Of course not!” he said indignantly.

“Well then, you abandoned her then? You didn’t spend time with her and cherish her when you were together?”

“Oh no, no,” Ed protested. “I did everything I could think of to make her happy.” Then in a semi-whisper he added, “But it just wasn’t enough.”

During the next few sessions, I heard the full story of Ed’s marriage, and it did not come across at all as he had first presented it. I found Ed to be a most endearing fellow—charming, respectful, and considerate in every way. Ed’s story about being a neglectful, inattentive husband did not make sense.

It was apparent, however, that his level of depression was such that formal multimodal assessments were contraindicated. He felt so hopeless and overwhelmed that he would undoubtedly find the task of filling out questionnaires or being subjected to systematic behavioral evaluations counterproductive. Nevertheless, working from a multimodal perspective, I jotted down some of the salient problems across the BASIC I.D.

Behavior: Apathetic, withdrawn.

Affect: Profoundly depressed.

Sensation: Anhedonia.

Imagery: Pictures of gloom. Images of failure.

Cognition: “I am guilty.” “I deserve to be punished.”

Interpersonal: Loss of wife and adopted family.

No network. No friends.

Biological: Taking Effexor. Losing weight.

The most obvious lacuna seemed to be his interpersonal losses that had probably precipitated his major depression. “I wonder,” I ventured, “if

your wife might consent to join us for a session or two? That way I could hear her version of things." What I was hoping to achieve was an opportunity to assess their interactions and reconcile Ed's perception of things with those of his wife. I had a strong suspicion that the wife was a demanding, self-centered, controlling person who kept her husband firmly under her thumb. She had apparently dumped him because she'd found a more obedient slave.

I realized, of course, that this impression was hardly fair. Each of the partners in most relationships train one another to behave in a mutually antagonistic fashion. If I could get the wife to come in for couples work, or at least to tell her version of the story, this might enable me to help Ed to move on.

"No," Ed insisted. "She will absolutely refuse to come in. She says she's done with me." As he said these last words, he tucked his head down in the most pitiful manner. He looked shrunken and miserable.

Yet there were also times, now and then, when Ed would flash a most radiant smile. These glimmers of his inner warmth were rare and fleeting, but nevertheless powerful signs of what an engaging person he could be.

Finally, I managed to reach the wife on the phone at her place of work. I introduced myself and said simply, "May I have a few words with you about your husband?"

"If you're calling me to come in there, I told him, and I'm telling you that. . . ."

"No, no," I interrupted, "there's no need for us to meet in person. I certainly respect your wishes on that score." This was hardly the case, but I could see no point in aggravating her further through increased pressure. I wanted her in some way just to get a better handle on what was going on. Ed was still insisting that all their marital woes were the result of his own ineptitude.

"I've got nothing to say," she insisted. "I'm done with the man. I told him that. And I'm telling you. I just wish you'd all leave me alone so I can get on with my life."

"Yes, but. . . ."

"Why don't you just talk to his other doctor, that psychiatrist fellow? He'll fill you in. Then you can stop pestering me."

She was referring to a psychiatrist who had been treating Ed previous to his seeing me. Apparently, he had met with Ed and his wife a few times. I had spoken to him, but he refused to say much about the case except to mutter, "She's some piece of work. I'll tell you that."

"Well, I'll certainly do that. But I was still wondering if you might fill me in a little more on what's been going on. According to your husband, it's all his fault that your relationship fell apart."

"Look. I just don't care. Is that clear? I'm done with the guy. And good riddance to him! And to you! Can I be any more clear than that?" And then she hung up.

During my next session with Ed, I decided to find out more about Ed's background, because it was clear I was not going to be getting any help from his wife, and Ed was not about to sit down and fill out the Multimodal Life History Inventory. Sure enough, once we began to talk about the safer past rather than the tumultuous present, Ed proved to be an articulate, charming, animated guy. He had been a successful corporate executive and had previously been married. He had discovered that his first wife was involved with another man. "We *have* a daughter together. And I was awarded custody of her when she was eight. My ex-wife and I—we've always been on good terms and all—we still keep in touch."

Ed explained that he remarried 4 years after his divorce and became the stepfather to his second wife's children, who were about the same age as his own daughter. Her previous husband had died in a tragic accident, and Ed soon realized that she had never really recovered from this loss, as she was always comparing him unfavorably to her departed spouse. Nevertheless, he worked as hard as he possibly could to be the best husband and parent he could be even if his efforts always seemed to fall short.

Ed encouraged his wife to enroll in a graduate program and with his support and help—financially and emotionally—she completed her degree and embarked on a new career. As she became more and more involved and successful in her own profession, the marriage seemed to deteriorate further to the point where Ed felt like a guest living in his own home—and a guest on probation who might be evicted at any time.

Whenever he broached the subject of his sense of distance or complained in any way about the status of things, his wife unfailingly threatened: “If you don’t like it around here, then why don’t you get the hell out?”

It was at this point that Ed felt so distraught that he consulted a psychiatrist who prescribed antidepressants and saw him in individual therapy once a week. After about a year, his wife accompanied him to sessions on occasion, but they just seemed to make things worse. She became even more antagonistic and abusive toward Ed. Finally, she’d had enough of his sniveling and sued him for divorce.

“I felt like I’d been hit by a stun gun,” Ed recalled, still immobilized by what he perceived as an ambush.

“Okay,” I urged him to continue the narrative. “Then what?”

“Well, she just moved out one day. She wouldn’t tell me where she moved. I still don’t know where she lives.” Since the separation, his wife forbade any of her children to have any contact with Ed whatsoever and this wounded him deeply. It was as if he had lost not only his wife but his entire family and support system. On top of this, his wife threatened their mutual friends that if they continued their relationships with Ed she would no longer have anything to do with them. Finally, on the verge of suicide, he had decided to see me at the insistence of a friend.

“Can you see now why I deserve what I’ve gotten?” Ed asked, feeling like he had made a strong case. “Actually,” I replied, “I can’t see that at all. What I see is a man who is profoundly depressed, lonely, isolated, and is recovering from long-term emotional abuse that he never deserved. What I see is someone who has been unloved and betrayed. What I see is someone who is beating himself up over crimes he never committed.” Ed went on to explain that the divorce was becoming quite messy. His wife was demanding virtually all of their assets, most of his pension, nearly all the furniture in their home, including pieces that had been in Ed’s family for years, and even his old Jaguar that he loved to tinker with.

As already stated, I had abandoned any plan to conduct a systematic multimodal assessment with Ed. It seemed to me that what Ed needed

more than anything else was some common sense. Somebody had to talk straight to him. Someone had to challenge his crazy ideas that he was 100% at fault for all his marital problems and that he deserved to suffer as a result. It seemed to me that the attorney that Ed had retained was not pursuing the matter seriously enough, and with Ed’s permission I called his attorney. I asked him if he was aware that Ed’s wife had been earning substantial sums of money, that she never repaid him for all the money he had spent by sending her to graduate school, and she never chipped in a dime toward household expenses but squirreled all her funds away for herself. As I had suspected, the lawyer knew none of this because, in his submissive way, Ed had not provided him with the facts. I then impressed on Ed that he was best advised to spell out these details to his lawyer, whereupon his attorney took a much more aggressive stance on Ed’s behalf.

At this juncture, I received a call from Ed’s first wife. I was delighted to talk with her, to finally get some corroboration that Ed was a decent man who had been mistreated. “He’s just about the nicest man I’ve ever known,” she said with genuine affection. “I can’t tell you how many times I’ve regretted cheating on him.” I inquired if he had ever been abusive or neglectful. “Quite the contrary, she said. “He’s just a sweetheart. Surely you know that about him if you’ve been working with him?” “Well, sure,” I answered. She then said: “How about his second wife, the bitch. Have you met her?” “Ah no,” I said, smiling to myself, “I haven’t had that pleasure.” “Well, then, consider yourself lucky and leave it at that.”

After conducting another quick mental BASIC I.D. scan, it became even more evident to me that I had to keep challenging Ed’s insistent self-blame. Each session he would come in with a new list of things he could have done better and things he should have done differently. “I just don’t deserve anything better,” he continually insisted. “On the contrary,” I argued quite bluntly, “you married a woman who never loved you, who never even *liked* you. She never got over the death of her previous husband and married you out of convenience and desperation. She used you. You put her through school. You took care of her children. You gave her all the love you could—she took the money but never let you get



close to her. Then, once she could support herself, she didn't need you any more, and she moved on with her life. And now that it's all over, she still wants to take you for every penny you've got."

I waited a few seconds to see how Ed was taking this confrontation before I proceeded further. I knew that it took some pretty strong statements to get Ed's attention, much less make anything stick. "You'll just have to excuse me if I am being too presumptuous," I said, "but this lady you married is no angel and you are no rogue." Ed closed his eyes and shrugged his shoulders. Then he nodded his head. I hoped he was thinking: "That could very well be. Maybe there *is* some need in me to punish myself needlessly and to glorify my wife. And maybe it's perfectly true that I am not this awful person."

This was wishful thinking. It became clear that it had not yet sunk into Ed that his wife had brainwashed him over the years into viewing himself as pretty reprehensible. He had been poisoned, almost to death, to believe that he was worthless and perhaps not even worthy of being alive. I saw my job as providing an antidote to the poison and kept administering measured doses again and again. At this juncture, I worked almost exclusively in the cognitive modality.

The first sign of real progress was when Ed reported that he had presented his lawyer with additional facts and figures and he announced that he intended to fight this divorce by negotiating for his fair share of the assets. His attorney resolved to take a much firmer stance. Ed was almost cheerful as he reported the progress that had been made with his attorney. For the first time, he actually seemed open to the arguments that I presented to him about the distorted ways that he had been looking at the situation. "Look Ed, I want you to fully recognize that it isn't your fault. You married a woman who never recovered from the tragedy of her first husband's death. She is bitter and twisted. There was no way that you could rewrite that script because it was etched in steel, granite, and tungsten."

At times, it seemed that I had finally managed to persuade him to stop perceiving himself as a villain and victim. Unfortunately, the effects would not last long, and Ed would slip back into old patterns of self-blame. That was when I de-

cidated to try the use of paradox, because direct action was having only a temporary impact. "All right," I stated. "You've convinced me. You really are a worthless piece of trash just as your wife claims." Ed seemed stunned for a moment. "And furthermore," I continued, "I also agree that you aren't entitled to be happy, and I have concluded that you are a terrible person. Here you married this perfect person, this goddess who never makes mistakes and who was actually totally loving and accepting, and you absolutely screwed it up all by yourself." Ed had the most delicious, hearty laugh, and when he launched into a contagious bout, I couldn't help but join him. "Okay, okay," Ed agreed in between his giggles. "I get your point." (When paradoxical statements fail to elicit laughter, one is in serious trouble.)

At this point, yet another BASIC I.D. checkpoint brought home the realization that Ed did not have even one friend with whom he could share pleasant times, let alone confidences. Clearly, building a support system was where he would have to go next. "Have you thought about going to one of those support groups in your area?" I asked him. "There are several such organizations nearby that are designed for those going through divorce or loss." "Yeah, I went to one of those meetings once," Ed countered. "They were just a bunch of losers." I smiled at Ed's feistiness. A few months earlier, he had been so compliant it would have been inconceivable that he could have disagreed about anything. I stated: "The purpose is not for you to meet dozens of scintillating and fascinating people who would become your lifelong friends. You could go to a few meetings just to get out of the house and get together with a few people." I had switched from Cognitive restructuring to Interpersonal interventions. Somehow, I had to break the cycle of Ed's isolation and loneliness. I decided to remain insistent about his joining a support group. To get me off his back, Ed agreed to attend several meetings. As luck would have it, he met Kathy, a woman with whom he formed a rapid bond because of their mutual attraction and shared interests. Then on a roll, he made another friend, Colin—a man who shared his love of tinkering with old cars.

Soon thereafter, Ed announced that he no longer needed therapy. "Thanks to you, and to

my new friends Colin and Kathy," he said, "I've come back from the dead. I feel like a young man again!" Then with a warm and radiant smile he added, "Viagra has taken over from Effexor."

Several months later, when the divorce was final, I received an invitation from Ed to attend a "Feeling Better Party." This was a catered affair, complete with a piano player. I had the chance to meet Kathy, Ed's new friend, his physician, his lawyer, and even his first wife and their daughter. There were even some friends there who had chosen to ignore the edict from his second wife and elected to remain friends with Ed.

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## THERAPY RELATIONSHIP

The multimodal orientation is not yet another system of psychotherapy to be added to the hundreds already in existence. It is an approach that uses techniques that are likely to prove helpful regardless of their point of origin and contends that the larger the clinician's repertoire of methods and procedures, the more likely treatment will prove to be effective. But in addition to techniques of choice, the multimodal clinician is well aware that the relationship between client and therapist is the sine qua non of salubrious outcomes. Thus, emphasis is placed on trying to be an authentic chameleon who also selects *relationships of choice* (Lazarus, 1993). Decisions regarding different relationship stances or styles include when and how to be directive, supportive, reflective, cold, warm, tepid, gentle, tender, tough, earthy, chummy, casual, informal, or formal.

How does the clinician determine or arrive at specific relationships of choice? By very carefully observing the client's reactions to various statements, tactics, and strategies. One begins neutrally by offering the usual facilitative conditions—the therapist listens attentively, expresses caring and concern, exudes empathy—and notes the client's reactions. If there are clear signs of progress, one offers more of the same; if not, the clinician may take a more active or directive position and note whether this proves effective. Moreover, those who com-

plete the Multimodal Life History Inventory (Lazarus & Lazarus, 1991b) are asked to describe their "Expectations Regarding Therapy" (p. 4) including their views of the personal qualities of the ideal therapist. A client who describes the ideal therapist as "a good listener" will probably respond to a different treatment trajectory from a person who wants "a good teacher and coach." Sometimes the client's expectancies leap out at one. Thus, when I used the word "ephemeral" with a client who was a philosophy professor, she immediately said, "Ephemeral? Did you say ephemeral? Or did you mean to say abstruse, evanescent, transient, cursory, or illusive—and do you know the difference?" She made it very clear that she was uninterested in my advice or opinions but wanted a sounding board, an active listener. This was one of the few cases in which a strictly Rogerian or person-centered approach seemed indicated. MMT practitioners endeavor to provide what the client appears to desire, especially the clinical ambiance from which he or she is most likely to benefit.

## EMPIRICAL RESEARCH

Multimodal therapy is so broad, so flexible, so personalistic and adaptable that tightly controlled outcome research is exceedingly difficult to conduct. Nevertheless, the Dutch psychologist Kwee (1984) organized a treatment outcome study on 84 hospitalized patients suffering from obsessive-compulsive disorders and extensive phobias, 90% of whom had received prior treatment without success. More than 70% of these patients had suffered from their disorders for more than 4 years. Multimodal treatment regimens resulted in substantial recoveries and durable 9-month follow-ups. This was confirmed and amplified by Kwee and Kwee-Taams (1994).

In Scotland, Williams (1988), in a carefully controlled outcome study, compared multimodal assessment and treatment with less integrative approaches in helping children with learning disabilities. Clear results emerged in support of the multimodal procedures. Although

the multimodal approach per se has not become a household term, recently, the vast literature on treatment regimens has borrowed liberally from MMT, with authors referring to multidimensional, multimethod, or multifactorial procedures.

Follow-up studies that have been conducted since 1973 (see Lazarus 1997, 2000a) have consistently suggested that durable outcomes are in direct proportion to the number of modalities deliberately traversed. To reiterate an important point made at the start of this chapter, although there is obviously a point of diminishing returns, it is a multimodal maxim that *the more someone learns in therapy, the less likely he or she is to relapse*. In this connection, circa 1970, it became apparent that lacunae or gaps in people's coping responses were responsible for many relapses. This occurred even after they had been in various (non-multimodal) therapies, often for years on end. Follow-ups indicate that teaching people how to cope with problems across the BASIC I.D. ensures far more compelling and durable results (Lazarus, 2000a). MMT takes Paul's (1967) mandate very seriously: "What treatment, by whom, is most effective for *this* individual with *that* specific problem and under *which* set of circumstances?" (p. 111). There are serious limitations of group designs in comparative therapy research, and a strong case can be made for the idiographic analyses of individual cases (Davison & Lazarus, 1994). One cannot study identical cases (because everyone is unique), but there are often sufficient similarities and obvious dissimilarities to permit the evaluation of treatment effects on the basis of various related and unrelated features. Be that as it may, from a research perspective, the major thrust in MMT is to attempt to unravel the complex interplay among personal biases, professional allegiances, epistemological assumptions, theoretical preferences, and familiarity with the use of certain bodies of data. A sustained and widespread emphasis on the documentation of clinical research, with special reference to objective ratings and a thorough account of the course of a given patient's treatment—in concrete and operational terms—may yet transform psychotherapy into a clinical science.

## BRIEF REITERATION AND FUTURE DIRECTIONS

Cost-effective multimodal therapy underscores the notion that treatment should be "custom-made" for the client. The client's needs come before the therapist's theoretical framework. Instead of placing clients on a Procrustean bed and treating them alike, multimodal therapists look for a broad but tailor-made panoply of effective techniques to bring to bear upon the problem. The methods are carefully applied within an appropriate context and delivered in a style or manner that is most likely to have a positive impact.

Flexibility is the major impetus. Thus, as already indicated, if an assessment reveals the need to do little more than listen attentively and reflect the client's feelings, a multimodal therapist will do just that. If the situation calls for a directive stance involving role-playing and other active strategies, that is what will be implemented. In searching for the best match in terms of the therapeutic alliance and the specific treatment trajectory, a multimodal practitioner is quite willing to refer a client to someone else—a colleague who may be a more effective resource. This is in stark contrast to many clinical schools of thought wherein the client will receive what the therapist offers—whether or not that is what is required.

It would seem that if a true scientific ethos is maintained and more and more empirically supported methods are accumulated to treat specific problem areas, and if these procedures are placed within a broad-based framework, the victims of mental and emotional suffering may receive the help to which they are fully entitled. And as a most relevant aside, I hope that more therapists and members of licensing boards will soon come to realize that by crossing certain formal boundaries, the impact can be most positive and healing. Thus, the emphasis on good client-therapist relationships tied to the notions of flexibility were exemplified by my attendance at Ed's party—a move that solidified his positive feelings about the therapy and its outcome. Those who follow a rigid rulebook of proscriptions as laid down by many licensing boards will often fail to provide

the basic humanity from which their clients can gain a sense of genuine acceptance and self-affirmation (see Lazarus & Zur, 2002).

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## Systematic Treatment Selection and Prescriptive Psychotherapy: An Integrative Eclectic Approach

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### THE STS APPROACH

Systematic Treatment Selection (STS) arose from three converging observations: (1) an exponential growth in the number of psychotherapies available as manuals and touted to be “empirically supported” (Chambless & Ollendick, 2001), (2) evidence that most treatment packages produce equivalent effects suggesting that the effects of treatment are heavily influenced by nonprocedural factors such as the treatment relationship (e.g., Castonguay, 2000; Luborsky et al., 2002; Wampold, 2001), and (3) the persistent disparity between what clinicians consider to be important to effective change and the predominant targets of research investigations (Beutler, Williams, Wakefield, & Entwhistle, 1995). The foregoing suggests that the factors that are most relevant to psychotherapeutic change are broad ranging, interactive, and are not yoked to specific theories or treatment models (Beutler, Clarkin, & Bongar, 2000).

The perennial search for new treatment methods and the associated proliferation of theories may be taken as a sign of both vibrancy in the field and failure in that our theories and methods have failed to produce either the levels of effect desired or the assurance needed to direct the work of those who provide those services. By focusing heavily on technical interventions and diagnosis rather than on psychopathology and change, research on psychotherapy has often ignored important contributors to change and has failed to capture the complexity of effective treatment. Thus, contemporary research using treatment manuals and comparing treatment models has minimized the roles of patient, therapist, environmental, and relationship factors that both cut across theories and that form the context for effective interventions (Lambert, 1992; Wampold, 2001). The result is a considerable discordance between what seems to work from the perspective of the clinician and the types of variables that occupy the attention of the re-

searcher. These collective failures of research, theory, and practice suggest a need for integrative approaches, wherein specific interventions can be designed for specific purposes, patients, populations, and conditions. A useful integrative approach, however, must account for the universe of factors that contribute to psychotherapeutic change rather than focusing on the limited variables associated with a single theoretical model.

Systematic Treatment Selection, as it has evolved and expanded during the past decades (see Beutler, 1979; Beutler, Arizmendi, Crago, Shanfield, & Hagaman, 1983; Beutler & Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000; Beutler & Groth-Marnat, 2003; Beutler & Harwood, 2000; Gaw & Beutler, 1995), has its roots jointly planted in clinical practice and in empirical research. From practitioners has come an appreciation for the crosscutting nature of the healing relationship and an awareness of the need for a pragmatic form of eclecticism. Also notable are the accompanying but usually implicit assumptions that different interventions are effective for different types of patients, and that the most effective interventions are almost never captured within a single theory. These clinical observations have also given us a degree of skepticism regarding the value of traditional diagnoses for planning psychosocial interventions (Beutler, 1989). This skepticism has been shared by clinical scientists, many of whom have observed the low relationship that exists between diagnosis and treatment assignment and argued for a diagnostic system that is predictive of treatment outcome (Beutler & Malik, 2002; Carson, 1997).

From researchers have come an appreciation of the power of controlled observations and of the relative advantages of both efficacy and effectiveness research. From research findings, we have also become acutely aware of the strangely contrasting and seemingly contradictory views about the contributors to psychotherapy benefit. On one hand, respected scientists who have reviewed large bodies of research have frequently reiterated the conclusion that all of the various approaches to treatment yield similar effects—training in specific therapies

and their associated procedures does not enhance either the likelihood or magnitude of positive treatment outcomes (e.g., Lambert, 1992; Luborsky et al., 2002; Wampold, 2001). On the other hand, there is also a large body of research that suggests that some treatments are more effective than others for particular kinds of problems (e.g., Chambless & Ollendick, 2001), a viewpoint that is supported by a plethora of news stories that provide a constant reminder that some treatments are ineffective and even place patients at risk (e.g., Beutler, 2000).

Responding to these disparate conclusions, the first author (L. E. B.) has led an effort to uncover the conditions under which various procedures do and do not work. We have sought to gain this understanding by conducting a series of investigations that have targeted the role of patient transient reactions and enduring characteristics as factors that moderate the effects of almost any intervention (e.g., Beutler, 1991; Beutler & Clarkin, 1990). The result of these efforts has been the development of Systematic Treatment Selection, or STS (Beutler, Clarkin, & Bongar, 2000), a model of treatment planning and patient-treatment matching designed to address the ways that patient, therapist, relationship, treatment, and treatment fit interact with one another. STS represents an attempt to bridge the gap between the disparate views that have characterized science and practice. It does so by translating contemporary research and effective practice into a list of working principles that lend themselves to selecting interventions and guiding the development of common, healing qualities.

In other words, STS represents an effort to define relevant variables from which the differential effects of various treatments may be predicted. This effort began with an intensive and comprehensive review of outcome literature (Beutler, 1979) and proceeded to the construction of a model of treatment decision making (Beutler, 1983; Beutler & Clarkin, 1990). STS has also been subjected to prospective empirical tests (Beutler, Clarkin, & Bongar, 2000; Beutler et al., 1991; Beutler & Mitchell, 1981; Beutler, Mohr, Grawe, Engle, & MacDonald,

1991; Calvert, Beutler, & Crago, 1988) and has led to a refinement of methods for applying psychotherapy (e.g., Beutler & Harwood, 2000). In doing so, the STS model has systematically eschewed adopting a causal theory of change. Instead, STS provides the clinician with a descriptive method for identifying, recognizing, and facilitating the conditions that tend to be present when therapeutic change occurs.

Most psychotherapists identify themselves as eclectic (Garfield & Kurtz, 1976; Norcross & Prochaska, 1983), an orientation that would seem to dictate the use of those procedures that fit the patient best, regardless of the theoretical origins of those procedures. It is to this ideal that STS aspires. Accordingly, the STS system is based on three cardinal assumptions. First, it assumes that all or most psychotherapy approaches are beneficial for some individuals but that none are effective for all. Second, it assumes that therapists can implement various therapeutic techniques quite independently of their originating theories if one but knows the principles that determine when they should be used. Finally, the STS system suggests that an inordinate focus on problem etiology as well as attempts to neatly fit each case within a particular theory of patient change tends to be less important than a focus on improving the quality of clinical decision making used by individual therapists.

## APPLICABILITY AND STRUCTURE

The promise of any integrative or eclectic psychotherapy generally, and STS specifically, is grounded in the conviction that research can identify the patterns between beneficial outcomes on the one hand and characteristics of treatment, patients, and therapists on the other. This credo extends to the implicit belief that doing so will allow one to make maximally effective, reliable, and discriminating decisions about how to treat a particular patient. In order to select and fit particular treatments to patients, three questions must be answered: (1) what patient and treatment variables and characteristics are related to beneficial thera-

peutic change? (2) What combination of patient and treatment qualities best predicts and facilitates benefits? And, (3) what are the relative contributions to improvement of patient, treatment, relationship, and patient-treatment matching factors? These are interrelated questions, the answer to each serving as a foundation for the next, but all requiring somewhat different methodologies by which to derive answers.

The first question can be addressed by inspecting available research, and for our purposes was addressed by a series of comprehensive literature reviews. The second question requires a more complex methodology. To answer it, one must both develop a means for measuring the dimensions identified in the literature reviews and conduct a systematic prospective test to determine if these variables predict treatment benefits. Similarly, an answer to the third question requires an analysis of the separate components of effective treatment and a determination of the amount of variance contributed by these components.

In order to identify relevant predictors and correlates of therapeutic change, our research group initiated a series of reviews of the empirical literature (Beutler, 1983; Beutler & Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000; Beutler, Harwood, Alimohamed, & Malik, 2002; Gaw & Beutler, 1995). Consistently, these reviews pointed to a relatively small number of recognizable and reliable variables that were related either directly to therapeutic change or that moderated the effects of some aspect of treatment (i.e., differential treatment efficacy/effectiveness). Initially, extensive lists of variables were identified based on these reviews, with no effort to collapse or refine the list. More recently, our research efforts reduced the redundancies among the identified variables in the list in order to identify the most consistently useful dimensions of treatment and participants. Collectively, these reviews have resulted in the identification of six patient dimensions and a corresponding number of treatment qualities that predict treatment prognosis or differential treatment effects. These patient dimensions are problem complexity,



chronicity, functional impairment, coping style, resistance level, and level of distress.

### Problem Complexity

Problem complexity reflects the degree to which the presenting problem is associated with other areas in which problems are manifest (i.e., comorbidity), to the spread or overlap of dysfunctional behavior across environments, and to the degree to which the observed disturbances are associated with trait-like qualities of the patient (for predicting distal effects, traits are more likely to be useful than situational reactions). The diagnosis of a current personality disorder, for example, typically indicates the presence of an enduring and cross-situational disturbance in interpersonal functioning that can be predictive of one's long-term response to change efforts.

### Chronicity

A related patient predictor of prognosis is found in the degree to which a problem is either present over time or is recurrent. A problem of a longstanding or recurrent nature is less likely to respond to treatment than one with a much shorter, acute course. Likewise, a frequently occurring problem bodes more poorly for achieving a positive response than one that has been present on only one occasion.

### Level of Functional Impairment

Though identified as a separate dimension, patient impairment level is related to both complexity and chronicity. Functional impairment expresses how successfully the patient is able to adapt to the demands of the environment and is related to prognosis. However, it is also related in a differential way to both the intensity of treatment and to the relative efficacy of specific treatment formats.

Functional impairment is defined as the degree to which social, interpersonal, and intimate relationships are negatively affected by the identified symptoms. Impairment ranges from behaviors that reflect minimal distur-

bance of life patterns, or acute disturbance in one area of life, to those in which behavior is impaired in all areas of function.

Further along the dimension of impairment are behaviors that incapacitate a person or reduce their effectiveness in maintaining functional performance in a variety of areas, such as self-care and intimate functioning, but that leave other social activities (school, work, friendships, support systems) relatively unaffected.

Even further along the dimension are those cases in which disturbance extends to all or most social activities as well as interpersonal and intimate functioning (e.g., reduced work, limited friendships, loss of social support, impaired recreation, reduced sexual performance). Such levels of impairment may require extensive or frequent treatment and the application of a variety of different technical interventions in a variety of contexts.

### Coping Style

Coping styles reflect the patient's efforts to adjust to change. Though coping styles are trait-like characteristics, they are not in themselves indicative of a patient's problems, including self-defeating and inhibiting behaviors as well as those that are undercontrolled and directed toward others. With the intent of crafting a theory-neutral definition, we have come to identify coping style in terms of trait-like behaviors that by definition cut across situations and tend to be favored under stressful conditions. Coping styles are most easily conceptualized as representing a continuum, although this idea is not uniformly accepted among personality theorists. For the sake of simplicity, we have come to identify coping styles by their extremes, as either "internalizing" or "externalizing," while recognizing that within each are different levels of adaptability and functioning.

A patient with an *internalizing* coping style is most often described as being self-blaming and engaging in self-devaluation accompanied by compartmentalization of affect and idealization of others. Internalizers attribute faults and mishaps to their lack of skills or abilities and then try to compensate by engaging in ritualistic behavior that is initiated with the intention

of undoing the faulty behavior. An internalizer is prone to be intrapunitive and to constrict his or her emotional response to the point of being constrained and stilted in emotional expression. This style parallels some of the traits associated with diagnostic groupings of avoidant and obsessive personality disorders.

*Externalizers*, in sharp contrast to internalizers, attribute responsibility for their lack of well-being and discomfort to external objects or to others. They seek constant stimulation and tend to blame situations, their symptoms themselves, and other people for their problems. They also tend to avoid taking responsibility for change, leaving their future well-being in the hands of others or in the hands of fate. Frequently associated traits among the mild to moderate externalizers and full-blown diagnoses among the severe externalizers include paranoid and antisocial personality, narcissistic, and passive-aggressive personalities.

In treatment, externalizers tend to respond best to symptom-oriented procedures and those interventions that provide structure, feedback, and enhance behavioral skills. In contrast, internalizers tend to respond to evocative interventions, such as those that tend to promote insight and awareness or those that facilitate interpersonal sensitivity.

### Resistance Level

Resistance is a concept that has widely been applied, even too widely, to explain all types of therapeutic and social behavior. A more narrow concept, reactance, has been applied by social psychologists and cognitive theorists to explain both trait- and state-like behavior within the context of social persuasion theories (Brehm, 1976; Brehm & Brehm, 1981; Goldfried & Davison, 1976). Reactance is seen as the tendency to respond oppositionally to external demands. Reactance has trait-like properties—an attribute whose likely expression varies from person to person and that is related to an individual's acquired sensitivity to perceived interpersonal threats to one's autonomy. Reactance can be indexed by a given individual's ability to comply with externally imposed demands.

Tolerance of external demands indicates the level of therapist directiveness that will be tolerated without eliciting oppositional resistance. Those who are easily threatened by a perceived loss of autonomy respond more positively both to low levels of therapy directives and to the use of paradoxical interventions (e.g., prescribing the symptom or symptom exaggeration), compared to those who have high tolerance for such threats (Ollendick & Murphy, 1977; Shoham-Salomon, Avner, & Neeman, 1989). Mismatching the use of highly directive procedures with patients who are prone to reactance may result in worsening of symptoms (e.g., Forsyth & Forsyth, 1982).

### Distress

Affective arousal has both positive and negative consequences. The relationship between affective level and productivity is usually described as an inverted U. High and low levels tend to reduce performance levels, whereas midrange arousal is conducive to effective problem solving. In psychotherapy, arousal represents a situationally responsive and transitory quality, but it generally functions in the same way as in other situations. Low levels are associated with poor motivation, whereas high levels are associated with difficulty concentrating and focusing. Thus, in psychotherapy, patient level of distress can be used, from moment-to-moment, as an index of whether to provide support to the patient or whether to confront them.

Support, reassurance, and structure tend to reduce excessive and disruptive levels of distress. On the other hand, confrontation, lack of structure, and withdrawal tend to evoke arousal and may produce motivation to find comfort.

## ASSESSMENT AND FORMULATION

Reliable and valid assessment of treatment-relevant patient characteristics benefits by a structured or semistructured intake battery of standardized psychometric devices. However, very few clinicians employ standardized assessment in their intake procedures. Often, and potentially to the detriment of the patient, ther-

apists rely solely on unstructured and unstandardized clinical interviews to make their judgments. This is unfortunate, as therapists are often called upon to make life-changing decisions, such as whether to hospitalize a patient, to refer for medication consultation, and so forth.

We propose a systematic, multitiered method for psychotherapists to interview psychotherapy patients. The first tier of this system is decidedly *patient-focused*. It includes an assessment of patient problems, including *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnosis, the patient's personality, and the patient's living environment and their functionality. Most importantly, this tier of decision-making looks at the major predisposing dimensions set forth in the STS system; namely, problem complexity, chronicity, functional impairment, coping style, resistance level, and level of distress as prognostic indicators. In the following paragraphs, we discuss each dimension, including some of the more important measurable facets of these dimensions.

The second tier of a clinician's decision-making process involves looking at the overarching *context of treatment*. It involves adjusting treatment setting (e.g., is the setting restrictive or otherwise), treatment intensity, treatment modality (e.g., psychosocial, pharmacological, combined), and treatment format (e.g., group, individual, family). There is some evidence that patient diagnosis tends to be involved as a factor in making decisions at this level; however, more often than not clinicians focus on variables such as patient prior functioning, chronicity, and the patient's cooperativeness.

The third tier of decision-making is *enhancing relationship variables*. Factors that may need to be adjusted by the therapist in order to facilitate the impact of the therapeutic relationship and include the degree of correspondence between therapist's and patient's perspectives and backgrounds (which are, admittedly, difficult variables for therapists to gauge and adjust); the kinds of interventions and treatment models to employ; and the use of nonspecific skills to pace the emerging therapeutic alliance.

The fourth tier of decision-making involves *treatment fitting*. This is the most finely tuned

level of treatment planning. Decisions by therapists at this stage rely on at least four dimensions and related decision points.

The first decision point at this tier involves selecting the optimal match of patient level of functional impairment with treatment intensity. Generally, the more severe the patient's impairment, the more intensive the desired treatment should be. Functional impairment can be related to the degree of social support provided to the patient by family and reference groups. Low levels of social support are indicative of the need to provide assistance in developing attachments and social outlets (Longabaugh, Beattie, Noel, Stout, & Malloy, 1993). In the latter case, referral of the patient to group and family therapy may be useful to consider.

The second decision point invokes matching patients on the basis of coping style, with those who manifest internalizing styles of adjustment being directed toward insight- and emotion-focused interventions. Conversely, those with externalizing coping styles are guided to procedures that emphasize the development of problem-solving strategies and direct behavioral change. These latter are symptom-oriented strategies, for the most part.

The third decision point is based on patient level of trait-like resistance. Those with high propensities to resist the efforts of others to change them are unlikely to benefit from directive interventions and goal-driven therapists. These patients are more responsive to interventions that emphasize patient self-direction and that de-emphasize therapist control and guidance. The effective therapist in this instance is more evocative than guiding and directive. The exception to this rule is the use of paradoxical procedures, which seem to be quite effective among highly resistant patients. Patients who are low on resistance find comfort in therapists who assume directive and guiding functions. These patients seem to experience good results, and surprisingly, to retain these effects when treated by a structured and directive therapist using targeted goals, homework, and instruction.

The fourth decision point indexes patient level of subjective distress and discomfort as a

marker for assuming a supportive versus a confronting role with the patient. Low levels of distress fail to provide a platform of motivation to move the patient forward and keep them focused on goals and tasks of treatment. Thus, emotion-focused interventions, including abreactive (emotionally arousing) procedures are often helpful. In contrast, among those with very high levels of distress, focus is impaired by patient distractibility and short attention span. For these patients, cognitive control and stress inoculation procedures are likely to be most helpful.

The STS system condenses the various contributors to predicting outcomes and assigning treatments into eight dimensions. Below, we will review some of the instruments that may be useful in identifying each of the STS patient dimensions.

### Impairment

In clinical research, obtaining an accurate assessment of patient impairment is crucially important. The Global Assessment of Functioning (or GAF) in the *DSM-IV* is a commonly used indicator of impairment. There are also a number of measures with more specificity, such as the Anxiety Disorders Interview Schedule (ADIS; DiNardo et al., 1983) and the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967). The severity of a given patient's problem tends to be a very salient predictor of treatment response. McLellan, Woody, Luborsky, O'Brien, and Druley (1983) studied treatment matching in substance abuse treatment and found the dimension of functional impairment highly predictive of treatment response.

Social support is strongly and negatively correlated with problem severity or impairment level, and it moderates the optimal treatments of patients with chronic and complex problems. A competent analysis of support systems and resources looks at both social resources that hinder as well as facilitate the process of change. An evaluation of the social resources provides an indication of the likelihood that the patient will seek and use information or advice from others and provides information

regarding an individual's available resources for coping. Clinicians measure social support separately from other aspects of impairment. If so, social support can be assessed either as an estimate of quantity, such as the number of family and friends within a proximal area (e.g., Ellicott, Hammen, Gitlin, Brown, & Jamison, 1990) or as patient self-report of support, regardless of the number of people providing it (e.g., Moos & Moos, 1986). Some instruments, such as the Social Support Questionnaire (SSQ) (Sarason, Levine, & Basham, 1983), yield information about both the number of available sources of social support and the patient's satisfaction with the support received.

### Problem Chronicity and Complexity

Functional impairment is related to problem complexity and chronicity. Patients with complex and chronic problems tend to respond best to longer term and more intensive treatments, with a therapeutic focus kept on interpersonal domains. Patients with highly complex and chronic problems tend to respond the best to combined psychosocial and interpersonal treatment. Use of psychoactive medication is recommended in cases of patients with very high levels of problem complexity and chronicity (Beutler, Clarkin, & Bongar, 2000).

In the initial development of this construct, we urged clinicians to evaluate many different sources of information and have identified problem complexity as the presence of recurrent patterns that are manifest in the patient's life history, looking for unconscious needs and wishes that might be represented symbolically in these patterns (Beutler & Clarkin, 1990). As it turns out, the complexity of a problem can adequately be assessed much more directly and simply. Problem complexity appears to be a function of the presence of multiple diagnoses and is especially indicated when the patient presents with a personality disorder in addition to Axis I conditions. Structured interviews and objective assessment procedures that identify personality and Axis I disorders are useful to assess complexity.

In sum, problem complexity and chronicity are indexed by a history of long-standing and

recurrent problems, by multiple symptoms and comorbid conditions, by the presence of social and interpersonal disturbances, and by the presence of family disruption.

### Coping Style

The Minnesota Multiphasic Personality Inventory (MMPI-2) (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) and other omnibus personality measures are helpful in obtaining an estimate of the patient's coping style. When the MMPI-2 is combined with clinical history, a determination of reactance level is also possible. We have found that the relative constellation of scores described by Welsh (1952) distinguishes among patients with externalizing and internalizing coping styles (Beutler et al., 1991), typically done by generating an Internalization Ratio (IR). The IR is generated by using linear combinations of MMPI scales and also by making use of a variety of clinical, patient-provided cues. An IR score is a measure of the relative contribution of externalizing scales (Hy, Pd, Pa, Ma) as compared to that of internalizing (Hs, D, Pt, Si) ones. IR scores of 1.0 or below indicates that the patient tends to exhibit an internalizing coping style, whereas scores greater than 1.0 indicate an externalizing coping style.

Clinical signs that can indicate internalization include a greater tendency toward internalizing negative affect rather than expressing outward anger, as well as timidity and introversion. The range of clinical cues that one can expect to observe from those who are "externalizers" includes gregariousness, sociability, sensation seeking, and impulsiveness. Externalizers tend to behave in a manner easily characterized as aggressive, they tend to actively avoid blame or responsibility, and they tend to exhibit denial.

When one determines that an internalizing coping style is present and insight-oriented treatment is indicated, the next major task is to define a focal theme to guide and organize the relevant interventions. The exact framework by which one formulates a dynamic focus, however, is not specifically dictated by STS. The

eclectic approach emphasizes the importance of explicitly defining a theme or conflict, using whatever terminology one finds compatible with one's own theory, and then using this theme to maintain treatment consistency.

We find the empirically based methods of defining interpersonal themes elucidated by psychodynamic theorists (e.g., Luborsky, 1984; Strupp, 1981b; Strupp & Binder, 1984) to be helpful. The Core Conflictual Relationship Theme (Bond, Hansell, & Shevrin, 1987; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985) encourages the therapist to make a global judgment about the principal needs or wishes that guide the patient's interpersonal behavior. Once defined, the most frequently observed motive or behaviorally expressed "want" is then considered along with other patient qualities, such as coping style, reactance against loss of autonomy, and expectations, to complete a thematic formulation.

### Resistance/Reactance

A well-established measure of therapeutic resistance is the Dowd Therapeutic Reactance Scale (DOWD-TRS; Dowd, Milne, & Wise, 1991). Also useful for this purpose are the TRT (negative treatment indicators) and TPA2 (competitive drive) content component scales of the MMPI. Also useful is the clinical subscale Pd2 (authority problems) or the supplementary scale Do (dominance) from the MMPI-2. High scores on these scales and subscales tend to indicate interpersonal defensiveness (Harwood & Williams, 2003).

More informal methods of detecting low patient resistance include aspects of patient history and cues exhibited in the therapy session that indicate a tendency to avoid confrontation and to be obedient to authority. Highly resistant individuals tend to express frequent resentment of others, tend to enjoy competition, and are quick to look for ways to "get even" with others when slighted. In general, if low resistance is detected, a therapist can be more comfortable employing directive techniques, such as the use of confrontation, close-ended questions and interpretations.

## Distress

Patient distress is subjective and any attempt to measure it must depend to some degree on self-report. Patient distress is also implicated as a powerful motivator for patient change, with optimal levels of distress being invaluable to maintain a patient's personal investment in treatment. An effective clinician will manage patients' arousal and distress levels without allowing it to get too low or too high. Excessive distress impairs focus, and insufficient distress lowers motivation to change.

For assessment, we recommend measures that sample both trait and state indicators of distress, such as the State-Trait Anxiety Inventory (STAI) (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). Therapists need to be mindful of cues exhibited in the therapy session that indicate an unhelpful turn in arousal levels. Patients in high levels of (state) distress (say, in the 75th percentile) tend to be unable to exercise planful action and often fail to respond positively to emotionally arousing or abreactive techniques (e.g., Litz, Gray, Bryant, & Adler, 2002).

Typically, high levels of arousal tend to be indexed by patient reports of flashbacks and derealization, signs of restlessness and inability to focus, evidence of distractibility, irritability, agitation, and anxiety. Also, high arousal is indicated by marked changes in vocalizations (e.g., tense or jumpy vocalizations or sudden changes in pitch). A low level of arousal in patients is indicated by an absence of typical signs of high arousal levels; also, the patient may appear apathetic, bored, or disinterested.

## PROCESSES OF CHANGE

As we have pointed out, Systematic Treatment Selection is a treatment planning model consisting of clinically and empirically informed guidelines to assist practitioners in their decision-making process of how best to treat patients.

STS recognizes a vast spectrum of change processes that can systematically be ordered

into a more manageable set of change principles. These change principles can be separated into two groups. Basic principles are those that apply to all treatments, and their application is apparent from observing the structure, duration, format, and modalities of treatments. That is, they apply to the use of multiple person therapy, different settings and levels of care, psychoactive medication, and to factors that reduce patient risk. Optimizing principles, on the other hand, identify the conditions that take place within the treatment relationship to maximize the fit between patient and therapist. An assessment of compliance with these optimal principles requires direct observation and measurement of the treatment processes.

The most basic of principle resonates with the old adage that an informed consumer makes for a better one. In other words, the likelihood of positive psychotherapy outcomes is significantly increased when patients are properly informed of how to make best use of the services offered to them. It is of particular importance to address issues related to expectations that patients bring to treatment and to spend time redressing any misperceptions or unrealistic prospects while educating patients on the roles and activities to be expected of them.

The second basic principle affirms the importance of honoring patients' degree of functional impairment by generating an amount of treatment intensity sufficient to make a difference. Though we recognize that "too much of a good thing is not necessarily better," we have encountered that not enough treatment intensity is likely to make a wash and to further erode the confidence and optimism of patients (and therapists!).

Beyond these two basic principles, the optimizing principles work to facilitate change and stability processes in patients. The first optimal principle concerns important therapist characteristics including but not limited to trust, acceptance, acknowledgment, collaboration, support, and respect. These characteristics are likely to be present in most therapists, perhaps many of who have chosen this "impossible profession" because of consistent praise they re-

ceived precisely on these interpersonal abilities. Therapists' psychological well-being and personality play important roles to the extent that they are likely to significantly mediate their capacity to resonate empathically with their patients' struggles and accomplishments. Furthermore, therapists' personal styles and match or mismatch with those of each of their patients are also likely to influence significantly the outcome of psychotherapy (Beutler, Moleiro, & Talebi, 2002; Fernández-Alvarez, 2001).

Though the well-being of therapists plays an important role in the quality of service provision, so do patients' characteristics, particularly with respect to the process and outcome of psychotherapy. High problem complexity, marked chronicity, significant functional impairment, maladaptive coping styles, high reactance levels, and extreme distress all are likely to have a negative impact on treatment and perhaps make difficult the therapists' abilities to actualize a caring relationship (Beutler & Consoli, 1993).

The second optimizing principle addresses the importance and generality of exposure as a process that brings about human change while curtailing the potentially harmful influence of avoidance. Treatment success is likely to be brought about if patients can be persuaded to expose themselves to objects or targets of behavioral and emotional avoidance.

The third optimizing principle is based on the old adage, "different folks benefit from different strokes." It distinguishes procedural emphasis in facilitating change among patients whose coping style can be described as externalizing contrasted with internalizing ones. For the former, the relative balance of interventions ought to favor the use of skill building and symptom removal procedures, whereas for the latter, the balance should tip toward insight and relationship-focused procedures.

The next two principles concern themselves with patients' resistance. The fourth optimal principle affirms that therapeutic change is most likely when therapeutic procedures do not evoke patient resistance. The fifth principle honors the importance of tailoring interventions to redress the level of resistance. When

patient resistance is high, interventions most likely to facilitate change are those that are the least directive or those that are paradoxical in nature such as prescribing the continuation of symptomatic behavior.

The sixth optimizing principle is predicated on the importance of moderating a patient's emotional distress. Therapeutic change is maximized when the distress experienced by patients is moderate. This principle describes therapists as emotional managers who seek to facilitate change by activating an optimal level of emotional arousal. Therapists are called upon to use therapeutic strategies that will modulate emotional arousal such as structure and support when emotional level is too high; confrontation, experiential, and open-ended/unstructured procedures when emotional level is too low. A powerful heuristic that therapists may want to systematically consider in honoring patient differences in readiness is that of stages of change (Prochaska & DiClemente, 1983; Prochaska & Norcross, 2002): precontemplation, contemplation, preparation, action, maintenance, and termination. Put simply, therapists may consider the question of what the patient is a *customer for*, then tailor interventions that would move the patient along in the corresponding stages of change.

The seventh principle affirms the importance of sustained emotional arousal until problematic responses diminish. And finally, the last optimizing principle recognizes that positive change is more likely to occur when the initial foci of interventions are to build new skills and to alter disruptive symptoms.

## THERAPY RELATIONSHIP

The therapeutic relationship occupies an important role in STS. The therapeutic relationship, or working alliance, has been described as "the quintessential integrative variable" of therapy (Wolfe & Goldfried, 1988, p. 449). Much of what will happen in therapy as well as outside of therapy will be mediated by the persuasive and influential qualities of not only the therapeutic relationship but also of those relationships most significant in the patient's

life. Two of the therapeutic principles articulated in the preceding section frame the STS contribution to the topic. The basic principles emphasize the importance of the patient's preparation and role induction, and the optimal principles emphasize the therapist's preparation and role activation; these principles are most relevant to the development and facilitation of the therapeutic relationship. Therapists formally prepare the patients and themselves for therapy, present and actualize therapy as a process characterized by alliance, mutuality, and collaboration, and ultimately seek to engage patients in change and stabilizing activities.

Patient's preparation begins even before the first session and serves the purpose of not only putting the patient at ease but also to begin setting the stage for change. Preparation takes the form of official procedural outlines describing role expectations, confidentiality and its limitations, purposes and potential length and outcomes of therapy, billing procedures, and consent to treatment.

Therapist's preparation for therapy involves knowledge, training, and supervised experience. It also involves the development of what Laing described as a "harmless, inviting, cultivated" state (Tougas & Shandel, 1989) refined not only through personal therapy but also through lifelong exercises that expand the therapist's latitude of acceptance (Beutler, Consoli, & Williams, 1995).

The actual therapeutic relationship has received much focus recently in an effort to offset the lopsided emphasis on empirically supported treatments (Norcross, 2002). The task force on empirically supported therapy relationships of Division 29 of the American Psychological Association found strong support for several elements of the therapeutic relationship such as therapeutic alliance, cohesion, empathy, goal consensus, and collaboration (Steering Committee, 2001). STS is congruent with these findings as it emphasizes therapists' characteristics of respect, kindness, caring, empathy, and relationship characteristics of collaboration and mutuality.

It is difficult for psychotherapists to assess the quality of the relationship. Therefore, STS

practitioners are encouraged to assess of the quality of the therapeutic relationship relying not only on their clinical impressions but also on standardized measures such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) completed by the patient, the therapist, and perhaps an authorized observer, such as a supervisor. We make use of specific strategies to facilitate the working alliance. For example, we acknowledge patient's feelings and express an authentic understanding of these feelings while seeking to comprehend patient's meanings and perceptions. Also, the use of collaborative language with words such as *we*, *us*, and *our* that refer to patient-therapist dyad are important relationship builders.

At the same time, therapists using STS principles refrain from criticizing or correcting the patient, making assumptions, interrupting, or discounting or minimizing the patient's perspective. Therapists resort to strategies such as acknowledgment, reassurance, and reflection, particularly reflection of feelings.

Though possessing sound interpersonal abilities is an important first step to having a productive therapeutic relationship, the most crucial challenge is finding a way to put them into action with any and every patient for the purpose of fostering a caring relationship. This caring relationship is likely to engender a safe and respectful environment that could be described as "a secure base" (Bowlby, 1988). Such base is not an end itself but a sine qua non foundation that will permit meaningful exploration and important risk-taking by the patient, the therapist, and their relationship. In partial agreement with Rogers (1957), we view these therapists and potentially therapeutic relationship characteristics as necessary though not, in and of themselves, sufficient conditions for change.

Incipient ruptures in the therapeutic alliance flagged by signs of hostility, negativism, criticism, intolerance, or anger are to be redressed through reparative healing. Reparation may require an active consultation with a supervisor or colleague because, many times, patient hostility may drag therapists into negative complementary sequences expressed through hopelessness, belittling, and criticism, which



may prove quite difficult to overcome. In other words, coldness, distancing, counterhostility, and rejection toward patients are the markers of serious potential disruptions to a collaborative, fruitful therapeutic alliance. Unaddressed, these feelings are likely to evolve into small and then possibly sizable ruptures in the alliance (Safran, Muran, & Samstang, 1994).

Ultimately, establishing a warm and caring therapeutic relationship can be conceptualized as a crucial principle of change. As Norcross put it, in a spin off of Bill Clinton's unofficial presidential campaign slogan, "It is the economy, stupid!," "It is the relationship, stupid!" (2001, p. 347). Yet, with all its healing properties, the therapeutic relationship is not an end to itself. As we see it, the therapeutic relationship ought to evolve from therapists' actions reflecting acceptance and affirmation to those processes that expand the repertoire of emotions experienced by patients and associated meanings (Wachtel, 1997). In the context of this "secure base," patients are appropriately encouraged to take the necessary risks to face avoided material, emotions, and circumstances. We now turn to the methods and techniques involved in such risk-taking activities.

## METHODS AND TECHNIQUES

STS methods and techniques are those that respond to one or more patient dimensions that are deemed to be most relevant to treatment and that operationalize one or more principles of change. In this section, we discuss the most frequently used methods and techniques when addressing the patient dimensions of functional impairment/coping style, resistance level, and distress. Before turning to these dimensions, we would like to address some important things to consider at the point that treatment gets underway.

Most treatments should focus, at least at the beginning, on direct change procedures addressing external symptoms. Therefore, the methods and techniques that characterize this stage are those that facilitate initial changes to

ensure patients' safety and relative stability. Immediate behavioral targets listed in order of priority include physical violence toward self or others; drug abuse, cravings, and withdrawal symptoms; intolerance for stress; high-risk situations; social isolation; maladaptive cognitions and interpersonal schemas; and marked disturbances in sleep, appetite, or sexual life. Though specific interventions for each of these behavioral targets are beyond the scope of this chapter, we would like to highlight here the main elements in their application. All these interventions involve self-monitoring, seeking to make connections between actions and consequences. We address now the most salient patient dimensions.

The intensity of treatment should be determined by the patients' level of functional impairment. Treatment intensity is defined by the frequency and length of sessions; the nature of homework assignments, supplementary contacts outside sessions, and the use of adjunct treatment or support sources; the treatment setting and its restrictiveness; and the use of combined interventions (e.g., individual and group therapy; psychosocial and pharmacological approaches). For certain, marked difficulties such as substance dependence and suicidality, the intensity of treatment is likely to peak in order to make a difference and meet the seriousness of the circumstances.

Another important patient dimension we would like to highlight is coping style, defined as "the typical and usual way an individual interacts with others and responds to a threatened loss of safety and well being" (Beutler & Harwood, 2000, p. 74). And as articulated previously, patients could be described as internalizers or externalizers based on their preferred or dominant coping style while change principles guide clinicians to match patients to procedures based on their coping style. Externalizers tend to benefit more from skill-building exercises and systematic feedback designed to reduce their avoidance of blame and responsibility and decrease their impulsivity and aggression. Internalizers benefit from insight and awareness methods that identify and activate the emotions being avoided and that expose

them to social environments previously shunned or endured.

A third consideration is patient resistance level. Highly resistant patients tend to respond better to methods and techniques that are low in the therapist's use of directiveness and are presented as suggestions. Highly resistant patients do best in the context of methods that are evocative and self-directed and that generate in the patient a sense of autonomy and self-reliance. If such straightforward, first-order change strategies are not sufficient to catalyze the necessary or desired changes, then therapists are encouraged to use paradoxical or second-order change strategies. These interventions may take the form of, for example, prescribing the symptoms or reframing the lack of progress as lack of readiness to change.

Patients who are low in resistance tend to benefit more from guidance, assignments, and interpretations. Therapists may resort to structured homework including self-monitoring and direct suggestions that redress presenting complaints. They may also use traditional cognitive-behavioral methods such as cognitive attributional analyses, activity scheduling, and evidence gathering and analysis. Other techniques may include interpersonal analysis, experiential work facilitating emotional awareness, and voice therapy (Firestone, 1988).

A final dimension for consideration is patient's distress or emotional intensity. Practitioners assess and monitor patient distress, as its degree is an active index of motivation. The quality of patients' emotions is also likely to not only modulate treatment but also be part of the treatment's process, goals, and objectives. Practitioners can use a range of methods to modulate the patient's level of distress and emotional intensity. And while clinicians strive for an optimal, overall moderate level, they seek to facilitate some peak, in-session experiences of both intense arousal and relaxation. The techniques used with apathetic patients, for example, seek to bring motivation and engagement through confrontation, abreaction, and cognitive dissonance. The techniques used with highly distressed patients seek to bring support, structure, and relaxation through cathartic methods, cog-

nitive voice work, and cognitive-behavioral procedures (Beutler & Harwood, 2000).

Of course, treatment methods do not exist beyond the practitioners that use them, and patients are more than diagnoses and character traits. It is as important to know the patient who has a given disorder as it is to know the disorder the patient has. Therefore, the effectiveness of treatment is predicated on therapist skills to adapt treatment to the most salient patient dimensions beyond diagnosis. Though methods are important, even more important is the systematic selection of those interventions that are most likely to make a difference for a given patient.

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### CASE EXAMPLE

H. G. was a 45-year-old, married male who voluntarily participated in a research study on the treatment of comorbid stimulant abuse and depression. He reported that he had been a poly-drug abuser off and on for nearly 25 years. His preferred drug was heroin, but he also abused cocaine, methamphetamines, alcohol, as well as various "downers." He had been through rehabilitation several times, and on one occasion had remained drug-free for 5 years. At the time he was referred, he was using heroine and cocaine on a weekly basis, as well as engaging in daily marijuana use. He was recently unemployed and was trying to support himself and his family (one child) as a telephone solicitor. His work had been negatively affected by frequent absenteeism; finally, he had been terminated because of drug use at work. His wife vowed support for him but no longer trusted that he would be able to take care of the family or that he would stay chemical-free as he promised.

In the initial assessment, the patient presented a chaotic family history in which both parents were alcoholic and frequent drug users. The patient began drug use at age 13 under the tutelage of his older brother who supplied him with marijuana and heroin for the next 4 years until he was arrested for the first time for possession.

Assessment with the STS computer-based system (Harwood & Williams, 2003) revealed the

patient to have chronic problems, to have both a polysubstance abuse disorder and major depression, and to have a probable personality disorder. Thus, problem complexity and chronicity were both high.

Likewise, functional impairment was high, with impaired work, social, and intimate functioning. At the same time, but somewhat surprisingly, H. G. felt social support was moderate, with the patient placing much reliance on the support of his wife and one other friend. Collectively, the patient's status on dimensions of chronicity, complexity, impairment, and social support suggested that treatment should be intense. Inpatient care was considered but rejected because of insurance coverage. Though the patient was depressed, there were no indicators of current suicidality. This finding generally supported outpatient care. A program of daily contact and three times per week treatment sessions, occasionally supplemented by collateral treatment with his wife was initiated. Weekly blood tests for drugs complemented this work.

Assessment indicated that H. G. had a relatively strong externalizing/impulsive tendency, was moderately resistant to external control, and operated at a high level of subjective distress. Given these factors, the treatment targeted symptom change and interpersonal skill development, especially in the area of impulse control. The patient's resistance level required that strong assertions and control on the part of the therapist and the patient's family be avoided. We emphasized self-control and were willing to compromise therapist goals in the face of the patient's need to maintain a sense of control and direction.

Accordingly, the initial treatment focus was on achieving symptomatic change in drug use. Little emphasis was placed on insight, given his impulsive and externalizing coping style. Thus, daily monitoring, assisted by the patient's wife, provided the degree of oversight needed to help him transition off of drug use. His preferences for outpatient care and self-monitored drug withdrawal were accepted in order to fit the treatment to the patient's resistance. However, a contingency plan of involuntary hospitalization was presented in the event that these initial self-care efforts were not successful. This was presented paradoxically, as a fall-back position that would be employed if

the patient demonstrated that he could not control his impulses. We anticipated that this presentation might strengthen his resolve to be self-controlling.

Finally, the patient was provided, within treatment sessions, with training in anxiety and impulse control. Cognitive and self-monitoring skills were the focus of training and homework assignments. Of special note, we encouraged the development of social contacts, including ALANON, as ways of improving social support and facilitating monitoring. H. G. selected ALANON from among a list of potential social reference and support groups provided by the therapist, again trying to work with, rather than against, the patient's resistance tendencies. Thus, homework assignments encouraged monitoring of abstinence, urges, effective cognitive and behavioral coping strategies, increased social activities, job-seeking behaviors, and support seeking from his wife.

Treatment proceeded for an initial 4-month period, the initial contracted treatment length, and then was renewed for another 6 months. Initially, the patient frequently came to appointments late or did not show. Telephone contact was made to encourage attendance, and eventually a program that required him to call each morning was instituted to ensure his continuing focus. With this program, drug use began to decline under the initial suggestion that he monitor urges and attempt only to delay use. As he gained some control in delaying gratification, the task of withdrawal was instituted in collaboration of a physician of his choice. Drug withdrawal was complete by the end of the third month and he remained substance-free through the duration of the treatment and a 6-month, planned follow-up period.

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## EMPIRICAL RESEARCH

Research on STS principles has been in two fundamental areas. The first area has addressed the matching of patients and therapists; the second area has emphasized matching of patients to therapeutic procedures.

Research on patient-therapist matching has emphasized the roles of similarities and dissim-

ilarities in belief and value systems. Two related programs of investigation have been undertaken in this regard. The first applies to similarities and dissimilarities between the belief systems of patients and therapists. The second applies to the acceptability of belief systems, a concept that is only indirectly associated with similarity. Both of these lines of research rely in part on the demonstration that effective psychotherapy is accompanied by attitudinal convergence between the two participants. This latter point of view is supported by a large number of research studies that have used a wide variety of personality, attitudinal, and value concepts (cf., reviews by Beutler, 1981; Kelly, 1990; Tjelveit, 1986).

Our investigations have confirmed the observation that initial (pretreatment) patient-therapist dissimilarity on attitudinal value dimensions is positively associated with productive therapeutic processes (Beutler, 1971; Beutler, Arizmendi, Crago, Shanfield, & Hagan, 1983). Its relation to therapy outcome is more complex and difficult to assess. Attitudinal acceptability must be considered along with the dimension of attitude similarity in order to understand therapeutic improvement. In our investigations of this issue, for example, we (Beutler, 1971; Beutler, Jobe, & Elkins, 1974; Beutler, 1979) determined that if the therapist's attitudes were acceptable to the patient, the patient was more likely to adopt the therapist's belief systems about sex, authority, and discipline. Not surprisingly, we also discovered that if the therapist's latitudes of acceptance were broad enough to encompass the patients' preferred viewpoints, therapeutic process and outcome were facilitated even if the patient found the therapist's preferred viewpoint unacceptable.

Initial dissimilarity in values between patient and therapist, accompanied by a subsequent convergence of therapist and patient values, tends to predict later patient improvement (Beutler, Arizmendi, Crago, Shanfield, & Hagan, 1983). This notion, that the eventual adoption of the therapist's values throughout therapy can partially explain therapy outcome seems a given at this point, given the weight of the empirical evidence (Beutler & Bergan,

1991; Beutler, Arizmendi, Crago, Shanfield & Hagan, 1983; Talley, Strupp, & Morey, 1990). However, there needs to be further sophistication and much more specificity in this area before treatment outcomes can be significantly enhanced by the systematic matching of patient to therapist (Beutler & Bergan, 1991).

A growing number of studies have been devoted to matching specific therapeutic technologies with patient dimensions (Shoham-Salomon, 1991). There have been some earlier large-scale attempts to match certain theoretically driven patient dimensions with broad therapeutic techniques, such as the Project MATCH study and the National Institutes of Mental Health Treatment of Depression Collaborative Research Program, which in combination studied literally thousands of patients. But in these, like many studies in this area, the so-called Dodo Bird effect reigned supreme (i.e., the application of manualized treatments appeared to produce equivalent effects). This appears to be true for manualized psychotherapies, as well as drug therapy; this effect holds even when drug therapy and psychotherapy are compared against each other (Antonuccio, Danton, & DeNelsky, 1995; Elkin et al., 1989; McLean & Taylor, 1992).

However, when one looks closer at the results of Elkin et al. (1989), we see that high levels of functional impairment predicted more positive response to a combined trial of psychotherapy (specifically interpersonal therapy) and antidepressants, whereas low functional impairment tended to contraindicate the use of medications. Even with its larger scale failure to confirm their larger hypotheses regarding the matching of broad treatments (e.g., different medications, different manualized therapy models, etc.) to certain patient groups, Project MATCH (Project Match Research Group, 1997) did find limited support for at least one matching dimension: patients high in anger, which is a precursor to resistance, responded best to therapy that tended to avoid confrontation and emphasized self-control.

Work by our group on the STS dimensions extracted have produced stronger yields, likely because our research tends to go beyond gen-

eral models of treatment and instead focuses on what therapists actually do in-session with clients.

Karno, Beutler, & Harwood (2002) studied alcohol abuse treatment employing family-systems and cognitive-behavioral therapy (CBT). In terms of the straightforward comparisons between therapies and their effects on outcome, it was found yet again that the two therapies produced equivalent effects. However, built into the study were a number of hypotheses relating to coping style, reactance levels, and subjective distress and their relationships to specific aspects of treatment. It was found that high emotional distress predicted better response when the therapy addressed emotional experience and vice versa. Likewise, patients high in reactance tended to do better when therapy was less directive and vice versa. These results highlight the deficiencies of focusing on simply comparing broad treatments to one another rather than focusing on proximal and relevant patient dimensions and their interaction with treatment features.

Research is turning increasingly to specific procedures rather than broad models and to treatment fit rather than searching for a single treatment that is uniformly effective. The history of our own research illustrates this movement and change over time.

There have been a number of foundational studies, at least seven total (Beutler & Mitchell, 1981; Calvert, Buetler, & Crago, 1988; Beutler, Engle, Mohr et al., 1991; Beutler, Mohr, Grawe, Engle, & MacDonald, 1991; Karno, Beutler, & Harwood, 2002; Beutler, Clarkin, & Bongar, 2000; Beutler, Moleiro, et al., 2003) that have provided support for the predictive utility of patient coping style and resistance potential as well-established predictors of differential response to various psychotherapy procedures. These studies have demonstrated significant patient characteristic by treatment interaction effects, one of which comprised a cross-validation on an international sample (Beutler, Mohr, Grawe, et al., 1991). Two of these studies (Beutler & Mitchell, 1981; Calvert, Beutler, & Crago, 1988) used naturalistic designs and heterogeneous outpatient samples.

These studies provided the foundation for a larger and more tightly controlled randomized clinical trial on patients with major depressive disorder to which most of our attention here will be devoted.

A seminal study for the development of the STS system (Beutler, Engle, Mohr, et al., 1991) used three manualized treatments designed to vary along two dimensions: The first dimension was insight focused (focused expressive psychotherapy [FEP] and supportive, self-directed procedures, or S/SD) to symptom focused (cognitive therapy, or CT). The second dimension was directive (FEP and CT) to non-directive (S/SD).

The differences in outcomes among the three therapy conditions (group cognitive therapy, focused expressive psychotherapy, and supportive self-directed therapy) were relatively small. Variables denoting the fit of treatment to patient were more important predictors of outcome than the treatment model. The persistently small or negligible differences in outcomes among treatment models raise serious questions about the value of inspecting treatment outcomes solely through the models and theories used without making reference to client mediators of treatment.

When outcome was looked at as a function of patient coping style, broadly identifiable themes emerged. Among patients assigned to CT, treatment outcomes were greater among patients whose initial MMPI configurations consisted of high scores in sociopathic and impulsive indices (externalization) as compared to those whose scores indicated fewer of these qualities. Conversely, among patients seen in the two insight-oriented treatments (FEP, S/SD), the reverse was true. Though mean outcomes for this latter group were nearly identical to those in CT, it was those whose MMPI indicators of externalizing patterns were relatively low who experienced the greatest amounts of symptom reduction.

The results also indicated that patients who were initially assessed to have high levels of anxious defensiveness (high reactance potential) did better when assigned to the nondirective treatment (S/SD) than when assigned to

either of the other, directive treatments. Conversely, those with low levels of initial defensiveness, as assessed at intake, performed comparably and well when assigned to the two treatments, which employed a relatively frequent amount of therapist directives (Beutler, Engle, Mohr et al., 1991).

The patterns of results for both patient variables and both types of treatment were subsequently cross-validated in a subsequent study, which used several different measures of coping style and resistance potential. In this study, a sample of anxious and depressed patients from the Bern (Switzerland) Psychotherapy Research program (Beutler, Mohr, Grawe, Engle, & MacDonald, 1991) was studied using a randomized clinical trial design. Coping style significantly predicted the differential value of symptom focused (behavior therapy) and insight focused (client-centered therapy) interventions. Likewise, resistance potential was differentially predictive of the use of these directive and nondirective procedures.

Karno, Beutler, & Harwood (2002) replicated the above studies by conducting a randomized clinical trial wherein they pitted cognitive therapy (CT) and family therapy (FT) against each other in their sample of alcoholic clients. STS dimensions of the clients were assessed, and the expectation again was that patient coping style and level of distress would interact with the level of directiveness and the level of emotional focus.

However, this particular study took the previous results to an additional level. As opposed to looking at techniques broadly classified as "directive" and "nondirective," Karno, Beutler, & Harwood (2002) applied a fine-grained analysis of process variables across both therapies as they were being conducted, using the Therapy Process Rating Scale (TPRS). The TPRS analyzes the therapy process according to relevant STS dimensions, including (1) the extent to which the therapist is attempting to increase or decrease emotional arousal, (2) the extent to which the therapist is focusing on insight- or behavior-oriented change, and (3) the extent to which therapy is directive or nondirective (Fisher, Karno, Sandowicz, Albanese & Beu-

tlar, 1995). Each of these dimensions were thought to interact with patient dimensions such as problem severity, subjective distress, and client coping style.

This latter study found limited main effects of treatment (namely, CT was found to be generally superior to FT, an unexpected result not generally seen in the literature), and no interactions between patient attributes and therapy effectiveness. However, the interactions between process variables and therapy techniques was striking: patients assessed as being high in reactance improved more when therapy was nondirective, and those low in reactance responded the best with nondirective therapy techniques. Similar results were found regarding emotional distress levels within session: patients with high emotional distress appeared to respond best to emotion-focused techniques, whereas patients low in emotional distress displayed the opposite pattern.

Beutler, Moleiro, Malik et al. (2003) constructed an even more fine-grained study of therapy–client matching within the context of a pilot test conducted within a larger randomized clinical trial. Forty stimulant-dependent, comorbidly depressed patients were offered either CT, narrative therapy (NT), or prescriptive therapy (PT). The choice of CT and NT were made deliberately as they were thought to be the most in contrast to each other in terms of therapy process variables (such as focus, directiveness, and level of arousal). The data were subjected to hierarchical multiple regression, considered superior to the typical analyses conducted in randomized clinical trials. In spite of the small sample size, results indicated that although all psychotherapies appeared to exert similarly powerful effects, STS-based PT produced significantly superior outcomes.

The application of STS principles in therapy has successfully been extended to such diverse clientele as psychotherapy clients with clinical depression in adults and older adults (Beutler, Clarkin, & Bongar, 2000), and to those who are dually diagnosed (Beutler, Moleiro, Malik et al., 2003). Research has progressed to the point where it has successfully been extended to the treatment of couples

where alcoholism is a problem with one of the members (Beutler & Harwood, 2000).

In the latter case, the Couples Alcoholism Treatment (CAT) project was designed to test the collective contributions of several matching dimensions discussed in this chapter. Two manualized therapies were employed, namely, cognitive therapy (CT; Wakefield, Williams, Yost, & Patterson, 1996) and family systems therapy (FST; Rohrbaugh, Shoham, Spungen, & Steinglass, 1995). Both therapies were designed to contrast as much as possible in terms of therapy process dimensions. Namely, CT focused on symptoms, whereas FST focused on systems. Also, CT was designed to be therapist directed, whereas FST was designed to be patient directed. By chance, our therapies differed in intensity as well (i.e., FST tended to take more sessions than CT).

Because this was a project focused on substance abuse treatment, outcome measures were focused on providing indicators of continued alcohol consumption or substance use. Outcome data was modeled using growth curve procedures, which revealed a steady, expected decline of symptoms throughout treatment, independent of treatment type or level of fit between patient and treatment qualities. Indicated at the 6-month follow-up interview, three of the four matching dimensions proved to be related to desirable changes in alcohol usage. Mismatch on the following dimensions tended to lead to the worst outcomes. Specifically, patients with high functional impairment had improved outcome as therapy intensity was increased (which was operationalized as the amount of actual therapy time it took to complete 20 weeks of treatment). Patients high in resistance reduced their alcohol intake to a greater degree when therapy was nondirective, whereas patients low in resistance reduced their alcohol intake to the greatest degree when therapy was directive. Also, patients with low levels of distress treated with emotional activating procedures and those whose high level of distress was treated with emotional reduction procedures were more likely to benefit.

Collective analysis of the contribution of the matching dimensions alone accounted for 76% of abstinence outcome. Therapist direc-

tiveness and low levels of patient impairment were also positive predictors of patient change, independent of their fit with corresponding patient qualities. However, when these two independent variables were added to the analysis, they accounted for an impressive 82% of unique variance contributing to drinking outcomes.

Regarding treatment guidelines, Beutler, Clarkin, and Bongar (2000) describe guidelines as following a series of steps, which generally are in the order (1) identification and measurement of prognostic indicators, (2) assigning the context of treatment, and (3) managing risk. None of these steps can possibly be followed properly by a therapist without thorough, ongoing assessment of the client. Below, we summarize the findings extracted from the STS literature and cross-validated with 284 patients, who consisted of males and females ranging from ages 17 to 79 and who presented with a variety of problems and a range of functional impairment levels. These patients were given a variety of treatments that varied in context, intensity, format, and modality. All subjects were assessed via process ratings that coded subjects by treatment intensity. Relevant STS dimensions were assessed in all subjects via standardized tests (e.g., EPI, MCMI, MMPI).

First, regarding prognosis: The likelihood of clinical improvement in a given patient was found to be positively related to social support and negatively related to functional impairment. Clinical improvement was less likely as problem complexity/chronicity increases and also as subjective distress decreases.

Second, regarding treatment context: Medication was found to be best applied to patients high in functional impairment and high in problem complexity/chronicity. High complexity/chronicity was best matched with treatment contexts involving multiple persons (e.g., family therapy, group therapy, or couples therapy). Also, the greater the level of functional impairment in a given patient, the greater the corresponding treatment intensity required to induce change.

Third, regarding risk management: Treatment necessitates the assessment of high-risk situations in the context of diagnosis and clinical history. This speaks to the basic duty of a

therapist to have concrete plans in place to manage (as an example) suicidal risk in depressed patients.

Risk is reduced (and patient compliance increased) if treatment context includes family members. Risk is also reduced if patients are fully informed about their treatment (such as probable duration, costs and benefits, and probable length of treatment) and are routinely questioned about suicidal feelings, intent, and plans. Finally, ample documentation and consultation with at least one other professional throughout the course of treatment is a mainstay of reasonable and basic risk-management practice, as well as being highly advisable from a legal and ethical perspective.

## FUTURE DIRECTIONS

The most pressing needs in STS, as in psychotherapy generally, are the validation of therapeutic efficacy and the delineation of the processes that portend therapeutic changes. The past 7 years have seen a substantial increase in the number of empirical studies on therapy-patient-therapist matching. Yet, much needs to be done in extracting, from the hundreds of variables that have been touted as matching dimensions, those that do serve as indicators and contraindicators. Our own research has successfully moved from correlational demonstrations of the efficacy of various matching dimensions to prospective studies. Work is needed to operationalize concepts of problem complexity and severity, as well as further work on developing measures for assessing reactance, coping style, and motivational distress.

STS suggests that the concepts of treatment matching should generalize across diagnostic groups. However, no research is currently available to support this contention. Hence, research is sorely needed to see how well the relationships that have been observed between coping style and level of focus and between reactance level and directiveness translate from major depression and general anxiety symptoms to other diagnostic groups. At this point, it is still not certain whether all patients or disorders can efficaciously be matched with spe-

cific therapy procedures. Systematic research is needed in order to determine if the procedures currently available are sufficiently broad and flexible to encompass most patient patterns.

There is also the question of what to do to enhance outcome when therapist and patient are incompatible and referral is not possible. Are there behaviors and methods that will help the therapist to enhance the quality of therapeutic contacts in those cases where patients and therapists cannot suitably be matched?

Finally, a great deal of research is still needed on training effective therapists. The questions of whether one can become equally or minimally proficient in employing the variety of therapeutic strategies proposed by the STS is yet to be answered. Of equal concern is the question of the degree to which proficiency-based training enhances therapeutic outcome. Chiefly, what are the methods that will best teach therapists to apply therapeutic procedures in ways that include both common and specific variables that enhance outcome? Similarly, much work is needed to specify the relevant components of therapists' cultural competence as well as the value of culturally congruent interventions (Sue, 1998).

Beyond these research questions, it is expected that the future will see a continuation of interest among therapists in the clinical application of eclectic methods. As research questions are addressed, the methods for assisting clinicians directly in developing effective treatment plans are likely to become available. Ultimately, if any eclectic approaches to psychotherapy prove to be more beneficial than the theories they attempt to integrate, they must stand the empirical as well as the clinical test. The concepts derived must be useful to the clinician, verifiable to the scientist, acceptable to a diversity of practitioners, and relevant to a pluralistic society.

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## *C. Theoretical Integration*

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## The Transtheoretical Approach

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Impetus for the transtheoretical approach came from several different sources. First and foremost was a discontent with the state of affairs in psychotherapy theory, research, and practice. The narrowness and frequent dogmatism of the proponents of many therapies and the consistent research findings of few differences in outcome between therapy systems encouraged a search for alternatives. Each therapy system focused more on theories of psychopathology and single mechanisms of change than on an exploration of the process of change. Positive regard, authenticity, living in the here and now, confrontation of beliefs, social interest, conditioning, and contingencies are valuable rules for human functioning but are not sufficient to explain psychotherapy change.

In 1977 Prochaska, with the help of his graduate students, embarked on a journey through the various systems of therapy to seek the commonalities across the rigid boundaries of the most popular theories of psychotherapy. *Systems of Psychotherapy: A Transtheoretical*

*Analysis* (Prochaska & Norcross, 2002) represents the culmination of this journey. The map used for the journey indicated that theories of psychotherapy can be summarized by 10 separate processes of change. Although the framework used in this analysis appeared to have face validity, it remained a theoretical construct with no empirical basis. Since that initial work, we and a number of collaborators applied The Transtheoretical Model, expanded its scope, and explored its limitations in studies of intentional change, surveys of practitioners and patients, and in the creation of assessment instruments. This research supported our model and encouraged us to continue the development of what we have called *The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy* (1984). As our applications expanded beyond office-based psychotherapy of psychiatric disorders in individuals to a proactive treatment of health problems in entire populations, we have expanded the model. *Changing for Good* (Prochaska, Norcross, & DiClemente, 1994) is an apt title for helping



individuals and populations progress across the stages of change.

A final impetus for our work was found in the *zeitgeist* among psychotherapy practitioners and theorists. We heard clearly the pleas of the participants of those who called for a more integrated and comprehensive approach to psychotherapy. Needed was an approach that would take into account the differences in the experiences of therapists and clients. Moreover, in our thinking, an integrative approach should be able to account for how individuals change on their own (unaided by psychotherapy) as well as how individuals change as the result of psychotherapy.

## TRANSTHEORETICAL APPROACH

The proliferation of psychotherapy systems reflects the complex, interactive nature of psychotherapy. The daily dilemma facing the clinician is what to do, when, with whom, in what way, with which problem. Both in the research literature and in clinical experience, it has become clear that no one system of therapy addresses adequately all these questions.

From our perspective, an integrative perspective will accomplish the following goals:

1. Preserve the valuable insights of major systems of psychotherapy. Trying to reduce all therapy systems to their least common denominator removes their richness.
2. Provide some practical answers to the questions faced by clinicians. However theoretically elegant it might be, an impractical, overly simplistic, or irrelevant integration will never be adopted.
3. Bring some order to the chaotic diversity in the field of psychotherapy. But merely throwing an assorted collection of techniques into the toy box will only hide the chaos.
4. Offer a researchable alternative to single system and comparative types of research. Explanation without experimentation will not silence the critics of both integration and psychotherapy.
5. Generate a systematic approach: a structure or set of principles and constructs that are comprehensive enough to include the crucial dimensions of psychotherapy and, at the same time, that are adequately flexible to promote collaboration, creativity, and choice.

The transtheoretical approach attempts to meet these goals by means of four crucial dimensions: the processes of change, the stages of change, the pros and cons of change, and the levels of change. Below we review these four dimensions and their crucial interconnections.

## Processes of Change

An analysis of the 24 most popular theories of psychotherapy (Prochaska & DiClemente, 1979) yielded the first of the four basic dimensions of the transtheoretical approach: the processes of change. Transtheoretical therapy began with the assumption that integration across a diversity of therapy systems most likely would occur at an intermediate level of analysis, between theory and techniques. Coincidentally, Goldfried (1980, 1982) in his well-known call for a rapprochement, independently suggested that the principles of change were the appropriate starting point at which rapprochement could begin.

The processes of change, then, may best be understood as a middle level of abstraction between the basic theoretical assumptions of a system of psychotherapy and the techniques proposed by the theory. A process of change represents types of activity initiated or experienced by an individual in modifying thinking, behavior, or affect related to a particular problem. Although there are a large number of coping activities, there appear to be a finite set of processes that represent the basic change principles underlying coping activities. In a similar manner, techniques of therapy can be analyzed to see which type of process they would draw upon or promote. Thus, confrontation by the therapist would provide new information, challenge current thinking about the problem, and offer feedback. All these therapist activities

would enable the individual to engage in more accurate information processing. From a transtheoretical perspective, these activities represent the process of change named consciousness raising.

Subsequent modifications of our original formulation through research yielded 10 distinct processes of change: (1) Consciousness Raising; (2) Self-Liberation; (3) Social Liberation; (4) Counterconditioning; (5) Stimulus Control; (6) Self-Reevaluation; (7) Environmental Reevaluation; (8) Contingency Management; (9) Helping Relationships; (10) Dramatic Relief.

Our studies indicate that people in the natural environment generally use these 10 different processes of change to modify problem behaviors. Most major systems of therapy, however, theoretically employ only two or three processes (Prochaska & Norcross, 2002). One of the assumptions of the transtheoretical approach is that therapists should be at least as cognitively complex as their clients. They should be able to think in terms of a more comprehensive set of processes and be able to apply techniques to engage each process when appropriate.

## Stages of Change

A second basic element of the transtheoretical approach is the stages of change, which reflect the temporal and intentional aspects of change. Intentional change is not an all or none phenomenon, but a gradual movement through specific stages (cf. Beitman, 1987; Egan, 1986). Lack of awareness of the stages led some theories of therapy to assume that all clients presenting for therapy are in the same stage of change and are ready for the same change processes.

Studies of various outpatient populations (McConaughy, DiClemente, Prochaska, & Velicer, 1989; McConaughy, Prochaska, & Velicer, 1983; DiClemente & Hughes, 1990; Carbonari & DiClemente, 2000) have found a variety of profiles on the Stages of Change Scale. Clearly, all individuals who come to therapy are not at the same stage of change. We have been able to identify five basic stages of change:

precontemplation, contemplation, preparation, action, and maintenance.

A stage of change represents both a period of time and a set of tasks needed for movement to the next stage. Though the time spent in each stage may vary, the tasks to be accomplished in order to achieve successful movement to the next stage are assumed to be invariant. In the move from precontemplation to contemplation, an individual must become aware of the problem, make some admission or take ownership of the problem, confront defenses and habitual aspects of the problem that make it difficult to control, and see some of the negative aspects of the problem in order to move to the next stage of seriously contemplating change.

One of the most helpful findings to emerge from our research is that particular processes of change are emphasized during particular stages of change (Prochaska & DiClemente, 1983). The integration of stages and processes of change can serve as an important guide for therapists. Once a client's stage of change is clear, the therapist would know which processes to apply in order to help the client progress to the next stage of change. Rather than apply change processes in a haphazard or trial-and-error approach, integrative therapists can begin to use change processes much more systematically.

Table 7.1 presents a diagram showing the integration that was revealed from our exploration of the stages and processes of change (Prochaska & DiClemente, 1983; DiClemente, 2003). During precontemplation, individuals use change processes significantly less than people in any other stage. Precontemplators process less information about their problems; spend less time and energy reevaluating themselves; experience fewer emotional reactions to the negative aspects of their problems; are less open with significant others about their problems; and do little to shift their attention or their environment in the direction of overcoming their problems. In therapy these are clients who are labeled resistant.

What can help assist people from precontemplation to contemplation? Table 7.1 suggests several change processes are most helpful.

TABLE 7.1 Processes of Change Emphasized at Particular Stages of Change

Precontemplation	Contemplation	Preparation	Action	Maintenance
Consciousness Raising Dramatic Relief Environmental Reevaluation	Self-Reevaluation	Self-Liberation	Contingency Management Counterconditioning Stimulus Control	

First, *consciousness-raising* interventions, such as observations, confrontations and interpretations, can help clients become more aware of the causes, consequences, and cures of their problems. To move to the contemplation stage, clients have to become more aware of the negative consequences of their behavior. Often, we have to help clients become more aware of their defenses before they can become more conscious of what they are defending against. Second, the process of *dramatic relief* provides clients with helpful affective experiences (e.g., psychodrama or the Gestalt empty chair), which can raise emotions related to problem behaviors. Life events, such as the disease or death of a friend or lover, can also move precontemplators emotionally.

As clients become increasingly more aware of themselves and the nature of their problems, they are freer to reevaluate themselves both affectively and cognitively. The *self-reevaluation* process includes an assessment of which values clients will try to actualize and which they will let die. The more central problems are to their core values, the more will their reevaluation involve changes in their sense of self. Contemplators also use *environmental reevaluation* to reevaluate the effects their behaviors have on their environments, especially the people they care most about. Addicted individuals, for example, may ask, “How do I think and feel about living in a deteriorating environment that places me and my family in increasing risk of disease, death, poverty and/or imprisonment?”

Movement from precontemplation to contemplation, and movement through the con-

templation stage, involves increased use of cognitive, affective, and evaluative processes of change. To better prepare individuals for action, changes are required in how people think and feel about their problem behaviors and how they value their problematic lifestyles.

Preparation indicates a readiness to change in the near future and acquisition of valuable lessons from past change attempts and failures. They are on the verge of taking action and need to set goals and priorities accordingly. They often develop an action plan for how they are going to proceed. In addition, they need to make firm commitments to follow through on the action option they choose. In fact, they are often already engaged in processes that would increase self-regulation and initiate behavior change (DiClemente et al., 1991). People typically begin by taking some small steps toward action.

During the action stage, it is important that clients act from a sense of *self-liberation*. They need to believe that they have the autonomy to change their lives in key ways. Yet, they also need to accept that coercive forces are as much a part of life as is autonomy. Self-liberation is based in part on a sense of self-efficacy (Bandura, 1977, 1982), the belief that one’s own efforts play a crucial role in succeeding in the face of difficult situations.

Self-liberation, however, requires more than just an affective and cognitive foundation. Clients must also be effective enough with behavioral processes, such as *counterconditioning* and *stimulus control*, to cope with those external circumstances that can coerce them into relapsing. Therapists can provide training, if

necessary, in behavioral processes to increase the probability that clients will be successful when they do take action.

Just as preparation for action is essential for success, so too is preparation for maintenance. Successful maintenance builds on each of the change processes that has come before and also involves an open assessment of the conditions under which a person is likely to be coerced into relapsing. Clients need to assess the alternatives they have for coping with such coercive conditions without resorting to self-defeating defenses and pathological responses. Perhaps most important is the sense that one is becoming more of the kind of person one wants to be. Continuing to apply counterconditioning and stimulus control is most effective when it is based on the conviction that maintaining change maintains a sense of self that is highly valued by oneself and at least one significant other.

### Pros and Cons of Changing

A third basic element of the transtheoretical model is the pros and cons of changing, which represent the decisional and motivational aspects of change. Our original work on the pros and cons of changing was inspired by Janis and Mann's (1977) model of decision-making. Janis and Mann identified from interviews four types of pros or benefits of decisions: instrumental benefits to self, instrumental benefits to others, approval from self, and approval from others. They also identified four types of cons or costs: instrumental costs to self, instrumental costs to others, disapproval from self, and disapproval from others.

In our work with quantitative questionnaires, we always included items to represent each of these eight constructs. Principle components analyses consistently demonstrated that decision-making could be reduced to two core constructs: the Pros and Cons of changing (Velicer, DiClemente, Prochaska, & Brandenburg, 1985). When weighing important life changes, people do not differentiate benefits to self from those for others nor do they clearly differentiate instrumental benefits from affective or evaluative.

They do clearly differentiate the pros from the cons.

Most importantly, there are clear and consistent relationships between the stages of change and the pros and cons of changing across all types of problems. Hall and Rossi (2003) performed a meta-analysis of the relationships of pros and cons and stages of change across 43 behaviors in more than 60,000 people from 9 nations with 7 languages. The problem behaviors included depression, stress, anorexia, alcohol abuse, heroin addiction, cocaine abuse, obesity, smoking, partner abuse, and more. Figure 7.1 demonstrates how clear integration can be even in the face of so many differences.

Across 43 behaviors, the cons of changing outweigh the pros by .7 standard deviations (*SD*) for people in precontemplation. The opposite is true for people in maintenance where the pros of changing are .7 *SD* higher than the cons. The pros of changing are clearly higher in contemplation than in precontemplation. Here the pros and cons are equal, reflecting the profound ambivalence that characterizes the contemplation stage. The pros and cons cross over for people in the preparation stage who are more convinced that the huge efforts needed during the action stage are likely to be worth it. The further along people are in the stages, the more convinced they are that the struggles to change are worthwhile.

Let's briefly apply these change dynamics to people's decision to participate in treatment. We need to keep in mind that the weighing of the pros and cons of changing is not fully conscious or rational. The clear patterns in Figure 7.1 only emerge if standardized scores rather than raw scores are used. If raw scores were used, the pros of changing would outweigh the cons at each stage. It is much easier for people to endorse the pros of getting free from depression, addiction, anorexia, or partner abuse than it is to enhance the cons.

Imagine clients in the precontemplation stage who are prescribed psychotherapy or medication for depression. Their cons of treatment would clearly outweigh the pros. So if they started treatment, they would likely be among the 40% to 50% who would discontinue treatment quickly and prematurely. This

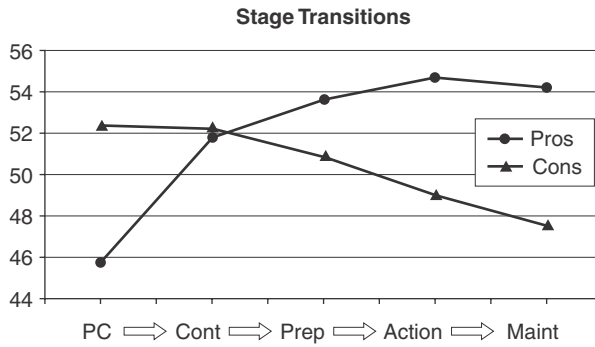


FIGURE 7.1 Integration of Pros and Cons by Stages of Change Across 43 Behaviors

is exactly what we found in predicting more than 90% of premature termination from psychotherapy: those in precontemplation were highly likely to discontinue. Those in the action stage were likely to finish therapy quickly but appropriately, as judged by their therapists (Brogan, Prochaska, & Prochaska, 1999).

Faced with clients who recently took action by quitting an addiction, the clinical plan for most clinicians would be relapse prevention. But would relapse prevention be appropriate for patients in precontemplation? Here, our clinical plan would be dropout prevention. Fortunately, there are a growing number of studies that indicate that by matching processes of change to stage of change, patients in precontemplation can complete a treatment program at the same high rates as those in preparation (e.g., Prochaska, Velicer, Fava, Rossi, & Tsoh, 2001; Prochaska, DiClemente, Velicer, & Rossi, 1993; Prochaska et al., 2001).

### Levels of Change

At this point in our analysis, it appears that we are discussing only how to approach a single, well-defined problem. However, as all of us realize, reality is not so accommodating, and human behavior change is not so simple. Although we can isolate certain symptoms and syndromes, these occur in the context of complex, interrelated levels of human functioning. The fourth element of the transtheoretical approach addresses this issue. The Levels of Change represents a hierarchical organization of five distinct but interrelated levels of psychological problems that can be addressed in psychotherapy:

resents a hierarchical organization of five distinct but interrelated levels of psychological problems that can be addressed in psychotherapy:

- Symptom/Situational Problems
- Maladaptive Cognitions
- Current Interpersonal Conflicts
- Family/Systems Conflicts
- Intrapersonal Conflicts.

Historically, systems of psychotherapy have attributed psychological problems primarily to one or two levels and focused their interventions on these levels. Behavior therapists have focused on the symptom and situational determinants; cognitive therapists on maladaptive cognitions; family therapists on the family/systems level; and analytic therapists on intrapersonal conflicts. It is crucial to us that both therapists and clients agree as to which level they attribute the problem and at which level or levels they are willing to target as they work to change the problem behavior.

In the transtheoretical approach, we prefer to intervene initially at the symptom/situational level because change tends to occur more quickly at this level, which often represents the primary reason for which the individual entered therapy. The farther down the hierarchy we focus, the farther removed from awareness are the determinants of the problem, and the more historically remote and more interrelated the problem is with the sense of self. Thus, we



Each system of psychotherapy has distinctive strengths within the transtheoretical model. Table 7.3 illustrates where leading systems of therapy fit best within the integrative framework of the transtheoretical approach. The therapy systems included in Table 7.3 have been the most prominent contributors to the transtheoretical approach. Depending on which level and at which stage we are working, different therapy systems will play a more or less prominent role. Behavior therapy, for example, has developed specific interventions at the symptom/situational level for clients who are ready for action. At the maladaptive cognition level, however, Ellis’s rational-emotive therapy and Beck’s cognitive therapy are most prominent for clients in the contemplation and action stages.

By definition, we have not excluded any therapy systems from the transtheoretical approach. Our approach is an open framework that allows for integration of new and innovative interventions, as well as the inclusion of existing therapy systems that either research or clinical experience suggest are most helpful for clients in particular stages at particular levels of change.

**ASSESSMENT AND FORMULATION**

Accurate assessments of the clients’ stage, level, and processes of change are crucial to the transtheoretical approach. Therapy would be

most effective if patient and therapist were matched and working at the same stage and level of change. The joining of the patient and therapist is centered around the structure and process of intentional change. The therapist’s role is one of maximizing self-change efforts by facilitating neglected processes, de-emphasizing overused processes, correcting inappropriately applied processes, teaching new processes, and redirecting change efforts to the appropriate stages and levels of change.

Clinical assessment of the stages, levels, and processes requires some modification of the traditional interview. Knowledge of both the attitude toward a problem, as well as the actions taken with regard to it, are needed for assessment of the stages of change. It is important to know that an individual stopped drinking 1 week ago when his wife left him. However, equally important is knowing whether this is the first step in taking significant action toward intentional change of his drinking or an attempt to change his wife’s behavior. Another method of assessing the current stage of change is to evaluate both time and energy used in accomplishing the tasks of any prior stage of change. If someone has contemplated changing only casually or for a couple of weeks, for example, then that person would not be prepared to take action.

Assessment of the levels of change requires a clinical interview that addresses each of the levels. In a case of vaginismus, we must know the symptomatic expression and situational de-

TABLE 7.3 Integration of Psychotherapy Systems Within the Transtheoretical Framework

Levels	Stages				
	Precontemplation	Contemplation	Preparation	Action	Maintenance
Symptom/situational	Motivational interviewing			Behavior therapy Exposure therapy	
Maladaptive cognitions	Adlerian therapy		Rational emotive therapy Cognitive therapy		
Interpersonal conflicts	Sullivanian therapy		Interpersonal therapy		
Family/systems conflicts	Strategic therapy	Transactional analysis Bowenian therapy		Structural therapy	
Intrapersonal conflicts	Psychoanalytic therapies	Existential therapy	Gestalt therapy		

terminants of the sexual dysfunction but should also explore self-statements, the couple's interpersonal functioning, family-system involvement, and any possible intrapersonal conflicts regarding identity, self-esteem, and so on. In this assessment, it would be important to establish at which level or levels the patient perceives the problem, as well as the levels that the clinician assesses are integrally involved in the problem.

Evaluating the processes of change being employed by the patient can be a rather extensive task. Therapists should explore what the patient is currently doing with regard to the problem, how often these activities are occurring, and what has been done in the past in attempts to overcome the problem. An obsessive patient may be relying heavily on consciousness raising as the most important process while neglecting more action-oriented processes.

In our research, we developed assessment instruments to evaluate the stages, levels, and processes of change. The University of Rhode Island Change Assessment Scale (URICA), or Stages of Change Questionnaire, is a 32-item questionnaire with 4 scores: precontemplation, contemplation, action, and maintenance.

Several forms of a questionnaire to assess the processes of change have also been developed. The questionnaires typically contain two to four questions about activities that would represent each of the processes, and clients are asked to indicate how frequently each activity occurs on a five-point, Likert-type Scale (1 = not at all; 5 = very frequently). Because change process activity is somewhat different for diverse problems, we have attempted to adapt this basic format to a variety of problems, such as alcoholism, overeating, distress, and smoking. These questionnaires have shown remarkable consistency across problem areas (Prochaska & DiClemente, 1986), and principal component analyses have yielded 10 or more consistent components in their use with both clients and therapists. These Processes of Change Scales can be used to assess change processes used before and during therapy to examine how therapy interventions affect the utilization of the processes. Change process activ-

ity has been found to relate to therapist theoretical orientation (Prochaska & Norcross, 1983), client activity in the various stages of change, and to be predictive of successful movement through the stages of change.

A Level of Attribution and Change (LAC) Scale contains four or more questions representing each of the five levels of change used in the transtheoretical model. In addition, five other levels are assessed because people do not attribute their problems only to psychosocial sources. The other levels include bad luck, spiritual determinism, biological determinants, insufficient effort, and preferred lifestyle (Norcross, Prochaska, & Hambrecht, 1985; Norcross & Magaletto, 1990).

## APPLICABILITY AND STRUCTURE

We are attempting to develop a transtheoretical framework applicable to all clinical problems of psychological origin. The levels of change represent a means of categorizing patient problems that is compatible with *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnoses but is somewhat more comprehensive, as it includes systems and interpersonal types of problems. Thus, we envision the framework as appropriate for all types of psychopathology and health-related problems. In addition, the framework can be used to categorize treatment delivery systems according to the types of clients and problems they primarily address.

Because we often intervene first at the symptom/situational level, the transtheoretical approach can be used in both a short-term and a long-term format. Ideally, length of therapy, setting, and modality would be determined more by the stage of change, level of problem involvement, and type of change processes employed rather than a predetermined set on the part of the therapist. But, in reality, length of therapy is determined most often by managed care. When possible, a family intervention that brings family members together to make an effective intervention with the patient can be used for a precontemplative alcoholic. Individual and couples therapy can be used to



work through contemplation issues and achieve effective action when working with sexual dysfunctions. Group Therapy can be tailored to patients in all stages of change (Velasquez, Gaddy-Maurer, Crouch, & DiClemente, 2001).

Because our approach concentrates on intentional change, contraindications for the use of the transtheoretical approach would be a setting or problem where intentional change was not the primary goal. In a correctional setting or in managing the self-destructive behavior of a child, control, not intentional change, may be the primary goal. In this context, being aware of the stages and levels of change may nonetheless be desirable. However, external behavioral control appears to be the treatment of choice using the processes of contingency control and stimulus control. Once the immediate threat to self or others has been managed, therapists can work to bring the problem behaviors under intentional self-control rather than external control. In fact, this should be an important secondary goal if treatment or incarceration goals are to be maintained after the individual is released into the community.

In working with intentional change, the transtheoretical approach is quite compatible with the traditional treatment structure of psychotherapy (Connors, Donovan, & DiClemente, 2001). Weekly, hour-long sessions can be used to implement the treatment process. Because we envision psychotherapy as an adjunct to self-change, what occurs between therapy sessions is as important as what happens within therapy sessions. A longer, more intense therapy session with the inclusion of significant others may be needed for an individual in precontemplation to overcome defenses. Less frequent sessions can be used for individuals in contemplation and maintenance. For the former, more time between sessions can allow individuals time to use the processes of consciousness raising and self-reevaluation in the service of decision-making. For the latter, time between sessions can be used to monitor temptation levels and encounter any obstacles to continued action or maintenance that occur less frequently. Thus, in effect, therapy sessions become booster sessions.

The goal of our clinical and research work on intentional change is to identify the variables that are most effective in helping clients move through the stages of change with regard to a particular problem. In this context, *treatment selection* is too generic a term. The more specific issue is to identify which process would be most effective in helping to move an individual from one particular stage of change to the next with regard to a certain level or levels of change. The decision to use a particular process is multiply determined. Rather than stating a priori that counterconditioning is the treatment of choice for phobic problems, we prefer to analyze first the stages and levels of change before making prescriptions.

We realize that this approach places a sizable burden on the therapist. However, in the case of psychotherapy, we believe that simplicity can be a source of mediocrity and confusion. We have found, for example, that insufficient use of consciousness raising in the contemplation stage forces individuals to rely excessively on self-liberation or willpower in their efforts to change and opens the way to what Janis and Mann (1977) have called "post-decisional regret." The overuse of self-reevaluation during maintenance, on the other hand, is predictive of relapse (DiClemente & Prochaska, 1985). Thus, matching patients with processes requires both a general knowledge of the stages, processes and levels of change as well as specific knowledge about individual clients and what they have been doing to effect changes in their lives.

Though matching is a complex process that has not yet been adequately researched, mismatches from our perspective are more readily apparent. A therapist committed to consciousness raising and exploration of all the levels of change prior to taking action will frustrate a client ready to take action at the symptomatic level. An action-oriented therapist will be constantly disappointed by precontemplative clients who drop out quickly or fail to implement the suggested behavioral techniques. The family therapist, who insists that change take place at the family systems level with the whole family present, may be unable to engage a system with a member in precontemplation.

Treatment matching should not simply focus on disorders, which amounts to a continuation of the medical model. From our perspective, the problem with using this model in psychotherapy is it is not applicable to intentional change. Even with physical problems that require some health behavior modification, the medical model has been problematic. Medication compliance, diet control, and exercise all require intentional change and are extremely difficult problems for a medical model that relies on processes of change like surgery, which are invasive, externally applied procedures. Disorder is an important concept for developing a taxonomy that enables us to bring together certain symptoms and syndromes for classification. Though this information is important in understanding a problem, knowledge of a disorder by itself has limited value in prescribing therapy interventions (Beutler, 1983).

## THERAPY RELATIONSHIP

Although psychotherapists have not struggled with all the particular problems faced by different clients, all therapists have had some experience with the processes of change. This is the common experiential ground that forms the basis of the relationship between therapist and client. In general, the therapist is seen as the expert on change; not in having all the answers, but in being aware of the crucial dimensions of change and being able to offer assistance in this regard. Clients have potential resources as self-changers that must be used in order to effect a change. In fact, clients need to shoulder much of the burden of change and look to the therapist for consultation on how to conceptualize the problem and ways to free themselves to move from one stage to another.

As with any interactive endeavor, rapport must be built to accomplish the work. However, the type of relationship will vary with the stage and level of change being addressed. Initiation of therapy with a precontemplation client, for example, takes on a different flavor. A client's unwillingness to see or own a problem is not viewed as resisting the therapist or being uncooperative but as resisting change. Ther-

pists must become aware of how frightening and anxiety provoking the prospect of change can be. With this shift in perspective, the therapist can take on the role of a concerned advisor or nurturing parent who can help the individual explore the problem (DiClemente, 1991). The therapist becomes an ally rather than another person attempting to coerce change.

For a person contemplating change, the therapist should take care not to be too impatient. Contemplation can be a lengthy, frustrating stage of change. Though therapists should not support chronic contemplation, they must also avoid blame, guilt, and premature action. In order to make a decision to change a problem behavior, individuals must see that change is possible and in their own best interests. The therapist, like a Socratic teacher, can challenge clients by making explicit the pros and cons of both the problem behavior and the change. Support, understanding, and a relationship that would enable the therapist to make explicit the fears and concerns of the client is needed during this time.

During the action stage, the therapist can assume a more formal teaching relationship. During these stages, the client is likely to idealize the therapist. When initiating action, the client needs the support of a helping relationship and may need to lean on the confidence of the therapist rather than a self-generated sense of efficacy. Initial efforts are likely to be tentative, and seeing the therapist as the expert on change can be comforting. However, as soon as is feasible, it is important to have the client develop more self-confidence and independence from the therapist. For therapists who need to be needed, this can pose a difficult problem.

In the maintenance stage, the therapist becomes an occasional consultant—preventing relapse, consolidating gains, and identifying potential trouble spots. Letting go and helping the client assume ownership of the change are the final tasks of the therapy relationship.

## PROCESSES OF CHANGE

As already noted, transtheoretical approach identified the processes that are most impor-

tant in producing change at different stages. The mechanisms that move someone from precontemplation to contemplation are different from the processes that move someone from preparation to action (Velasquez, Gaddy-Maurer, Crouch, & DiClemente, 2001).

The important issue here is that intentional change, such as occurs in psychotherapy, is only one type of change that can move people. Developmental and environmental changes are other events that can cause people to alter their lives. The transtheoretical approach focuses primarily on facilitating *intentional change*, but it recognizes and, at times, relies on other types of change when working with clients. It is assumed, however, that unless developmental or environmental changes produce intentional change as well, clients can feel coerced by forces not of their choosing and will likely revert to previous patterns once the coercion is removed.

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### CASE EXAMPLE

By its very nature, an integrative therapy cannot be illustrated by a single case. Rather, it would take a long series of cases to reflect the full range of stages, levels, and processes of change used with a diversity of clients. Thus, if the reader were looking over the shoulder of a transtheoretical therapist, the therapist's interventions would vary tremendously depending on the needs of particular clients. Nevertheless, we will try to illustrate some of the richness of our approach through the treatment of a psychologically distressed client, partially with the context of couples therapy.

Tom was a 50-year-old schoolteacher who was referred for marital therapy by a colleague who had been working with Tom's wife, Barbara, in individual therapy for about a year. Barbara's therapist did not believe that Tom would stay in treatment for more than three sessions, even though he was quite distressed. Barbara's therapist actually thought that Tom needed individual therapy, but he agreed to go to therapy only if they went as a couple.

Tom and Barbara were seen together in the first session to assess their problems and their ability to work together at the interpersonal level.

Usually, we begin therapy by talking about the problems that bring people to therapy, but the first problem at hand in this case was Tom's resistance to therapy. Confronting the problem directly communicates to the client that we are going to try to deal with problems in a straightforward and direct manner. It communicates that the therapist cares about the client's resistance and the client need not be defensive about it. It also communicates the therapist's hope that maybe there is something the client and/or therapist can do to make it easier for the client to be a more willing participant. Many spouses have said that their partners would never come to therapy, and if they did, they wouldn't stay. And yet, we have found clinically that almost all reluctant partners would come in for at least one session if the therapist asked, and most would continue in therapy.

Tom said, "I don't believe therapy is worthwhile. My wife has been going to therapy for a year, and she's still always lying and spending money like it's going out of style."

"Sounds like you might be angry at her therapist," the therapist responded.

"You're damn right! He just feeds into her wasting money," said Tom.

"Have you let him know you're angry?" the therapist asked.

"No, he doesn't want to talk to me," Tom said.

"Would you like me to let him know you're angry?" the therapist asked.

"Yeah, I would appreciate that," said Tom.

So we're off and running. Tom's resistance to therapy is being addressed, if only at the situational level. But at least he does not have to be defensive about his defensiveness. He may be able to experience the therapist as someone who cares about his defensiveness and is trying to understand it. He may, to his surprise, experience the therapist as being helpful in dealing both with his resistance and with his anger.

At the same time, the therapist has to be concerned with Barbara experiencing the therapist as Tom's ally. The therapist could have addressed Tom's anger toward his wife for what he labels "lying and wasting money." But this would have

risked putting Barbara on the defensive, and if she counterattacked, the couple could slip into the blame game that involves partners quickly shifting from the offensive to the defensive position.

"It must be hard to have your husband accusing you of lying and wasting money." I said this to Barbara, knowing I was still risking the blame game but feeling that I wanted to empathize with her as well as with Tom. I also wanted to communicate that I appreciated that there are two sides to every marital conflict, and that her perspective was as important as Tom's.

These opening segments of therapy indicate that treatment usually begins immediately. There usually is not a formal assessment period, although assessment occurs right from the start. In the course of the first two sessions, the following information was shared. Tom's mood was usually depressed; he couldn't relax; he was having trouble sleeping; he was irritable and often verbally abusive; he felt lousy about himself; and he was having trouble relating to his students, his colleagues, and the customers that sought his services in his after-school job. Tom's distress increased whenever he approached Barbara to be sexual and she refused, which happened at least once a day.

Barbara was really angry at Tom. She was angry about his constant accusations about her lying, spending money behind his back, and having affairs when she went out on Friday night with her female friends. He would check the phone bill to see whom she had been calling; he would open mail addressed to her to see what money she owed; and he would sometimes follow her out with her friends to see if she was seeing other men. How could she want to make love when they were so embroiled in a game of "cops and robbers." Tom had coerced her into having sexual intercourse a couple of times, and she resented it.

Barbara also resented Tom's preoccupation with money. If he wasn't preoccupied about her spending money, he was preoccupied with his compulsive gambling. Tom denied that his gambling was no longer a problem. If they lost everything on his gambling, it would come to \$1,000 a year, and between the two of them, they were making more than \$80,000.

What is a psychotherapist to believe? At worst, we have a compulsive gambler and an obsessive

and possessive lover married to a compulsive liar and an impulsive spender. We may have classic personality disorders who have trouble managing their own lives, let alone managing marriage effectively. Personality disorders often do not stay in therapy or they stay forever.

From the transtheoretical perspective, it appeared that Tom was in the precontemplation stage in regard to most of his problems. The exception was his gambling, which Tom had changed on his own to relatively controlled gambling. Barbara, on the other hand, was prepared to take action. She had been contemplating changes in her marriage for the past year in therapy. The problem was that the action she most likely was going to take—although she did not say so directly—was divorce. Unfortunately, few couples present asking for divorce therapy. Most couples present asking for marital therapy. Assessing whether a couple is likely to be a divorce case rather than a marital case can make a considerable difference in therapeutic outcomes. Elsewhere, we present in detail the subtle and not so subtle signs of impending divorce that we use to assess a couple's case (Prochaska & DiClemente, 1984).

In the current case, some of the obvious signs included the fact that Barbara had been contemplating divorce for some time. More importantly, she had told some of her family and friends that she was contemplating a divorce. When people go public with their contemplations, they are moving much closer to action. Barbara had also lost her excess weight and engaged in other self-improvement activities. Making oneself more marketable is preparatory action for people heading for divorce. Barbara had also been in individual treatment for a year, with the theme being increased independence and autonomy.

Tom, on the other hand, was psychologically distressed. He had not been contemplating divorce, although he knew that Barbara was. On the contrary, he was obsessed with trying to control Barbara's actions to prevent losing her. Tom was resistant to change, as if he knew the ultimate change in their marriage was going to be divorce. He was also distressed by the prospect of having the drastic change of divorce imposed upon him. The imposition of change is one of the most common causes of psychological distress.

Psychological distress caused by imposed change is likely to lead to people resisting change. Change can be experienced as a threat not an opportunity, and people may defend against any awareness of needs to change as they dig more deeply into the precontemplation stage. Moreover, they have trouble contemplating change as they become cognitively impaired by distress (Mellinger, Balte, Uhlenhuth, Cisin, Manheimer, & Rickles, 1983) and have trouble making decisions and trouble taking action, even action that could lead to self enhancement.

What do we do when we have spouses in two different stages of change, which is common in couples therapy? What do we do when we have spouses in two different stages of divorce, which is even more common in divorce therapy?

The most common pattern is to have one spouse in precontemplation and one who is ready for action, like Tom and Barbara. When we are treating psychological distress precipitated by an impending and imposed divorce, we need to slow down the spouse who is ready for action and speed up the spouse who is resisting change. Barbara was willing to spend some time trying to resolve their interpersonal problems. The psychotherapist made it clear that they were going to work at the interpersonal level to improve their relationship whether they stayed together or got divorced. Either way, they were going to have a long-term relationship, in part because they shared two lovely daughters.

The couple needed to become more conscious of the interactive nature of their conflicts. Tom and Barbara agreed that their struggles over control produced the most conflict. The therapist presented feedback based on his assessment of what was transpiring at the interpersonal level. Tom's actions appeared to be based on his intention to keep the marriage going, and his actions were based on values of closeness and togetherness. Barbara, on the other hand, had developed an increased need for independence; her actions were based on values of individualness and separateness. The problem was the more Tom tried to control their being together, the more Barbara felt a need to be apart. Barbara agreed. Conversely, the more Barbara pulled apart, the more Tom felt the need to control her to keep them together. Tom agreed. The needs and values that Tom was

expressing set off opposite needs and values in Barbara. The blame game is based on our preference for linear causality—she acts and I react. Circular causality, on the other hand, can help couples appreciate that they both act and react—that their behavior is both a cause and an effect of their ongoing relationship (cf. Wachtel, Kruls, & McKinney, this volume).

Tom and Barbara were becoming more conscious of what they personally contributed to their control struggles. They were going beyond the blame game. They were also able to reevaluate their partner's behavior to some extent. Togetherness is somewhat more positive than dependence. Separateness is something different from selfishness. With the help of the therapist's mini-lectures based on his experience with family life education (Prochaska & Prochaska, 1982), Tom and Barbara became aware that a more mature relationship includes both togetherness and separateness. They were taught that individuals mature in their relationships from dependence to independence to interdependence, with interdependence being the caring and sharing of two independent individuals.

The problem was that Tom was entirely in charge of togetherness and Barbara was only standing for separateness. They were, however, willing to risk acting differently. The therapist recommended that Tom be in charge of separate activities and Barbara be in control of shared activities. Tom was going to liberate himself from a vicious circle by acting more like Barbara and vice versa. The longer they could continue such reversal of roles, the more they would condition themselves to respond with new alternatives.

This action worked, for a while. Tom took charge of recording on the calendar Barbara's nights out with her friends and his golfing dates. Barbara recorded their dates together on the calendar and was in charge of initiating shared activities. They were communicating better and feeling better. Tom's chief complaint was that Barbara was not initiating sex.

Because they were doing better, the therapist recommended that gradual involvement in sexual relating could help them overcome anxieties about sexual performance. They had been avoiding sex for quite a while, and the first steps of sensate focusing (Masters & Johnson, 1970) might

give Barbara, in particular, a chance to deal with her feelings about gradually getting close again. They agreed with the idea and agreed that they would start with light massage.

Tom came alone to the next session. "Barbara is not coming back again. She said she knows she just wants out of the relationship." The therapist probably had made a mistake in too quickly encouraging the couple to move to action in their sexual relationship. After the session, the therapist called Barbara and expressed his concern that he might have made a mistake and inquired if she would be willing to come in to talk about how she was feeling.

Barbara came in for a couple of sessions. She said that the only thing the therapist's recommendation had done was force her to realize that she just did not want to be close to Tom anymore. The fact that their relationship had improved made her even more aware that she just did not feel the same about Tom. She still was concerned that Tom wouldn't be able to handle a divorce, but she wanted out.

Tom was distressed but not devastated. Fortunately, psychotherapy had become a place where he could be open about his feelings. He was not all alone as he had feared. He allowed himself to relive the memories of losing his first love. He had felt more rejected than he felt now. He had so many regrets about not having tried harder in that relationship. But this time he had been trying. Back then, he withdrew from everyone. He stayed in his room. He wasn't able to eat. He couldn't work. His parents, were concerned but they left him alone.

No wonder he avoided contemplating divorce. He never, ever wanted to go through such emotional hell again. He didn't think he would make it. He thought he couldn't handle another rejection, but now realized he didn't have to go through it alone this time. Not only was therapy available, but he had other helping relationships. But now, Tom could talk more openly and rely more on the social supports in his natural environment.

The therapist encouraged Tom to explore fully why that rejection as a young man had been so distressing. Eventually, Tom focused on the rejection he had experienced from his parents. When Tom was about 7 or 8, his parents had lost their

business and did not have the financial resources to care for him. Tom had gone to live with an aunt and uncle who had no children. They weren't particularly loving, but they did give him a lot of money. After a couple of years, Tom's parents were on their feet again and were able to have him back. Tom recalled not wanting to go back and not wanting to give up all that money. He had forgotten how rejected he had felt as a child. The therapist suggested that perhaps he had substituted the money for the love he had lost. Yes, maybe that was why money had come to mean so much to him. Gambling was fun but he also felt more lovable when he won. And when he lost? Well, maybe he was getting used to losing love.

After that early separation, Tom had closed off his relationship with his parents or maybe it had always been too closed. The therapist took a lead from Bowen (1978) and encouraged Tom to act on his emerging feelings. He encouraged Tom to talk to each of his parents individually about how they had experienced that time in their lives.

Tom's mother was especially pleased with the opportunity to talk. She had never told Tom how much it had hurt her to give him up and how much it hurt when he didn't want to return home. She felt that Tom was always angry at her after that. Tom began to realize that his hurt and his anger had caused him to close off close contact with others. But now Tom was risking new ways of relating—with his parents, his daughters, and his friends. He was communicating more spontaneously and openly and felt more sensitive to the needs of others. He was asserting himself more at work without having to get angry.

Tom was making many self changes after a total of 22 therapy sessions but was puzzled by his reluctance to take action and move out and get a place of his own. He told himself that it was because he wanted to be close to his daughters, but he knew he was really afraid that Barbara might turn them against him. He also realized that he was still concerned about money and didn't want to spend the money on an apartment if he could help it. Furthermore, staying in the house was a safe way of expressing his resentment at Barbara for rejecting him. At a deeper level, Tom became aware that leaving his home stirred up painful feelings about when he had to leave his family's

home. And at an intrapersonal level, Tom became aware that he really did have unresolved dependency problems. He had, for example, never lived alone.

The therapist helped Tom to appreciate that moving out and living on his own was a maximum impact action that could facilitate further progress at each level of his life. At a situational level, Tom would be moving into a new environment that would reflect the new era of his life, free from all the reminders that elicited so many painful thoughts and feelings. At a cognitive level, Tom would be challenging his "awfulizing" tendencies that added to his distress, such as his belief that it was awful that he was the one to have to move when he didn't want the divorce in the first place (cf. Ellis, 1973).

At the interpersonal level, Tom could further let go of his desire to remain in control of his relationship with Barbara. As long as Barbara wanted him out and he refused to leave, Tom felt in control. But he could let go of this need to control and accept that Barbara was getting the house. At the family level, Tom was very tempted to move back with his parents. Moving on his own, however, would enable Tom to separate further from his parents without rejection or resentment. And at the intrapersonal level, Tom could experience himself as becoming more fully adult. He would be moving beyond dependence to independence and would be better preparing himself for an interdependent relationship.

After a couple of months of encouragement in therapy and additional harassment at home, Tom was ready to leave the nest. This was a major move in his life. It evoked a variety of countertransference feelings in his psychotherapist, who felt like a parent watching his 50-year-old son going off to college. Would he be distressed by loneliness and homesickness or would he spread his wings and fly? Needless to say, Tom soared. He felt more fully connected to life than he had ever known. For the first time in his life he began to appreciate activities like concerts and plays. He asserted himself and found women responding rather than rejecting. Certainly he felt lonely at times, but never alone. He even felt a spiritual awakening for which his empiricist therapist takes no credit whatsoever.

Therapy was already terminating when Tom met a special woman. Ironically, she too had just come out into the world in the past few years. She had hidden in a nunnery while Tom had hidden within himself and his home. She had had several years of psychotherapy struggling with intrapersonal conflicts both before and after leaving the nunnery; Tom was terminating after 9 months of therapy.

Tom had made a remarkable transformation from a distressed and defensive individual preoccupied with a small portion of his existence to a growth-oriented person able to function more freely and fully at each level of life. What process or processes account for such rewarding changes? First, Tom had been facing turning 50, and he probably had the benefit of developmental changes urging him on to a new stage of life. Second, he faced dramatic but distressing environmental changes being imposed upon him. Third, psychotherapy had helped Tom shift from a resentful and resistant position in the precontemplation stage to becoming more conscious of and committed to the self-liberating qualities of intentional change. And fourth, Tom, the gambler, would also attribute some of his good fortune to lady luck. The last time the therapist talked to Tom, not only was he doing well with his woman friend, his family, his daughters, his friends, and himself; he also had just won \$750 in the lottery 2 weeks in a row. Tom was on a roll!

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## EMPIRICAL RESEARCH

Considerable care has been taken to operationalize and validate each of the core constructs of the transtheoretical approach. The stages of change, for example, have been identified and validated with a questionnaire applied to a range of patients entering psychotherapy (McConaughy et al., 1983; 1989; Brogan, Prochaska, & Prochaska, 1999), alcoholics entering treatment (DiClemente & Hughes, 1990), and obese patients entering behavior therapy (Prochaska, Norcross, Fowler, Follick, & Abrams, 1992). Brief algorithms have been used to validate stages of change for a broad range

of problems (see Prochaska & DiClemente, 1992). The processes of change also have been replicated and validated across a broad range of problems. These include smoking (Prochaska & DiClemente, 1983; Prochaska, Velicer, DiClemente, & Fava, 1988), psychological distress (Prochaska & DiClemente, 1985; Prochaska & Norcross, 1983), weight control (Prochaska & DiClemente, 1985; Prochaska, Norcross, Fowler, Follick, & Abrams, 1992), alcoholism (Snow, Prochaska, & Rossi, 1992), cocaine abuse (Rosenbloom, 1991), heroin abuse (Tejero, Trujols, Hernandez, Perez de los Cobos, & Casas, 1991), exercise acquisition (Marcus, Rossi, Selby, & Niaura, 1992), and a mixture of mental health disorders. The levels of change have received less empirical attention but have been replicated and validated with such problems as alcohol abuse (Begin, 1988), cocaine abuse (Rosenbloom, 1991), smoking (Norcross, Prochaska, Guadagnoli, & DiClemente, 1984), and a mixture of DSM disorders (Penny, 1987; Brogan et al., 1999).

The systematic relationship between the stages and processes of change has been well supported across problem areas. In fact, a recent meta-analysis of 47 cross-sectional studies (Rosen, 2000) examining the relation between the stages and processes found moderate to large effect sizes: .70 for variation in cognitive-affective processes by stage and .80 for variation in behavioral processes by stage.

Another line of research has examined the stages and processes of change in substance abuse treatment (DiClemente, 2003). Individuals entering alcohol and substance abuse treatment have very different profiles on the stages of change (Carney & Kivlahan, 1995; DiClemente & Hughes, 1990). Using a motivational readiness score based on the second-order factor structure of the stages of change scales, Project MATCH investigators found that baseline readiness scores were one of the strongest predictors of posttreatment drinking outcomes for the 952 outpatients in this large multisite alcoholism treatment matching trial (DiClemente, Carbonari, Zweben, Morrell, & Lee, 2001; DiClemente, Carroll, Miller, Connors, & Donovan, 2003; Project Match, 1997,

1998). Baseline motivation predicted outcomes when treatment type did not. Moreover, there was a clear relationship between clients' initial motivation to change and their acknowledgment of consequences and problems with drinking. Client motivation at baseline also related to how individuals engaged with the therapist (working alliance) and how active they were in using the processes of change and other external resources to modify their drinking (DiClemente, Carroll, Miller, Connors, & Donovan, 2003). Finally, indicators of the process of intentional behavioral change (experiential and behavioral coping activities, readiness to change, and self-efficacy) varied during the course of treatment and were significantly related to the changes in drinking behavior throughout the 1-year follow-up period (Carbonari & DiClemente, 2000).

The importance of process of change is highlighted by the fact that individuals who attended different treatments in Project MATCH reported remarkably similar process activity both during treatment and at the posttreatment assessment. Process of change activities during treatment, particularly behavioral process activity, predicted drinking outcomes (Carbonari & DiClemente, 2000). These results indicate that outcomes are much more a function of what clients do than what therapists do.

In a longitudinal analysis of subjects who progressed, regressed, and remained the same during a 6-month period, discriminant functions predicted movement for the groups representing the precontemplation, contemplation, action, and relapse stages. Predictors included the 10 processes, pros and cons, and measures of self-efficacy and temptation, all variables that are open to change (Prochaska, DiClemente, Velicer, Ginpil, & Norcross, 1985). When more static variables such as age, education, smoking history, withdrawal symptoms, reasons for smoking, and health problems were used as predictors, the results were much less significant (Wilcox, Prochaska, Velicer, & DiClemente, 1985). The point is that dynamic measures are much better predictors of change than are the more commonly used static measures, like client characteristics.



At least five longitudinal studies have found that the amount of progress individuals make after intervention is directly related to the stage they are in prior to intervention. During an 18-month follow-up, smokers who were in the precontemplation stage initially were least likely to progress to the action or maintenance stages following intervention. Those in the contemplation stage were more likely to make such progress, and those in the preparation stage made the most progress (DiClemente et al., 1991; Prochaska, Velicer, Prochaska, & Johnson, 2004). In an intervention study with smokers with heart disease, Ockene and her colleagues (1989) found that 22% of the smokers who were in the precontemplation stage prior to treatment were not smoking at a 6-month follow-up. Of those who were in the contemplation stage, 44% were not smoking at 6 months and approximately 80% of those in preparation or in action were not smoking at 6 months. With a household sample of Mexican Americans in Texas who smoked, Gottlieb, Galavotti, McCuan, and McAlister (1990) replicated most of the cross-sectional relationships between stages and processes and other dynamic variables like decisional balance and self-efficacy. Furthermore, during a 12- to 18-month follow-up, they found that smokers who were originally in the contemplation stage progressed to the action and/or maintenance stages four times as frequently as smokers who were originally in the precontemplation stage. The amount of progress head-injury adults made in rehabilitation was directly related to their stage of change prior to treatment (Lam, McMahon, Priddy, & Gehred-Schultz, 1988).

Dropout is major problem for psychotherapy patients in general and for addictive patients in particular. In some studies for addictive problems, as many as 80% of participants drop out (Prochaska et al., 1992). In a study of psychotherapy dropouts using such variables as socio-economic status (SES), age, and gender, we were unable to predict the 40% of patients who terminated prematurely. Using the stages-of-change questionnaire, however, we were able to predict these dropouts with 93% accuracy (Brogan, Prochaska, & Prochaska, 1999). In a cognitive-behavior therapy intervention for

weight control, the stages and processes of clients early in therapy were the best predictors of both premature termination and progress at follow-up (Prochaska, Norcross, Fowler, Folllick, & Abrams, 1992).

During the past dozen years, we have conducted a series of clinical trials from a transtheoretical perspective. In our first clinical trial, we randomly assigned 770 smokers in Rhode Island by stage to one of four treatment conditions: standardized, individualized, interactive, and personalized (Prochaska, DiClemente, Velicer, & Rossi, 1993). The standardized treatment involved the best self-help program currently available; namely, the American Lung Association's action and maintenance manuals. The individualized self-help manuals were individualized to the stage of change of each participant. The interactive condition (ITT) involved computer-generated progress reports that included feedback about the participant's stage of change, decisional balance measures regarding the pros and cons of quitting smoking (Velicer, DiClemente, Prochaska, & Brandenburg, 1985), up to six processes of change that were being underutilized, overutilized, or utilized appropriately (Prochaska, Velicer, DiClemente, & Fava, 1988), temptations and self-efficacy across the most important smoking situations (Velicer, DiClemente, Rossi, & Prochaska, 1990), and techniques for coping with specific situations. The personalized condition (PITT) included the stage-based manuals, computer reports, and four counselor calls. The calls were proactive, initiated by the counselors rather than reacting to calls from the participants. Except for one call, counselors had the computer reports to help counsel clients about changes they were making on key process variables.

The results were revealing. The two manual conditions basically replicated each other through the 12-month follow-up. At the 18-month follow-up, however, the individualized transtheoretical manuals (ITT) (18.5% abstained) appeared to be performing better than the standardized (ALA) manuals (11%). The interactive (ITT) computer reports outperformed both manual conditions at each of the four follow-ups. The computer reports pro-

duced more than twice as much quitting at each follow-up than did the gold standard ALA manual (e.g., 25.2% vs. 11% at 18 months). The personalized counselor call condition about doubled the quit rates of the two manual conditions up to the 12-month follow-up. By the 18-month follow-up, effects from the PITT condition appeared to have plateaued (18%). At 18-months, the PITT condition only outperformed the ALA manuals, whereas the transtheoretical manual condition seemed to have caught up with the counselor call condition.

These results suggest that interactive computer feedback on stage-related variables has the potential to outperform the best self-help program currently available. These results indicate that the field may now have self-help programs that are appropriate and effective for the vast majority of smokers who are not prepared to take action. Providing smokers interactive feedback about their stages of change, decisional balance, processes of change, self-efficacy, and temptation levels in crucial smoking situations can produce greater success than just providing the best self-help manuals currently available.

The next test was to demonstrate the efficacy of the expert system when applied to an entire population recruited proactively. With more than 80% of 5,170 smokers participating and fewer than 20% in the preparation stage, we demonstrated significant benefit of the expert system at each 6-month follow-up (Prochaska, Velicer, Fava, Rossi, & Tsoh, 2001). Furthermore, the advantages over proactive assessment alone increased at each follow-up for the full 2 years assessed. The implications here are that expert system interventions in a population can continue to demonstrate benefits long after the intervention has ended.

In the next clinical trial, we showed remarkable replication of the expert system's efficacy in an HMO population of 4,000 smokers with 85% participation (Prochaska et al., 2001). In the first population-based study, the expert system was 34% more effective than assessment alone; in the second it was 31% more effective. Though working on a population basis, we were able to produce the success normally found only in intense clinic-based programs

with low participation rates of much more selected samples of smokers. The implication is that, once expert systems are developed and show effectiveness with one population, they can be transferred at much lower cost and produce replicable changes in new populations.

The next challenge was the extension of the assessment-based expert systems to provide treatments for populations with alternative problems, like stress. With a national sample suffering from stress symptoms, we proactively recruited more than 70% ( $N = 1,085$ ) to a single behavior change program (Evers, Johnson, Padula, Prochaska, & Prochaska, 2002). The Transtheoretical Model (TTM) program involved assessments on each of the TTM constructs to derive three expert system tailored communications during 6 months and a stage-based self-help manual. At the 18-month follow-up, the TTM group had more than 60% of the at-risk sample reaching action or maintenance compared to 42% for the control group. Compared to studies on smoking cessation, this study produced much more effective action at 6 months in the TTM group, and this outcome was maintained during the next 12 months.

In recent benchmarking research, we have been trying to create enhancements to our expert system to produce even greater outcomes. In the first enhancement in our HMO population of smokers, we added a personal handheld computer designed to bring the behavior under stimulus control (Prochaska et al., 2001). This commercially successful innovation was an action-oriented intervention that did not enhance our expert system program on a population basis. In fact, our expert system alone was twice as effective as the system plus the enhancement. There are two major implications here: (1) more is not necessarily better; and (2) providing interventions that are mismatched to stage can make outcomes markedly worse.

Another important aim of the HMO project was to assess whether interactive interventions (computer-generated expert systems) are more effective than noninteractive communications (self-help manuals) when controlling for number of intervention contacts (Velicer, Prochaska, Fava, Laforge, & Rossi, 1999). The in-

teractive programs require assessments at each intervention point and therefore are more costly and demanding than noninteractive interventions. It is essential, therefore, that such assessment-driven interventions be more effective to justify the additional costs and demands. At 6, 12, and 18 months for groups of smokers receiving 1, 2, 3, or 6 interactive versus noninteractive contacts, the interactive interventions (expert system) outperformed the noninteractive manuals in all four comparisons. In three of the comparisons (1, 2, and 3), the differences at 18 months were at least five percentage points, a difference between treatment conditions assumed to be clinically significant. Those results clearly support the hypothesis that interactive interventions will outperform the same number of noninteractive interventions.

Those results support our assumption that the most powerful behavior change programs for entire populations will be interactive. In the reactive clinical literature, it is clear that interactive interventions like behavioral counseling produce greater long-term abstinence rates (20% to 30%) than do noninteractive interventions such as self-help manuals (10% to 20%). It should be kept in mind that these traditional action-oriented programs were implicitly or explicitly recruiting for populations in the preparation stage. The implications are clear. Providing assessment-driven interactive interventions via computers are likely to produce greater outcomes than relying on noninteractive communications, such as newsletters, media or self-help manuals.

In one of our recent clinical trials we actively recruited populations of patients with multiple health problems. Applying the best practices of a stage-based multiple behavior manual and three assessment-driven expert system feedback reports, we proactively intervened on a population of parents of teens who were participating in parallel projects at school (Prochaska et al., 2002). First, the study had to demonstrate that it could proactively recruit a high percentage of parents if impacts were to be high. This study recruited 83.6% ( $N = 2,460$ ) of the available parents. The treatment group

received up to three expert system reports at 0, 6, and 12 months. At 24-month follow-up, the smoking cessation rate was significantly greater in the treatment group (22% abstinent) than the controls (17%). The parents did even better on diet with 33.5% progressing to the action or maintenance stage and going from high-fat to low-fat diets compared to 25.9% of the controls. With sun exposure, 29.7% of the at-risk parents had reached action or maintenance stages compared to 18.1% of the controls.

With a population of 5,545 patients from primary care practices, we proactively recruited 65% for a multiple behavior change project. This represents one of our lowest recruitment rates and appeared to be due to patient concerns that project leaders had received their names and phone numbers from their managed care company, which many did not trust. With this population, mammography screening was also targeted, but most of the women over 50 were in the action or maintenance stages, so relapse prevention was targeted. Of the targeted behaviors, significant treatment effects were found for all four. At 24 months, the smoking cessation rate for the treatment group was 25.4% compared to 18% for the controls. With diet, 28.8% of the treatment group had progressed from high-fat to low-fat diets compared to 19.5% of the control group (Redding et al., 2002). With sun exposure, 23.4% of the treatment groups were in action or maintenance compared to 14.4% of the controls. And, with mammography screening, twice as many in the control had relapsed (6%) compared to the treatment group (3%).

With a population of patients in Canada with Type 1 or Type 2 diabetes, we proactively recruited 1,040 patients to a multiple behavior change program for diabetes self-management (Jones, Edwards, Vallis, Ruggiero, Rossi, Rossi et al., 2001, 2003). With this population, self-monitoring for blood glucose (SMBG), diet, and smoking were targeted. Patients were randomly assigned to standard care or TTM. The TTM program involved monthly contacts that included three assessments, three expert system reports, three counseling calls, and three newsletters targeted to the participant's stage of

change. At 12-month assessments, the TTM group had significantly more patients in action or maintenance for diet (40.6% vs. 31.8%) and for SMBG (38% vs. 25%). With smoking, 25% of the TTM group were abstinent compared to 15% of usual care. This was not significant due to statistical power, but the abstinent rate fell within the 22% to 25% rate for single and multiple behavior change programs for disease prevention.

With a population of patients in Hawaii with Type 1 or Type 2 diabetes, we proactively recruited 400 patients to a multiple behavior change program for diabetes self-management (Rossi et al., 2002). The same three behaviors were targeted as in the Canadian study. The TTM program, however, did not include counselor contacts but did have monthly contacts. At the 12-month assessment, the TTM group had significantly more patients in action or maintenance for diet (24.1% vs. 11.5%) and for SMBG (28% vs. 18%). There were too few smokers to do statistical comparisons, but the abstinence rates were 25.9% for TTM versus 15.9% for the controls.

We believe that the future of behavior change programs lies with stage-matched, proactive, and interactive interventions driven by sensitive assessments. Much greater impacts can be generated by proactive programs because of much higher participation rates, even if efficacy rates are lower. But we also believe that proactive programs can produce comparable outcomes to traditional reactive programs.

Empirical research has been highly supportive of the core constructs of the transtheoretical approach and the hypothesized integration of the stages and processes. Longitudinal studies have supported the relevance of these constructs for predicting premature termination and short-term and long-term outcomes. Comparative outcome studies indicate stage-matched interventions outperform the best alternative treatments available. Population-based studies support the importance of developing interventions that match the needs of individuals at all stages of change. These same studies suggest the relevance of this approach for generating participation rates that are dramatically higher

than traditionally reported and for producing unprecedented impacts.

## FUTURE DIRECTIONS

Health care systems are either collapsing or have collapsed. The health of our nation and the health of our health care systems cannot wait 25 years for the dissemination of psychotherapy integration. The top priority for the Transtheoretical Approach is the rapid dissemination of available science and systems. The first problems that are likely to be treated on a population basis are high-cost conditions such as depression, addiction, and stress. Populations with multiple behavior problems are also high-risk and high-cost and are major candidates for population-based treatments. We are working with health care systems, employees, governments, and other organizations to bring the most effective and cost-effective therapies to these populations.

One clinical strategy that we are studying is a step-care approach, where we begin with the least intensive and least costly of treatments, such as computer-based TTM programs. Participants who are progressing with these programs would continue with them. Those who are not progressing would be stepped up to a more intensive treatment such as proactive telephone counseling. Those not progressing with this help would then be stepped up to face-to-face psychotherapy with TTM-trained therapists.

We also need to test the limits on how many behavior problems can be treated simultaneously without reducing effectiveness. To date, we have been able to treat three or four behaviors on a population basis with no decreased efficacy but with increased impacts on health and health care costs. Even single behavioral targets such as smoking could benefit from multiple behavior therapies that can treat major barriers to successful cessation such as stress, depression, alcohol abuse, and weight gain.

The future for TTM is to continue to produce innovative interventions that can produce

breakthroughs in the impacts we can have on the most deadly, disabling, and costly of behavioral conditions.

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## Cyclical Psychodynamics and Integrative Relational Psychotherapy

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Cyclical psychodynamics is the theoretical basis for an integrative relational therapy that seeks to synthesize key facets of psychodynamic, behavioral, and family-systems theories. The first statements of this theoretical point of view appeared in 1977 (Wachtel, 1977a, 1977b), and significant revisions and additions were incorporated in several later books (Wachtel, 1987, 1993, 1997; Wachtel & Wachtel, 1986).

Cyclical psychodynamics seeks to provide an internally consistent theoretical approach to personality functioning, as well as a way of proceeding clinically within the therapy hour. In contrast to a technically eclectic approach, in which techniques are selected probabilistically because they have worked with patients possessing similar characteristics, cyclical psychodynamics seeks to develop a coherent theoretical structure to guide clinical decision-making.

Cyclical psychodynamic theory approaches the issue of compatibility between putatively competing theories and techniques by probing beneath the differing terms and vocabularies to find the actual core observations of each and

by selecting from among the various competing perspectives those aspects of each that can be put together in a new synthesis. Each of the theoretical perspectives that cyclical psychodynamics draws upon is attuned to a different, and only partially overlapping, set of observations and clinical interventions. Cyclical psychodynamics attempts to forge a new, more inclusive conceptualization that can encompass the full range of observations addressed by its contributory sources and that provides a context for as wide a range of clinical interventions as can be coherently employed.

As the name implies, cyclical psychodynamics, although drawing upon multiple contributions and perspectives, has been most influenced by the psychodynamic point of view. It can thus be seen not only as an instance of theoretical integration but also as an exemplar of assimilative integration. The psychodynamic core of the theory draws on traditional Freudian ideas such as the emphasis on unconscious processes, inner conflict, and the importance of transference in the patient's relationship

with the therapist. But it also builds upon the interpersonal conceptualizations of Horney and Sullivan, the social and cultural explorations of writers such as Fromm and Erikson, the clinical insights about the impact of new relational experience introduced by Alexander and French (1946) and later modified and elaborated by writers such as Weiss and Sampson (1986), Kohut (1977), and Frank (1999), and the relational synthesis in psychoanalytic thought introduced by writers such as Mitchell (1988, 1993) and Aron (1996). The current version of cyclical psychodynamics can best be understood as one of a number of partially overlapping models that constitute the relational point of view in psychoanalysis.

In contrast to most psychodynamic models, cyclical psychodynamics places its primary emphasis not on the notions of fixation or developmental arrest but rather on the vicious circles set in motion by early events and relationships and on the ways those cyclical patterns persist into the present (see, for example, Wachtel [1982, 2003], Zeanah, Anders, Seifer, & Stern, [1989], and the discussions of empirical research on vicious circles and self-fulfilling prophecies later in this chapter). Its analyses show how problematic patterns are sustained and strengthened not in spite of, but precisely because of, our current reality.

Complementing (but functioning compatibly with) the psychoanalytic perspective of cyclical psychodynamic theory, behavioral and family-systems traditions have attuned us to the importance of detailed inquiry into how and when neurotic patterns are evoked and into the patient's current social and cultural context. From the perspective of cyclical psychodynamics, the distinction between the person's "inner world" and his or her "external" reality breaks down, and they are seen as continually defining and redefining each other in recursive fashion. Both behavioral and systemic models provide therapeutic change techniques to complement the psychoanalytic emphasis on insight and examination of the transference. Rather than assuming that change will follow insight rather automatically, the cyclical psychodynamic therapist views change as a synergistic process in which new behaviors and feedback

promote new insights and such insights in turn generate increased motivation to try new behaviors (see, in this connection, Frank, 1999; Wachtel, 1997; Weiss & Sampson, 1986).

## THE APPROACH

In order to avoid awkward locutions and referring to oneself in the third person, this section of the chapter, written by the first author, will be in the first person singular: I was originally trained in the psychodynamic tradition. My doctoral training, at Yale, emphasized psychoanalytic ego psychology, complemented by a strong dose of Hullian learning theory, as mediated by the work of Dollard and Miller (1950). My psychoanalytic training, in the New York University postdoctoral program in psychoanalysis and psychotherapy, combined a further grounding in classical psychoanalytic theory and ego psychology with a strong exposure to interpersonal and existential-phenomenological models. These experiences were seminal for me; I have remained strongly interested in and committed to psychoanalytic ideas to this day. As my psychoanalytic training proceeded, however, I became increasingly dissatisfied with a number of prominent features of psychoanalytic thought, which seemed to me both impediments to clinical practice and far less essential to the psychoanalytic point of view than is commonly assumed.

### Overemphasis on Early Experience

One of the most significant sources of dissatisfaction with standard psychodynamic accounts was what I experienced as an excessive emphasis on very early experiences, and in particular an emphasis on early experience formulated in a way that made it seem as if those early experiences remained lodged in the psyche as a foreign body, unchanged by later experience (see Wachtel, 1977, 2003). Such an emphasis leads the therapist to pay insufficient attention to the influence of ongoing events in the person's life, and indeed places theoretical obstacles to full consideration of such influences. Both daily personal observation and my reading of the re-

sults of empirical research (see below) persuaded me of the powerful and continuous impact of ongoing life events. Both our behavior and our experience vary greatly in different contexts, and a theory that did not fully and readily accommodate this obvious fact was unnecessarily limited. I sought an alternative that could retain the important insights and surprising observations deriving from the psychoanalytic tradition, yet could integrate into its account of personality development and psychological distress the important role of environmental context (cf. Mischel, 1968, 1973; Wachtel, 1973a,b).

### Overemphasis on Insight

Around the same time, I began to be skeptical that *knowing* something about oneself was the major source of change. The idea of insight seemed an inexorably cognitive notion, and although the distinction between intellectual and emotional insight was clearly rooted in sound clinical observation, it was conceptually problematic. It seemed to me that judgments about whether an insight was intellectual rather than emotional were frequently post hoc decisions that reflected rather circular reasoning. With hindsight, insights were accorded the status of merely intellectual insights if not followed by clinical change and of emotional insights if the results were more favorable. This made the theory relating insight to change invulnerable, but not very useful.

The basically negative attitude of the psychoanalytic community toward Alexander's notion of the corrective emotional experience (e.g., Alexander & French, 1946) seemed to me unfortunate. In my own clinical experience, it seemed that the experiential component was a crucial one and that not only new experiences in the relationship with the therapist but also new experiences more generally that disconfirmed neurotic expectations were of greater import than insights that were of a more cognitive sort.

Many of the methods used by behavior therapists seemed to me valuable alternative ways of providing such corrective experiences, and their frequent focus on corrective experiences

in the person's daily life offered a useful complement to the more psychoanalytic emphasis on corrective experiences with the therapist. Even today, when behavior therapy has largely evolved into cognitive-behavioral therapy, I view traditional behavioral interventions as a more useful complement to the psychoanalytic method than I do the methods of more cognitive-behavioral approaches. This is largely due to the fact that my interest in moving beyond exclusively psychoanalytic ways of working was prompted in part by my view that psychoanalysis, with its overvaluation of insight, was itself too cognitive in its approach to therapy, and that what was needed as a corrective were interventions that brought people closer to affective and experiential contact with what they had been warding off. In recent years, I have become clearer that my reservations about the cognitive therapies derive as well from the tendency for some versions to try to persuade the patient that he or she is being irrational (and to the implicit message contained thereby that the therapist is the one who knows what is rational). As cognitive and cognitive-behavioral therapists have themselves increasingly articulated differences between "rationalist" and "constructivist" approaches to cognitive therapy (Arkoff & Glass, 1992; Neimeyer & Mahoney, 1999), I have found myself increasingly interested in the convergences between the constructivist branch of cognitive therapy and the relational approaches to psychoanalysis (Wachtel, 1997).

### Unclarity About the Change Process and Insufficient Exploitation of Freud's Revised Anxiety Theory

Having been trained at Yale during the days when John Dollard and Neal Miller were there (see Dollard & Miller, 1950), I was alerted early to the possibilities of understanding the observations of Freud and later analysts in ways that differed somewhat from standard psychoanalytic language and that opened up new possibilities. In particular, I began to feel that the concept of extinction of anxiety as a major source of change captured the implications of Freud's (1926) late insights into the role of anx-

xiety in neurosis better than most of the standard psychoanalytic literature did.

The extinction concept was closely linked to an important procedural variable—exposure to cues that were previously avoided as a consequence of fear. Avoidances resulting from fear prevent new encounters that might demonstrate that the fear is no longer warranted. Dollard and Miller's analysis, rooted in psychoanalytic observations as well as those deriving from the laboratory, suggested that the cues being avoided were not limited to external cues of the sort typically emphasized by behavior therapists. They could include as well what Dollard and Miller called "response-produced cues"—cues associated with the person's own thoughts and affective reactions. Thereby, Dollard and Miller forged a link between psychoanalytic concepts of repression and the avoidances addressed by more behaviorally oriented therapists. As implied in a different but related way in Freud's notion of signal anxiety, when the individual begins to perceive cues that are even marginally associated with a thought that has become a source of anxiety, there is a strong inclination to avoid those cues. Whether described in terms of "repression" or "defense" in traditional psychoanalytic terminology, in terms of "selective inattention" in Sullivan's (1953) terminology, or in terms of the response of "not-thinking" in Dollard and Miller's conceptualization, what is being addressed is a tendency to not notice, to reinterpret, to change the subject, or in other ways to avoid or attenuate the experience of the forbidden.

Everything we know about extinction of anxiety associated with more overtly observable cues suggests that what is crucial is repeated exposure to the frightening stimulus in circumstances where the expected harmful consequence does not occur. Almost always, this exposure must occur on many occasions, and the reduction of anxiety occurs only gradually. If the reader is following the logic of the argument being developed here, it will be apparent that what is being described is another perspective on what in psychoanalytic terms is referred to as "working through."

Psychoanalytic accounts of working through are often rather vague. Freud sensed early that

singular flashes of insight are unlikely to lead to permanent change, that something more arduous and less dramatic was usually required. This observation has been confirmed so readily in clinical practice by others that therapists reading or talking about working through feel they know precisely what is being referred to. But though the *experience* of working through is a familiar one, the *process* that is represented is not nearly as clear. Psychoanalytic accounts tend to discuss it in terms of examining the newly discovered thoughts, feelings, and experiences from a variety of different perspectives until it is fully understood. The emphasis, in other words, is again often cognitive.

The extinction concept, together with Freud's revised theory of anxiety, suggests another explanation. Working through is needed because what is most essential in therapeutic change is the overcoming of anxieties learned early in life that are no longer appropriate (if they ever were). Fears and inhibitions resulting from the cognitive and motor limitations of children, their misunderstanding and overgeneralization of parental prohibitions, and the restrictions placed on children that are not applied to adults (for example, about sexuality) must be unlearned. The unlearning of these fears, however, is impeded by the avoidance they engender, which makes impossible the needed experience of encountering the source of fear and discovering it is no longer a danger. And once the therapist does manage to bring about exposure to the previously avoided cues, repeated exposure to them is necessary. In the case of formulations guided by psychoanalytic thought, this implies bringing the patient back into contact with the thoughts and affects that have been repressed—that is, avoided. Thus, it is not enough merely to "see" what you have blinded yourself to; it is essential to see it again and again—in other words, to undergo repeated extinction trials for the anxiety associated with these cues or, in psychodynamic terminology, to participate in working through.

From this perspective, one of the key functions of "interpretations" is that they are comments that either interrupt the person's way of avoiding cues associated with the feared thought (defense interpretations) or, by stimulating as-

sociations and/or saying out loud the thought that can't be spoken, increase the likelihood that the patient will begin to be exposed to the therapeutically relevant cues. When psychoanalytic treatment is successful, it is likely that a good deal of its success is due to its effectiveness in bringing the patient into contact with thoughts and images that have theretofore been fearfully avoided. The process of working through, however, may be approached inefficiently if it is primarily conceptualized as a quasicognitive process of exploration and understanding rather than as a reflection of the need for repeated exposure in order for maladaptive anxiety to be extinguished. Rather than looking for "new material" or new perspectives or new understanding, the therapist might more deftly accomplish the therapeutic task by helping the patient to be exposed to the same cues over and over until an efficient, focused extinction process is effected.

### Insufficient Attention to the Role of Social Skills

A further important consequence of the anxiety and avoidance so regularly associated with psychological disorders is that it generally leads, in the course of development, to bypassing or truncating important developmental experiences. The complex social skills required of every adult in an advanced society take many years to learn, and their effective learning requires both careful observation of others and much practice and honing of one's interactional style. That much of this observation and practice goes on automatically, without self-consciousness or even awareness that one is doing such things, does not in any way diminish its ubiquity or importance. If anxieties make it more comfortable to avoid certain kinds of experiences early in life, and the countless practice sessions that life offers are not encountered, there will be an impact on one's ability to negotiate the shoals of social interaction.

This does not necessarily mean that the individual will be grossly inappropriate or a social outcast. To begin with, the deficits are often quite focused, showing up only in very specific contexts. Thus, the patient might in

many ways be a highly skilled participant in social interactions, showing just a few odd lacunae in an otherwise general picture of competence. The lacunae in each case would be related to specific areas of anxiety and avoidance, but the relationship is not necessarily a simple one-to-one. Many dimensions of life experience—including just where one is forced to sink or swim despite one's anxiety and where in contrast well rationalized avoidance is possible—will influence where reasonable skillfulness develops and where avoidance takes its toll.

### ACTIVE INTERVENTION AND THE INCLUSION OF A BEHAVIORAL VIEW

These and other considerations led me to believe that much more active intervention into people's difficulties was both possible and desirable than I was taught by my psychodynamic teachers. I began to be struck by the possibilities inherent in the interventions developed by behavior therapists, whose conceptions did not prevent them from intervening actively. As I began to be more familiar with their work, it seemed to me that behavior therapy was particularly strong in some key areas where the psychodynamic tradition was relatively weak. Behavior therapists, for example, had available to them a variety of active intervention methods for which there was impressive evidence of their capacity to bring about changes desired by the patient. The psychoanalytic tradition, in contrast, had few specific interventions. The process of exploration was forced to serve double duty as both a diagnostic procedure and the intervention to which the emerging diagnostic picture necessarily and almost inevitably seemed to point.

### Variability and Context

A second area of strength for behavior therapy that filled (and highlighted) a gap in the psychoanalytic approach was its considerably greater attention to the role of context in human behavior and, *pari passu*, to the variability

of our behavior and experience in different contexts. This seemed to me consistent with my own experience, both in observing others and in observing myself, of substantial fluctuations and vicissitudes in functioning—both in specific behavior and in the “level” of organization or maturity—depending on the situation and the other people involved. Such a recognition of variability with context need not lend itself to what Bowers (1973) has called “situationism”—an overemphasis on the determining influence of situations that excludes or underestimates the concurrent role of the perceptions, motives, and prior experiences of the individual who finds him or herself in the situation. Rather, in its more sophisticated versions, it points to an appreciation of how characteristics of the individual and the situation interact to jointly codetermine what occurs (see also Magnusson & Endler, 1977; Wachtel, 1973a, 1987, 1999).

This emphasis on the contextual nature of human behavior provided an important corrective to formulations that emphasized the person’s fixation or arrest at a particular developmental level and that, in effect, treated the enormous variability in the actual level of functioning of almost every individual as “noise.” Moreover, it provided a much better handle on appreciating and building on the patient’s strengths rather than focusing the therapist’s attention almost exclusively on pathology (see Wachtel, 1993).

### Validation and Research Commitment

Still a third contribution of the behavioral tradition that drew my attention was its emphasis on the need to validate concepts and procedures. At the time I began my integrative efforts, psychoanalysis was quite weak in this area. The emphasis on privacy, the corollary resistance to tape recording and the indifference to—or even antipathy toward—the experimental method shown by many analysts all contributed to an atmosphere in which clinical lore and private convictions predominated. The vulnerability of uncontrolled clinical observations to bias and to selective perception and

memory seemed to me greatly underestimated by the psychoanalytic community at the time, and the possibility of adding techniques that were being seriously evaluated by strenuous methods was very appealing.

In more recent years, psychoanalytic investigators have taken major steps in correcting this deficiency in the psychoanalytic literature and in the psychoanalytic community (see, for example, Luborsky, 1996; Luborsky, Barber, & Crits-Christoph, 1990; and the series, now in its eighth volume, of *Empirical Studies of Psychoanalytic Theories* (e.g., Bornstein & Masling, 1998). Moreover, both psychoanalytic and cognitive-behavioral thinkers have introduced new perspectives critiquing and expanding our understanding of the nature of evidence in our field, and the result has been a greater convergence between the epistemological perspectives of some key authors in both traditions (see, for example, Mitchell, 1993; Hoffman, 1992; Neimeyer & Mahoney, 1999). Nonetheless, one continuing difference between the cyclical psychodynamic version of psychoanalytic thought and other contemporary psychoanalytic approaches is the greater attention of the former to research findings deriving from non-psychoanalytic origins. Both in developing therapeutic interventions and in understanding personality development and the sources of psychological disorder, the cyclical psychodynamic approach attempts to incorporate the findings of well conducted research, whatever its provenance.

### THE CONTINUED IMPORTANCE OF THE PSYCHODYNAMIC PERSPECTIVE

Despite these dissatisfactions, my basic outlook continues to be best characterized as a version of psychodynamic thought, and various features of the psychodynamic approach have seemed to me crucial to retain. The emphasis in psychodynamic thought on conflict and on the ubiquity of self-deception have been particularly important for me, as have the guidelines it provides as to where and how to look for inclinations and experiences that are being disavowed (Wachtel, 2000, 2001a). Although the

rules of inference that countenance analytically oriented therapists' claims have still not been sufficiently spelled out, the situation is not as arbitrary as many critics of psychoanalysis would have it. Close examination of the logic of inference among responsible psychoanalytic clinicians reveals a variety of useful rules that can be followed with reasonable consistency. It is certainly true that eschewing the kinds of inferences that analysts make can protect the clinician from numerous errors of overinterpretation. But a state of affairs exists that is akin to the unavoidable tradeoff in statistical inference between Type I and Type II errors: Avoidance of the danger of erroneous inferences that the psychoanalytic interpretive method does indeed present can only be achieved by a clinically even greater danger of missing crucial areas of conflict and self-deception. Relying too preponderantly on what the patient can consciously report increases the danger of misformulations of the patient's aims and difficulties.

In observing non-psychoanalytic clinicians at work, I have noted a tendency to assume that what people want and feel are the things that society teaches them they should want and feel (Wachtel, 1997). When one looks and listens closely, however, in the way that the psychodynamic tradition teaches us to look and listen, one may be struck by how often people's actual governing motives and assumptions do not correspond to what is socially expected or normative. Naturally, it is just such nonnormative motives and experiences that are most likely to be inaccessible to the person's conscious awareness, as they frequently elicit guilt and shame.

It is interesting to note—and this bears particularly on the issue of the potential compatibility of psychodynamic and behavioral perspectives—that the inferences on which psychoanalytic formulations are based are often most essentially rooted in paying attention to people's *behavior*, to how what they do differs from what they say. It is in noticing contradictions between patients' avowed intentions and the consistent consequences of their actions that dynamic inferences are frequently born.

### Compatibility of Dynamic and Behavioral Approaches

The key to reconciling psychoanalytic and behavioral conceptualizations—the central theoretical turn in moving beyond what, in many respects, only seemed to be fundamental incompatibilities—was attention to the largely circular nature of causality in human affairs: The events that have a causal impact on our behavior are very frequently themselves a function of our behavior as well. If situations have a greater impact on our functioning than most psychodynamic formulations tend to acknowledge, it is also the case that the situations we encounter are not simply independent variables, as they might appear from the perspective of the experimental studies to which early behavior therapists largely attended (cf. Wachtel, 1973a). Rather, they can themselves be understood as a function of the extant personality organization. By choosing to be in certain situations and not others, by selectively perceiving the nature of those situations and thereby altering their psychological impact, and by influencing the behavior of others as a result of our own way of interacting, we are likely to create for ourselves the same situation again and again. The situations we find ourselves in are not just what the world throws us into but are very largely consequences or expressions of our personalities.

Both the reality of the impact of the situation or context on our behavior, and the reality of our capacity to choose and alter the situations we encounter, must be taken into account if our theories and practices are to capture the full complexity of human behavior. Neither is more basic or correct. By and large, psychodynamic theorists have given greater weight to what might be called the “inside-out” direction of causality, and behavioral theorists to the “outside-in.” Interpersonal and relational versions of the former and social learning and cognitive versions of the latter tend to treat the causal sequences less unidirectionally (e.g., Bandura, 1978, 1999; Horney, 1939, 1945; Mitchell, 1988, 1993; Sullivan, 1953), providing further footholds and handholds for those seeking an integrative model.

In attempting to develop a more fully integrative picture of personality development, I have increasingly relied upon the analysis of vicious circles that maintain consistency in personality functioning over time despite the considerable forces potentially pushing for change. The name “cyclical psychodynamics” reflects the dual concern of this point of view with elucidating the cyclical nature of causal processes in human affairs and with elucidating the unconscious motives, fantasies, and conflicts that are so crucial in almost everything we do (cf. Strupp & Binder, 1984).

From a cyclical psychodynamic perspective, it became clear both (1) that the active interventions of behavior therapists (and later of therapists from other perspectives; see, for example, Wachtel & Wachtel, 1986) could be of significant value in promoting the changes dynamic therapists were working toward, and (2) that those methods could be employed logically and consistently within a modified psychodynamic context. The key to the latter point was the recognition that the transference phenomena that were at the heart of much of the psychoanalytic therapist’s concerns were being conceptualized in most psychoanalytic accounts in a needlessly constricting way.

From a cyclical psychodynamic perspective, transference reactions are understood as the individual’s idiosyncratic way of construing and reacting to experiences, rooted in past experiences, but always influenced as well by what is really going on. The therapist’s interventions do not “muddy” or “distort” the transference because all transference reactions are reactions to *something*. Moreover, it is as important to understand what occurrences the patient is reacting to as to understand why, based on past history, he reacts to the situation in the particular way he does. From this vantage point there is no neutral point from which, if the therapist just gets out of the way and doesn’t interfere or distort, the real transference will “emerge or unfold” (cf. Wachtel, 1987, chapter 3). Rather, transference is a complex set of responses, varying with context, but highly informative about the patient’s key interpersonal experiences and maneuvers. Whatever therapists do—whether they remain largely silent, actively direct the

treatment, assist the patient in devising a regimen of therapeutic experiences—their behavior with the patient will have an impact. And whatever they do, the meaning of that impact is essential to understand. As this point of view emerged clearly for me, I began to get training in behavior therapy and to study closely the work of leading behavior therapists. I also began experimenting with ways to incorporate behavioral methods into my clinical work. At first, my use of behavioral methods was fairly orthodox—even if the setting in which I employed them was not. That is, when I used these methods I looked pretty much the way a traditional behavior therapist looked when he or she used them (though it was not long before at least some variations began to become evident—the consequence of my having had psychoanalytic training and retaining a strongly psychodynamic point of view in many respects). Before long, however, I began to notice that the dividing line between which aspects of my clinical work represented the behavioral side of my work and which represented the psychodynamic side began to blur. Not only did I begin to give a psychodynamic flavoring to my use of behavioral methods, but my style of carrying through the psychodynamic side of the work—of interpreting, of communicating my understanding, and even of listening—began to be influenced by my increasing immersion in the behavioral point of view.

The evolution of the cyclical psychodynamic point of view, then, is characterized by a movement from combining approaches or incorporating methods from one approach into an approach informed by another point of view, toward a fuller synthesis or integration. In much of the work currently approached from a cyclical psychodynamic approach, it is hard to say which is the psychodynamic part and which is the behavioral. The work, one might say, is becoming more seamless.

## APPLICABILITY AND STRUCTURE

Cyclical psychodynamic theory and the integrative relational therapy associated with it evolved out of a psychoanalytic model, and



many aspects of the treatment model reflect these origins. Most typically, it is practiced in an outpatient setting and is associated with relatively long-term treatment rather than a time-limited approach. However, the cyclical psychodynamic perspective, because it is compatible with and encourages more active intervention, is not in principle opposed to briefer treatments, and in particular circumstances more time-limited versions have been undertaken. Most typically, because the goals of the treatment tend to be ambitious ones, the course of treatment is several years. But in the case illustration below, for example, the course of treatment was about 8 weeks. Rapid change is viewed as a desirable consequence of the treatment, rather than as “flight into health,” but the patient is also encouraged to consider whether there are other issues he or she wishes to work on.

Cyclical psychodynamic theory and integrative relational therapy have mainly been applied to patients with neurotic and borderline level characterological difficulties. As in the case example below, it is also applied fairly commonly to a range of symptomatic complaints, particularly involving anxiety and interpersonal difficulties. It has generally not been applied to the treatment of psychosis. Cyclical patterns almost certainly become a part of the difficulties encountered by psychotic patients as well, but the role of genetic and biological factors in those disorders and the concomitant centrality of medication point in different treatment directions. Also, most experience with this approach to therapy has been in outpatient settings, and the treatment of acute psychosis in particular does not readily fit this setting.

This is not to suggest that the use of adjunctive medication is in any way incompatible with a cyclical psychodynamic approach. Psychopharmacological aids for the relief of depression or anxiety are quite common in this approach and are viewed as helping the patient to participate more successfully in the effort to break the vicious circles in which he or she is caught.

Integrative relational psychotherapy is primarily an individual treatment, but the cyclical psychodynamic perspective points quite direct-

ly to the relevance of working as well with the “cast of characters” in the patient’s life (Wachtel & Wachtel, 1986). Thus, even in an individual treatment, occasional sessions with a spouse or partner to address a particular impediment is common, as are occasional sessions, primarily for the purpose of gaining additional perspective, with significant others in the patient’s life.

## THE THERAPY RELATIONSHIP

In integrative relational therapy, the relationship is seen as a central element in the process of change, although by no means the only important element. Alexander and French’s (1946) concept of the corrective emotional experience, Weiss and Sampson’s (1986) ideas about the therapist passing the patient’s “tests,” as well as more contemporary relational writings on the therapeutic relationship and the impact of new relational experience (e.g., Aron, 1996; Frank, 1999; Maroda, 1999; Mitchell, 1993), all have played a role in the way the therapeutic relationship is conceptualized. Especially relevant and helpful in understanding the cyclical psychodynamic understanding of the role of the relationship is the explication by Stolorow, Brandchaft, & Atwood (1987) of the ways that accurate understanding of the patient’s experience and the development of a facilitative therapeutic relationship are part and parcel of each other.

A particular concern of integrative relational therapy is to aid the patient in reappropriating aspects of his or her psychological life that have been cast out of consciousness or rejected from the evolving sense of self. A central focus of *Therapeutic Communication* (Wachtel, 1993)—to date the most detailed description of the actual clinical practice that derives from this approach—is to illuminate the ways in which many common features of therapists’ interpretations and comments to patients are unwittingly critical or discouraging. The creation of a relationship in which the therapist is a helpful collaborator, whose comments are met not with a wince but with a sense of being empath-

ically understood and accepted, is a central aim of the work.

The attention of the therapist shifts back and forth from what is transpiring in the room, what the patient reports about his or her daily life and interactions, and what is learned about the important relationships and experiences in the patient's past. The experience of the therapist in interacting with the patient helps her to understand better what are the likely mutual dynamics in the patient's key relationships and typical interactions. Change is seen as in part deriving from the new experience with the therapist and from the emergence and acceptance of broader and deeper aspects of the self as a result, but this salutary change is seen as depending very crucially as well on changing the experiences the patient encounters daily in interacting with the key figures in his or her life. Ultimately, the therapy relationship and what transpires in the sessions is understood as serving as a *catalyst* for changes in daily life.

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### CASE EXAMPLE

John N. was a quite prominent member of his profession who had, to his great consternation, never passed the licensing exam. He had taken the exam five times before and had failed each time, despite the fact that his professional stature was such that his own work was occasionally addressed on the exam. Although he presented himself as a case of "test anxiety" and informed me of that self-diagnosis in the first session, it quickly became clear that more was involved. John had grown up in a prominent Boston family, and had been taught by his parents, who were quite demanding and status-conscious, that he must not only excel but also appear to do so effortlessly.

This was not something that John was able at the outset to say directly. At first I was merely struck by his various efforts to let me know, indirectly but most assuredly, who it was I was dealing with. He worked very hard at conveying both his stature in the profession and his social status and seemed very uncomfortable with being in the role of patient. In looking for a way to inquire into this tendency that did not leave John feeling

criticized or put down (see Wachtel, 1993; Wile, 1984), I wondered out loud if his parents had been very concerned about status and what the impact on him might have been. At this, he seemed to experience a good deal of relief and immediately relaxed some. He said yes, they were like that and it was very oppressive.

John's conscious views were much more liberal than those of his parents, and this added still further to his dilemma: He could not readily acknowledge his concerns about status, or appreciate the role those concerns played in his life, because he had struggled hard to disavow them and, as far as he knew, he had done so. By raising them as his parents' concerns, I made it possible for him to begin addressing them while still maintaining his view that he himself did not endorse them, indeed while expressing his distaste for them.

Attempting to open further a path for John's exploration of attitudes I sensed were an important part of his difficulties, I then added that it must have been difficult growing up in such an environment not to adopt some of their views simply in self-defense; with their relentless emphasis on status and success, it would have been extremely painful not to attend to this himself. This comment seemed to make it a bit easier for John to take a look at his own concerns about status, most likely because it implicitly conveyed that it was not his fault that he felt this way.

Through this process of gentle and gradual confrontation with his disavowed status concerns, John began to recognize that he had felt defensive and humiliated by having to take the exam and had as a consequence not prepared seriously enough. This was somewhat the case even the first time he took the exam: He felt he had to be very cool and casual about his preparation despite considerable anxiety—*anxiety largely prompted by the internal necessity not just to pass but to do spectacularly well and to do so without "sweating it."* Needless to say, the pressure became even greater as he took and failed the exam over and over.

This initial bit of insight-oriented work modified the program of behavioral interventions that was to be employed. Although, as I will describe shortly, I did indeed use systematic desensitization to help John overcome his test anxiety (the treatment John had come to me expecting), I also,

on the basis of the exploratory aspects of this initial work, concentrated more than I otherwise might have on his preparing more thoroughly for the challenge the exam represented. By helping him to see the unacknowledged feelings and ideas that had led him to treat the exam dismissively, the initial work enabled John to address the exam more seriously this time. As he came to see, it was not just a matter of anxiety that had to be overcome. The anxiety, though in certain respects excessive, and certainly interfering with his performance on the exam, was not entirely unrealistic: It was based in part on his unacknowledged perception that he had not taken the exam seriously enough to be properly prepared.

After working a good deal on the internal pressures that had led John to be dismissive toward the exam and on how he could study for it more seriously this time, we did turn to desensitization. Initially, the major dimension for the development of a hierarchy was a temporal one. The images moved from a period considerably before the exam, through increasingly close approaches to actually appearing at the door, to his sitting down at the desk, to his confronting the experiences he would encounter when actually taking the exam.

As will be apparent below, the "insight" part of the work did not come to an end once systematic desensitization began. Indeed, some of the most useful and interesting insights came during the course of the systematic desensitization itself. If the therapist approaches systematic desensitization, or any other kind of intervention, in a spirit of openness to the patient's experience, there is not a sharp dichotomy between insight-oriented work and active interventions (cf. Frank, 1999).

For example, as we went through the various images in John's original hierarchy, the nature of his discomfort became clarified in a number of specific situations. Thus, when he pictured walking into the exam room, he became aware of the crowd of exam takers pressing in together, and he experienced a strong sense of indignity at being pushed and at having his identity checked. This, more than any concern about failure, was his primary source of distress with these images. We discussed this in relation to the legacy of his upbringing, and it led to an important discussion of

his strategy for studying for the exam. He was struggling with dual inclinations to study much harder than anyone else taking the exam and to study much less. We worked on images of his being just one of the crowd until he could imagine this with little discomfort, and he found that this enabled him as well to have a much clearer sense of what would be an appropriate amount of preparation: He could do it "just like everyone else."

Similarly revealing was his reaction to the image of approaching the door of the exam building. It became clear as he immersed himself in the image that another source of discomfort was seeing the guard at the door. He recalled that the same man had been on duty on several occasions and felt very uncomfortable at the idea that this man would see that he was taking the exam still one more time. He worked on this image for much of a session, finally overcoming the anxiety when he pictured himself taking the bull by the horns and saying "good morning" instead of trying to slink in unnoticed (as he realized at some point he was doing in the image).

The most interesting developments occurred when John imagined himself visiting the exam room the day before the exam. The aim in this set of imagery exercises was for him to acclimate himself to the setting in which the exam would take place and thereby to experience a reduction in anxiety. He was asked to look carefully around the room, to touch the various surfaces such as the desk and walls, to experience the lighting, and so forth.

When he began the imaging, however, a fascinating series of associations and new images came forth. At first he spontaneously had the association that the room seemed like a morgue, and then that the rows of desks seemed like countless graves covering the site of a battlefield. Then he felt overcome with a feeling of impotence. I asked him if he could picture himself as firm and hard, ready to do battle. He did so (I left it ambiguous whether he should take this specifically to mean having an erection or as an image of general body toughness and readiness). He said he felt much better, stronger, and then spontaneously had an image of holding a huge sword and being prepared to take on a dragon. He associated this image to our various discussions of his

treating the exam as a worthy opponent, taking it seriously yet being able to master it. He was exhilarated by this image, and I suggested he engage in such imagery at home between sessions, a suggestion he endorsed with great enthusiasm.

In the next session, we began with his again picturing himself visiting the exam room the day before the exam. For a while, as he checked out the various features of the room, he felt quite calm and confident. But suddenly he felt a wave of anxiety, as if something was behind him. I asked him to turn around and see what was there. He reported seeing a large cat, a panther. Here I made a kind of interpretation. I offered that the panther represented his own power and aggression and that it was a threat to him only so long as he kept it outside of him or out of sight. I asked him if he could reappropriate the panther part of him, adding that what he was feeling threatened by was his own power, his own coiled intensity.

He pictured the panther being absorbed into himself and the anxiety receded. I then elaborated—quite speculatively, to be sure, but in a way rooted in the understanding we had achieved together about the dynamics of his difficulty with the exam—on why it might be that he had chosen a panther in particular to represent the part of himself that needed to be reappropriated. I noted that panthers were not only strong and purposeful but were also meticulous and supremely respectful of their prey. Despite being awesome creatures, I suggested, panthers did not take their prey lightly. They did not just casually leap out whenever they saw a potential source of nourishment. They did not act as if it were beneath their dignity to stalk for hours, crawling on their bellies. Panthers, I said, were diligent students who became experts on the habits of the creatures they tracked—and experts whose expertise was the result not just of instinct or superb natural equipment but of attention to detail and a respect for the difficulty of the task of conquest nature required of them. Their grace might look effortless but it was far from casual; panthers were supremely serious.

Now in all this, it is impossible for me to distinguish how much reflected an empathic grasp of the actual layers of meaning that led to John's experiencing that particular image and how much

was simply suggestion on my part (see Wachtel, 1993, chapter 9). The "interpretation" seems plausible, but at the very least I was gilding the lily, using the panther image to point toward attitudes I felt it would be useful for him to incorporate, whether they were the actual sources of the image or not.

What is important is that my comments were meaningful to the patient. Whether or not they accurately depicted the origins of the image, they did resonate with the ripples of meaning that the image engendered, and they helped to amplify and consolidate the utility of the image itself, which was, after all, John's creation. In further work on the test anxiety and—significantly—later on his own in dealing with a range of other concerns, John, for whom imagery turned out to be a very salient modality, made great use of the panther image and its variants (cf. Lazarus, this volume). He aided his efforts at relaxation, for example, by imagining himself as a big cat, relaxing and licking himself. When faced with a difficult challenge he imagined again himself and the panther as one, and felt that he didn't have to be overtly aggressive, as he knew deep inside he was capable of whatever was necessary. Sometimes he would even imagine himself emitting low murmuring sounds deep in his throat that, as he put it, "remind the panther that it's a panther."

One of my favorites of his spontaneous creative uses of the panther image came later in the desensitization work. We were at the point of his imagining actually sitting and taking the exam when a wonderful smile appeared on his face. He told me he had just had an image that the point of the pencil with which he was writing the exam was actually the claw of the panther; that the panther was firmly within him, incorporated and channeled, and as the claws came through the tips of his fingers they were pencils that were writing out exam answers with very sharp points.

This time around, his points were indeed sharp. After having failed the exam five times previously, he not only passed but did very well. I cannot, of course, determine whether he would have passed even without therapy of any kind, or whether a more orthodox course of either behavior therapy or psychoanalytic therapy alone (or of any other approach for that matter) would have

done just as well. Only systematic research can enable us to sort out with confidence the many questions that cases like this raise. Conceptualizing and implementing such research will be a considerable challenge that will tax our powers of persistence and methodological innovation.

#### FURTHER COMMENT ON THE CASE

The case just described was in certain respects a turning point, or at least a marker along the way to a change in the clinical applications of cyclical psychodynamic theory. The degree of synthesis of differing methods, the extent of the “seamlessness” of the therapeutic effort, was greater than had typically been achieved in my previous efforts. Previously (and still at times), cyclical psychodynamic therapy often was characterized by a less complete form of integration in which procedures deriving from different therapeutic traditions were combined largely by using one or another of them at different times in the course of the work. Although they fit together into a coherent framework, they were nonetheless clearly identifiable as separate parts. Increasingly, as in this case, what has evolved is a more seamless integration, in which the procedures at any given moment are not quite what most behavior therapists would do and not quite what psychoanalysts would do, but rather emergent procedures reflecting the integrative intent of the therapy.

The case differs from most cases seen from a cyclical psychodynamic perspective in that it had a rather narrowly defined goal. A variety of intriguing and important characterological issues, fantasies, and conflicts became evident in the course of the work, but John made it clear that what he was coming for was simply to overcome the anxiety that had impeded his ability to pass the exam. Had John been interested in pursuing further how these attitudes and anxieties influenced his life in other ways, the therapy would have addressed them more extensively and more in depth. This is the more typical course of the work from a cyclical psychodynamic perspective, but it is another essential feature that one understand and respect the viewpoint and the goals of the patient; there is a difference between a therapist and a missionary.

John’s case, nonetheless, illustrates well a number of features of the cyclical psychodynamic point of view. To begin with, we see a number of vicious circles evident in John’s difficulties, which interweave influences from his past, from his motivational conflicts and internal necessities, and from his daily transactions with the world of actual events. John’s conflicting needs to be outstanding and to appear to do everything effortlessly made it difficult for him to study sufficiently to do well on the exam and made the first failure especially painful. These influences then fed on themselves. Feeling so humiliated and embarrassed, John’s anxiety increased, making still further failure more likely. Moreover, his need defensively to deride the exam, and also not to appear shaken and therefore not to study too hard, both repeated the state of affairs associated with the first failure and set the stage for the next.

An additional circular process, reinforcing the interlocking set of influences just described, involved the excessively high standards that John had absorbed from his parents in his youth. Those standards were perpetuated as a continuing psychological irritant, not just by his attachments to the objects and images of his earlier days, but by the new relationships he continually established with others. By presenting himself as special, John evoked expectations of being special and created a life structure that replicated the circumstances of his childhood in this way. That he was in fact a very talented individual enabled this potentially fragile structure to be maintained, but at a very high psychic cost. As they became enmeshed with his difficulties with the exam, and with the other circles described above, these influences further exacerbated John’s difficulties. It was not really enough for him to pass the exam; he had to do extraordinarily well. This pressure increased as the number of his failures on the exam mounted and, of course, it interacted toxically with his anxiety. Thus, we may see that even in a therapy focused on a narrowly defined problem, the cyclical psychodynamic perspective points us to seeing how interacting circular processes tie together past and present and internal and external influences.

We also see in this case a number of characteristic features of the therapeutic approach that

are associated with the cyclical psychodynamic point of view. We see, for example, the emphasis on exposure to what one has been afraid of and on structuring that exposure in such a way that it will be both vivid and able to provide the patient with an experience of mastery. In addition, the therapist's efforts were directed toward helping John change his actual behavior with regard to the exam and his preparation. At various points, John's strategies for studying were examined quite explicitly and suggestions made, both implicitly and explicitly, for ways to achieve a better synthesis of his competing aims. Illustrated too is the concern with skills that have been impaired by anxiety and avoidance and with helping the patient explicitly to improve those skills (Wachtel, 1993, 1997). The primary focus in this instance was on study skills (in keeping with the more limited aims of this particular case), but even here other dimensions were brought to bear. For example, in working with John on his attitudes about other people who might notice that he was taking the exam again, at least some work was done on his more general assumptions about what others would think of him and on how he dealt with those attitudes.

It should also be apparent from this case illustration how a therapy rooted in the cyclical psychodynamic perspective integrates the exploration of warded off experiences and inclinations with direct and active efforts at promoting change. Although active interventions were employed, the direction toward which the therapeutic efforts were addressed depended considerably on the initial exploratory work done with John. Enabling John to acknowledge and understand how he had kept himself from appreciating the extent of his status concerns, and why he had needed to do so, was important in developing the focus of the overall approach. Appreciation of his conflict over working hard to prepare for the exam and of the unrecognized need he had to make it all appear effortless (not only to others but to himself) led to further active intervention efforts directed toward helping John study more effectively and take the exam more seriously. Moreover, understanding the importance of the indignity John experienced in the process and his embarrassment at retaking the exam provided another focus for desensitizing efforts, as well as for further explor-

ations of how these feelings (and how he dealt with them) affected his life more generally.

The case illustrates as well some of the subtleties of the therapist's use of language that have increasingly been at the center of the cyclical psychodynamic approach (Wachtel, 1993). The inquiry into John's status concerns—concerns that at first were vigorously disavowed by him—began by addressing his parents' concerns and proceeded only gradually to inviting him to explore his own. Moreover, the latter exploration was undertaken in a way carefully designed to enable John to examine these concerns in a manner that permitted him to maintain his self-respect. Ultimately, the aim was for John to be able to acknowledge and take responsibility for his attitudes, and the general evolution of the case indicates that he indeed was able to do so.

The path toward doing so, however, led initially through a preliminary *disavowing* of responsibility: It was his parents' attitudes that were really at issue, and he could not help absorbing some of them. Such a strategy for enabling people to recognize and take responsibility for their experiences by initially placing the responsibility outside themselves has been described in recent cyclical psychodynamic explorations of therapeutic language as "externalization in the service of the therapy." It is one of a number of cyclical psychodynamic strategies designed to ensure that the fostering of insight enhances, rather than diminishes, the patient's self-esteem (see also Wachtel, 1993; Wile, 1984, 1985).

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## EMPIRICAL RESEARCH

The research evidence supporting cyclical psychodynamic theory is as yet only indirect. Studies have not yet been done comparing the outcome of therapy conducted from this point of view with that of other approaches, nor has explicit testing of cyclical psychodynamic propositions been undertaken thus far.

There is, however, a significant body of research, especially in social and developmental psychology, that supports the basic tenets of the theory described here. Studies about self-fulfilling prophecies, also called expectancy ef-

fects or behavioral confirmations, are perhaps most strikingly relevant to the concepts underlying cyclical psychodynamics.

Numerous studies of expectancy effects have shown results consistent with the major thrust of cyclical psychodynamic theory—that the patterns of our lives are sustained and strengthened not in spite of, but because of, our current reality. To use the terminology of cyclical psychodynamics, in subtle and unconscious ways we induce others to act as unwitting “accomplices” in maintaining the beliefs that support our life structure, including those that maintain neurotic or maladaptive patterns (Wachtel, 1991).

The research cited below demonstrates both the range of situations in which accomplices may be found and the subtlety of the way that accomplices (usually unwittingly) are recruited. Until recently, much of the psychological research conducted on self-fulfilling prophecies focused on phenomena more amenable to the research laboratory, such as first impressions and the interactions of strangers. But as Jones (1986) points out, there is reason to think that such patterns are found in long-term relationships as well. He argues that the increasing contact can “generate patterns of behavioral escalation” (p. 46), a conclusion quite congruent with the conception of vicious cycles at the heart of cyclical psychodynamics. His assertion is supported by the research on rejection sensitivity and self-fulfilling prophecies in close relationships (e.g., Downey, Freitas, Michaelis, & Khouri, 1998) and work on the tendency of those struggling with clinical depression to seek out information and experiences that confirm their negative expectancies. “In effect, by engaging in a maladaptive interpersonal style, depressed individuals become caught up in a self-perpetuating cycle that sustains their depression” (Giesler, Josephs, & Swann, 1996, p. 358; see also Gotlib, 1991; Joiner & Coyne, 1999).

### The Self-Fulfilling Prophecy

First defined by sociologist Robert K. Merton (1948), a self-fulfilling prophecy is an under-

standing of a situation, originally incorrect, which leads to behavior that causes the false assumption to come true. We respond not to an objective reality but to the meaning we ascribe to our perceptions. Sociologists and psychologists have followed Merton’s lead to show how self-fulfilling prophecies may explain a host of social problems, especially ethnic and sexual prejudices (Jussim, 2000; Snyder, 1981, 1982; Wachtel, 1999). Expectancies perpetuate negative stereotypes about race (Chen & Bargh, 1997; Snyder 2001; Steele, 1997; Word, Zanna, & Cooper, 1974), social class (Darley & Gross, 1983), mental health problems (Farina, Gliha, Boudreau, Allen, & Sherman, 1971; Sibicky & Dovidio, 1986; Vrugt, 1990). As early as 1978, Rosenthal and Rubin conducted a meta-analysis of 345 studies of expectancy effects and concluded that the phenomenon exists “beyond doubt” and is substantial in its impact.

Self-fulfilling prophecies appear to be especially powerful when they involve the maintenance of an individual’s self-image. Swann and Read (1981) report research that strongly suggests people seek out and attend to information that will preserve their vision of themselves, whether that vision be as likeable or dislikeable. Subjects also behaved in ways that reinforced their self-concept and selectively remembered social feedback that confirmed their view of themselves. Thus, confirmation bias occurred before, during, and after interactions. Swann and Reed concluded that self-verification can be an even more powerful motivation than self-enhancement. In later research (e.g., Giesler & Swann, 1999; Swann & Bosson, 1999; Swann & Pelham 2002), Swann and his colleagues found that the tendency toward self-verification was particularly strong in people with negative self-concepts and strongest in those suffering from depression.

The work of Downey et al. (1998) demonstrates quite nicely the effects of the self-fulfilling prophecy in close relationships. In previous work, they established the concept of Rejection Sensitivity (RS) (Downey & Feldman 1996; Downey, Lebolt, Rincon, & Freitas, 1998; Feldman & Downey 1984), which they define as “the disposition to anxiously expect, readily

perceive and overreact to rejection” (p. 545). Downey and her group have determined that those who are repeatedly subjected to rejection experiences develop “rejection expectancies” in later situations where rejection is possible. These rejection expectancies lead subjects to see ambiguous events as evidence of rejection more readily than others. They theorize that these perceptions ironically elicit the very behavior that high RS people are attempting to avoid. The findings of this research, discussed largely in terms of the attachment and social cognition literatures, converge substantially with the premises of cyclical psychodynamic theory.

Considerable research supports the view that the expectations of both patients and therapists inevitably influence the therapeutic relationship and its success. In Jerome Frank’s classic work *Persuasion and Healing* (1973; Frank & Frank, 1991), the role of expectations is linked with placebo effects, symptom relief, and treatment duration. The authors review studies that show that inert medications or placebo-attention therapy can be as effective as psychotherapy because the placebos arouse hope in demoralized patients (e.g., Bootzin & Lick, 1979; Elkin et al., 1989).

Sibicky and Dovidio (1986) and Vrugt (1990) demonstrated how the negative expectancies that both the general public and clinicians themselves have about those who seek out psychotherapy result in confirmatory behaviors from people who are perceived to be patients. In Vrugt’s research, she found that beginning clinicians had a more negative attitude toward subjects who were randomly identified as clients in need of psychotherapy than non-clients. Interestingly, it was found that this attitude was communicated nonverbally to clients and resulted in the clients becoming more uncomfortable and acting in ways that one would expect of a distressed person. Thus, interpersonal messages and influences, acting often nonverbally and probably with little awareness on the part of either party, can maintain the expectations of each party in a process that one of us (P. W.) has called “pseudo-confirmation” (Wachtel, 1999).

## Developmental Studies of Cyclical Processes

Studies in infant development during the past four decades have raised questions about the conception of infants as passively reacting to environmental forces or inner drives and have suggested instead that the infant is an active participant in the creation of its interpersonal world. Studies have shown that even neonates have the capacity to detect contingencies between actions and environmental events and to develop causal expectations (Finkelstein & Ramey, 1977; Millar & Watson, 1979; Watson, 1985). By 3 months of age, an infant needs only two encounters with a novel event to form expectancies about whether that event will recur (Fagen, Morrongiello, Rovee-Collier, & Gekoski, 1984).

The terms used by these researchers all highlight the cyclical nature of the interactions of focal interest. For example, Brazelton and colleagues refer to “reciprocity” (Brazelton, Kozlowski, & Main, 1974), Beebe and Lachman (1988, 2002) write about the implications of “mutual influence,” and “bidirectional” impact is the focus of work by Cohn and Tronick (1988). The findings of contemporary infant research suggest that in normal mother–child dyads there is a continual exchange of cues in which each member has an impact on the expressive state of the other (e.g., Beebe, Lachman, & Jaffe, 1997; Cohn & Tronick, 1987; Jaffe, Stern, & Peery, 1973; Jasnow & Feldstein, 1986; Stern, 1977; Tronick, Als, & Brazelton, 1977; Weinberg & Tronick 1996).

Infants with unresponsive parents may learn that their social cues are ineffective, as appears to be the case when parental psychopathology interferes with caretaking skills. Studies of depressed mothers and their infants have shown that such mothers are less able to respond appropriately to their babies’ signals, and thus the infants experience themselves as having little impact on their social environments (Cohn, Matias, Tronick, Connell, & Lyons-Ruth, 1986; Field, 1984, 1986; Weinberg & Tronick, 1998). This may be one reason why infants and young children of depressed mothers are at increased



risk for developmental problems (Tronick & Gianiana, 1986). From the first month, the child develops expectations with regard to the effectiveness of its interpersonal signals and whether or not social interactions will be satisfying and enjoyable.

The findings by developmental researchers of dyadic reciprocity and the cyclic impact of expectations is having growing impact within the psychoanalytic community on therapeutic work with adults. In a paper on the implications of infant development research for psychodynamic theory and therapy, for example, Zeanah, Anders, Seifer, and Stern (1989) come to conclusions remarkably similar to those on which cyclical psychodynamics is founded. The “continuous construction model” proposed by these authors prompts them to call for integrative treatment that focuses more explicitly on the here and now, especially through the transference relationship.

### Disconfirmation of Pathogenic Expectations

In contrast to the large body of research about self-fulfilling prophecies, there are relatively few studies that have explored the conditions necessary for expectations to be broken. A self-disconfirming prophecy occurs when the original belief leads to behavior that prevents that expectation from coming true. For example, falsely expecting someone to be shy and withdrawn might lead one to act especially solicitous and comforting, thus inducing that person to open up and behave more gregariously than usual.

Snyder and Stukas (1999) attempt to lay out the conditions that increase the likelihood of confirmation or disconfirmation of expectancies. They review evidence that suggests that perceiver reliance on expectations—and thus a decreased likelihood of maladaptive self-fulfilling prophecies becoming disconfirmed—is increased when expectancies are automatically as opposed to overtly activated (Skowronski, Carlston, & Isham, 1993), when perceivers are under greater cognitive load (Biesanz, Neuberg, Smith, Asher, & Judice, 2001), and when the perceiver hypothesizes that confirmatory strate-

gies (even of negative expectancies) have high social value (Judice & Neuberg, 1998). These studies lend support to the value of making unconscious interaction patterns conscious and of attenuating anxiety and enhancing social skills.

Motivation also appears to be a key factor in whether prophecies are confirmed or disconfirmed (Judice & Neuberg, 1998; Snyder & Stukas, 1999). For example, Neuberg, Judice, Virdin, and Carillo (1993) found that the motivational set with which individuals approached an interaction influenced whether or not negative expectations were confirmed. In this study, they recruited subjects to conduct job interviews over the telephone. They provided the interviewers with false data on the people they were interviewing in order to manipulate their expectancies regarding the person’s performance. Additionally, they instructed some of the interviewers to attempt to persuade the target to like them. Those interviewers with no goal did replicate the expectancy effect, whereas those with “liking goals” had their negative expectancies disconfirmed.

A more recent study indicates that the perceiver’s motivation to form accurate impressions of the target may not be enough to succeed at doing so without adequate attentional resources at hand. Biesanz, Neuberg, Smith, Asher & Judice (2001) gave interviewers instructions to attempt to perceive their targets accurately and then told them whether or not a particular applicant was well suited for the position or not. Interviewers were given various distracting tasks to perform during the interview, ranging from mildly to highly distracting. They found that accuracy-motivated interviewers who were only mildly distracted during the interview were indeed able to form accurate impressions of applicants. However, those interviewers who were highly distracted behaved toward and formed impressions of the applicant that were consistent with their expectancies. This suggests that current stress and anxiety can be a considerable barrier to overcoming unwanted self-fulfilling prophecies.

These findings are congruent with the cyclical psychodynamic emphasis on interaction cycles as depending on the characteristics and actions of both partners, and with the broader,

two-person and constructivist models that characterize contemporary relational theory (e.g. Aron, 1996; Hoffman, 1996; Mitchell, 1988, 1993). They also provide further understanding of why it is that patients may sometimes learn to interact in new and adaptive ways within the therapy hour yet may revert back to old patterns in interacting with friends and family, whose expectations and ways of interacting differ from those of the therapist (Wachtel, 1993, 1997). The cyclical psychodynamic approach to therapy is very much concerned with these phenomena. It is one of the key reasons that cyclical psychodynamic work on the transference is usually complemented by explicit attention to the patient's interactions in his or her daily life.

The tenacity with which beliefs are held also points to the conclusion that insight may not be enough to lead to change in most cases. A number of lines of research point to limits in the capacity of understanding, even "emotional" understanding or insight, to shift opinions. Many studies have shown, for example, that when research subjects are misled, their erroneous beliefs persist even after debriefing (Davies, 1997; Nisbett & Ross, 1980; Ross, Lepper, & Hubbard, 1975). If these newly formed self-concepts are so difficult to modify, how much more impervious are longstanding beliefs about the self. It is interesting to note in this context that even most "cognitive" therapies include considerable effort to bring about changes in behavior and to induce patients actively to test out the assumptions by which they have been living.

## FUTURE DIRECTIONS

In the development of cyclical psychodynamic theory, the first major challenge was the integration of psychodynamic and behavioral theories and practices (Wachtel, 1977). Even before that first effort was completed, it became apparent that the evolving theoretical framework, with its stress on circular, recursive processes and on the context of behavior and experience, offered as well a framework for integration of individual and family-systems ap-

proaches (Wachtel & Wachtel, 1986; see also E. Wachtel, 1994).

More recently, the cutting edge of cyclical psychodynamic thinking has been directed toward the integration of an experiential perspective. This can entail the explicit incorporation of methods from the experiential-humanistic "schools" of therapy, but it also entails appreciating and emphasizing the experiential foundations of all successful psychotherapy. One of us has recently clarified, for example, that a central attraction of behavioral interventions, from the very beginnings of the cyclical psychodynamic approach, was the capacity for such interventions to bring the individual into closer experiential contact with defensively warded off material than do exclusively verbal approaches (Wachtel, in press). This is a dimension of the use of behavioral interventions that can be obscured both by the rhetoric of behaviorism that misleadingly characterized the early behavioral movement (see Wachtel, 1977) and by the political and sociological divisions in our field that assign the label "experiential" only to a particular subset of therapeutic approaches.

A second vector in the evolution of the cyclical psychodynamic approach has been the increasing move toward a more "seamless" approach to integration referred to in the case example. This development has greatly been aided by the cyclical psychodynamic exploration of the use of language as a multifaceted medium of therapeutic intervention. Beyond its specific context, language is a way that the relationship is given its particular qualities, a way of conveying approval or disapproval (whether acknowledged by the therapist or not), a way of bringing the patient into contact with forbidden experiences, and a great deal more (cf. Stolorow, Brandchaft, & Atwood, 1987).

Although the title of the book embodying the cyclical psychodynamic exploration of language was *Therapeutic Communication* (Wachtel, 1993), it could as readily have been titled "Therapeutic Intervention." A central message of the book was that our language as therapists always conveys affect-laden "meta-messages" along with whatever content messages the therapist intends to communicate, and that these

meta-messages are, inevitably, a form of intervention whose impact can either aid or impede the therapy depending on the therapist's skill and awareness. For therapists operating from a cyclical psychodynamic vantage point, there now exist options for intervening in ways that serve many of the same functions (e.g., exposure, development of new, more adaptive behavior) that are served by explicit behavioral interventions but that fit more comfortably and less intrusively into an exploratory or psychodynamically structured approach.

A third vector of cyclical psychodynamic theory is represented by the applications of the theory to larger social questions. The integrative framework of cyclical psychodynamics, with its emphasis on understanding the continuing back and forth between individual dynamics and the context in which those dynamics are manifested, points to not only the immediate interpersonal context but the larger social, economic, political, and historical context as well. *The Poverty of Affluence* (Wachtel, 1983) was an early application of this perspective, focusing on the psychological (as well as ecological and sociopolitical) implications of a society in which there are powerful forces converting the multiplicity of our psychological needs to the single homogeneous motive of economic growth and advancement. More recently, further explorations of the interface between social and psychological processes from a cyclical psychodynamic point of view have appeared. These have included issues of race and racism (Wachtel, 1999), greed and materialism (Wachtel, 2003), and trauma and terrorism (Wachtel, 2001b, 2002).

Finally, a current central thrust of cyclical psychodynamic theory entails situating the theory in relation to the evolving relational point of view in psychoanalytic thought. From the beginning, cyclical psychodynamic theory approached the task of integration from a psychoanalytic foundation, assimilating new ideas into that base (Messer, 1992). Initially, it was the interpersonal perspective in psychoanalysis that seemed to offer the best conceptual tools for bringing together both the observations that had long been central to the psychoanalytic

point of view and the further observations, generally ignored or overlooked by psychoanalysts, that derive from other orientations that were entering into the new synthesis.

Although cyclical psychodynamic theory preceded the appearance of the term *relational* as a central theme in psychoanalytic discourse, it is apparent in retrospect that it was from the beginning an instance of relational theorizing. Ongoing efforts to refine and further elaborate the cyclical psychodynamic point of view are largely centered on exploring more deeply both the convergences with and differences from other relational theories. One of the distinctive features of the cyclical psychodynamic version of relational thinking, of course, has been its much greater attention to developments outside the psychoanalytic realm altogether. Cyclical psychodynamics will continue to be an integrative theory as well as a relational one. In a book currently in progress (Wachtel, in preparation), the implications of the ongoing rethinking both of cyclical psychodynamic theory and of relational theory and practice more generally are being further explored. It is hoped that the fruits of this exploration will include a greater understanding as well of the possibilities for integrating relational psychoanalytic thought and important developments in other branches of psychological and psychotherapeutic theory and practice.

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## Cognitive Analytic Therapy

ANTHONY RYLE

### ORIGINS OF THE APPROACH

Cognitive Analytic Therapy (CAT) originated from a practical and theoretical integration of psychoanalytic, cognitive, and constructivist ideas. It is usually applied within predetermined time limits in individual therapy, but the model has been extended to group therapy, systems work, and case management. The origins and development were influenced by psychotherapy outcome research and by the need for effective time-limited methods. Its key feature is the early reformulation of the issues to be addressed, carried out with the patient's participation and recorded in writing and diagrams, and the use of these to enhance patients' self-reflection and to support therapists in providing an accurate, noncollusive, and reparative relationship. CAT is directed at the high-level self-processes underlying symptoms and disturbances of mood and behavior. The model offers a guide to treatment and management for the whole spectrum of outpatient psychotherapy.

### Influence of Research

Cognitive Analytic Therapy was identified as a specific psychotherapy in the mid-1980s but was derived from clinical work and research carried out during the two previous decades. During that period, I had combined the practice of dynamic psychotherapy with small-scale research into process and outcome, based in particular on the use of repertory grid techniques. The repeated experience of thinking about my patients in two different "languages" coincided with the growing interest in integration of the 1970s (see Ryle, 1978).

In addition, being aware of the need for psychodynamic therapists to devise measures of the changes aimed for, I sought ways of defining dynamic goals early in the course of therapy. A study of the case notes of completed psychotherapies showed that the therapeutic conversation had largely been concerned with only one or two persistent problematic areas and that these were usually already identifiable

in the first meeting. The research task was to describe these and to define the reasons for their persistence; put simply, this required answering the question “Why do patients fail to revise ways of thinking and acting that have negative outcomes?”

Three patterns underlying this nonrevision were identified: *dilemmas*, where the possible ways of acting or relating were perceived in terms of polarized alternatives; *traps*, where negative assumptions generated ways of acting, the consequences of which evidently confirmed the assumptions; and *snags*, where appropriate goals were abandoned as if not permitted by others or by the self (Ryle, 1979a). Once the patient’s individual difficulties were conceptualized in terms of these patterns, the aim of therapy could be defined as their revision. During this same period, I was working to identify dynamic concepts and therapeutic aims in terms of repertory grid features, and these provided parallel outcome measures (Ryle, 1975, 1979b, 1980).

Other changes in my practice were a consequence of these research activities. Developing descriptions of an individual patient’s dilemmas, traps, and snags and constructing repertory grids required joint work with the patient and involved the use of writing by both patient and therapist. The positive impact of this shared activity on the progress of therapy was so marked that the original research plan was abandoned and, in place of conventional dynamic therapy, I began to practice what became CAT, a defining feature of which remains the early, joint written reformulation of the patient’s problems.

### The Need for Focused Time-Limited Work

A second factor in the development of the CAT model was a commitment to making psychotherapy available within the National Health Service in the United Kingdom. My earlier experience in general practice (Ryle, 1967) had confronted me with the high prevalence of psychological distress and the largely inadequate availability of treatment. This pointed to the

need for time-limited work, and here the work of Mann (1973) was encouraging.

### Object Relations, Kellyan, Behavioral, and Vygotskian Influences

In my clinical work, I made full use of the branch of object relations theory represented by Winnicott and Guntrip. I was also influenced by Kelly (1955) who, as well as developing Personal Construct Theory from which repertory grids were derived, offered a model of nonauthoritarian practice that I respected. From behavioral and cognitive theory (e.g., Miller, Galanter, & Pribram, 1960; Neisser, 1967), I learned the value of describing the *sequences* of contextual, cognitive, and behavioral events involved in the maintenance of normal and dysfunctional behaviours. From cognitive therapy (Beck, 1976), I learned the usefulness of patient self-monitoring. I developed a preliminary formal theory, the Procedural Sequence Model (PSM) (Ryle, 1982), through which many psychoanalytic ideas were restated in cognitive terms.

This early model was based on a relatively complex unit of description. It described aimed behavior in terms of *procedures* incorporating in sequence: event or context, appraisal, choice of action, enactment, appraisal of consequences, confirmation or revision of the procedure or aim. This descriptive unit includes, therefore, external, mental, and behavioral components. Subsequently, the Procedural Sequence Object Relations Model (PSORM) placed a central emphasis on relationship procedures. As the aim of a relationship procedure is to anticipate, respond to, or elicit the response of the other; these were called *reciprocal role procedures* (Ryle, 1985).

The name Cognitive Analytic Therapy reflected the two main sources but, in reality, as clinical and research activity continued and colleagues from different backgrounds were recruited, the net was cast more widely, and other important influences played their part. Notably, the introduction of Vygotskian ideas led to a systematic revision of object relations

theories in which the importance of the joint creation and internalization of mediating signs was emphasized and in which the early sources of reciprocal role patterns and of internal dialogue in the child's experience and activity were described (Leiman, 1992, 1994; Ryle, 1991). The main concern shifted from theoretical *integration* to *differentiation* and *elaboration*. The theory, besides being closely linked to practice, now offers a general account of psychological development and of therapeutic change, as well as providing a basis for an ongoing critique of other psychotherapy models (Ryle, 1992, 1993, 1995, 1996, 2001, 2003).

### ASSESSMENT AND CASE FORMULATION

The CAT model has been applied to a wide range of diagnostic groups, largely in the context of National Health Service outpatient psychotherapy. Within the overall CAT framework, a wide variety of techniques may be used; the specific aims, defined as procedural revision, will be determined by the individual patient's needs and capacities.

Assessment seeks to decide the following: Is this patient in need of therapy? Would an alternative approach be preferable, for example, cognitive-behavioral therapy or group therapy? If the difficulties are clearly associated with a family situation or a particular relationship, would it be better to offer conjoint assessment or therapy right away or could this be considered after individual work? Is there evidence of serious Axis II pathology? Is there a serious risk of harm to self or others? The significance of how these questions are answered will in part reflect the setting. Thus, as most services are underresourced, the availability of alternative, particularly long-term, treatments may be strictly limited. A risk of self-harm or suicide, intermittent psychotic episodes, and substance abuse can be accepted in clinic or hospital settings with professional backing but not in isolated practice. It is important to gauge how far the patient's present circumstances make therapy a realistic possibility in terms of time and, in private practice, of insurance coverage or

personal money and of the presence of important others who may offer emotional support or who may resist change.

Psychological mindedness and motivation are not prerequisites for offering CAT. If patients attend for assessment, then it is assumed they will be engendered by the therapist's capacity to convey acknowledgment of the patient's experiences and an accurate and empathic understanding of the patient's difficulties. The assessment interview and the first therapy sessions should provide patients with an example of focused attention and offer preliminary understanding of how their story might be understood and of what therapy entails.

Psychometric questionnaires may serve various purposes. Routine self-report symptom questionnaires are of value in indicating the levels of disorder treated and in providing simple measures of individual pathology and change. Therapists should discuss their patients' replies to these as an acknowledgment of the patients' work in completing them and because their replies—for example, about suicidal ideation—may be franker than those elicited at interview. Other instruments may provide some measures but serve more explicitly as screening devices.

As suggested above, one function of the assessment interview(s) is to convey something of the nature of therapy. In the case of CAT, this will involve a preliminary reformulation of the patient's presenting problems. It is helpful to detail what the patient will be expected to do in terms of attendance and homework, and this can be linked with an account of what the therapist undertakes to provide. This may be recorded in the form of a contract so that failures by either party can clearly be recognized and the reasons dealt with within the therapy. As the patient tells his or her story and conveys, directly or indirectly, expectations about the therapy, the therapist will listen carefully for evidence of emotionally important episodes and themes and will seek to identify recurrent patterns in terms of dilemmas, traps, and snags and in terms of reciprocal role procedures, looking for evidence of the latter in the developing therapy relationship.

This process will be aided by the patient's completion and discussion of the Psychother-

apy File, which offers instructions in symptom self-monitoring. It also provides examples of dilemmas, traps, and snags and of difficult and unstable states of mind. Patterns identified by the patient are discussed and clarified.

At the fourth session, the therapist offers a written account of what has been discussed. This *reformulation letter* summarizes the therapist's understanding of the history and of how it is related to current difficulties. The letter suggests preliminary descriptions of the current patterns of relating to others and of self-management and will be accompanied by a list of Target Problems and Target Problem Procedures.

At some point, *sequential diagrammatic reformulation* (SDR) will be carried out. The conventional form of this provides a list of key reciprocal role procedures in a central box (a mnemonic device deduced from the gathered material) from which procedural loops will be constructed describing how the roles may be enacted in relation to others and in self-management. An example from a depressed patient is given in Figure 9.1. These diagrams are used in sessions and in homework as a way of alerting patients to the antecedents and consequences of their established dysfunctional procedures and as an indication to therapists of how they may be perceived or invited to reciprocate.

Treatment goals involve procedural change and integration; rather than selecting and prioritizing specific symptoms or beliefs, these will

be described in general, high-level terms. The relief of symptoms is, of course, one goal, but the direct treatment of symptoms is seldom required and can be counterproductive. The focus of therapy is on self-management and relationship procedures, the revision of which can be expected to control or abolish symptoms. The exception to this is when procedures that are potentially life-threatening or are liable to lead to dropping out of therapy are identified. In such cases, alternative ways of coping will be rehearsed and immediate resources, such as telephone counseling services or emergency department psychiatrists, will be accessed. The relation of such potentially harmful procedures to the general procedural system will be established as soon as possible.

APPLICABILITY

CAT is a general model, the practice of which involves a small number of specific techniques. The CAT model is not prescriptive; working toward procedural revision and integration may involve a wide variety of therapeutic techniques. It is a suitable approach for the majority of the patients referred for psychotherapy. Most of the patients who present with mixed anxiety, depression, and somatization have underlying long-term procedural restrictions or distortions; they seek treatment at moments of decompensation. With such patients, CAT will focus on the repertoire of dysfunctional role

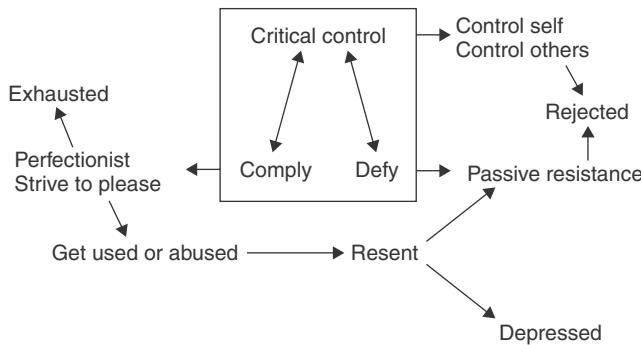


FIGURE 9.1 An example of sequential diagrammatic reformulation

procedures rather than on the symptoms or unwanted behavior.

The adaptation of the CAT model to different patient groups and different settings is illustrated by the following brief accounts written by CAT therapists who have pioneered work in their particular fields.

### In General Practice (Jackie Baker)

Working in the context of general practice means that patients are spared multiple assessments and long waiting lists; this typically results in greater compliance. CAT may be delivered in the usual 16- to 24-session format or in an adapted shorter form. Working in primary care allows close cooperation with the patient's general practitioner (GP), and this close liaison offers containment for more disturbed patients.

Two brief case examples illustrate the work. Anne was referred by her GP because her depression had failed to respond to medication. She had married 2 years previously, and her husband, fearing her rejection, had become increasingly controlling. Anne had left a job she enjoyed and had severed contact with family and friends. The eight-session therapy focused on the target problem "I find it difficult to stand up for myself" and, as she became more assertive, she identified her aim as "To begin to allow myself good things." She found work and recontacted friends, and her husband became able to speak directly about his fear of her leaving him.

Susan, a police officer who worked with both perpetrators and victims of abuse, was referred with depression and stress symptoms. She had been sexually abused by her father for a number of years but had never spoken of this to anyone except her partner. Her target problem was "Feeling unable to trust anyone, I find it difficult to access the help and support I need." Her relationships with others were stormy due to her expectation of being able to offer, and of finding, the ideal care she had never received; disappointment led to anger, and she would either withdraw or would punish herself and the other. Susan received 20 sessions. Once she recognized her target problems, she became more able to voice her needs

directly and to build a more realistic relationship with her partner. At work, she became more realistic in her expectations of herself and others; her self-esteem and confidence improved.

### Patients with Learning Difficulties (Val Crowley and Ros King)

CAT can be used effectively with people with a mild to moderate learning difficulties (LDs). Modifications to the usual practice include: simplifying the wording of the CAT documents, such as the Psychotherapy File; using audiotapes rather than writing for the reformulation and goodbye letters; having concrete visual representation of the time limit; and complementing the verbal aspects of therapy with nonverbal techniques, using drawing, color, or buttons as symbols. The Vygotskian concept of the zone of proximal development, which directs therapy to those areas where progress can be made through the provision of appropriate tools and concepts, is particularly relevant to this work.

CAT emphasis on the recognition of reciprocal role patterns, in particular regarding the therapeutic relationship, is very helpful in allowing therapists to avoid being drawn into the common responses of trying to assume the powerful caregiver or magical rescuer roles, which leave clients powerless and dependent, awaiting rescue or perfect care.

By actively engaging with LD clients through the development of shared signs and language, CAT empowers these clients who can so easily feel unheard, powerless, and stupid. The explicitly collaborative approach of CAT and its use of narrative are powerful ways of helping individuals to find their voice and for that voice to be witnessed, an experience that supports the development of self-reflection.

### Eating Disorders (Lorraine Bell)

The collaborative work involved in the reformulation process can enhance eating disordered (ED) patients' self-efficacy and, by describing dysfunctional procedures before seeking to change them, can recruit even precontempla-

tive patients to therapy. Reformulation explores the personal meaning of the symptom and can circumvent the battles for control, which are common between ED patients and therapists. Bell (1999) demonstrated the importance of both self-management issues and interpersonal problems in 30 ED patients; reformulation in terms of reciprocal roles links these and supports therapists in managing them as they affect the therapy relationship.

CAT, however, is a relatively demanding therapy and calls for 5–6 hours of work outside the therapy contact. As Cognitive-Behavioral Therapy (CBT) may be effective for uncomplicated cases of bulimia, CAT may be reserved for patients with associated Axis II disorders or when other treatments have failed. It is appropriate for the treatment of anorexia nervosa but will need to incorporate, or work in parallel with, direct practical support with eating and behavioral treatment of the symptoms. CAT may need to be prolonged or it may provide a basis for CAT-informed management.

### Management of Insulin-Dependent Diabetes (J. Fosbury)

“Why don’t they look after themselves properly so that they don’t go blind?” Mental health professionals treating people with long-term, poorly controlled diabetes often ask this question—as if patients, confronted with a medical problem, could at once see the error of their ways and initiate good self-care.

During the past 12 years, CAT has been used to treat patients who, despite diabetes education, fail to manage their diabetes because of psychological difficulties. These are resistant and “non-cooperative” patients who miss appointments, fail to carry out blood tests, neglect prescribed diets, and provoke irritation and frustration. CAT addresses these behaviors by understanding them as they are repeated in the therapy relationship and by relating them to the sequential diagrammatic reformulation of the patient’s reciprocal role repertoire. Particular noncompliant behaviors, such as bingeing on chocolate or omitting insulin, will be located in the sequential diagram on the general procedure of which they are examples. An ex-

ample of such a sequential diagram is given in Ryle, Baa, & Fosbury (1993, p. 162).

These damaging behaviors are usually rooted in patterns of self-neglect or punishment, of resistance to authority, or of self-indulgence compensating for long-term emotional deprivation, all originating in early life. These are repeated in relation to the clinic, often being mobilized by the stringent requirements involved in the control of insulin-dependent diabetes. Disappointment with imperfect care or disillusion with previously idealized clinicians can further fuel the rejection of necessary constraints and good advice.

The work of collaborative reformulation and the therapist’s ability to offer noncollusive care can help patients abandon their potentially life-threatening behaviors. Sharing the understandings derived from the reformulation with the doctors, dieticians, and nurses involved with the patient can help them avoid reinforcing the damaging patient procedures. Without some such appreciation of the patients’ specific procedures, unhelpful responses such as irritation, authoritarian control, or offering special care are often elicited. This approach has a significant effect in improving diabetic management as shown by reductions in HbA1 levels (Fosbury, Bosley, Ryle, Sonksen, & Judd, 1997).

### In Later Life and Old Age (Laura Sutton)

Problems in older people may reflect the loss of the ability or opportunity to relate to others in ways that have served them throughout life, for example, by continuing achievement or by being a helpful person making no demands on others. They may also reflect the encroaching losses of mental and physical vigor, which can activate the sadness of incompletely mourned losses from earlier life (Sutton, 2002).

Psychotherapy with older people involves acknowledging the balance between dependence and independence, whereas in younger age groups the implicit aim, reflecting cultural norms, is to work toward greater autonomy. The changing needs of older people are often discounted or ignored because of therapeutic

nihilism; in this way, pre-existing reciprocal role patterns involving rejection or neglect may be reinforced. The activation of patterns such as *critical-criticized* or *controlling-submissive* in the relationships with care staff and psychotherapists may induce depression or hopelessness or, through role reversal, may lead to rejecting, uncooperative behaviors.

CAT therapists need to challenge the ageist snag (Hepple, 2004) whereby continuity and growth are put aside as if no longer possible or permitted. As with patients of all ages, therapists can identify and challenge self-defeating procedures and, through the process of narrative reconstruction, can help patients find a sense of their own continuity (Robbins & Sutton, 2004). Coleman (1999) reviews research that shows that some people in old age have yet to attain a coherent sense of self and suggests that, in this respect, research in gerontology has been impeded by an overemphasis on the stability of personality through the life span. The twin emphases in CAT on the continuing exchange between intrapsychic and interpersonal reciprocal role procedures and on the importance of continuing reciprocation by others in maintaining stability of the self support the view that continuing change is possible. The CAT practice of ensuring that therapists and other professional carers avoid inadvertent collusion with damaging and limiting procedures and is as relevant to work with older patient as it is earlier in life. Full accounts of current CAT approaches to work with older people will be found in Hepple (2002) and Hepple and Sutton (in press).

### Borderline Personality Disorder (Anthony Ryle)

The development of CAT coincided in time with a major increase in the percentage of patients referred for psychotherapy who suffered from Borderline Personality Disorder (BPD) or had marked borderline features, usually accompanied by Axis I and other Axis II disorders. Until recently, and still all too often, such patients were considered untreatable by many psychotherapists.

The process of diagrammatic reformulation in these patients proved difficult until we realized that there were two or more distinct procedural systems operating. These were manifest alternately, switches between them being confusing to patients and therapists. Once diagrams were constructed around two or more core reciprocal role patterns, the recognition of the different states and of shifts between them became possible (Ryle & Beard, 1993). The ability of patients to develop clear discriminations between their different states was demonstrated by a repertory grid study of 20 borderline patients (Golyunkina & Ryle, 1999).

Drawing on this work and on some psychoanalytic theories of borderline structure, we elaborated a general model of BPD, the Multiple Self States Model (MSSM) (Ryle, 1997a, 1997b; Ryle & Kerr, 2002). Naturalistic outcome study of 24-session CAT for BPD was carried out (Ryle & Golyunkina, 2000); the results demonstrated that half the patients no longer met BPD criteria at follow-up. Following this, the Personality Structure Questionnaire (PSQ) (Pollock, Broadbent, Clarke, Dorian, & Ryle, 2001), based on this model, was developed, offering a useful screening test for the identity disturbances of BPD.

CAT reformulation offers a unique understanding of the inconsistency of BPD features, which provides patients with a basis for self-reflection and provides therapists with much needed support in managing transference-countertransference shifts. CAT reformulation is also a basis for continuing noncollusive management and support from clinical psychologists, psychiatrists, or community nurses in inpatient or community settings (Dunn & Parry, 1997; Kerr, 1999). Leighton (1997) discusses the use of CAT in personality-disturbed substance-abusing patients. Case histories of CAT with borderline patients are given in several sources (e.g., Ryle, 1997a; Ryle & Kerr, 2002; Pollock, 1996, 2001; Pollack & Belshaw, 1998).

### Psychosis (I. B. Kerr)

The application of CAT theory and procedures to the treatment of psychosis requires an exten-

sion of the model to account for neuro-cognitive damage. Even minor damage can interfere with the developing child's ability to process information and enter social interaction, and this difficulty may in turn evoke rejecting responses from carers. The resulting negative reciprocal role procedures will both continue to distort relationships and to shape self-management procedures; in the latter case, they may represent internal expressed emotion with the tendency to exacerbate dysfunctional patterns.

The therapeutic implications of this model are important. Adopting simple biological explanations for symptoms can contribute to staff members colluding with negative reciprocal role patterns. Avoiding this, attending to the internal sources of arousal, and understanding the way in which voices can be understood in terms of reciprocal roles all support the provision of a therapeutic context that facilitates the patient's healthier and more integrated procedures (see Kerr, Birkett, & Chanen, 2003).

## PROCESSES OF CHANGE

The common factors identified in different therapies by Frank (1961; Frank & Frank, 1991) are a basic feature of CAT, in which an emotionally charged relationship involving the active participation of patient and therapist sets the creation of shared concepts and procedures. The power of the common factors and the ability of patients to make use of many different forms of help is understood, in CAT theory, as reflecting the facts that revising any one stage in a procedural sequence can modify the whole sequence and that change at one level in the procedural hierarchy may be generalized to higher or lower levels (Ryle, 1984). But this does not imply that there are not a number of powerful specific methods.

In CAT, techniques focused on particular symptoms, behaviors, or beliefs are little used. Instead, all interventions are based, as far as possible, on an understanding of the whole procedural system and within the context of a relationship with the whole person. Modifying the high-level procedures expressed in relation-

ships and self-management leads to a reduction in symptomatic, defensive, and avoidant procedures. Thus, symptom-directed work along cognitive or behavioral lines is seldom called for. Therapeutic change of this nature is seen to depend on two main factors; namely, on the patient's development of a new capacity for self-reflection and control and on the maintenance of a therapeutic relationship supportive of this. The joint creation and use of reformulation tools in both the patient's ongoing life and in the therapy relationship are the specific techniques of CAT; they play a crucial role in building and maintaining an effective therapy relationship with patients whose problems stem from their tendency to destroy or distort relationships, and they aid transfer of learning from therapy to daily life.

The basic repertoire of reciprocal roles is acquired early in life and consists of high-level patterns concerned with care in relation to dependency, control in relation to submission, and issues of cruelty in relation to victimization. For example, the child of an anxious obsessional mother is likely to internalize the reciprocal role procedures controlling-controlled. This might be manifest in the adoption of a controlling, submissive, or passively resistant role in relation to others and in high demands on the self for order and performance and in a tight control over emotion. Mood disorders and somatization would commonly be associated with the submissive and passive resistant roles.

The reformulation process usually establishes an early positive working alliance (in which initial idealization must be guarded against). Though past and present issues will be linked, insight into the origins of difficulty is less emphasized than a detailed understanding of current dysfunctional procedures. These are described in ways that might seem to offer "cognitive" understandings, but they are derived from joint work involving the experience and exploration of feelings as well as thoughts and actions. Descriptive reformulation and the therapy relationship provide a containing framework for exploring confusing and contradictory affects, allowing access to guarded-against emotions and memories. Because patients are vul-



nerable and because reformulation focuses on powerful and incompletely assimilated issues, role procedures concerned with threat, defence, dependency, and control are quickly mobilized in the therapy relationship.

Therapists must be aware from the beginning of transference-countertransference interactions if they are to avoid being drawn into damaging reciprocations of dysfunctional role procedures. Such interactions are not static; changes within the patient's repertoires of role procedures will occur and either pole of each reciprocal role pattern may be enacted, with its reciprocation perceived or sought for in the therapist. Moreover, therapists, as well as feeling pressures to reciprocate the patient's role procedures, may simultaneously be drawn into empathic identification with a particular role, often one that the patient has difficulty in acknowledging. Naming and exploring these are often helpful (Ryle, 1998). Recognition of complex and shifting transferences is greatly aided by sequential diagrams, which summarize the array of possible role patterns. Such recognition, shared with the patient and coupled with a principled noncollusion with problematic procedures and with the exploration of alternative ways of perceiving and acting, plays a key role in most therapies.

In addition to work within the therapy relationship, patients will be encouraged to watch for the same patterns in their daily life by diary keeping and procedural self-monitoring. Recognition alone enables some patients to block or modify their dysfunctional patterns, but for others, active methods such as role-playing, empty chair technique, writing, or painting may be encouraged, especially where recognition is largely intellectual and is not accompanied by feeling. The revision of specific dysfunctional procedures may be supported by behavioral tasks, but such direct work is best postponed until the basic role repertoire is understood and reliably recognized, unless the procedure effectively blocks therapeutic work.

Stable change involves both the internalization of the conceptual tools and the internalization of the therapist as a new, respecting, and accurate inner "voice." Clearly, therapists vary widely in personality, and their personal

attributes may make them more or less immediately accessible to patients. But people of different ages, genders, and temperaments can be effective therapists provided they feel and convey a genuine human concern. In CAT, the translation of this concern into useful and appropriate communications, even in the face of negative patient behaviors, is supported by the collaborative approach and by the various technical procedures.

In summary, CAT therapists (1) work with patients to achieve clear descriptions of their current dysfunctional role procedures, (2) devise conceptual tools to recognize these and allow accurate self-reflection, (3) explore memories and feelings that emerge after reformulation, (4) resist pressures to reciprocate dysfunctional procedures, (5) support the exploration of new ways of acting, and (6) provide a respecting relationship that can be internalized. The model requires therapists to follow the basic methods of reformulation and to aim at procedural change but, beyond that, allows considerable flexibility; which of the various aspects of therapy are most relevant for a given patient will become apparent in the early sessions, the general principle being to "push where it moves."

## THERAPY RELATIONSHIP

A powerful and essentially positive therapy relationship is an essential factor in psychotherapy. Understanding how patients' difficulties are expressed in the relationship, and may be resolved through it, is basic to CAT practice. The guiding theory is derived from psychoanalysis, but the concepts of transference and projective identification have been reconceptualized in procedural terms (Ryle, 1994). Without awareness of these processes, the progress of change is liable to be distorted or halted by the same dysfunctional procedures that operate in daily life and that have prevented learning from everyday experience. The positive use of the therapy relationship stems from the fact that it offers an arena where manifestations of dysfunctional procedures can be recognized and challenged each time they occur and provides a lived and felt experience of a different

possibility. The use of the same descriptions to describe the repetitions of dysfunctional reciprocal role procedures and their manifestations in the patient–therapist relationship facilitates the transfer of learning from therapy to daily life and does not invest the therapist with mysterious powers.

But the work of therapy should not focus exclusively on the therapy relationship. Change can also follow applying new understandings to past and present “real-life” relationships, and for some patients, provided therapists remain alert to how the therapy relationship is perceived, the main work is done there.

The CAT therapist offers attention, acknowledgment of the patient’s experience, recognition of significant underlying processes, and reflection upon the evolving therapy relationship. The repeated use of the descriptive tools elaborated in the early sessions may involve therapists in a quasididactic role, but the responsibility for linking new events to the reformulation is increasingly handed over to the patient. As this process is internalized, and as the containing impact of the relationship and work increases the patient’s sense of safety and reduces the need for defensiveness, an increasing amount of time will be spent on exploring the meanings of past experiences, recovered feelings, and on considering new possibilities. The detailed attention and the acknowledgment of the patient’s emotional experiences usually generate trust and hopefulness in the patient. Idealization based on this needs to be guarded against, and the doubt or disappointment that usually follow it (commonly around the 10th session of a 16-session therapy) needs to be identified; patients may not express these directly, and here countertransference is an important clue.

The therapist needs to maintain the work of therapy at a manageable pace, confronting blocks due to old procedures, and offering containment when new painful affects and memories emerge. Patients vary in their capacity to take on-board the understandings derived from the therapeutic work, and therapeutic tact and judgment are required. In general, their capacity is greater than one might anticipate and is relatively independent of educational level or

initial “psychological mindedness” provided that therapists are genuinely collaborative and find the right words to explore and express new ideas. There is, however, no point in continuing to press patients to work in ways they find incomprehensible and no justification in labeling all such events as resistance; the therapist’s task with every patient is to find the best way to work effectively. For some patients the therapy relationship rapidly offers a key metaphor for exploring their problems. For some patients, the reformulation concepts are at once taken on-board and applied to daily life, and for a few, a more directive approach aiming to modify specific procedures may be necessary. Every therapy is different, and part of good practice is to find with each patient the best way to work.

There are three overlapping phases in CAT. The early sessions are dedicated to getting to know the patients, to involving them in the kinds of thinking and activity that the model requires, and to discussing and drafting the reformulation letter and diagram. This phase is formally completed when these are finalized. At this stage, active therapy involving the use of these tools in activities such as procedural (rather than symptom) monitoring and diary keeping is initiated. The further developments usually include an active, cooperative period during which new understandings are acquired and new access to feeling and memory is achieved, but this is often emotionally painful and is frequently accompanied by the emergence of ambivalence in the therapy relationship. This ambivalence is further heightened in the third phase, leading up to termination, which may mobilize feelings associated with incompletely mourned past losses. Most patients will acknowledge change and express gratitude, but therapists need also to allow or assist the expression of sadness, anger, and disappointment at the incompleteness of the experience. The therapist’s acceptance of this is recorded in a “goodbye letter,” which indicates what has been achieved and points of the procedural problems that still require work. The aim is to encourage a realistic internalization of the therapist; change in time-limited therapy is dependent on establishing an internal conversation the continuing use of the conceptual tools.

The therapy relationship combines many strands, all of which contribute to a positive outcome. Therapists must aim to offer clarity and accuracy based on careful attention and respect, but objectivity must be based on emotional responsiveness and must extend to an awareness of personal reactions and an ability to measure how far these are primarily personal and how far induced by the patient. Non-specific empathy and warmth are not enough, because at times lack of empathy and negative responses may be appropriate or unavoidable reactions; in the end, what use to make of positive or negative feelings is a professional decision, but it is seldom helpful to try to conceal them. Ultimately, most patients have suffered from harsh or uncaring responses from others. Even though they have themselves repeated such attitudes to others, the understanding of the story summarized in the reformulation letter can make it possible for therapists to combine accurate responsiveness with basic acceptance. The detailed task remains difficult, and good supervision is important. When therapists are drawn into collusive or unduly negative reactions, it is helpful to be able to discuss how these are related to the patient's diagram and how they may be an example of what is frequently evoked from others. The acknowledgment of negative or inappropriate feelings and the ability to reflect on them may in fact be a useful model for the patient.

As therapy proceeds, the patient's ability to distinguish between appropriate reactions and those based on past experience grows. This, in turn, allows therapists to be more transparent and spontaneous; self-disclosure is not necessarily helpful, but at this stage a move from firmly delineated professional distance toward a more "normal" relationship signals an acknowledgment of the patient's growth.

## METHODS AND TECHNIQUES

The technical aspects of CAT combine those common to most approaches, such as empathic listening, the instillation of hope, and those specific to CAT theory. A considerable proportion of most early sessions are devoted to the

largely unstructured flow of the therapeutic conversation. The CAT techniques used in these early sessions are designed to assist gathering of information and to encourage patients to reflect on their own processes, thus recruiting them to the idea of participating in the work and introducing them the ideas and methods of the approach. Three paper-and-pencil procedures may be employed during this phase: the Psychotherapy File, the Personality Structure Questionnaire, and the States Description Procedure. (These are available on the Web site of the Association for Cognitive Analytic Therapy: [www.acat.org.uk](http://www.acat.org.uk).)

### The Psychotherapy File

The Psychotherapy File is usually given to the patient at the end of the first session. It offers (1) a brief account of the formation and persistence of problems, (2) instructions in the self-monitoring of symptoms and unwanted behaviors, (3) descriptions and examples of the three common patterns of nonrevision (traps, dilemmas, snags), and (4) descriptions of unstable and extreme states of mind. This last section, which seeks to identify borderline phenomena, may be replaced by the Personality Structure Questionnaire (see below). Patients are asked to study the file and to mark items that apply to them; these will be discussed at the next session and detailed examples sought, to ensure that the descriptions are applied accurately. This process contributes to the reformulation, and it equips patients with ways of thinking about their own active contribution to the maintenance of their problems.

### The Personality Structure Questionnaire

The Personality Structure Questionnaire (PSQ; Pollock, Broadbent, Clarke, Dorian, & Ryle, 2001) was developed within CAT on the basis of the Multiple Self States Model of BPD. It is a simple instrument in which patient's rate themselves on eight bipolar scales according to how far they experience shifting mental states. Items are scored from 1 (stable) to 5 (unstable); total scores correlate significantly with mea-

asures of dissociation and multiplicity, and high scores are associated with the clinical and psychometric diagnosis of BPD. In practice, where patients score 28+, their responses offer a useful basis for further discussion of their different states; further exploration and self-monitoring can then lead to the characterization of their different self-states or may involve the use of the States Description Procedure.

### The States Description Procedure

The States Description Procedure (SDP) (Bennett, Pollock, & Ryle, in press) is designed for use with patients who are liable to switches between recognizable, recurring states, each characterized by mood, behavior and sense of self and others. In practice, such patients can be identified by scores on the PSQ of 28 or more or by a diagnosis of BPD. Once such patients have accepted the idea that aspects of their negative experiences are only experienced in certain states or are related to switches between states, they are given the States Description Procedure to complete, either on their own or with assistance.

The first part consists of names and descriptions of commonly encountered states, drawn from clinical experience and from the grid study referred to above. Each named state is described by two lists, one headed "I feel" and the other "People in my life." Respondents identify those states they experience, modify the title if they wish, and select from or add to the listed descriptions those that apply to them. The second part of the SDP is completed for each identified state. It consists of detailed enquiries about the frequency, duration, mode, and provocation of entry into and exit from the state and the accompanying emotional and physical symptoms.

The responses to both parts of the SDP are then collated to provide a list of states in which the symptoms, feelings, and behaviors are linked with the perceived roles of self and others. A given state will always be seen to be identified with a given interpersonal role, and each such role will be seen to be in explicit or implicit relation to its reciprocal. Describing the reciprocal roles deduced from the SDP responses

indicates which roles may be attributed to, or elicited from, others including therapists and other clinicians. It also makes clear how the inconsistent behaviors of borderline patients may result from three different processes; namely, role reversals (e.g., from victim to abuser), response shifts (e.g., from victim to revengeful in relation to perceived threat or abuse), or self-state shifts (e.g., from ideally cared for in relation to ideal carer to angrily abandoned in relation to unreliable neglectful other). It also provides a basis for linking the interpersonal enactments of dysfunctional role procedures with equivalent interpersonal self-management procedures. For example, it is common for borderline patients to accept abuse from others and to inflict it on others but also to inflict it on themselves.

### Reformulation Letters

Reformulation letters are drafted for discussion at session 4 and, after revision, are retained by both patient and therapist. They present provisional summaries of the patient's formative experiences and describe how persistent negative patterns formed in early life, or symptomatic or avoidant alternatives, to them are now responsible for the problems for which therapy is sought. Current difficulties will be explained in terms of traps, dilemmas, and snags, of dysfunctional reciprocal role patterns and of dissociation between self-states. The ways in which these may interfere with the work of therapy will be anticipated. An example is given in the case history below.

### Sequential Diagrams

Target problems and identified traps, dilemmas, and snags and the repertoire of reciprocal role procedures will be summarized in writing and diagrammatically. Sequential diagrams are constructed around a core that lists the problematic reciprocal role procedures that the therapist has deduced from the accumulated historical evidence, the assessment questionnaires, and the developing therapy relationship. In Cluster B patients, there will be two or more such cores, each describing the recip-

rocal role pattern of a partially dissociated self-state.

The enactments of the various core procedures will be traced on procedural loops that detail the consequences of playing the role. These may serve to confirm the procedures or may end with a switch involving a role reversal, a response shift, or a self-state switch. Sequences of such switches may be traced by dialogic sequence analysis (Leiman, 1997), which tracks the succession of changing reciprocal role patterns. Constructing diagrams requires careful inquiry and discussion, monitoring, and thought. The last task is to reduce them to a manageable simplicity so they can function as mnemonic tools through the therapy.

### The Work of Therapy

Through the remaining sessions, the reformulation tools will be available as a shared summary of the problems being tackled. Developments in daily life or in the therapy relationship and new memories, dreams, or feelings will be considered in relation to them. Self-reflection may be enhanced by ratings of change and by diary keeping linked to the diagram. Homework tasks related to the diagram may be proposed, aimed at the recognition and control of dysfunctional procedures. These technical tasks must be carried out with tact and must leave unstructured time; reformulation creates a stage, but the patient must be given the chance to perform on it.

The CAT therapist's use of the therapy relationship differs from that of the psychodynamic therapist in being more explicit, collaborative, and direct and also in limiting interpretation to making links with past and present patterns as generalized in the descriptive reformulation. The so-called deep interpretations of some psychoanalysts—those that assert links between unconscious transference attitudes and developmental and current issues—are avoided. An example of such a genetic or deep reconstruction is given in Kernberg (1989): "Whipping prostitutes and acting tough with me have a similar function: to behave in a macho fashion like your father, rather than giving in to your

wishes to be taken care of by me and to be sexually penetrated by me. . . ." Such comments would be judged in the CAT perspective as authoritarian and abusive; indeed, any claim to know the truth about what the patient is unconscious of is likely to echo early experiences with controlling and intrusive parents.

In both CAT and cognitive-behavioral therapies (CBT), teaching plays a part. CAT therapists, however, are particularly concerned to reframe the ways in which patients define their problems, as such definitions are often themselves part of the problem. CAT places more emphasis on clarifying what patients do and do not have responsibility for, on understanding how behaviors may be maintained by the perception of alternatives as feared or forbidden, and on setting all understandings within the high-level model of self processes. The specific problem behaviors, symptoms, and "faulty cognitions" of cognitive and behavioral approaches are described in terms of procedural sequences and linked to the high-level general procedures summarized in the reformulation. Reformulation presents a general outline that offers a workable hypothesis derived from the detailed account of the past and tested for accuracy and relevance (and sometimes revised) during the remainder of the therapy. The CAT therapist differs from orthodox CBT therapists in their use of the therapy relationship to understand the patient's reciprocal role patterns, in particular (but not only) in the case of patients whose role procedures make them resistant or uncooperative in therapy.

### Resistance and Technical Errors

The failure of patients to progress is usually due to the manifestation of a dysfunctional procedure in the therapy relationship, often linked with the therapist's failure to identify his or her collusive reciprocation. If therapy loses its momentum, it is useful for therapists, with the help of supervision, to write a halfway letter to the patient, linking the identified procedures with what has happened or is not happening between them. The CAT model itself, being time-limited and requiring work, can induce

overactivity in therapists and passive resistance in patients.

### Maintenance and Relapse Prevention

The maintenance and continuation of change after a 16- or 24-week therapy depend on the internalization of the therapist as a corrective voice and on the continuing use of the tools developed in the therapy. Follow-up at 3 months usually shows that more has been retained than appeared likely during the ambivalent phase of termination. This experience of coping alone is a positive one for most patients. Nonetheless, a proportion of patients, especially those with personality disorders, may need further help.

This may take the form of further spaced follow-up sessions or a short spell of “top up” sessions designed to reinforce what was learned. In other cases, long-term “dilute” supportive therapy informed by the understanding of the reciprocal role patterns may be appropriate. Patients needing a continuation of active therapy may be referred to group therapy, therapeutic community, or day hospital programs, preferably to receive various inputs (such as other group activities, psychodrama, or art therapy) coordinated by CAT-informed management. There may be a place for a second CAT after a gap of a year or more, for example, with patients who, building on a first therapy, risk greater involvement with others and encounter new forms of difficulty.

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### CASE EXAMPLE

Kate, aged 33, consulted with the aim of obtaining psychiatric support for her request to be allowed more access to her 3-year-old daughter who was in the custody of her husband, from whom she had separated shortly after the birth of the child. She did not want psychotherapy, but agreed to attend for four assessment sessions. At the end of this time, she accepted a further 20 sessions.

Kate was an intelligent and attractive woman who told her story histrionically and incoher-

ently. She described her father as very stern and cried when describing how critical he was but added, “It was for my own good.” Later, she verbally attacked the psychotherapist for “making her say bad things about him,” adding that he was a perfect parent who, had he not died a few years back, would have been very upset by the mess her life was now in. She described how her mother, with whom she currently shared a house, had never sided with her against the father and had never trusted her to manage anything in the home. Neither parent had expressed any pleasure when she graduated from college.

Kate “fell desperately in love” at the age of 20. Despite episodes of mutual physical violence, she lived with the man and became pregnant by choice when aged 27. No sooner was her daughter Lily born than the couple separated, Kate being given custody. At 29, she met and married a “well-off and good looking” businessman and had her second daughter, Tina. Soon after the birth, she requested a legal separation and the husband was granted custody of the child. She was currently trying to increase her access to Tina but did not wish to take over full-time parenting and, in any case, Social Services were concerned about her inconsistent behavior toward the children.

Kate herself described her attitude to her daughters in strongly contrasting terms. Sometimes she would be overwhelmed with longing and sadness for Tina and would describe Lily as an unmanageable monster; at other times, she would reject Tina and praise Lily.

Kate was given the Psychotherapy File. She checked *traps* concerned with the fear of hurting others, depressed thinking, and social isolation. She identified the following *self-management dilemmas*: *either* I try to be perfect *or* I feel guilty, and *either* I keep things and feelings in perfect order *or* I fear a terrible mess. *Relationship dilemmas* identified were: *either* I am involved and likely to get hurt *or* uninvolved, in charge but lonely; *either* I stick up for myself and am disliked *or* I give in, get put upon and feel cross and hurt; and when involved with someone *either* I *or* they have to give in. Her score on the PSQ was 37.

Kate missed her third session, explaining at the next meeting that she had felt too upset. The therapist suggested that this might reflect the self-

management dilemma of “either I keep things and feelings in perfect order *or* I fear a terrible mess” and the relationship dilemma of “*either* I am involved and likely to get hurt *or* uninvolved, in charge but lonely.” At the next meeting, the provisional reformulation letter was read.

After recording how, as a child, she had had to work hard to avoid father’s criticism and how mother had never trusted her to be capable, the reformulation letter continued:

It seems to me that, although your parents gave you a lot, they did not give you any secure sense of your own worth. You experienced your father as particularly rejecting when you became adolescent, mocking your appearance and your normal interest in boys, and you felt too anxious to risk getting close to people of your own age. The one way you could feel good about yourself was through your achievement at school. It seems that it is still very important for you to win admiration and praise but you still have no close friends and often feel lonely and empty. With both the important men in your life you seem to have started by expecting too much and then, as things became difficult, you alternated between desperately striving to please them and angry, sometimes violent, disappointment. Similar switches affect how you are with your children. It seems to me at this point that with Lily you are sometimes harsh like your father was to you and at other times you try to make it up to her and be a perfectly caring parent. With Tina you are facing the consequences of handing her over to her father; as we discussed, I wonder if this was your way of protecting her from what you feel is bad in you. Now, though you miss her desperately, you feel unable to take full care of her and can become very impatient when she is with you, as a result of which your ex-husband and Social Services are only allowing you restricted access.

It seems that you can be angry, loving, destructive, and unhappy in extreme ways and that deep down you feel irrationally bad. Our first important task will be to continue to work on the map we started as a way of understanding the switches between these different states. It is probable that we will experience these states, for working at therapy may make you feel exposed or angry or well cared for or disappointed at different times; our job will be to recognize and manage these changes and to

continue to work together to make sense of what, at present, is so often bewildering.

Kate was moved by the reformulation letter and brought it to the next session. She said it was perfect and needed no revision, adding that nobody had ever understood her before. Work on the diagram was started, but when a draft was offered at session 6, she said it made no sense at all and tore it up. The final version (Figure 9.2), which encapsulates her borderline features, was agreed on two sessions later.

Kate became far more aware of her idealization, of her slavish striving for praise, and of her switches into destructive anger. At session 11, she reported how she had prepared for a meetings with her husband and social worker about Tina with the aid of the diagram and how this had enabled her to be calm and coherent for the first time.

Kate stopped her therapy after 15 sessions, saying it was too demanding to go on and that she felt less distressed and more controlled than before. She had achieved more independence from her mother and was looking for separate accommodation. The therapist wrote a brief goodbye letter, noting the changes that had been achieved and the residual instability of mood and emphasizing the need to continue self-reflection with the help of the diagram. At follow-up meetings at 3 and 6 months, Kate reported that she now had a clearer understanding of her childhood and of how it had affected her attitude toward her children. She also reported that her mood and behavior were more even and controlled.

Two main problems had faced the therapist in this case. The first stemmed from the fact that the patient came seeking support for her wish for more access to Tina, rather than for help with her personal difficulties. The experience of the first assessment meetings was distressing, and she missed the next appointment. (Normally patients lose any sessions missed without notification, but during assessment this rule is relaxed.) However, after completing the assessment process and receiving the reformulation letter, she was able to commit herself to therapy, although she did fail to attend on one subsequent occasion. The preliminary understandings of the role procedures derived from the history and the Psychotherapy

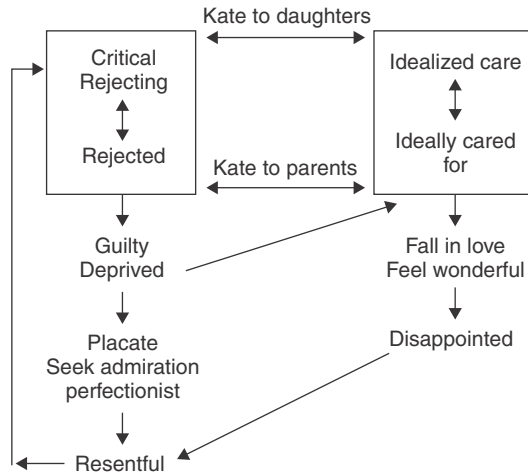


FIGURE 9.2 Diagram of Kate. The numbers in brackets indicate individuals with whom the procedures are clearly operating: 1 = Lily; 2 = Tina; 3 = first husband; and 4 = second husband

File had helped the therapist to contain the dysfunctional procedures that threatened therapy from the beginning.

The second problem stemmed from the patient's "narrative incompetence" (Holmes, 1998). Kate's account of her life was full of the illogical jumps, obvious contradictions, and violent mood swings typical of patients with borderline personality features. The idea that these could reflect alternating states of mind, which could be understood and connected, was put to Kate at the second session. The process of identifying and describing her different states was initiated by a detailed consideration of her replies on the PSQ. The development of the diagram supported the therapist in making sense of the patient's various and at times extreme attitudes. Although Kate failed to carry out agreed self-monitoring based on it, her use of it to prepare for her meeting with her ex-husband and social worker demonstrated that she had achieved more understanding and control through the use of it. Kate did not complete the 24 sessions offered, and this doubtless reflected a persistent uncertainty about self-exposure. However, her attendance for follow-up and her reports of continued change suggested that she had achieved significant changes in personality functioning.

## EMPIRICAL RESEARCH

As explained above, many CAT features were originally developed in the context of research (Ryle, 1980), and small exploratory studies have continued to influence developments. The rapid expansion of CAT training, the fact that it takes place in a large number of centers, and the extreme shortage of research funding during the past two decades have limited large-scale studies, but some are now being undertaken. The following are the main published studies.

### Controlled Outcome Studies

1. A small, randomized comparison of CAT with focused dynamic therapy carried out by the same therapists and using both nomothetic and ideographic (grid-derived) measures showed a significantly larger effect for CAT on the latter. The results indicated more change in the patients' dysfunctional self-attitudes and in associations between caring, depending, controlling, and submitting (Brockman, Poynton, Ryle, & Watson, 1987).
2. Insulin-dependent diabetic patients with poor diabetic control despite nurse edu-



cation were randomized between CAT and an equivalent number of sessions with a diabetic specialist nurse offering intensive education. The procedures associated with poor self-management included depressive self-neglect (sometimes amounting to slow suicide), passive resistance to the clinic staff, and personality fragmentation. The CAT focus on high-level procedures seemed particularly relevant for such problems. HbA1c levels, indicating the average level of diabetic control, fell in both groups at the end of 16 sessions, but this was not maintained in the nurse education group, whereas in the CAT group further reductions occurred. Measures of interpersonal difficulties improved significantly in the CAT group only.

3. In a similar randomized controlled trial, Cluely (personal communication, March 2001) reported a significant effect of CAT on increasing the quality of life and improving treatment adherence in patients with poorly controlled asthma.
4. There have been two unsatisfactory randomized controlled trials (RCTs) of CAT in anorexia nervosa. Treasure et al. (1995) compared CAT with educational behavior therapy, and Dare, Eisler, Russell, Treasure, & Dodge (2001) compared CAT with routine care, a psychodynamic intervention, and family therapy. It is hard to draw conclusions from these studies for, though CAT was reasonably effective and patients were positive about the approach, in neither case were the CAT therapists trained. Further, in the latter study, the effect of a 7-month CAT was compared to 12-months of the other interventions.
5. Pollock (personal communication, October 2002) compared 16 sessions of CAT with a waiting list control condition in female survivors of childhood sexual abuse. CAT showed clinically and statistically significant treatment effects.
6. Controlled trials are currently in process with personality-disordered patients and with seriously disturbed adolescents.

### Naturalistic Outcome Studies with Measured Outcomes

1. Mitzman and Duignan (1993; Duignan & Mitzman, 1994) described a CAT therapy group in which the patients' reformulation letters and diagrams, constructed in four individual sessions, were shared in the subsequent 12 meetings of the group. Five of the eight group members had Axis II diagnoses. One patient dropped out after two meetings. Mean changes in questionnaire scores and grid-derived measures in the remaining 7 cases were similar to those achieved in 16 sessions of individual CAT.
2. Garyfallos and colleagues (1998) assessed the effect of CAT in a large series of outpatients in Greece using the MMPI. They concluded that CAT offered a satisfactory approach in this setting.
3. Kerr (2001) described the use of CAT in post-acute manic psychosis and also CAT treatment of a case of schizoaffective disorder (Ryle & Kerr, 2002, pp. 167-172).
4. Ryle and Golyukina (2000) described the outpatient treatment of a series of patients with borderline personality disorder with up to 24 sessions of CAT, in most cases by trainees. Of the 31 patients starting treatment, 4 dropped out. The remaining 27 patients were all assessed at a 6-month follow-up, and 18 attended at 18 months posttherapy. At 6 months, mean psychometric scores were significantly lower, and half the sample no longer met *Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV)* criteria for BPD; these were categorized as improved. The pretherapy assessments showed that the unimproved patients were less likely to have been in employment or in any ongoing relationship and were more likely to have a history of self-harm, violence, and alcohol abuse than were the improved group. Follow-up at 18 months showed further reductions in psychometric scores in both groups.

## Studies of Phenomenology and Change

Clarke and Llewelyn (1994; Clarke & Pearson, 2000) reported studies of adult abuse survivors. Ryle and Marlowe (1995) described the clinical and research uses of the self-states sequential diagram. Golyunkina and Ryle (1999) used repertory grids to identify the characteristics of the partially dissociated states of a series of borderline patients, and Ryle (1995) linked state diagrams to measurements of variations in transference and countertransference during the therapies of two borderline patients. Pollock (1996) reported repertory grid studies of a group of sexually abused women who had committed violence against their partners, demonstrating how it was necessary for the therapist to acknowledge the patients' self-perceptions as guilty abusers before the guilt irrationally associated with the victim role could be reconsidered. Sheard et al. (2000) described a CAT-derived three-session intervention for patients presenting to emergency departments with repeated deliberate self-harm.

## Measures of Model Adherence and Process

Bennett and Parry (1998), using reliable alternative analyses of the therapy dialogue, demonstrated the accuracy of the CAT joint reformulation of a borderline patient. Methods for the microanalysis of audiotapes or transcripts of therapy sessions were developed (the Therapist Intervention Coding) with the aim of identifying how threats to the therapeutic alliance were managed (Bennett, 1998; Bennett & Parry, 2003). The use of an early version of this in the supervision of CAT therapists is described in Ryle (1997a). Bennett and Parry (in press) have also developed a method of measuring competence in delivering CAT.

## FUTURE DIRECTIONS

The development of CAT is not over. As a framework for individual therapy, it is being applied in different contexts and to different

clinical disorders. The approach will doubtless continue to be modified and will need evaluation in these various applications. It is likely to be applied more frequently to work with couples and families, where it is compatible with systems theory approaches, and to group therapy.

In the care and management of personality disorders and major mental illnesses, CAT has, I believe, an important contribution to make. It provides, in accessible language, descriptions of interactions that can be shared by patients and staff. The more technical contributions of CAT, notably the value of written and diagrammatic reformulation, have two parts to play: one in extending patients' capacity for self-reflection, and the other in supporting clinical workers in the creation and maintenance of a working alliance that can guard against inadvertent collusion and allow an authentic human interchange.

CAT continues to aim for integration at the level of theory and practice, being committed to the creation of a conceptual base that is compatible with what is reliably known about human development, personality, and therapy. Such a base supports the critical evaluation and continuing selective assimilation of ideas from other models.

This should generate a continuing debate, but so far this has not been forthcoming. Expositions of the differences between the idea of the schema and the procedure and of the nature of sign-mediated internalization as opposed to representation have not been discussed; the radical critiques made of selected psychoanalytic ideas and practices have remained uncommented upon. The CAT dialogical understanding of early development, self-processes, and therapeutic change implies a challenge to common philosophical assumptions about how humans should be thought about and will, I suspect, be widely misunderstood but I hope will eventually be constructively debated. Differences in language and underlying paradigms, even though they often conceal considerable areas of agreement, make much debate as constructive as conversations in the Tower of Babel. However, the difficulties cannot be resolved by adherence to parish

loyalties or by bland assertions that we are all doing the same thing really.

In both theory and in values, CAT is insistent on the need for psychotherapists to work from an understanding of the whole person. Reductive models of human functioning, whether by overemphasizing the role of genes, behaviors, cognitions, or unconscious forces, have damaging ethical implications. In its emphasis on the profound and subtle influence of human culture on individual personal development, CAT does not deny these factors. But nor should psychotherapists deny that we and our patients live in, and internalize much of a world where increasing wealth is linked with persistent gross inequalities, increasing loneliness, depression, passivity, and powerlessness. These forces effectively diminish the individual's sense of self and connection with others; we need to bear witness to this. In our relationships with our patients, we need to challenge, not reinforce, the internalized social sources of psychological damage.

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## *D. Assimilative Integration*



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## Assimilative Psychodynamic Psychotherapy

GEORGE STRICKER AND JERRY GOLD

Our patients and our work as psychotherapists have puzzled us, tantalized us, humbled us, and ultimately taught us to question the validity of a “one truth” position in the world of psychotherapy. We both were trained as psychodynamic psychotherapists and remain committed to that orientation. Yet, we have learned much from colleagues of all orientations and have found that our psychodynamic ideas and methods can be empowered by, and can synergize with, concepts and techniques from several therapeutic schools.

### INTEGRATIVE APPROACH

The Assimilative Psychodynamic model of psychotherapy refers to a broadly psychodynamic therapy into which active interventions (cognitive-behavioral, experiential, and family-systems techniques) are assimilated, producing an altered purpose and expanded impact of those interventions, and to a changed and enlarged view of psychodynamic functioning.

We have described the evolution of the theory and technique of this therapy in a series of articles and chapters that have appeared during the past 15 years (Gold, 2000; Gold & Stricker, 2001; Stricker & Gold, 1988, 1996, 2002). Our approach to psychotherapy integration grew out of a number of experiences, individual and shared, academic, collegial, and clinical, that taught us about psychotherapy integration in general and about its role in psychodynamic psychotherapy in particular.

One of us (G. S.) was an initial organizer and is a current member of the Steering Committee of the Society for the Exploration of Psychotherapy Integration (SEPI; information about SEPI can be located at <http://www.cyberpsych.org/sepi/> or by writing to [stricker@adelphi.edu](mailto:stricker@adelphi.edu)) and, as such, has been involved in this scholarly and clinical movement since its beginnings. Stricker has been privy to, and a contributor to, the central conversations about psychotherapy integration for more than 20 years and has attended and presented at almost all of the SEPI conferences during that period. The second

author (J. G.) currently is editor of the *Journal of Psychotherapy Integration* and, in that role, has examined many scholarly submissions and contributions to psychotherapy integration. Gold was Stricker's doctoral student just prior to the founding of SEPI, and during our work together on what would become Gold's (1980) doctoral dissertation, we discussed early papers and books on psychotherapy integration, which were and which remain shared influences. These included Dollard and Miller's (1950) seminal integration of learning theory and Freudian psychoanalysis; Alexander and French's (1950) radical revision of psychoanalytic therapy, in which the concept of the corrective emotional experience was introduced; and classic articles on the integration of various psychotherapies. Some of the more influential papers were French's (1933) examination of the relationship between Pavlovian conditioning and Freudian theory; Rosenzweig's (1936) description of common factors in psychotherapy; Alexander's (1963) description of the therapist as a source of rewards, punishments, and corrective learning experiences; Beier's (1966) description of the way in which therapist's reinforce unconscious mental processes; and the psychodynamic behavior therapy contributed by Feather and Rhodes (1972).

A critically important influence on both authors was the seminal book by Paul Wachtel (1977), *Psychoanalysis and Behavior Therapy: Towards an Integration*, which we read together soon after its publication and which was a serendipitous find as we struggled to conceptualize the research questions that shaped Gold's (1980) dissertation. The theoretical model of cyclical psychodynamics contained in this book, and the integrative intervention strategies therein, were and remain important foundations of our integrative model. The relative flood of integrative writing that followed Wachtel's (1977) watershed publication has influenced us as well. Important contemporary integrative writers who have taught us much include Ryle (Cognitive-Analytic Therapy; Ryle & Low, 1993) Fensterheim (1993; Behavioral Psychotherapy), and Allen (1993; Unified Psychotherapy).

We also have been influenced by Messer's (1992) seminal writing on assimilative integration. In this much cited article, Messer (1992) articulated the crucial idea that the meaning and impact of all therapeutic concepts and techniques are contextually determined and thus cannot be understood in isolation. Our integration of active interventions from therapies other than psychoanalysis always conforms to this contextual perspective.

The direct antecedents of Assimilative Psychodynamic Psychotherapy include the aforementioned, integrative psychoanalytic approaches introduced by Alexander and French (1946), Dollard and Miller (1950), Beier (1966), and Wachtel (1977). These authors all described new versions of psychoanalytically oriented psychotherapy in which change accrued from many sources, including but not limited to insight. This collective of innovators all demonstrated that psychodynamic changes can and do follow from behavioral changes as frequently and as powerfully as when insight precedes change. Essentially, all of these therapists and therapies place insight and psychodynamic variables within a multidirectional and multidimensional model of personality and of psychological change. It then follows that new learning and the provision of new experiences, as well as important as interpretation and insight, are crucial in a psychoanalytically informed integrative therapy. It was from this conceptual and technical foundation that our approach grew.

Another "brick" in the foundation of our model was our own effort (Stricker & Gold, 1988) to conceptualize personality and personality disorders within an expanded psychodynamic theory that would take into account conscious cognitive and perceptual processes, as well as overt behavior and interpersonal relationships. Although not meant as an overtly integrative theory at the time it was written, we have returned to this model repeatedly (Gold & Stricker, 1993; Stricker & Gold, 1996) and have explored its integrative implications in the development of Assimilative Psychodynamic Psychotherapy. This "three-tiered" theory (behavior, cognition and emotion, and psychodynamics) allowed us to consider how to incorporate

nonanalytic ideas and methods in a flexible but systematic way into our psychoanalytically oriented work.

Our conceptual foundation is broadly psychoanalytic in nature and fits best into the “relational structure” (Greenberg & Mitchell, 1983) group of psychoanalytic therapies. That is, we believe that each person’s psychological structures and ways of consciously and unconsciously remembering and representing our experiences accrue in the context of significant interpersonal relationships. Central to our model is the traditional psychoanalytic notion that those memories and experiences that are painful and that contradict our cherished notions of who we are, and of who our parents and other loved ones were, are excluded from consciousness, yet continue to influence our thinking, behavior, and emotional experience. Yet, as integrative theorists and therapists, and following our own “three-tiered” model, we believe that consciousness and its components (emotion, cognition, and perception), and behavior play significant roles in personality and psychopathology and often require direct intervention as well. Furthermore, we assume that there are dynamic linkages between the tiers that play significant roles in reinforcing and maintaining phenomena at all levels. In other words, we have found that problematic thinking and troubling interpersonal relationships patterns often express and stabilize unconscious conflicts and representations and prevent interpretive work from being completely effective.

As a result, there are times when we must intervene directly in the patient’s behavior and consciousness, in much the same ways as do cognitive, behavioral, experiential, and family-systems therapists. This leads to the assimilative nature of this therapy. When employing an intervention that is meant to change thinking, emotional processing, or behavior, we do so with two purposes: to change the targeted psychological issue and at the same time to intervene in the significant psychodynamic sphere that is connected to that issue. Thus, active interventions are assimilated into a broadly psychoanalytic framework. At the same time, this theory and its associated technical perspective

expand to accommodate novel concepts of change and novel interventions (Stricker & Gold, 2002).

Our selection of interventions is guided primarily by clinical experience and necessity and by our reliance on psychodynamic principles, but we are aware of, and use whenever possible, empirical guidelines. For example, our psychoanalytic interventions reflect our training and ongoing experience as clinicians, yet we also rely on research findings that substantiate the clinical effectiveness of psychodynamic exploration and of interpretation of transference (cf. Luborsky, 1996; Weiss & Sampson, 1986). Similarly, when an active intervention is assimilated into our psychodynamic approach, we do so first with an eye toward the immediate and long-term clinical needs of the patient, but also with awareness of the literature on prescriptive matching of patient, problem, and empirically tested intervention (Beutler, Alomohamed, Moleiro, & Romanelli, 2002). Finally, and of crucial importance in our relational psychodynamic approach, we are cognizant that there is empirical support for the impact of the therapeutic relationship (Norcross, 2002) as well as the therapy technique. Interestingly, this brings us full circle, as that was the crucial finding of Gold’s (1980) dissertation.

## ASSESSMENT AND FORMULATION

Although we assign patients *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV) diagnoses for record keeping, for the appropriate psychiatric referrals, and for insurance purposes, we have not found that this nosology, or any other “official” diagnostic typology, is of much use in the complex environment of ongoing psychotherapy. Our assessment begins with the first contact with the patient and continues throughout the treatment. It usually is interwoven in a relatively seamless way with the psychotherapeutic process. This is inherent in an exploratory, psychodynamically informed psychotherapy, wherein a central goal of the treatment is the progres-

sive expansion of our understanding of the patient and of her or his self-knowledge.

We do not separate the treatment into phases of formal assessment and psychotherapy, but as new material and understanding progressively emerges, we revisit our initial assessment and formulation. We are not adverse to the use of formal tests or questionnaires to answer specific questions about issues such as diagnosis, risks, or psychological abilities and disabilities, but our model of assessment is not linked to such instruments, and we use them only as a particular need emerges with an individual patient.

Our assessment of each patient, and the formulation of each ongoing psychotherapy, relies heavily on the three-tiered model of psychological functioning that we introduced earlier in this chapter (Stricker & Gold, 1988). These tiers are behavior and interpersonal relatedness (Tier 1); cognition, perception, and emotion (Tier 2); and psychodynamic conflict, self-representations, and object representation (Tier 3). We evaluate the patient's functioning, strengths, and weaknesses at each tier and look in particular for the linkages between variables in each tier and for the ways in which problems and processes in one tier may express or maintain a problem in another tier. We also evaluate deficits and skills at each level of experience and try to identify how filling in these gaps, or using specific strengths, might support change at the other levels. In general, we try to spot those issues in Tiers 1 and 2 that would prevent effective psychodynamic work from going forward, and that, if ameliorated, could serve as the kernels of "corrective emotional experiences," and thus as the seeds of new images of self and of others (Gold & Stricker, 2001). That is, current interactions with others (Tier 1) are motivated, skewed, and limited by unconscious perceptions, motives, conflicts, and images (Tier 3), yet can be and are limiting factors in the patient's ability to change these issues. Similarly, one's conscious thinking and perception (Tier 2) exist in an ongoing, circular interaction with the people in one's life. Finally, each patient's set of character traits, or enduring patterns of adapting to the interpersonal world, limits the chance for

new interaction with others and for new experiences at Tiers 1 and 2. At the same time, these traits are not carved in stone, but seem inflexible and enduring at least in part due to the contributions of others in the patient's life, who channel his or her actions down well worn, familiar paths.

As an example, consider the patient who suffers from a Tier 2 problem of self-critical thinking. In addition to thinking about ways to help this person to test these thoughts and to modify them, we explore the possible role of Tier 3 (psychodynamic) factors in motivating such thinking, and we consider such thoughts to be a potential defense against unconscious issues such as hostility toward a loved one with whom the patient is identified. Then, and perhaps most importantly, we ask ourselves, and attempt to explore clinically, the question of whether these thoughts can and need be changed through exploration of their unwitting symbolic and defensive role or whether their modification via the use of active, cognitive techniques would be a more effective step that would lead us to the same exploratory goal. Another component of this piece of the assessment would be to think about the interpersonal or transference impact of the active intervention. Will the patient experience our attempt to intervene actively in her or his problematic thinking to be an expression of concern or an intrusion? Will the patient take away from this intervention a sense of being worthy of care and of the therapist as being caring, which will help the patient to revise old self and object representations? Or, will our attempt to help actively unwittingly reinforce the patient's sense of vulnerability and images of authorities who are arbitrary and condescending?

As is typical of most psychodynamically oriented psychotherapists, we begin to develop a case formulation at the beginning of the treatment and add to or revise this formulation on an ongoing basis. Our formulation is of course based on the model just described, and it serves as a general, cognitive-experiential roadmap that allows us to organize the vast array of data that emerges in each session and during the course of many sessions. However, we do not go into each session with an agenda based

on this formulation and are quite willing to abandon its guidance when the clinical situation dictates otherwise. This follows from our belief, common to most psychodynamic and humanistic therapies, that it is the patient who determines the course of the therapy; from whom we take the lead in prioritizing goals (Bohart & Tallman, 1999; Hubble, Duncan, & Miller, 1999). There does exist, however, a dynamic tension between this philosophical and clinical stance and our willingness to assimilate active interventions into this therapy. We are willing to live with this tension continuing without complete resolution, but at the same time consider there to be a difference between the long-term goals of the therapy, which are set by the patient, and the clinical needs of the patient, which are to be identified and met by the therapist.

#### APPLICABILITY AND STRUCTURE

We believe that Assimilative Psychodynamic Psychotherapy is suitable for a broad range of patients, and that in fact it extends the range of applicability of traditional psychodynamic therapies well beyond its usual limits. We have found that most adult patients who are seen in private therapy offices, or in outpatient clinics, can benefit from and are successfully treated with this form of psychotherapy. We do not believe that this approach would be particularly useful in a hospital or other confined institutional setting as we present it here. However, it is very likely that therapists based in inpatient units or residential settings might be able to use our assimilative perspective within their particular therapeutic models, especially if those modes are psychodynamic. As such, we might conclude that it is indicated for adults who have anxiety disorders, stress-related disorders, mood disorders, and personality disorders. Due to both its psychodynamic foundation and its integrative assimilation of active techniques, this model permits and encourages easy shifting between a more immediate, symptomatic focus, and a more extended, exploratory, personality-oriented focus. These parallel tracks allow the therapist to assist the patient in at-

tending to and in lessening the patient's current suffering, as well as offering the patient the opportunity to explore and to change the underlying patterns of organizing experience and of relating to others that are implicated in that suffering.

The decision to start off with a symptom reduction focus or an exploratory focus is based on the therapist's assessment of the patient's beginning psychological state, including his or her level of suffering and ability to tolerate that suffering, capacity to delay gratification, and his or her psychological sophistication and interest in self-understanding. With patients who are relatively high on these variables, we usually begin the treatment in a fairly standard psychodynamic mode, using integrative, active techniques as indicated. With those patients whose suffering is too great to delay symptom reduction, or for whom psychological exploration is too great a strain, we begin the therapy in a more active, cognitive-behavioral or experiential mode, and move gradually toward psychodynamic work as the patient improves. We have found that this approach allows more fragile or volatile patients (perhaps those who might be diagnosed with Axis II personality disorders, especially borderline and narcissistic disorders) to experience early success in therapy. This contributes to improvement in the patient's self-esteem, to the attainment of an expanded sense of competence and mastery, and to the perception of the therapist as a benign, positive, and helpful presence. These experiences in turn lend themselves to the establishment of a solid therapeutic alliance and to the lessened likelihood of the destructive hostility and negative transference that many writers have posited are inevitable with more disturbed patients (Gold & Stricker, 2001).

We do not believe that this approach is particularly useful with patients whose primary problems are substance abuse, schizophrenia and other active psychotic disorders, organic disorders, or acute relationship (e.g., marital conflicts) disturbances. This therapy probably is contraindicated in acute emergencies and crises when management and safety are crucial. We have not tested this approach with children, though we have no reason to believe

that competent psychodynamically oriented child therapists could not adapt their work to be consistent with our assimilative model. The effectiveness of the short-term psychodynamic psychotherapies are very likely to be enhanced by the type of assimilative integration that we propose. Indeed, certain of the more influential and demonstrably effective therapies of this type, such as Levenson's (1995) Time Limited Dynamic Psychotherapy, are highly similar to our model in their integrative perspectives.

This therapy usually is conducted on a once weekly basis for 45 to 50 minutes, though not infrequently we see people twice weekly for extended periods. The therapy usually is designed as long-term and open ended, though more and more often we find that third-party issues, such as insurance and managed-care limits, force therapy to be constructed as short-term or to end sooner than we would like. The typical therapy lasts a year to 2 years and consists of approximately 40 to 100 sessions, though both authors have had several patients with whom we have worked for many years and for many hundreds of sessions, usually with a great deal of mutual satisfaction.

We often work in combined formats where a patient in individual therapy is referred to couples, family, or group therapy or to a psychiatrist for medication. Usually, these supplementary treatments are carried out by colleagues. We conceptualize these referrals within the same assimilative framework as we do when using an active intervention in the patient's individual therapy. That is, we make these referrals for at least two simultaneous purposes: first, to assist the patient in changing troublesome symptoms and patterns of relating at Tiers 1 and 2; and second, to remove a problem that may be expressing, reinforcing, and warding off Tier 3 (psychodynamic issues) phenomena that we have not been able to reach within the context of psychotherapeutic exploration.

## PROCESSES OF CHANGE

Among the main reasons for our ongoing interest in psychotherapy integration is our shared goal of enlarging the range of change factors

that can be included in a comprehensive psychoanalytic theory and which can be used in the comprehensive therapy that follows from that theory. At the same time, we hope to preserve the inclusion of insight, in all of its myriad forms and definitions, as a crucial change factor. As we noted earlier, we have located Assimilative Psychodynamic Psychotherapy historically and contextually within the segment of the psychotherapeutic literature that describes a "stretching" of psychoanalytic theory and therapy beyond the confines of interpretation and insight, but we have not abandoned that cornerstone of the psychoanalytic model.

The literature on psychotherapy integration (Prochaska & DiClemente, 1992; Wachtel, 1977) has emphasized repeatedly that there are many facets of change and that change accrues from many factors. We are happy to make use of as many of those factors as is possible, noting that each person changes somewhat differently and that, as a result, each therapy is constructed somewhat differently as well. We believe that change can and does result from insight in both its historical and interactional forms, as well as from exposure to fearsome internal and external stimuli, from the modification of cognition and perception, from observational learning and via operant conditioning, from the ability to access and to symbolize emotional experiences, and from the internalization of benign, corrective interpersonal contacts.

Because ours is a psychotherapy that is rooted firmly within the framework of psychoanalysis, we emphasize exploratory work in which insight in its broadest sense is a central mechanism of change. We believe that an enhanced and expanded awareness of the warded off, unconscious meanings of one's life experience, of the effects of intrapsychic conflict, and of an appreciation for the ways in which we unwittingly repeat our histories and find our parents and significant others in current relationships, often leads to a greater sense of psychological freedom, to a more stable and effective sense of identity and self-esteem, and to a lessening of anxiety, depression, and other symptoms. We try to accomplish this expansion and deepening of meaning in typical psychodynamic ways. This is done through a

detailed inquiry into past and present relationships, fantasies, dreams, behavior, and feelings, and through the gradual building up of a series of hypotheses and inferences about the connections between past and present, intrapsychic and interpersonal, desire and fear, that eventually leads to clarification and interpretation. We thus rely on historical insight and interactional insight in a mutually influential way, in that we have found that understanding the role of the past in shaping the present can inform, and is informed by, the patient attaining a more complete understanding of her or her current interactions and the ways in which these relationships keep the past alive (Wachtel, 1977).

Insight accrues from careful questioning of the patient's reports of memories, associations, and other events and experiences. It derives from the gradual, painstaking expansion of awareness of ones' role in shaping ones psychological world and relationships. We do not prize one source of insight above any other. Therefore, at times we work with the patient to better understand the past and its role in determining his or her current sense of self, whereas at other times the work focuses exclusively on the present and on clarifying what is going on in the patient's significant contacts with others. At other times, we work within the therapeutic relationship, trying to unravel the ways in which we have stepped into the patient's intrapsychic and interpersonal world, and the symbolic manifestations of transference, countertransference, resistance, and interpersonal enactment as they emerge. We have not found a proportion or formula that can dictate a priori which of these spheres is most important, but rather try to follow the patient's lead: some work best within the heated context of the therapeutic encounter, whereas others focus on outside relationships or on the interpenetration of past and present.

For many patients, the therapy moves from one sphere and one variant of insight to the other and back again. To this point, our description of assimilative psychodynamic psychotherapy does not differentiate it clearly from any other variant of psychoanalytically oriented treatment. And, if someone were to

observe our work and make this comment, we would agree. The differences emerge most clearly when we approach the limits of insight as a change factor, or when we discover that our exploratory, interpretative approach is not the best way to get to certain conflicts, meanings, or other (Tier 3) psychodynamic issues. We understand that people often need to learn new skills, or to unlearn maladaptive skills, in order to change. We often are humbled by the power of old images of significant others and their staying power in the face of interpretation and insight and by the need for the therapist to do something different from those figures from the past in order for the patient to change and in order for the patient to achieve useful insight. We have repeatedly seen how helping the patient to expose herself or himself to a feared situation, experience, or emotion can lead to the discovery of new meanings, memories, and conflicts, which neither the patient nor the therapist had learned about through exploratory work.

When we find that we are stuck temporarily, that exploration has led to a dead end, that the patient is too pained by a symptom or problem to continue, or when the transference seems too real and too hot to explore, we make an assimilative, technical shift in which we attempt to use other change factors for a dual purpose: to change the immediate problem situation, and to clear the way for the emergence of the potential new meanings and other psychodynamic factors that may be implicated in the current problem or stalemate.

Traditional psychodynamic therapists consider the points at which insight and exploration stall to be those moments during which the patient's conflicts and pain have stimulated defenses, the manifestation of which are the source of resistance to the therapy. These therapists explore and interpret such conflicts, defenses, and resistance much as they do any other material or phenomena, often with great success. We often use this approach as well, but find that an unvarying interpretive approach can be unsuccessful and sometimes may reflect an unwitting enactment of a past relationship in which the patient was misunderstood, hurt, or neglected (Frank, 1999; Gold & Stricker,



2001). For example, it is not uncommon for psychodynamic work to stall around a “crisis” in a relationship for which the patient demands immediate help, or when a symptom, such as a fear of air travel, comes to dominate the sessions leading up to the patient’s vacation. These issues often reflect the impact of defenses against warded-off conflicts, self-images, object representations, and transference reactions. Yet, they are real concerns as well, and they may be worsened by the therapist’s refusal to intervene actively because of allegiance to theoretical principles, even though he or she knows how to do so.

Such an interaction may represent a re-enactment of a parental disregard of or refusal to respond to the patient’s need and may reinforce an underlying pessimism on the part of the patient. It also may provide convincing evidence to the patient that he or she is not deserving of help. Frequently, these issues only become accessible after the therapist has made an assimilative shift, introducing a technique that can help quiet a conflict in a relationship or lessen severe anxiety. The therapist’s willingness to respond, to be flexible, and to demonstrate immediate concern may constitute a powerful corrective emotional experience, which allows the patient to perceive and experience the therapist as different from an internalized parent. Such a powerful interpersonal event may allow the patient to access, express, and resolve old feelings about that past relationship and to use this new positive experience as the kernel of a new self-image and images of others.

We (Gold & Stricker, 2001; Stricker & Gold, 2002) have identified several clinical situations in which we have found it to be advantageous to make such an assimilative shift and expect to find others as our experience with this model continues and as new patients teach us more about psychotherapy. These situations include those mentioned above (exposure and extinction of anxiety, resolution of transference issues and enactments that cannot be handled through interpretation alone, and provision of a corrective emotional experience) as well as two others: correction of developmental deficits through skill building and success experiences, and support of a patient’s active attempts to

change through our active intervention (Gold, 2000). We use cognitive-behavioral and other didactic methods when exploration reveals that the patient suffers from a faulty learning history and that the necessary Tier 1 and Tier 2 skills cannot easily be gained in the context of the therapeutic relationship. That is, most psychoanalytic therapies operate from the tacit assumption that new skills will be acquired as the patient interacts with, observes, and identifies with the therapist and with others in his or her social world. Although this may be true sometimes, we prefer not to rely on this kind of hit-or-miss observational learning (how can we be sure that therapists or significant others in the patient’s life have these skills or that the patient knows where to look?). Instead, systematic and purposeful filling in of cognitive, behavioral, and experiential deficits leads to new successes, enhanced self-esteem, and internalization of the therapist as an effective, benign, and helpful parent substitute. Similarly, making suggestions about ways of thinking or behaving, and then standing by as a supportive audience, often allows the patient to actively and creatively experiment with new ways of relating outside of therapy and provides the patient with the experience of being allowed and encouraged to explore his or her own creative and exploratory powers. This type of experience also can serve to modify and correct many of the more malignant self and object images with which the patient has been burdened.

This therapy places considerable demands on the psychotherapist as a person and as a professional. Any treatment that is psychoanalytic in nature requires a considerable amount of self-awareness and of self-reflection, as well as the ability to delay gratification, to remain silent for relatively long periods, and to tolerate high levels of ambiguity and uncertainty for extended stretches of time. The capacity to look at one’s role in the transference–countertransference matrix, to think about and to own one’s inadvertent repetitions of the patient’s formative interpersonal relationships, and of the therapist’s power to hurt as well as help, all are crucial. In addition to these characteristics, the assimilative psychodynamic therapist must be able to acknowledge and to be aware of the

limits of the psychodynamic approach, must be familiar with theories and methods from other therapies, and must not get caught up in ideological conflicts or “clan loyalties” at the patient’s expense. Unresolved issues about being true to one’s family of origin that express themselves in the therapist’s experience or behavior as interfering with assimilative shifts, or in too rapid shifting away from psychodynamic exploration when it is called for, will compromise this psychotherapy.

Although we believe that the assimilative, integrative nature of this psychotherapy make it useful for a wide range of patients, it is of course not a panacea and will not be successful for every patient. As we noted early, it is not indicated for patients with severe psychopathology or uncontrolled substance abuse issues. Success in assimilative psychodynamic psychotherapy seems more or less likely depending on the patient’s interest in, and ability to tolerate and enjoy, a depth oriented, developmentally influenced psychotherapy in which the expansion of awareness is a central goal. Such patients typically have, or develop during therapy, a certain level of psychological mindedness, an interest in their own history and curiosity about their own minds and their psychological development, and some capacity for delay of gratification and tolerance of frustration. If the patient is at all interested in this type of work, a relative lack of these capacities (as might be found with patients suffering from personality disorders) can be overcome by starting with active interventions and then moving toward a more exploratory approach once the therapist and therapy have been established in the patient’s mind as benign and positive.

But, even highly sophisticated, intelligent, and socially successful persons may not make good use of this therapy if they simply “want results” (symptom relief, interpersonal change) without caring about the intrapsychic journey toward those results. For example, a talented, mature man of significant financial means recently sought out therapy with one of the authors. He came to therapy due to the great pain that he was in because of his wife’s recently disclosed infidelity. He stated that he wanted “some psychological techniques that would work

like pills, that will make me able to handle this pain and go on functioning.” He worked diligently with cognitive-behavioral techniques such as relaxation and self-soothing and obtained some relief. Yet, he also made it clear that he had no interest in exploring anything other than the obvious meanings of this event, and that he considered his developmental history to be off-limits and irrelevant. As such, once he had achieved the maximal, but far from complete-relief from the circumscribed techniques in which he was interested, he ended the therapy.

## THE THERAPY RELATIONSHIP

The therapeutic relationship as consisting of a unique interpersonal environment that the patient may experience as a supportive safe haven from which he or she may embark on the tasks of psychodynamic exploration and participation in potentially mutative experiences (Stricker & Gold, 2002).

We consider this relationship to be uniquely suited to the interrelated goals of revealing and participating in the patient’s intrapsychic life, which includes his or her representations of self and of others, psychodynamic conflicts, cognitive processes, character traits, interpersonal style, and range of emotional experiences. In spite of the inevitability of transference and countertransference, which press the therapist to repeat or to enact past, pathogenic relationships with the patient, it is the therapist’s job to observe, identify, and understand the phenomena in which he or she has been ensnared. Furthermore, the therapist must find a way to react differently and correctively, allowing exploration of new intrapsychic, behavioral, experiential, cognitive, and interpersonal possibilities and pathways.

As we noted earlier, we rely on the exploration and analysis of the transference–countertransference matrix much as most psychoanalytically oriented therapists do. With greater insight into the ways he or she recreates the past in present relationships, the patient will be better able to cease doing so and to find new

and potentially healthier relationships in the present. We have found that acceptance, warmth, and concern also are powerful antidotes to the past. In this way, our ideas about the relationship converge with Client Centered Therapy (Rogers, 1961) and more closely with Self Psychology (Kohut, 1977). However, we think that the impact of the relationship goes further than described in a nonpsychodynamic system of therapy, and we are equally concerned with the provision of new experiences within the therapeutic relationship. We have found that as the patient feels accepted, secure, and understood in the context of therapy, he or she is more willing and better able to explore life in new ways: to take chances, to question previously drawn conclusions, and to own and tolerate painful emotions, perceptions, and other previously unacknowledged internal states. As Bowlby (1980) noted, exploration is only possible when one has a secure base of attachment figures to whom to return. We suggest that most patients, regardless of their diagnosis or presenting problems, were and are lacking in this foundation. If the therapist can supply a substitute for this lack, the task of psychotherapy can proceed more confidently and with a much greater chance of success.

Finally, as we have and will stress repeatedly in this chapter, new experience with the therapist becomes the stimulus for change at all three tiers of experience. When a patient tries out a new way of thinking or acting with the therapist and meets with acceptance and approval, those changes are likely to be experimented with outside of therapy. At a deeper level (Tier 3), the therapist's (perhaps) unanticipated positive reaction can go a long way to correct powerful, unconscious images of the self and of others that have been maintained by the patient's fears and inhibitions and by interpersonal responses from others that are ambiguous or as negative as the patient had anticipated.

The relational stance that the therapist adopts with each patient is a crucial variable in determining the emotional valence of the therapeutic alliance and of the effectiveness of the therapeutic process. A cartoon suggested by Stricker and featured in an article by Goldfried

(1999) illustrates our point very well: A patient and therapist meet for the first time. In the thought bubble above the patient's head is the worrisome idea, "I hope he treats the problem I have," while the therapist frets, "I hope she has the problem I treat." Goldfried used this cartoon to help explain his movement toward psychotherapy integration. We refer to it to underscore our attempt to tailor the therapeutic interaction to the needs of the patient rather than to the dictates of any particular therapeutic ideology or theory. We attempt to ascertain quickly whether the patient would benefit most from active interventions that are symptom focused, and if so, is this the best approach to solidify his or her trust and confidence in the therapist and the therapy? Or, is this a patient for whom active interventions would be experienced as pressured and intrusive and therefore would be met best with a more gentle, empathic, and reflective approach? Or, finally, is this person someone who can, and is interested in, "diving into" the relative depths of the unconscious nuances of transference analysis, dream interpretation, and free association?

We consider all of these approaches potentially to be equally valid and possible starting points, and we move from one relationship path to the other as the therapy unwinds and reveals itself to us in its unique characteristics and complexities. We have found, for example, that many more fragile and easily disrupted patients, for whom affect and self-esteem regulation are crucial issues, benefit at first from a more structured, symptom focused therapy. This is because, as their pain is alleviated, they gain a more positive sense of their own capacities, an enhanced sense of mastery, increased ability to tolerate and to symbolize emotions, and crucially, a sense of the therapist as an ally. These experiences can serve as the foundation of a stable therapeutic alliance that could not have been present at the start of the therapy and, after being established, can be the starting point from which successful exploratory therapy can proceed. Had this type of work been initiated from the start, such patients often are overwhelmed and exhibit the erratic behavior that is considered typical of personality-disordered persons. These experiences may

parallel the dire warnings of earlier generations of psychoanalysts about the possibility of symptom substitution that could result from direct intervention in symptoms.

In contrast, the sequence that we have just described might be unsuitable for a person whose presenting complaints are clustered around chronic dissatisfaction with intimate relationships or with work and who has some sense that these problems are connected to his or her developmental history and to other aspects of intrapsychic history. To start with active interventions with this type of person might contribute to the patient feeling belittled, infantilized, or disrespected, and could interfere greatly with the establishment of an effective alliance. With such a person, who may be more psychologically minded and less in need of external structure, the therapeutic sequence may be reversed from what was described above: long periods of inquiry, interpretation, and transference analysis interspersed with occasional episodes of active intervention when the need to alleviate a symptom emerges or when the development of new skills might help the exploratory work move forward.

The therapeutic relationship is in a constant state of examination, exploration, and flux. This is a hallmark of a psychodynamic psychotherapy in which the analysis of transference and countertransference is a crucial, if not *the* crucial, ingredient. Because we believe that the provision of corrective emotional experiences is a central change factor, it is an important goal for us to adjust our interaction with the patient in such a way that the chances for the provision of new, ameliorative experiences are optimized. This requires us to be thinking about the potential impact of almost all of our behavior and language on the patient, to study her or his associations for clues about that impact, to interpret our hypotheses about the relationship when indicated, and to find ways to correct the interaction when it has become an enactment (unconscious repetition) of a past relationship.

The therapist's role may change considerably as therapy continues, or it may stay relatively constant. This may be gleaned from our discussion just above. To be most effective, the

therapist's role should be a reflection of the predominant clinical issues, needs, goals, and intentions of the patient, including the patient's latent and overt sense of what types of interactions and techniques would be most helpful (Bohart & Talman, 1999; Hubble, Duncan, & Miller, 1999). When a particular patient can be served best by more radical shifts in understanding and technique, then the therapist's activity will be observed to be quite different at various points in therapy: in the case of the more fragile patient described above, the therapist may start out in a very active, structuring, and didactic role (much like a conventional cognitive-behavioral therapist) and only later shift into a less active psychodynamic position in which her or his tasks are empathic reflection, questioning, and occasional interpretation. More frequently, the therapist's psychodynamic stance is interrupted by occasional episodes in which he or she suggests exercises, activities, and experiments, and does some teaching in regard to these techniques. We have found that, with most patients, these active interventions occur most frequently in the middle phase of the therapy, with the beginning being dominantly based on inquiry, empathic reflection, and some tentative interpretative work, and the final phase being characterized by deeper psychodynamic exploration and transference analysis. Of course, there are many exceptions to this general description.

## METHODS AND TECHNIQUES

We rely on questioning and clarification, confrontation (pointing out of an immediate behavior or experience about which the patient seems to be unaware), and interpretation as standard interventions that occur during a psychodynamically oriented therapy. At those times when active intervention is called for, we use such methods as behavior rehearsal, social skills training, relaxation in many of its forms, cognitive monitoring, guided imagery, systematic and in vivo desensitization, response cost, and experiential techniques such as the empty chair and two-chair methods. As we have stated, any or all of these methods may be used at any

time, and each patient differs to some degree with regard to which of these methods he or she finds most engaging. Different patients with different personality structures, relational styles, and psychological capacities seem to be best engaged with different techniques. In this perspective, we are in agreement with such authors as Beutler et al. (2002) and Lazarus (2002) who argue for prescriptive matching of patient and intervention. Patients who are more thoughtful, internally focused, and concerned with the “whys” of their behavior seem to be best engaged, at least at first, by the traditional methods of Client-Centered Therapy and Psychoanalysis: empathic exploration, reflection of feelings, and detailed inquiry into the historical sources and current manifestations of intrapsychic events. More action-oriented, externally directed patients who are more interested in the “whats” of life, often are engaged more effectively, as we have noted, by action-oriented, skill-directed interventions: cognitive restructuring, social skills training, in vivo- and imagery-based desensitization, or gestalt techniques such as the empty chair technique.

However, we also believe that matching patient and technique is only part of effective engagement. We concur with Strupp (1993), who argued that the patient’s sense of the therapist’s genuine commitment to being helpful to the patient may be the most important effective ingredient or common factor in all psychotherapies. Commitment probably is demonstrated in any number of ways, including the therapist’s warmth, genuineness, and unconditional positive regard (Rogers, 1961), as well as by his or her ability to recognize and to respond to the individuality of the patient, free of the constraint of any therapeutic ideology. It may be that willingness on the part of the therapist to assimilatively integrate new techniques is more helpful in engaging the patient because it demonstrates concretely the therapist’s commitment than because of the utility of those or any other techniques.

It is the therapist’s job, first and foremost, to listen to the patient. Listening is a skill that is in short supply in the world. Listening conveys and expresses commitment, warmth, and prizing, and only through empathic, committed

listening can effective assessment and formulation occur. From listening follows questioning, which also is a commodity that is in short supply in most lives. Levenson (1983) suggests that all effective therapies and therapists, regardless of orientation, share the ability to ask good questions. Out of listening and questioning grows understanding on the part of both participants in the therapy. When the therapist’s understanding outpaces or precedes the patient’s understanding, it is the therapist’s job to share that understanding in the form of interpretation (if what is understood is some possible meaning of an interaction or event) or suggestion of an active intervention (if what is comprehended is some way for the patient to gain new skills or to overcome a particular symptom). It is also the therapist’s job to accept the patient’s existing and newly attained insights, to help the patient to articulate and to make use of the patient’s theory of change (Hubble, Duncan, & Miller, 1999), and to accept and to use the patient’s feedback and observations of the therapist’s impact on the therapy.

Our usual approach to resistance to exploration, which can be manifested in any number of subtle or not so subtle ways, is to explore the meaning and the utility of such phenomena for the patient. As most psychoanalytic clinicians including and following Freud (1912) have known, resistance is a ubiquitous variable that signals potential self-discoveries for which the patient feels unprepared and about which he or she is frightened. Following Singer (1965), we look for the survival value in these defensive efforts; that is, how, in past and present relationships, did the patient benefit from not knowing or accepting some piece of experience, some wish, fear, or interpersonal perception? How, in the transference relationship, we ask also, are these issues being replayed? This type of inquiry often enables the resistance to be resolved, as insight into its sources allows the patient relief from the fear that brought it about and enables him or her to consider taking the risk of expanding his or her self-experience in the presence of a new relationship with the therapist.

Sometimes, resistances are manifested or are caused by problems and deficits in Tiers 1 and 2 and can best be resolved by active inter-

vention at those levels. A socially phobic patient may use psychodynamic exploration, the need to know more about the historical sources of his or her interpersonal discomfort, as a way of avoiding trying out new social behaviors, which in turn may keep new insights from being pursued. This point was made first by Freud (1912), who argued that, at certain crucial points in psychoanalysis, the analyst had to compel the phobic patient to face the object of his fears, lest the treatment become stale and intellectualized. (We are not the first to think that Freud might have been the first integrative therapist!) Thus, it is crucial to suggest an active intervention, such as social skills training combined with in vivo assignments to try out these new skills, in order to avoid or overcome this resistive pattern. We try to explore with the patient the meaning of the active intervention before, during, and after its introduction and have found that such exploration enhances the patient's ability to cooperate with these techniques. In our experience, a good deal of non-compliance with, or resistance to, experiential, cognitive, and behavioral interventions can be avoided or undone by exploring the psychodynamic meanings and defensive purposes of the symptoms at which these interventions are aimed and by understanding the interpersonal and transference impact of the suggestion of such techniques. As many symptoms and problematic ways of functioning are maintained because they are at least partially successful ways of warding off anxiety and other dysphoric feelings that are connected to unconscious memories, images, and motives, there are times that patients find symptom-oriented techniques threatening and painful rather than helpful. For example, we (Gold & Stricker, 1993) have found that certain patients are reluctant to use cognitive restructuring to change depressogenic thoughts because these thoughts unconsciously represent and defend against awareness of the patient's attachment to and identification with a parent. Similarly, patients sometimes are embarrassed by experiential techniques or by behavioral methods in which role-playing is required, often because these scenarios are connected unwittingly to situations in which the patient was shamed or felt exposed. Alternation

between active use of these interventions at Tiers 1 and 2 and psychodynamic exploration seems to allow more compliance in work at all three levels.

The Assimilative Psychodynamic therapist is prone to the same kinds of mistakes as is any psychotherapist, in terms of failing to listen well, to be tactful and considerate in responding to the patient, and to overlook important psychodynamic material in and outside of the transference relationship. The most serious errors that are unique to this approach involve too rapid, or too infrequent, shifts from one therapeutic stance and technique to another. There are important times when "staying the course" is the most crucial, useful approach, and a shift from psychodynamic exploration to active intervention may reflect a misunderstanding of the patient's need, or a countertransference issue that is "too hot" and is thus avoided by shifting the therapeutic focus. At other times, the therapist may err by overlooking the opportunity to expand or deepen the therapy by moving from exploration to active intervention. As Frank (1999) has suggested, at times this may be experienced as a repetition of a parental failure to respond to the patient's distress and may therefore have serious but undisclosed consequences. In particular, this lack of responsiveness may deepen the patient's conviction that help is unavailable or undeserved.

As probably is very much apparent to the reader, the assimilative psychodynamic therapist moves back and forth on the continuum of directiveness throughout the therapy, depending on the nature of the work and the task at hand. The long periods of psychodynamic exploration that typify this therapy place the therapist in a primarily nondirective role. Those instances that seem to call for the introduction of active interventions signal the therapist's assumption of a more directive, instructional, coaching, and encouraging position. We try to announce or prepare the patient for such shifts and to suggest experiential, cognitive, and behavioral techniques in a tentative, experimental way, allowing the patient to decide whether to use them, and to explore the meaning and emotional impact of this suggestion before continuing. We have found that a patient's de-

cision to use, or not use, an active intervention can be as or more important than the impact of that intervention. These decisions can tell us much about the patient's real and transference perceptions of the therapist, his or her lack of trust, his or her motivation for change, and about conflicts and memories that are stimulated by the therapist's assumption of a more active and directive stance.

The proportion of time in which the therapist is directive or nondirective varies from case to case, though in most we find that proportion weighted more heavily toward the nondirective. What is crucial in this treatment is not whether the therapist is directive or not, but the clinical impact of his or her activity on the patient. We share with Wachtel (1977) and other psychodynamically informed integrative therapists a concern about exploring and understanding the conscious and unconscious meanings of our shifting position, the presence or absence of our activity.

We have not developed any explicit guidelines with regard to relapse prevention and maintenance sessions; however, these are included frequently on a case by case basis. For example, as termination of any therapy nears, we often taper down the frequency of sessions (from weekly to biweekly to monthly) and then discuss with the patient the possibility of follow-up sessions after the official termination session. Quite often, these are issues that are brought-up first by the patient, and as frequently as possible, we follow the patient's suggested changes in schedule and desire for posttermination contacts. With patients who have made specific gains that seem tenuous (such as having overcome shyness or other social inhibitions or who have modified long-standing dysfunctional thoughts), we may engage in the type of relapse prevention practice sessions described by Marlatt & Gordon (1985), Lazarus (2002), and other cognitive-behavioral therapists.

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### CASE EXAMPLE

Mr. S. was a 37-year-old White male who sought psychotherapy after struggling with acute and se-

vere anxiety for several months. Mr. S. was married and the father of one child. He had never been in psychotherapy before this time and had not ever considered himself in need of it. Mr. S. identified the precipitant of his symptoms as "a crazy but important event": he had been playing golf, at which he excelled, and unexpectedly had missed several easy putts and had sliced several drives when ordinarily he had great control over his shots. He reported that he had "tried to laugh these off," but left the golf course with the unusual experience of self-doubt, which during the next days and weeks had spread to many areas of his life. He found himself doubting his capabilities when making business presentations, was more uncertain sexually about his potency than he had been, became anxious when driving if he had to make a decision about passing another vehicle, and had other experiences that he himself labeled as "performance anxiety."

Mr. S. stated that he was skeptical about psychotherapy, but that after suffering on his own he believed that he had no choice but to seek help. He stated emphatically, in response to a query about a possible medication referral, that he was very opposed to that idea, that he rarely took any sort of medication, and would consider the use of pharmacology to be another sign of his failure. Mr. S. agreed to attend weekly therapy sessions, and the treatment continued at this frequency until its end.

Mr. S. presented as a tightly controlled, proud, and somewhat aggressive man who seemed very angry and who appeared to have little, if any, awareness of that emotion. He described himself and his life in terse, controlled sound bites: "My marriage is great," or "I like being a father." He seemed to have little interest in exploring his own psychology and stated that he wanted to work in the fastest and most economical way possible, though he also pointed out that money was not an issue in his life.

Mr. S. manifested symptoms and problems at Tiers 1 and 2 that seemed to have as yet unexplored connections to Tier 3. He was suffering from indecision, from avoidance of situations in which he previously had felt in control and enjoyed (golf, basketball, business events, sexuality, driving) and was periodically overwhelmed by self-doubting thoughts and images of failure (tak-

ing five putts when one would have been successful in the past). These behaviors and thoughts were accompanied by, and evoked strong feelings of, anxiety and panic, which when prolonged, led him to experience periods of depression. During these depressive periods, which could last most of a week, he became convinced that he would never regain the mastery and control over himself and his life that he had had, and as a result, he would lose everything that was important to him: "I'll lose my job, my wife, my friends." Reassurance, which was supplied copiously at home and at work, was not helpful to him and in fact left him feeling ashamed and embarrassed.

The Tier 3 components of Mr. S.'s problems were only vaguely formulated at this point. Clearly, his "loss of control" on the golf course had many more powerful meanings to him than such errant play might have had to the average duffer. The therapist speculated privately that some highly valued self-image had been challenged and that such an image must have tendrils that spread to internalized relationships and identifications. His self-critical, self-doubting thinking seemed to be a possible symbolic expression of the disavowed anger that seemed to emanate from him. His lack of curiosity about himself, and the concrete, shallow ways he described his life also seemed to be avoidant and defensive.

Following Mr. S.'s stated desire for help with his symptoms, and because of his lack of interest in a more exploratory approach, the therapy began with a more active, cognitive-behavioral orientation. Mr. S. was given instruction in relaxation, a relaxation tape, and was encouraged to practice and use this technique. Monitoring of his cognitive symptoms was suggested, including keeping a log of his doubts and self-criticisms, which would lead toward cognitive restructuring. He was encouraged to attempt to keep an activity log, and some work in dealing with his social uneasiness was begun through the use of role-playing and behavior rehearsal.

These techniques were not particularly successful. Mr. S. did not use the relaxation tape, record his thoughts, or keep himself busy. Instead, he seemed to look for ways to subtly discredit the therapist and the therapist's suggestions and to seek out solitary times during which he could dwell on his self-doubts and imperfections.

Having noticed this pattern over several sessions, the therapist abandoned the active techniques and instead began to confront and to explore Mr. S.'s resistance and lack of compliance with the treatment plan. At first, Mr. S. was surprised and indignant, but during the course of several sessions, he gradually became more aware of, and interested in, the contradiction between what he had said that he had wanted from the therapist (symptomatic help) and his own behavior and attitudes in response to that help (perfunctory agreement and then avoidance and failure to comply). Eventually, Mr. S. pointed out that this pattern of relating reminded him of his way of interacting with his father during his adolescence, when he had thought of his father as a demanding tyrant.

He then went on to explore the ways he had carried this style into his relationship with his wife and business associates and into the transference relationship with the therapist. As these issues were explored, Mr. S. became aware of a great deal of anger that he had harbored toward his father and toward his wife, both of whom, he felt, "Only love me when I'm perfect." Both of these people, he went on to say, were very invested in his physical performance and attributes. His only memories of affection from his father, he now reported, were around Mr. S.'s athletic triumphs, whereas his wife seemed overly concerned with issues such as his receding hairline, his waistline, and his cholesterol levels.

Mr. S. now was able to explore the ways in which he and the therapist had inadvertently enacted Mr. S.'s relationship with an overly demanding father. The techniques that the patient had asked for, which were aimed at problems at Tiers 1 and 2, had unconsciously been perceived as demands for perfect performance, which evoked anger and resentment. Because Mr. S. had never been comfortable with the direct acknowledgment and expression of such emotions, he repressed them. At the same time, he allowed himself the unconscious symbolic expression of his anger and resentment and punished himself for that by shrugging off the therapist's attempt to help and by "indulging" in extended periods of self-doubt and self-criticism.

This extended period of psychodynamic exploration (about 15 sessions) ended with Mr. S.



stating that he was now ready to try the cognitive-behavioral approach again. There had been much change in the therapeutic relationship. Mr. S. seemed to perceive the therapist in a more positive way, and his embarrassment about being in therapy had decreased. He also seemed more cognizant of the ways his past relationships colored his perceptions of the present, particularly with regard to his wife and child, whom he found to be less demanding and more capable of loving him for himself than he had realized in the past. Yet his self-doubts, anxiety, and depression, although improved, were still significant. The relaxation tape, cognitive monitoring log, and behavioral rehearsal were revisited. This time, Mr. S. made much better use of these techniques. He learned to relax and to use these skills when driving, playing golf, or when he became anxious in other performance situations. He became more aware of the effects of his self-doubt and also of the ways that those thoughts (Tier 2) both expressed and distracted him from anger and resentment (Tier 3). As his behavior returned to normal, and as his symptoms diminished, he also became aware of, and interested in his dream life and in the memories that spontaneously emerged when he used a cognitive or behavioral technique. This new interest and facility led to a period in which sessions often were split between psychodynamic exploration, review of the results of previous active interventions, and formulation of new homework assignments, or sessions that alternated between the psychodynamic and cognitive-behavioral approaches.

This integration of psychoanalytic and cognitive-behavioral components led, within about 40 sessions, to complete remission of Mr. S.'s symptoms. His doubts about his performance had abated in all areas, he was no longer depressed, and he reported a closer, improved relationship with his family and friends. He was better able to identify when he felt overburdened, angry, or resentful and was able to talk about these feelings reasonable and effectively. He was less demanding toward himself, more able to decide what he enjoyed and what he did not enjoy, and to pursue activities on that basis, rather than because he had to be the best at it. (He gave up golf, noting that he had never had fun at it, and learned to play the piano, "badly but happily.") Nonethe-

less, he still felt that work remained to be done. He noted that he continued to feel uncomfortable with men who were older than he, and that he still felt oppressed by his father, whom he described as having mellowed into a "great grandfather and a good friend to me. But, I bristle whenever he says something." At this point, the therapist suggested the use of an experiential exercise in which he spoke to the father of his adolescence. This intervention had several goals: to resolve the "unfinished business" for which it was used typically by experiential therapists (Greenberg, Rice, & Elliot, 1993), to help Mr. S. to lessen his internal attachment to this negative, hostile internalized parent, and to help him to learn more about the meaning of that attachment. Mr. S. found, through this dialogue, that hidden behind his anger was sadness and longing for love and an unwillingness to believe that he could not return to his childhood and adolescence and therefore have the relationship with his father that he had not had. These discoveries were very painful for him and led to anger and resentment toward the therapist, who Mr. S. saw as the "killer of hope." Yet, as these issues were explored, Mr. S. was in fact able to let go of his anger and to better integrate his sadness, in great part because of his perception of the therapist's support, concern, and acceptance of Mr. S.'s feelings. The patient found himself less "bristly" with his father and other men, and reported that his hopes to re-live the past had been replaced by improvement in the present.

At this point Mr. S. decided to leave therapy. The treatment had lasted about 18 months and had consisted of about 60 sessions. He returned for follow-up sessions 6 weeks, 4 months, and 10 months after termination and reported that he had maintained all of his gains, was free of anxiety and depression, and was not in any need of help.

## EMPIRICAL RESEARCH

There is virtually no direct empirical evidence concerning the model we propose, but there are certain positive spheres of research that suggest that this and other integrative models of therapy are of demonstrable validity and

generalizability. We will begin this section by raising some important questions that only can be answered by research. We will then go on to review current empirical results that are relevant, if indirectly, to the status of this model of psychotherapy integration.

There does exist a relatively substantial body of research that provides empirical verification for psychodynamic formulations. This validation comes from a variety of well designed and extensive research projects. Methods such as the Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Cristoph, 1990) yield valid and reliable assessment of central dynamic themes, especially with regard to the state of the patient's transference relationship. Control-Mastery Theory (Silberschatz, 2003), which was developed at the Mt. Zion psychotherapy project (Weiss & Sampson, 1986), contains the Plan Formulation Method that allows an assessment of conscious and unconscious goals, pathogenic beliefs and conflictual emotions, plans for testing those beliefs, and necessary insights. Silberschatz (2003) and Gold (2003) recently have commented on the relevance of Control-Mastery Theory to the field of psychotherapy integration. Additional indirect support may be found in the findings of the Vanderbilt Psychotherapy Project (Strupp, 1993; Strupp & Binder, 1984). These researchers also have been able to formulate valid and replicable psychodynamically informed case formulations to guide and structure the therapist's strategies and techniques. The organizing factor in these formulations is the concept of the Cyclical Maladaptive Pattern (CMP). This variable, which refers to the ways in which patients involve others in repetitions of past maladaptive patterns of relating, expands the view of psychodynamic processes in ways that are identical to ours: both therapies include the view that psychodynamic processes influence and are influenced by interpersonal, cognitive, and emotional states through feedback and feed-forward processes.

These findings also may speak to questions of the generalizability and teachability of Assimilative Psychodynamic Psychotherapy. Each of these other psychotherapeutic research projects has generated psychotherapy manuals, which

provide empirically tested and supported guidelines for formulation of the patient's problems and current functioning. Compliance with these manuals has been demonstrated, and the level of compliance is linked positively to process variables and to outcome (Luborsky & Crits-Cristoph, 1990; Strupp, 1993; Weiss & Sampson, 1986).

Shapiro and his colleagues at the Sheffield Psychotherapy Project (e.g., Shapiro & Firth, 1987; Shapiro & Firth-Cozens, 1990) have completed an impressive and important collection of studies of integrative psychotherapy. These studies investigated the impact of two sequences of combined psychodynamic and cognitive-behavioral therapy: dynamic work followed by active intervention or vice versa.

The greatest gains were made, and the smoothest experience of treatment was reported, by patients in the dynamic-behavioral sequence. Patients in the behavioral-dynamic sequence more frequently deteriorated in the second part of the therapy and did not maintain improvement over time as frequently as did patients in the other dynamic-behavioral sequence group. These findings seem to confirm the principles of our approach, in which psychodynamic work usually precedes more active interventions.

## FUTURE DIRECTIONS

The Assimilative Psychodynamic model of psychotherapy rests on a foundation of psychodynamic theory, psychodynamic practice, and the practice (and perhaps the theory) of many other approaches to treatment. Further developments, therefore, will rely on each of these areas.

Perhaps the most important questions we must ask concern the effectiveness of this form of treatment. We must ask whether this therapy is equally as effective as, or is more effective than, the component therapies (psychodynamic, cognitive-behavioral, or experiential) that are assimilated? Equally important is the question of whether this therapy is more effective than any other systems of treatment? Associated with these queries are such concerns as the degree

to which this therapy can be prescribed for particular diagnoses, psychological characteristics, problems, and persons. Research that is guided by, and can test, theoretical issues such as our assimilative modifications of psychoanalytic theory also is necessary. We see the need for research that can investigate the incremental validity of our expansion of the psychodynamic perspective when compared to its traditional conceptualization. Finally, issues of generalizability come to the fore. Can this therapy work, or does it even exist, if therapists other than the authors of this chapter try to practice it? Can the model be taught? Can we identify and offer empirical guidelines that instruct us as to when and how to move from one technique to the next, or must clinical intuition be our exclusive guide?

Psychodynamic theory is an area of evolving development (Greenberg & Mitchell, 1983). In previous years, there has been a change from a one-person treatment that emphasized the internal processes of the patient to a two-person treatment that gave much more emphasis to relationship issues. Our approach has kept in stride with this change and is based on a theoretical model that emphasizes relationship issues. It is difficult to foresee future areas of growth in theory, but it must be emphasized that every step toward integration that is based on assimilation should be complemented by a step that produces an accommodation of the theory to the new clinical observations. Perhaps it was the clinical observations of the importance of relationship matters (e.g., the corrective emotional experience) that led to the expansion of psychodynamic models that took the relationship into greater account (e.g., interpersonal psychoanalysis, self psychology). As the success of assimilation becomes clear, the need for accommodation opens an exciting path to theory development.

Psychodynamic technique also has changed as the underlying theory has changed. The silent therapist of prior years has been replaced by a more active therapist who deals with relationship issues inside and outside the consulting room. Our model, particularly when behavioral, cognitive, and experiential techniques are being employed, calls for even more thera-

pist activity, and we expect that the future will move in this direction while continuing to retain the value of silent listening and empathy during the course of treatment.

Assimilative Psychodynamic Psychotherapy relies on the incorporation of techniques from other orientations to treatment. Techniques that are used today either were not available or were little known during our training. As the other orientations continue to grow, we must remain aware of these developments and be alert to the possibility that they may offer to our work with our patients.

The importance of basic research also must be understood. Advances in developmental psychology, cognitive psychology, social psychology, and neuropsychology all may bear on our work with patients and may suggest alterations in our technique or theory.

Finally, the previous section detailed many research directions that are more specific to Assimilative Psychodynamic Psychotherapy. Issues related to the relative value of different approaches, the generalizability of clinical observations and their demonstrable validity under more controlled conditions, and the potential disentangling of assimilative methods all remain to be studied. During this time, it behooves every practitioner to adopt the stance of a Local Clinical Scientist (Stricker & Trierweiler, 1995; Trierweiler & Stricker, 1998), treating each patient as a small research project and learning from each clinical encounter something that will be of use with the next patient.

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## Cognitive-Behavioral Assimilative Integration

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The educational and cultural backgrounds of the authors vary considerably. How frequently is a chapter written by a French Canadian, a Jewish woman from New Jersey, an ex-seminarian from the Midwest, a German-born living in Switzerland, and an Asian American born and raised in the Philippines? Nonetheless, each of us defines himself or herself, with more or less conviction, as a cognitive behavior therapist. Operationally, this means that we believe that distressing behaviors, cognitions, and emotions should be primary targets of our interventions. Severe social anxiety, frequent panic attacks, and chronic insomnia, to name a few specific impairments, deserve our clinical attention. We also agree that both situational (e.g., external contingencies) and intrapersonal (e.g., inaccurate cognitions) factors are involved in the etiology and/or maintenance of our clients' impairments. As cognitive behavior therapists, we also believe that a fruitful strategy to identify the determinants of clients' difficulties is to conduct comprehensive func-

tional analyses that are grounded in known empirical knowledge.

Although we believe that psychotherapy can reduce clients' impairments, we are convinced that cure is not a possibility. Even after successful therapy, the difficulties of life will likely continue to trigger vulnerabilities that are linked to years of complex learning, implicit meaning structures, biological processes, and genetic predispositions. In our opinion, the ultimate goal of therapy is to facilitate the acquisition of coping skills (emotional, cognitive, and behavioral) that will help clients cope with life's stressful demands.

Along with the theoretical writings of leading figures in cognitive-behavioral therapy (CBT), however, our clinical experience has suggested that traditional cognitive-behavioral therapy techniques are not always sufficient to treat clients' distress and to help them develop better ways of dealing with life's difficulties. On more than one occasion, we have found it helpful to let clients talk extensively about

early relationships with their parents, to encourage them to experience and “stay with” painful feelings, or to draw links between what is taking place in the therapy relationship and what has occurred in their interpersonal relationships outside of therapy.

The beneficial use of what many would consider non-cognitive-behavioral therapy (non-CBT) methods has raised the question of how best to incorporate methods derived from (or consistent with) humanistic, psychodynamic, interpersonal, or systemic approaches into our CBT practice. The integrative approach described in this chapter represents our effort to improve the efficacy of CBT via a systematic and theoretically cohesive assimilation of treatment procedures typically associated with other psychotherapy orientations.

#### EXPANDING COGNITIVE-BEHAVIORAL THERAPY

Our integrative approach is based on the assumption that clinical improvement is due in part to principles of change that cut across different forms of therapy (Castonguay, 2000). As described by Goldfried (1980; Goldfried & Padawer, 1982), we believe that several techniques associated with particular orientations are idiosyncratic manifestations of common principles. These principles include the acquisition of a new perspective of self, the establishment of a therapeutic alliance, the facilitation of new or corrective experiences, and generalization of therapeutic change to the client’s daily life. Thus, from a clinical standpoint, our approach is based on the premise that the repertoire of interventions of a particular orientation (e.g., CBT) can be increased by adding techniques that reflect general principles of intervention while allowing this specific approach to address more directly or adequately certain dimensions of human functioning. Based on research findings, as well as on conceptual critiques and modifications of CBT, we concluded that the most fruitful way to improve CBT’s efficacy was to add techniques aimed at

facilitating interpersonal functioning and emotional deepening.

#### Interpersonal Focus

Several authors have criticized CBT (and especially cognitive therapy) for not paying sufficient attention to interpersonal factors involved in psychopathology (Coyne & Gotlib, 1983; Goldfried & Castonguay, 1993; Robins & Hayes, 1993). As demonstrated by Blagys and Hilsenroth (2000), there is convincing evidence that cognitive-behavioral therapists focus less on interpersonal experience than psychodynamic-interpersonal (PI) therapists. In addition, while one preliminary study found that CBT therapists tended to focus more on interpersonal issues than intrapersonal issues (Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992), the reverse was found in two later studies (Castonguay, Hayes, Goldfried, & DeRubeis, 1995; Castonguay, Hayes, Goldfried, Drozd, Schut, & Shapiro, 1998). More importantly, interpersonal focus in CBT has been found to be unrelated to client’s improvement in two studies (Castonguay et al., 1998; Kerr et al., 1992). Moreover, one study found that the therapist focus on interpersonal cognitions negatively related to outcome in cognitive therapy (Hayes, Castonguay, & Goldfried, 1996). By contrast, evidence suggests that when psychodynamic-interpersonal therapists focus on interpersonal issues, such focus is positively linked with outcome (Castonguay et al., 1998; Kerr et al., 1992).

Furthermore, process studies also suggest that clients do improve when cognitive behavior therapists focus on the kinds of interpersonal issues typically emphasized in psychodynamic treatment. For instance, Hayes et al. (1996) found a positive relationship between the therapist’s focus on early attachment patterns and client’s improvement in CBT. Other studies (Ablon & Jones, 1998; Jones & Pulos, 1993) also found that the therapist’s connections between the therapeutic relationship and other relationships were among a set of psychodynamic techniques positively related to therapeutic change in CBT. Taken together, these

findings suggest that adding techniques from the psychodynamic and interpersonal traditions to address client's maladaptive relationship patterns might increase the therapeutic impact of CBT.

Qualitative findings have also suggested that certain ways of dealing with problems in the therapeutic relationship observed in CBT may impede its efficacy. Castonguay, Goldfried, Wiser, Raue, & Hayes (1996) find that when confronted with alliance ruptures, cognitive therapists frequently increased their focus on cognitive therapy rationale or techniques. Rather than resolving the alliance difficulties, however, such interventions seemed to exacerbate them. These findings suggest that integrating new strategies to address alliance difficulties, such as the ones proposed by Burns (1989) and Safran and Segal (1990), might also improve the efficacy of CBT.

### Emotional Deepening

Prominent authors in the field have criticized CBT for approaching emotions as phenomena to be controlled rather than being experienced (e.g., Mahoney, 1980). One study (Wiser & Goldfried, 1993) provided evidence to suggest that cognitive-behavior therapists see the reduction of emotional experiencing as a significant event during the session. Summarizing the empirical literature, Blagys and Hilsenroth (2000) concluded that "recent studies lend very strong support for the notion that PI focuses more than CBT therapy on the expression of patients emotions" (p. 172). They also added that current findings

support the notion that PI therapy attempts to evoke the expression of patients' emotion while CB therapy attempts to control or reduce patients' feelings. The propensity of PI therapy to focus on affect not only conveys a greater emphasis on cathartic expression, but also a greater focus on emotional insight and a greater encouragement to identify, stay with and/or accept emotions.

Interestingly, a number of studies have found that the client's emotional experience in

CBT is positively linked with outcome (Castonguay et al., 1996; Castonguay, Pincus, Agras, & Hines, 1998). Processes and techniques related to emotional exploration were components of different sets of therapeutic factors found to be positively linked with outcome either in CBT (Ablon & Jones, 1998; Jones & Pulos, 1993) or across CBT and interpersonal therapy (Ablon & Jones, 1999; Coombs, Coloma, & Jones, 2002). Although not all studies have found emotional experience to be predictive of outcome (Hayes & Strauss, 1998), as a whole, research suggest that adding techniques that facilitate client experience and expression of emotions may also improve the effectiveness of CBT.

Our decision to emphasize interpersonal and emotional issues when attempting to improve CBT has also been influenced by Safran's expansion of cognitive therapy (Safran, 1998; Safran & Segal, 1990). Although endorsing the concept of schema, Safran has argued that such mental representation of self is intrinsically interpersonal. Relationships with others, according to Safran, are embedded in our understanding of who we are. In addition, core schema are not purely cognitive. Rather, they are cognitive-affective structures, or "hot" cognitions. The interpersonal and emotional nature of our core schema reflect the fact that our views of self are deeply shaped by our relationships with significant others. The ways we perceive and treat ourselves are based on the way important others (past and current) have viewed and treated us. Within this context, an emotionally immediate exploration of the clients' problematic relationships with important others (parents, spouse, therapist him/herself) provides a unique opportunity to better understand their interpersonal needs and fears, as well as to correct their maladaptive schema of self and others and their behavioral relationship patterns. In sum, Safran's model provided us with a conceptual framework accounting for and addressing interpersonal and emotional dimensions of human functioning when, as cognitive therapists, we attempt to provide a new perspective of self, to facilitate positive experience, foster more adaptive ways of dealing with



reality, and to enhance or repair our therapeutic alliances.

Having described the empirical and theoretical bases of our integrative approach, we now turn to a more pragmatic question: How do we actually combine traditional CBT techniques with interpersonally and emotionally focused interventions that are derived from (or consistent with) interpersonal, psychodynamic, and humanistic orientations?

## APPLICABILITY AND STRUCTURE

Our efforts to increase the effectiveness of CBT has evolved via the development and empirical testing of treatments for depression (Castonguay et al., 2004) and generalized anxiety disorders (GAD) (Newman, Castonguay, Borkovec, & Molnar, 2004). Because it is the most comprehensive of the two, the GAD treatment will be the main focus of this chapter.

CBT includes multiple techniques that directly address situational and intrapersonal factors involved in the etiology or maintenance of GAD. Previous studies have demonstrated that this treatment leads to statistically and clinically significant change in the short- and long-term and has an impact on both GAD specific symptoms and comorbid conditions. CBT has been found to be superior to no-treatment, nondirective therapy, psychodynamic therapy, and pharmacotherapy (Borkovec & Ruscio, 2001). A recent review of outcome studies on GAD concluded that “the most successful psychosocial treatments combine relaxation exercises and cognitive therapy with the goal of bringing the worry process itself under the patient’s control” (Barlow, Raffa, & Cohen, 2002, p. 326). In fact, CBT-oriented treatment currently stands as the only form of psychotherapy meeting criteria for empirically supported treatment for GAD (DeRubeis & Crits-Christoph, 1998).

The evolution of our integrative therapy for GAD and its incorporation of interpersonal and experiential techniques had its origins in empirical results that were emerging during the third author’s conduct of basic and therapy

outcome research on GAD from 1984 to 1995 (Borkovec, 1996). The fact that many clients in these earlier therapy trials were not returned to normal levels of anxiety by the end of treatment (Borkovec & Whisman, 1996) suggested that a therapeutic focus solely on intrapersonal processes may be insufficient. On the other hand, considerable evidence indicated that interpersonal processes were likely involved in the origins and maintenance of GAD. For instance, worry was most closely associated with social-evaluative fears (Borkovec, Robinson, Pruzinsky, & DePree, 1983) and interpersonal topics (Roemer, Molina, & Borkovec, 1997). GAD clients also reported elevated levels of role-reversed relationships with their primary caregivers in childhood (Cassidy, 1995; Schut et al., 1997), suggesting an understandable etiological basis for their world view as a dangerous place for both themselves and their parents. Moreover, a majority of GAD clients fall into an overly nurturing and intrusive interpersonal style that caused difficulties for them in their current relationships, possibly based on their childhood history of taking care of others (Pincus & Borkovec, 1994). Dimensions of interpersonal problems also significantly predicted posttherapy and follow-up clinical improvement (Borkovec, Newman, Pincus, & Lytle, 2002).

On the basis of this accumulating evidence, Borkovec decided that the next therapy investigation needed to test whether adding techniques that targeted interpersonal functioning could increase improvement rates generated by CBT. With the arrival of the first and second authors at Penn State and due to their expertise in interpersonal methods, he invited them to join future therapy projects and to make suggestions on how best to develop the envisioned interpersonal therapy element. The therapy element that was eventually added to CBT was created by the second author. Based in part on Safran and Segal’s (1990) work, this element combines techniques derived from both interpersonal and experiential therapies.

Despite the incorporation of techniques from different theoretical orientations, the third author was comfortable with the fact that exist-

ing empirical knowledge allowed such techniques to be used from within a cognitive-behavioral perspective. Interpersonal therapy can be viewed from within CBT as an approach that examines, and then attempts to modify by emotionally focused and interpersonally focused methods, the cause-and-effect links that exist among (a) environmental events, (b) the client's cognitive, affective, behavioral, and interpersonal processes, and (c) the consequences of the client's interpersonal behaviors. Moreover, the use of the therapeutic relationship to provide feedback to the client about his or her interpersonal effect on the therapist is fully in line with CBT principles of change (Kohlenberg & Tsai, 1991).

Finally, the use of emotional deepening techniques (prescribed in both experiential and interpersonal therapies) turned out to fit the behavioral learning view quite well, once recent discoveries were made concerning GAD and emotional process in general. Specifically, evidence now suggests that GAD clients largely ignore their emotions and indeed may be fearful of many of them, including positive ones. These findings suggest that worry, the cardinal symptom of GAD, may actually serve the role of cognitive avoidance of affect (Borkovec, Alcaine, Behar, 2004). From a CBT perspective, therefore, emotional deepening techniques can be used as exposure methods for the sake of full emotional processing of fear (Foa & Kozak, 1986).

The structure of the GAD treatment is unique. Rather than involving a simultaneous blend of theoretically diverse intervention, it involves a sequential application of two "pure" form of therapy. Specifically, our therapists are trained to conduct a 50-minute segment of CBT, which is immediately followed by a 50-minute segment of Interpersonal/Emotional Processing (I/EP) therapy (Newman et al., 2004).

This structure of our integrative therapy has been dictated by a specific scientific purpose. If this treatment combination (CBT+I/EP) can be shown to be superior to the combination of CBT and a supportive listening (SL) condition (CBT+SL), then our research would not only provide evidence that CBT can be improved

but also that such incremental improvement is causally attributable to the added interventions. Such an additive design is one of the few designs that can adequately address a major question that drives science: Causality (Borkovec & Castonguay, 1998).

Our concern with internal validity, however, comes at a price of external validity. Our integrative treatment, the way it is currently structured, is not easily transportable to the clinical setting. Effectiveness research will hopefully be conducted to assess the feasibility and impact of a treatment structure more in sync with the way psychotherapy is typically conducted (e.g., 1-hour session involving a more permeable implementation of the two treatments). We should mention, however, that with the exception of scheduling a 2-hour appointment every week, our therapists and clients have not found it onerous to work within a particular orientation for 50 minutes and then shift to a different treatment approach for another 50 minutes. In fact, our therapist have frequently mentioned that the sequential structure has helped them to focus on the tasks specific to each segment and has on many occasions prevented them from prematurely shifting to an "off-task" intervention.

Although we have developed the integrative approach specifically for GAD, we believe that it could be applied to other clinical problems. We would predict that many CBT protocols may be improved by adopting parts of our treatment when targeting any problems for which the etiology and maintenance involve interpersonal difficulties or the avoidance of painful emotions.

## ASSESSMENT AND FORMULATION

Because our GAD treatment has been developed and used in the context of clinical trials, the clients treated by our therapists have been assessed by two independent administrations of a semistructured interview—the Albany Anxiety Disorder Interview Schedule–IV (ADIS; Brown, DiNardo, & Barlow, 1994). The ADIS allows us to determine whether an individual

suffers from the clinical disorder targeted by our treatment and identifies the specific content of the client's worries. Moreover, it allows us to systematically assess comorbid conditions that are likely to influence case formulation. For instance, knowing that a client also struggles with social phobia helps us to determine our intervention targets (e.g., social skills) when addressing interpersonal issues.

Our assessment also involves a number of questionnaires and self-monitoring instruments. For example, the therapists use the Dysfunctional Attitude Scale (DAS; Beck, Brown, Steer, & Weissman, 1991) to identify the negative cognitions that may reflect and contribute to the client's worry and anxiety. Therapists also review the client's scores, obtained at pretreatment, on the Inventory of Interpersonal Problem—Circumplex (IIP-C; Alden, Wiggins, & Pincus, 1990), the Inventory of Adult Attachment (IIA; Lichtenstein & Cassidy, 1991), and the Structured Clinical Interview for DSM-IV Axis I (SCID-I; First, Spitzer, Gibbon, Williams, & Benjamin, 1994). Along with the gathering of interpersonal history information during sessions, as well as the observation of the client's behavior toward them, therapists use these pretreatment scores to understand the client's relationship patterns. The daily monitoring of clients' anxiety, as well as the systematic monitoring of their relationships, also help therapists conduct functional analyses of clients' problematic reactions.

The information derived by such an extensive assessment is used to construct case formulation, which in turn guides an ideographic application of the CBT and I/EP techniques. In CBT, therapists build their case formulations around the following questions: What are the early cues (situational and internal) of the client's anxiety reaction? What are the maladaptive elements (cognitive, imaginal, physiological) of such a reaction that could be replaced by more adaptive responses? In I/EP, the case formulations are centered around the following questions: What are the clients' most central interpersonal schema (i.e., core views of self in relation with others)? What do clients want and fear from others? What do they do to get their needs met? What is the impact they have

on others? Are their specific emotions that they are avoiding and that might tell them what they want from others?

## PROCESSES OF CHANGE

We assume that a substantial part of the process of change can be attributed to general principles that cut across different forms of psychotherapy and, needless to say, operate in both segments (CBT and I/EP) of our integrative approach. In line with Goldfried's model (1980; Goldfried & Padawer, 1982), however, the ways by which these principles were implemented vary from one segment to another.

Early in therapy, therapists work toward *creating positive expectations* for the clients. This is accomplished by providing a rationale explaining factors that might have contributed to their difficulties, as well as a description of techniques that will be used to address these factors. In CBT, the rationale focuses on situational and intrapersonal issues. Specifically, clients are informed that their experiences of uncontrollable worry and anxiety are learned responses to threat cues, which involve maladaptive and habitual interactions among cognitive, behavioral, and physiological systems. For example, GAD patients frequently have a preattentive bias to indications of danger, which can trigger images of negative events. These, in turn, lead to defensive somatic reactions. As one component in the spiraling intensification of anxiety, such somatic responses can result in greater attention to physiological activity, which can interfere with a client's attention to (and realistic appraisal of) external reality and further increase his/her internal response of worry and rumination. The goal of CBT is to identify early cues that indicate that an anxiety spiral is beginning and to help the client replace these maladaptive reactions with adaptive coping responses.

In the I/EP segment, the rationale focuses on both interpersonal and emotional issues. We inform clients that chronically anxious individuals frequently develop interpersonal styles that contribute to their anxiety. Therapists tell their clients that when they interact

with others, anxious people tend to focus more on avoiding what they fear rather than trying to get what they need. Unfortunately, attempts to avoid what one fears sometimes lead to specific—and anxiety provoking—reactions from others that one tried to avoid (e.g., being extra-attentive to another's need in order to not be ignored can lead the other to move away from the relationship because he or she is feeling intruded upon). The attention to what they fear has become such an automatic focus for chronically anxious persons that they are frequently unaware of many of their interpersonal needs. Clients are informed that one way to become aware of what they need from others is to explore their emotions. Accordingly, the goal of I/EP is to help clients become aware of, and then change, the maladaptive ways they interact with others, including the therapist. By exploring and owning emotions that are triggered by their relationship difficulties, clients will increase their abilities to get what they want and better deal with what they fear from others.

Another principle of change underlying each segment of our integrative treatment is the *provision of a new perspective*. By offering an explanation of the etiology and maintenance of GAD symptoms, the rationales described above intrinsically serve this principle. As described in the next section, each segment of the protocol includes additional procedures to foster a new understanding such as (a) helping the client challenge inaccurate thoughts, cognitive errors, and maladaptive attitudes, (b) experiencing and expressing previously implicit emotions and meanings, and (c) exploring wishes and fears about others, interpersonal schemas, and maladaptive relationship patterns. Though serving the same general principle of change, these interventions focus on different dimensions of human functioning (i.e., cognitive, emotional, interpersonal). Our clinical observations suggest that clients are able to recognize multiple types of determinants involved in their difficulties, as well as to establish meaningful connections among them. For example, they realize that some of their ways of thinking, at times, parallel their ways of relating with others or that being more open about their

emotions will help them to become less rigid about their appraisal of themselves.

Several of the techniques described later in this chapter directly serve the principles of *corrective experience* and *continued test with reality*. For example, relaxation and self-control desensitization techniques are used during CBT segments and between sessions to help the client to learn and rehearse new, more adaptive coping responses to anxiety-provoking cues. Similarly, attempts at fostering new and more meaningful ways of relating with others are done by paying attention to interaction with the therapist during I/EP segments, as well as between the client and others in his or her daily life.

Interestingly, though different techniques are used to foster these two principles of change, some of the techniques are based on the same learning processes. For instance, exposure in CBT is designed to help the client gain control over his or her anxiety. In I/EP, it is aimed at helping the client to stay with and own his or her painful emotions. In both situations, the mastery of previously intolerable situations is experienced as a positive corrective event. Modeling and problem-solving skills are also involved in the techniques used in each specific segment to correct maladaptive responses, learn more adaptive reactions, and implement them in situations outside the sessions. For example, such learning processes are at play when therapists help clients to react more adaptively to anxiety provoking cues or when therapists help clients to find better ways to get what they want from others.

Finally, as in all forms of psychotherapy, the use of the *therapeutic relationship* reflects a core principle of change in our integrative treatment. The ways in which therapists attend to the working alliance in each of the segment are described in the next section.

## THERAPY RELATIONSHIP

In both segments of our protocol, therapists pay careful attention to the development and maintenance of a positive therapeutic alliance. There is, of course, a good reason for this. The

quality of the therapeutic alliance currently stands as one of the most robust predictors of change in psychotherapy (Constantino, Castonguay, & Schut, 2001). Thus, during the whole course of the treatment, therapists make all possible efforts to be empathic, warm, and supportive toward their clients and to foster mutual agreement on the goals and tasks of therapy.

However, there is an important difference about the role of the relationship in the process of change in the two segments of our integrative therapy. In the CBT segment, the relationship is primarily viewed as a precondition for change. Therapists, in other words, adopt a supportive attitude mainly to build the client's trust in the treatment rationale and procedures, as well as to foster the client's willingness to do what he or she needs to do to develop better coping skills. It is assumed that if a good therapeutic bond (based on mutual respect and affection for each other) is created, that if the therapist genuinely understands the client's subjective experience, if he or she is flexible and tactful in the use of the prescribed technique, and if he or she encourages and reinforces the client's engagement in the treatment task, that it is then likely that the client will face what he or she had avoided in the past and will implement, during and between sessions, new ways of reacting to anxiety cues.

The same assumption is held in I/EP. A good relationship is viewed as a necessary condition for the client's engagement in the demanding and anxiety-provoking tasks prescribed in this therapy segment. In this segment, however, the therapeutic relationship is also used as a direct mechanism of change. Therapists use what takes place during the session to help client's gain awareness of, and change, their maladaptive patterns of interpersonal interaction. Therapists, in other words, not only attempt to build a positive relationship in I/EP but also to work with the relationship to identify and deepen authentic primary emotion and to modify interpersonal habits that have contributed to clients' anxiety.

In addition, specific techniques are included in I/EP to deal with alliance ruptures. Although therapists are asked to pay attention to markers of alliance ruptures in both the

CBT and I/EP segments, these markers are addressed only during the I/EP portion of therapy.

## METHODS AND TECHNIQUES

Although some principles of change cut across the two segments of our integrative treatment for GAD, the techniques used to implement these principles differ. Before describing these techniques, however, it is important to indicate that the stance of the therapist in both segments is fairly directive. Specifically, therapists must remain actively involved in making sure that the focus of the session is in line with the respective goals of each segment. While focusing on different dimensions of functioning in each segment, therapists help clients to be more cognizant of what they perceive as dangers (e.g., specific external events, internal images, negative emotions, interpersonal issues) and to replace their earlier coping responses (e.g., catastrophizing, scanning physiological reactions, avoidance of emotion, engaging in fear-reducing interpersonal behaviors). Helping clients to develop new skills to deal with anxiety requires that the therapist be task-oriented and directive, irrespective of the stimuli feared and the skills to be taught.

### CBT

The CBT segment is primarily aimed at modifying and reducing internal responses to specific threats. Following is a brief overview of standard methods employed in the CBT segment to achieve this therapeutic task (Borkovec & Sharpless, 2004; Newman, 2002)

#### *Self-Monitoring and Early Cue Detection*

Clients are taught to identify their earliest reactions to perceived threats, their reactions to these early reactions, as well as the spiraling chain of internal events (attention, thoughts, images, bodily sensations, emotions, and behaviors) that then occur. Clients can begin to discover early components of anxious responding by describing typical worry and anxiety ex-

periences and/or imagining situations involving different components of their anxiety responses. Therapists can also help clients detect early cues of anxiety by asking them to intentionally worry about a personal concern. Therapists are also asked to pay great attention to noticeable shifts in the clients' affective states as they occur during the therapy session. Immediately pointing out such a shift can sharpen the client's own early cue detection. In addition to these in-session experiences, the client is asked to self-monitor his or her worrying and anxiety responses on a daily basis. As sessions progress, clients are increasingly asked to pay attention to and process all immediately available experiences, both in the environment and internally. The goal is to help clients to shift attention to present-moment reality and away from the illusions of the future and of the past that their worrying and rumination create.

### *Stimulus Control Methods*

Once clients have learned to detect early cues for anxiety, a stimulus control method is used to reduce the amount of time spent worrying and to decrease the habit strength of worrying. Specifically, clients are instructed to postpone any early-detected worrying during the day to a fixed period of worrying—30 minutes at the same time and in the same place every day, during which they can engage in problem solving about the worry or apply cognitive restructuring skills to it. Such a deliberate postponement of worry enables clients to refocus attention to the present environment and the task at hand.

### *Relaxation Methods*

As part of the natural response to perceived threats (“fight or flight”), anxiety reactions are closely associated with the activation of the sympathetic nervous system (SNC). One way to attenuate the SNC at the early detection of anxious responding is by activating the parasympathetic system through learning and repeatedly using applied relaxation methods (Bernstein, Borkovec, & Hazlett-Stevens, 2000).

Multiple relaxation methods are taught in order to encourage flexibility in the use of coping resources and to find those that are most helpful for clients in different situations or in response to different internal cues. Slowed, paced, *diaphragmatic breathing* is an ideal starting point to provide the client with an immediate, noticeable, and positive effect of treatment and to teach him or her ways to reach a rapid relaxation response that is easy to learn and readily applicable in daily living. The client is instructed to slow-down breathing and to shift it from the chest to the stomach by letting the diaphragm rise and fall without expanding the chest. *Progressive muscle relaxation* (PMR) is aimed at reducing muscle tension and sympathetic activation via systematic tensing and releasing various muscle groups. *Meditational techniques* can be combined with PMR to facilitate the client's ability to shift away from anxiety-provoking cues and toward pleasant, internal stimuli. At the end of each PMR practice session, the client can be instructed to focus on a meaningful, pleasant internal stimulus (an image, a word, etc.) that is associated with safety, comfort, security, love, and/or tranquility. A related technique, *guided imagery*, can be used to further deepen the relaxation by leading the patient through a sequence of tranquil and pleasant images. The use of *applied relaxation* allows the clients to cultivate a more relaxed lifestyle and to cope adaptively with perceived threats as they occur in day-to-day living. It is applied on a moment-to-moment basis whenever clients recognize early cues of anxiety (and, eventually, any time clients are aware of the absence of a calm or tranquil state) and is intended to shift attention away from tension/anxiety toward relaxation. Therapist help clients to acquire and practice this coping skill during the session by frequently asking them to apply the relaxation response whenever therapists or clients observe signs of increased anxiety.

### **Self-Control Desensitization**

Self-control desensitization (SCD) involves the rehearsal of relaxation responses (and, later in

therapy, cognitive perspective shifts) while imagining frequently occurring anxiety-provoking situations (both environmental cues and internal cues). First, the client is asked to imagine himself or herself in a situation in which he or she detects anxiety cues. The therapist then repeatedly guides the client through imagining himself or herself successfully applying relaxation techniques in that situation. In the course of therapy, SCD is practiced with several sets of anxiety cues in order to generalize this adaptive coping response to various situations. Clients are also asked to include SCD at the end of their daily relaxation practice. Finally, in the course of cognitive therapy (described next), images of the most likely outcomes for worrisome topics are created, and these are to be imagined vividly as soon a worry is detected.

### *Cognitive Therapy*

From a CBT perspective, clients' inaccurate perceptions are important components of their worry and anxious experiences. As such, numerous cognitive techniques are used to help them develop cognitions that more closely correspond with the available environmental information. Clients are first instructed to observe their environment, as well as to monitor the content of their anxious thoughts on a daily basis. Clients' inaccurate perceptions and/or interpretations are then challenged by diverse methods, such the search for evidence to support and reject clients' cognitions, the generation of alternative perspectives, and the identification of core beliefs (or nonadaptive attitudes) underlying many of their specific inaccurate thoughts and negative images. Because worry frequently involves an exaggeration of the negative implications of specific events, the cognitive technique of decatastrophizing (i.e., a step-by-step analysis of what it is that the client fears might happen, including the probability of each of these steps and the client's coping resources to deal with them) is particularly useful for GAD clients. Perhaps differing from some CBT approaches, we place special emphasis on the creation of multiple perspectives for any

given situation in order to maximize flexibility in thinking.

Clients also complete a Worry Outcome Diary, wherein they write down (a) their worries when detected, (b) what they fear will happen, and (c) the actual outcome once it occurs. The purpose of this information is to help clients to build a new history of evidence of the way things actually are and to facilitate their processing of all available information from their environments, not just the negative biased information.

Behavioral experiments are also used to test unrealistic cognitions, as well as to provide additional exposure to feared situations and opportunities to practice applied relaxation and perspective shifts. On the basis of the data collected in these analytic and behavioral exercises, the clients learn to treat their perceptions as hypotheses and revise inaccurate predictions or assumptions involved in the spiraling intensification of their anxiety. By learning to pay less attention to negative environmental cues and by focusing less on the past or the future, the clients also learn to be fully immersed in their present reality, to process environmental information as needed, and to be confident that they will be able to deal with smaller or bigger challenges to come. Indeed, the eventual goal in therapy is to move from inaccurate expectations about the future, to relatively more accurate expectations, and ultimately to no expectations at all. Such expectancy-free living is our cognitive therapy method for contributing to the goal of living in the present moment, wherein there can be no anxiety or depression.

Finally, clients are encouraged increasingly to make use of intrinsically motivated behaviors for approaching worrisome or anxiety-provoking situations and for taking an active approach to daily living in general in order to maximize joy in life. Thus, drawing from the values that clients hold near and dear to their hearts, the therapist helps them to create emotional and cognitive sets reflective of those values and facilitative of a true, whole-organism approach to each life situation that they are about to enter.

## I/EP

I/EP has been added to CBT so that therapists can address the clients' problematic relationships and facilitate emotional deepening. Briefly put, the goals pursued in this segment are to facilitate clients' identification of interpersonal needs, fears, and schemas and to help them develop behaviors that will better satisfy their personal needs. Though the focus of interventions and the techniques used differ from CBT, the general goal is the same. Essentially, therapists attempt to help clients to live in the present—to focus on their immediate experience with others. Rather than paying attention to the past or the future (the bad things that happened and/or could happen), clients learn to focus on what they currently want from others, as well as on what others want from them. A greater awareness of their contributions to maladaptive patterns of relating and the acquisition of new social skills will also help clients to reduce their negative impact on others.

As in the CBT segment, I/EP directly targets the GAD clients' tendency to avoid. Clients are encouraged to expose themselves to feared emotions, feared critical feedback about their impact on others, and their fear of being vulnerable to other people by showing who they really are. By trying things that may help them confront their immediate fear, clients become aware of how their avoidance of negative emotions in the short term comes at a great cost in terms of a restricted lifestyle in which their needs are not met in the long term. The therapist also helps clients to shift their attentional focus away from danger anticipation and toward openness, spontaneity, and vulnerability with others as well as toward a greater empathic attention to the needs of others.

### *Exploring and Changing Interpersonal Functioning*

Early in the I/EP segment, the task of the therapist is to get a sense of the clients' interpersonal history. Open-ended questions about relationships with past and current significant others are aimed at providing the therapist with

a general understanding of clients' perceptions of their interpersonal needs and fears, as well as their typical attempts to deal with them. As early as in the second or third session, however, the primary focus of treatment shifts away from a description of these past and/or current relationships to an exploration, in an emotionally immediate way, of the therapeutic relationship.

Guided by Safran and Segal's (1990) integration of interpersonal therapy constructs (e.g., Sullivan, 1953), we assume that clients' maladaptive patterns of relating are likely to be repeated in the therapeutic relationship. As such, an important task of therapists is to identify when and how they have been participating in clients' interpersonal schemata. Safran and Segal (1990) have suggested that therapists actually *need* to be "hooked" into clients' maladaptive ways of relating to others—to be pulled by clients into behaving consistently with clients' expectations—in order to help them change the way they interact with others. Adopting an attitude of a participant-observer (Sullivan, 1953), therapists pay constant attention to signs of having been hooked, such as a feeling of being emotionally detached from the client, or the realization of having frequently let the client tell long tangential stories. Another indicator of therapists being hooked is when they and/or their clients are trying to find out *why* clients are reacting (or not reacting) in a particular way, instead of helping the client to become aware, own, or deepen their emotional experience.

Once hooked, the therapist stops acting in ways that are consistent with the client's expectations. Instead, he or she is asked to explore what is taking place in the relationship in order to help the client gain awareness of his or her maladaptive ways of relating, as well as the rigid construal of interpersonal relationships that underlies these patterns. Such exploration first requires the therapist to disclose, in an open and nondefensive manner, his or her reaction to what transpired in the relationship, such as saying "I feel pushed away, when you don't answer my questions." In some cases, the therapist self-disclosure immediately leads clients to being open to their own emotional ex-



perience. With our GAD clients, however, we have rarely observed such an ability or willingness to be vulnerable with another person. What is typically required is gentle but repeated invitations for the client to identify, experience, and express emotions triggered by the therapist's self-disclosure and/or the event that preceded it. The therapists' role is then to empathize with and validate the affective experiences expressed by the client, as well as to share his or her own reactions to the client's self-disclosures, such as saying "Of course, you would want to avoid a topic that made you uncomfortable. However, not answering my question also has an impact on me and makes me feel as though what I am asking for isn't important." Therapists are also encouraged to observe and communicate whether clients' responses to their openness help them feel understood by clients.

When used with warmth and support, these interventions can help the client become aware of his or her impact on another person. In addition, such an exploration of the therapeutic relationship allows the therapist to model an open communication style. By disconfirming the validity of the client cognitive-interpersonal schema (i.e., "It is dangerous to openly communicate with others), this way of working with the therapeutic relationship—of metacommunicating (Kiesler, 1996)—can provide the client with a unique corrective experience (Alexander & French, 1946; Goldfried, 1980).

Similar techniques of metacommunication are also used in I/EP to repair alliance ruptures. In fact, the enactment of client interpersonal schema during sessions, as when the client walls off the therapist or pulls for his or her hostility, will at times create alliance ruptures. This, however, in no way suggests that clients are always responsible for alliance problems. Such alliance tears can be caused or exacerbated by the therapist's less than adequate level of engagement, attention, empathy, warmth, tact, or attunement to the client needs. The therapist may frustrate the client's desire to be helped by not using the most appropriate technique, by failing to use competently a perfectly adequate intervention, or by being blinded by

his or her own interpersonal schema (avoiding core therapeutic issues because of his or her own fears of hurting the client or being hurt by outbursts of anger). From a cognitive-interpersonal perspective (Safran & Segal, 1990), alliance ruptures are events that can be expected when two individuals are involved in a complex, demanding, and emotionally meaningful relationship such as therapy.

Accordingly, our therapists are trained to recognize markers of alliance ruptures, such as clients' overt expressions of dissatisfaction, indirect expressions of hostility, disagreements about the goals or tasks of therapy, overly compliant behavior, evasive behavior, and self-esteem-boosting maneuvers (Safran, Crocker, McMains, & Murray, 1990). Therapists are asked to attend to markers of alliance ruptures during both the CBT and I/EP segments, but these markers can only be addressed during the I/EP segment because, for our additive design study, the protocols could not allow therapeutic work on interpersonal behaviors during CBT segments.

Based on the contributions of Burns (1989) and Safran (Safran & Segal, 1990), attempts are made to repair the alliance by following three steps. First, therapists invite clients to talk about their negative reactions (e.g., "I have a sense that you aren't as engaged as you have been in other sessions. Is that how you are feeling?"). Second, the therapist empathizes with the client's perception and emotions and invites him or her to express additional emotions and thoughts about what was unhelpful or invalidating in the treatment. When the therapist has the sense that the client feels understood, the therapist should then recognize and comment on his or her own contribution to their relationship difficulty. This last step, elegantly captured by Burns (1989) as a "disarming" technique, requires the therapist to find some truth in the client's reaction, even when the reaction may seem unreasonable. The use of this technique is based on the assumption that the therapist has invariably contributed in some way to the lack of synchrony between client and therapist. It is also based on the assumption that the therapist's openness to his or her experiences can lead to the client's open-

ness to his or her experience, which may in turn help them to exit an unproductive cul-de-sac in their relationship (Castonguay, 1996).

Contrary to the client's expectation, he or she learns that being emotionally vulnerable can lead to stronger and safer relationships. The client also learns that when "living in the moment" (such as when experiencing and exploring in an emotionally immediate way what is taking place in a relationship), he or she ceases to pay attention to the past and the future. Worries and ruminations dissipate as one becomes real and present with others.

In addition to paying attention to the therapeutic relationship, therapists also help clients to draw links between interaction patterns observed in the session and patterns in clients' past or current relationships with significant others. Therapists, however, are reminded that such connections are sometimes drawn (by the client or themselves) as a way to avoid processing negative events taking place in the therapeutic relationship. Such defensive maneuvers may prevent the client from fully experiencing his or her emotions and further reinforce longstanding avoidance strategies (e.g., intellectualizing or "staying in his or her head" as opposed to being open and vulnerable with another person). When part of an emotionally immediate exploration of the client's experience, however, such connections with outside interpersonal events frequently helps clients gain a deeper awareness of their rigid constructions of relationships and maladaptive ways of relating with others.

Therapists also ask clients to monitor and record events taking place between sessions with significant others. Specifically, clients are asked to describe specific interactions and to take note of the emotions they felt during these interactions, what they wanted and feared from the other person, what they did, and what happened next. Such functional analyses of intrapersonal and interpersonal factors frequently helps clients to identify what they need and what they actually get from others (McCullough, 2005). In particular, these analyses reveal the negative impacts that some of the client's behaviors have on others. When indicated, behavioral strategies (e.g., social skills training)

are then used to teach clients better ways to satisfy their interpersonal needs.

### *Facilitating Emotional Deepening*

In the I/EP segment, helping the client to experience, deepen, and express his or her emotion is aimed in part at extinguishing fear and avoidance (including worry as a cognitive avoidance response) of emotion. As mentioned above, basic research has suggested that when individuals with GAD worry, they do so in part to avoid painful events (future bad outcomes or distressing emotions). As such, worry is maintained, at least in part, by its negative reinforcement quality (e.g., suppression of somatic aspects of anxiety or the eventual nonoccurrence of low-probability, but feared, negative events). By exposing the client to his or her emotional experience, he or she learns that although some emotions can be painful, they are not dangerous (e.g., sadness and anger over another's betrayal). As such, the safety of the therapeutic relationship provides clients with yet another unique opportunity for corrective experiences. Indeed, if the experience with and exploration of feeling repeatedly fails to be intolerable, they learn that there is nothing to fear from their emotional experience. And when there is nothing to fear, there is no reason to avoid. Worry, as a consequence, loses its reinforcing impact, and clients begin to gain access to primary affects that can motivate and direct adaptive behaviors, as described below.

Emotions are an important source of information for what we need in life. As such, emotional deepening is also used in I/EP to help clients better understand what they need from others. Guided by the work of Greenberg and his colleagues (Greenberg, Rice, & Elliott, 1996; Greenberg & Safran, 1987), therapists are trained to track markers of emotionality in order to decide when to use techniques aimed at deepening feelings. Examples of such markers are changes in voice quality, the sound of tears in the voice, and a slowing or quickening of conversational pace. When such markers are noted, clients are encouraged to stay with their emotions and to allow themselves to fully experience them. Therapists also pay attention to

moments of emotional disruption or disengagement. When clients stop emoting and/or being attentive to their affective experience, therapists invite them to focus on their immediate experience. For example, “What just happened? You were allowing yourself to cry, and you quickly moved away from your feeling.”

When markers of a *self-evaluative split*—internal conflict experienced by clients—are observed, clients are invited to take part in a two-chair exercise. In the exercise, clients distinguish the two parts of themselves—as though they were two separate people—and then embody each one separately and repeatedly as one part speaks to the other until clients have gained greater insight into their feelings and their own needs in the internal conflict.

In contrast, markers of *unfinished business*—unresolved feelings toward another person—are dealt within an empty-chair exercise. Here, the client expresses his or her feelings while imagining another person sitting across in an empty chair.

The technique of “systematic evocative unfolding” (Greenberg et al., 1996) is also used to address markers of *problematic reactions*—when clients experience surprise or confusion about one of their own reactions. Clients are asked to close their eyes and imagine themselves back in the situation that evoked the reaction and play the scene in slow motion in their imagination. They are asked to vividly remember every aspect of the scene, describe in detail the events and their feelings during the situation, and to pay attention to every internal cue as they repeatedly describe the situation. By reexperiencing fine-grained details and their reactions to them, clients can better express and own the emotions that first surprised them, as well as gain access to previously implicit emotions.

Therapists also encourage clients to focus on and own their emotions as they go on in their day-to-day lives. It is indeed important to help clients generalize the corrective experiences of expressing feelings in the safe environment of the therapy session to interpersonal relationships outside of therapy. Continued attention to clients’ experience and behavior in the real world may well be crucial to help

them overcome their fear of vulnerability and achieve a lasting change in their habitual avoidance of emotion.

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### CASE EXAMPLE

The following case was chosen because it illustrates the major thrust of our integrative treatment. It demonstrates how the addition of specific techniques to CBT allows therapists to work with material not directly or adequately addressed in traditional CBT. As such, the case description will mostly focus on the I/EP segment of the therapy.

Wendy was a White undergraduate seen within the context of a National Institute of Mental Health (NIMH)-funded study aimed at providing preliminary evidence for the feasibility and impact of our integrative CBT+I/EP treatment for GAD (this study is presented in more detail in the next section). Although Wendy’s primary diagnosis was GAD, she was also diagnosed with comorbid social phobia, obsessive compulsive disorder, and a specific phobia. She reported that she had previously sought psychotherapy for an interpersonal problem and that this therapy lasted 2 months. She was not currently taking any medications nor had she taken any psychiatric medications in the past. In terms of her GAD symptoms, she reported that the current bout of GAD had been chronically ongoing for 7 years. She reported that she was not aware of any formal diagnoses of mental health problems in her immediate family but that she would characterize her mother as a worrier.

Wendy was treated by a White male psychologist, who was primarily trained in CBT. In addition to his full-time private practice, the therapist had served as a protocol therapist in several previous CBT studies.

Wendy felt very comfortable during the CBT segment. She took the therapist’s directives to heart and actively complied with the therapeutic tasks prescribed during and between sessions. On the other hand, the I/EP segment was much more difficult for her, at least initially. She was reluctant to reveal herself, expressing minimal emotion and, when she did, only in response to the thera-

pist's persistent requests. Although she wanted to please the therapist, he felt discounted by her lack of authentic interpersonal and emotional behavior toward him, probably due to her fear of being vulnerable. Though she tried hard to understand and follow the therapist's instructions (as the perfect client that she wanted to be—and felt that she could be in CBT), the therapist did not feel that she wanted to connect with him or allow herself to be emotionally close during the I/EP segment.

What was happening during therapy paralleled what had been taking place in Wendy's interpersonal relationships. Early on in I/EP, she reported that she felt that she had to be perfect with others. Her view of relationships was that she felt obligated to take care of others' happiness. Not surprisingly, she felt burdened by what she perceived to be the expectations of others, became angry when friends asked her to socialize because it was taking time away from her studies, and frequently avoided being with them.

As therapy progressed, it became clear that she had a hard time being empathic to others. In part, because her attention was on her own behavior (her attempt to please others), she did not fully listen to others. She was so focused on her fear of failure in meeting their needs that she had little energy left to listen to the needs they actually expressed. She thus found herself trapped in an unfortunate paradox: She spent so much time trying to do everything for others that she felt burdened by others and thus discarded them.

At the same time she was surprised to learn that she did not meet their needs. For example, when she asked the therapist after several sessions whether he liked her, she was quite surprised by his reply that he did not know whether he liked her or not, because he had not yet really met the real her. She thought that she was doing everything he wanted her to do, including self-disclosing.

She was also expecting important others in her life, including her boyfriend, to have a similar view of relationships. Specifically, she expected others to be vigilant and attentive to her needs. She expressed considerable frustration at the fact that her boyfriend was not always anticipating what she wanted from him. As therapy helped her to focus on her interpersonal needs, she became

aware that she had difficulty being spontaneous with others. One of her first realizations was that she felt angry at others. This led her to be more assertive with her boyfriend, but it also made it more difficult for her to be vulnerable, as well as to be attentive to his needs.

Her interactions with her boyfriend led the therapist to focus on her impact on others, including on the therapist himself, which in turn led her to become more emotionally expressive. The therapist then used emotional deepening techniques to explore the origins of her fear of being vulnerable with others. Specifically, the therapist used a systematic evocation technique and allowed her to reexperience her feeling of being betrayed by another person when she was in high school. This incident appeared to play an important role in her fear of trusting others, of letting her guard down, of being herself, of not worrying about (and therefore being burdened by) others. The use of an empty chair (where she expressed her feeling of being betrayed and hurt) in the same session allowed her to become aware that the price paid for not being herself was social isolation, loneliness, and sadness. She realized that she had missed her previous connection with others.

At the same time, she was genuinely surprised by the therapist's acceptance of her tears and sadness (of her vulnerability) expressed during the evocation of these memories: "You like me when I'm like this, really? This is what you were looking for?" Because the therapist's reaction to her first authentic emotional reaction in therapy was opposite to what she expected, it led to a significant corrective emotional experience.

In the following sessions, the client became more emotionally present, displayed a wider range of and more intense emotions, and began making numerous and adaptive changes in the way she was relating to others outside of therapy.

Wendy has now been followed up 2 years after therapy was completed. At pretherapy, her assessor severity level was 6 and by follow-up it was 1. Also, the client demonstrated clinically significant change and high endstate functioning (i.e., her score was within the range of a normative sample) on 6 of the 6 measures of GAD-associated symptoms (e.g., self-reported worry, self-reported trait anxiety, self-reported relaxation-induced anxiety, assessor-rated severity of GAD, observer-rated

anxiety symptoms, and self-reported diary measure of worry), demonstrating that she showed at least 20% change and was within the range of a normative sample on all measures.

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## EMPIRICAL RESEARCH

Our integrative treatment for GAD has been the object of two NIMH-funded clinical trials. The first was a preliminary study aimed at determining whether it could be implemented and if its outcome would suggest possible improvement over traditional CBT for GAD.

Eighteen adults meeting *DSM-IV* criteria for GAD received the CBT+I/EP described above. The treatment was delivered by three experienced therapists (one originally trained in CBT and two primarily trained as psychodynamic therapists). Numerous process findings and adherence checks suggested that what took place during each segment of therapy was consistent with the treatment manuals. An observer-rated measure of the therapist interventions, for example, showed that although therapists focused more on interpersonal issues (e.g., interpersonal pattern, general interactions with others) in I/EP than in CBT, they focused more on intrapersonal issues (e.g., the link between different aspects of functioning such as the impact of thoughts on feelings) in CBT than in I/EP (Castonguay et al., 2002). Also as predicted, both clients and therapists reported talking more about interpersonal matters such as the client's family and significant relationships in I/EP than in CBT, whereas talking more about matters related to work and anxiety triggers in CBT than in I/EP (Castonguay, Schut, Newman, & Borkovec, 1999). In addition, both self-report (client and therapist) and observe-measures showed that, as predicted, higher levels of negative emotions (e.g., sadness) were found in I/EP. For a number of positive emotions (e.g., confidence, joy), however, higher levels of intensity were found in CBT (Castonguay, Schut, Newman, & Borkovec, 1999; Castonguay et al., 2001), which is consistent with its focus on building skills and increasing self-efficacy.

Although tentative, the outcome findings obtained in this open trial were promising. The effect sizes (reflecting differences between pre-treatment and post-treatment outcome measures) indeed appeared to be superior to those obtained by previous studies conducted with traditional CBT. In fact, whereas the average within participant effect size from previous CBT studies was 2.44, our pilot study obtained a 3.5 effect size (Newman, Castonguay & Borkovec, 2002).

Based on these preliminary findings, we have embarked on a randomized clinical trial. When completed, more than 70 GAD clients will have been assigned to either CBT+I/EP or CBT+SL. The use of such an additive design will permit us to determine specifically whether the addition of specific components (interpersonal focus and emotional deepening techniques) will lead to an improved outcome over traditional CBT package. Our early results suggest that I/EP does show some added benefit at 2-year follow-up with a significantly greater percentage of participants receiving the integrative therapy demonstrating high endstate functioning when compared to the CBT/SL condition (Newman, Castonguay, & Borkovec, 2002).

We have also conducted a preliminary outcome study on an integrative treatment for depression which we called integrative cognitive therapy (ICT; Castonguay et al., 2004). Here, only one of the components of the I/EP package was added to a traditional form of CBT. Specifically, alliance ruptures were addressed in cognitive therapy (CT) by using techniques described by Burns (1989) and Safran & Segal (1990). Although the integrative treatment was conducted by inexperienced therapists (graduate students), the findings showed that it was superior to a waiting-list condition. As a whole, the findings also compared favorably with findings of previous results obtained with traditional CT. The effect size obtained for the Beck Depressive Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), for example, was more than twice that estimated in a meta-analysis of control studies comparing CT and wait-list or placebo condition (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998). Because

of its small  $N$  and the absence of a direct comparison with a traditional CT, however, these findings should be considered very cautiously.

## FUTURE DIRECTIONS

We hope to expand our research program in a number of scientifically and clinically important directions. Based on preliminary analyses conducted on the current GAD trial, we have submitted a research proposal for a study investigating the impact of our integrative treatment at different sites and with more diverse ethnic clients. It is indeed important to determine whether potential improvement of the efficacy of CBT for GAD can be generalized to different treatment environments and diverse clinical populations. We also hope to eventually conduct investigations in more naturalistic settings in order to investigate the effectiveness of our protocol. Directly relevant to effectiveness is the question of whether it would be possible and advantageous to combine the techniques involved in the integrative treatment within the same sessions—as opposed to dividing them into different segments of therapy sessions.

We are also interested in determining whether the treatment developed for GAD can be applied successfully to other clinical problems. Depression, for instance, is likely to be an appropriate target, as many of the process findings and theoretical arguments that guided our selection of the techniques to be added to traditional CBT emerged from the depression literature.

Much more research should be done on the less comprehensive protocol that we have begun to test on depression. Several other studies—with large sample sizes, conducted at different sites, and involving direct comparisons between ICT and CT—are required before it can be confidentially asserted that adding techniques to repair alliance ruptures improves the efficacy of cognitive therapy for depression. As with the protocol for GAD, future research should not be restricted to efficacy studies. Funding is currently being pursued by members of our team to determine if training thera-

pists to use alliance repair techniques in their day-to-day practice (irrespective of their theoretical orientation and across a variety of clinical populations) can improve their effectiveness.

Finally, we hope to continue using our clinical experience, the progress made in the theoretical and empirical literature, as well as the results of our current and future research to continue to develop and test treatment methods that might improve CBT, as well as to provide heuristics for the potential improvement of other treatment approaches.

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## **PART III**

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# Integrative Psychotherapies for Specific Disorders and Populations

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## Integrative Psychotherapy of the Anxiety Disorders

BARRY E. WOLFE

My interest in psychotherapy integration emanates from two different but interrelated sources: (a) my experience as a clinical practitioner, and (b) my previous career as a psychotherapy research grant manager at the National Institute of Mental Health (NIMH). As a practicing therapist, I learned what so many of my friends in the Society for the Exploration of Psychotherapy Integration (SEPI) have learned, that conducting therapy solely from the vantage point of a single psychotherapeutic orientation is a recipe for more than occasional failure. As a psychotherapy research grant manager at the NIMH, I learned that each perspective in psychotherapy possesses notable strengths and glaring weaknesses.

My interest in the anxiety disorders is a product of the cross-fertilization between these two endeavors, my work as a psychotherapist and my work as a research administrator. During a long career in my latter position, anxiety disorders and their treatment eventually became my primary focus of research grant administration. As I sought to integrate my clinical

experience with the findings of the research literature, my therapeutic interests evolved into a specialty in the treatment of anxiety disorders. Thus, it seemed to me a logical task to attempt to develop an integrative model for the treatment of the anxiety disorders.

### INTEGRATIVE APPROACH

My training as a psychotherapist generated a number of expectations regarding how patients develop and maintain their emotional problems. Perhaps the best way to describe the therapeutic approach in which I was trained is that I learned to talk “psychodynamic” but to practice “Rogerian.” A client’s problem might be formulated in psychodynamic terms but was expected to yield to the client’s own experiential search and processing that would occur within the confines of a safe, nonjudgmental therapeutic relationship (Rogers, 1957). This approach was developed during my second stint in graduate school at the University of

Florida, out of the ashes of my painful experience as a psychology graduate student at the University of Illinois, which at the time was a kind of "Behaviorist Baghdad" that brooked no opposition to its prevailing orientation (Wolfe, 2001).

As useful as this approach had been in the treatment of some patients, its benefits for many others were limited. I found with phobic patients, for example, that it provided little resolution of the avoidance behavior, as it lacked a performance-based, confrontative approach that was being touted in the research literature (Barlow & Wolfe, 1981). Despite my previous disenchantment with behaviorism and behavior therapy, I had to acknowledge that behavior therapists seemed to have a lock on effective treatment, particularly in the area of phobias. I then made the typical logical error in thinking that effective treatment necessarily implies an accurate conceptualization of the problem being treated; therefore, I eagerly received some training in a variety of behavioral techniques, including a number of exposure-based procedures.

When I attempted to employ traditional exposure therapy, however, my expectations were unsubstantiated once again. The application of imaginal exposure to the phobic patient's feared object or situation led to a series of recurring clinical observations that profoundly altered my conceptualization of the formation, maintenance, and treatment of phobic disorders. The following observations serve as the empirical foundation for my etiological model of anxiety disorders.

I had assumed that anxiety somehow becomes conditioned to the phobic object and that imaginal exposure would allow the patient to experience the habituation of that anxiety by means of continual exposure. What I serendipitously discovered, however, was that imaginal exposure uniformly elicited images of catastrophe associated with the experience of extremely painful emotions. The imaginal scenes that spontaneously arose would find the patient in a powerless position, about to be humiliated or badly harmed by the phobic object. As my patients and I would explore their catastrophic imagery, we would find that they were either

recapturing long-forgotten (repressed?) traumatic events in their own history or contacting previously constructed prototypes that symbolized their sense of helplessness, powerlessness, and doom originally experienced much earlier in their lives (cf. Weitzman, 1967).

As the serendipitous discovery of catastrophic imagery became a routine occurrence in my treatment of phobias, I was increasingly struck by the irony that unconscious conflicts were being elicited by a therapeutic approach that denied their existence. But this was not an original finding. Feather and Rhoads (1972a, 1972b) had demonstrated something like this phenomenon many years ago when they attempted to employ systematic desensitization to previously elicited unconscious fears. A few years before their work, Stampfl and Levis (1967) and Weitzman (1967) originally highlighted the importance of psychodynamic issues in the development and maintenance of phobias.

With phobic patients, images of confrontation with the phobic object would result initially in very high anxiety. If the patient was able to experience the anxiety associated with the catastrophic imagery, rather than trying to avoid or interrupt it, the anxiety eventually would give way to a variety of feared emotions, including rage, humiliation, shame, hopelessness/helplessness, and despair.

A similar phenomenon occurred with panic patients for whom there may not be an external phobic object. These patients typically fear their body sensations, particularly the sensations of anxiety (Reiss, 1987). Such patients would be asked to focus on the most prominent body site of anxiety. Once patients were able to maintain a continual focus on the experience of their anxiety, one or more of the aforementioned frightening and painful emotions would be experienced.

It was through such experiences that a patient would come to realize that the anxiety appeared to function as a signal or an alarm of very threatening emotions and their embedded meanings. For example, one patient who suffered from a severe fear of flying experienced his anxiety predominantly in his throat. He would feel a severe constriction whenever he imagined himself on a plane. When we were

able to induce this constriction through imaginal exposure, I would instruct him to maintain a strict attentional focus on his throat. After doing this for a few minutes, he suddenly burst into sobs as he reexperienced his long-dormant rage at his mother, which would eventually segue into an intense feeling of extreme sadness over her apparent neglect. As he experienced and explored the meaning of these feelings, his anxiety disappeared.

This particular patient, however, found depressive sorrow to be as painful as the anxiety and panic, and the anxiety reappeared upon the next trial of imaginal exposure. Repeated episodes of imaginal exposure demonstrated to the patient, beyond doubt, that his anxiety signaled the surfacing of depressive sorrow, a feeling for which he possessed virtually no tolerance. The meaning that was embedded in his sorrow was that he was so crippled that he could not ever hope to have a committed relationship.

These clinical observations are predicated on the patient's being able to explore the implicit meaning of his or her in-the-moment anxiety. But what if the patient is unable to stay in contact with the immediate experience of anxiety? Another set of recurring clinical observations was made in conjunction with the patient's inability to experience their anxiety directly. Anxious patients typically shift their attention away from the immediate experience of anxiety to a more perceptually distant focus on the self as anxious accompanied by *cogitation* about the implications of being anxious. I have chosen the word *cogitation* because it suggests that the individual begins to obsessively think about the implications of his or her anxiety rather than contacting it directly. Cogitating typically increases the level of anxiety experienced by the individual. This phenomenon was originally described by Goldstein and Chambless (1978) as the "fear of fear" and subsequently investigated by Reiss (1987) as "anxiety sensitivity." More recently, researchers such as Barlow (1988, 2000) and Ingram (1990) have emphasized the concept of "self-focused attention," which also captures the perceptually distant experiential stance.

These observations made it clear to me that it was necessary to treat both the surface symp-

toms of an anxiety disorders and the underlying conflicts and beliefs that seem to drive the disorder. I developed an integrative treatment model (to be described later) that combined an initial symptom-focused treatment with a later effort to help patients explore, allow, and eventually process the painful emotional meanings that seem to drive the anxiety disorder.

But I was also intrigued by the nature of the underlying etiology of these disorders, and I therefore have spent the past several years developing an integrative etiological model of the anxiety disorders. This was accomplished by reviewing the psychodynamic, behavioral, cognitive-behavioral, experiential/existential, and biomedical models of anxiety disorders. I was able to abstract the common and differentiating factors of these perspectives. The common factors can be viewed as constructs that form the foundation of an integrative etiological model. I then sifted through the research literature and my clinical experience with this population in order to develop a rationale for selecting certain differentiating constructs. Space does not allow a detailed description, but I will present in summary form the resulting integrative etiological model, which is more fully described in a forthcoming book, provisionally entitled *Understanding and Treating Anxiety Disorders: An Integrative Approach to Healing the Wounded Self*.

## AN INTEGRATIVE ETIOLOGICAL MODEL OF ANXIETY DISORDERS

My model attempts to provide an integrative perspective on the nature, development, and maintenance of anxiety disorders.

### The Nature of an Anxiety Disorder

A major premise of the model is that anxiety disorders are based in troubled self-perception and experiencing. Every anxiety disorder is rooted in a sense of danger or catastrophe to the self. Each anxiety disorder patient possesses specific unconscious catastrophes that he or she dreads; these catastrophes are accompanied by unacceptable painful emotions. This

expectation of catastrophe to the self is *self-endangerment*. At a conscious level, self-endangerment is characterized by a sense of losing control, lacking safety, and feeling powerless.

When one becomes anxious, there is typically an automatic shift of attention to a *more perceptually distant focus on the self as anxious*, accompanied by cogitation about the implications of being anxious. Cogitation typically increases the level of anxiety. Thus, a self-endangerment experience involves both the immediate anxiety and cogitation about its implications.

Because of this automatic shift of attention, the individual cannot discover the implicit or preconscious meaning of the anxiety. The implicit meaning of self-endangerment is that one anticipates a confrontation with an excruciatingly painful view of the self. I call these unbearably painful self-perceptions *self-wounds*. I use the metaphor of wounds because of the pain that is experienced when they are exposed. For persons suffering from an anxiety disorder, wounds to the self generate a chronic struggle with their own subjective experience. In other words, their immediate experience feels dangerous. Figure 12.1 provides a schematic model of anxiety disorders.

Self-wounds are basically organized structures of painful self-related experience—or generalizations of such painful experience—that are stored in memory. These wounds may be known directly as a damaged sense of self or known conceptually as beliefs and propositions about the self. These painful self-views may be specific memories that a person has experienced with a significant other or may represent a generalized self-view constructed out of a se-

ries of such painful experiences. The person fears both the meanings of these painful self-views and the accompanying emotions such as humiliation, rage, and despair. The wounds are mostly unconscious but are nevertheless influential in determining the person’s decisions, feelings, and actions.

There are basically three nodes to an anxiety disorder: (a) the immediate experience of the anxiety or panic; (b) cogitating about the implications of being anxious; and (c) the implicit meaning of the anxiety or panic attack. The external and internal cues that provoke anxiety are developed through the perception of relationships between certain life experiences and intense fear. That is, certain experiences are perceived as self-endangering. The cues themselves often function as abbreviated shorthand for the painful memory that exists beyond the individual’s conscious awareness. The feared catastrophes that are signaled by the sense of self-endangerment relate to both physical and psychological survival. Physical fears include the fear of dying, paralysis, or physical breakdown. Psychological fears include the fear of being unlovable, unworthy, unacceptable, inadequate, abandoned, isolated, rejected, weak, pathetic, humiliated, dominated, or controlled. In addition, there is dread associated with the pending loss or destruction of one’s meaning in life.

The content of the unconscious conflicts involve the wounded self struggling with the “ontological givens” in life; that is, the unavoidable human realities we all must face. These conflicts frequently concern how much freedom versus how much security one wants to

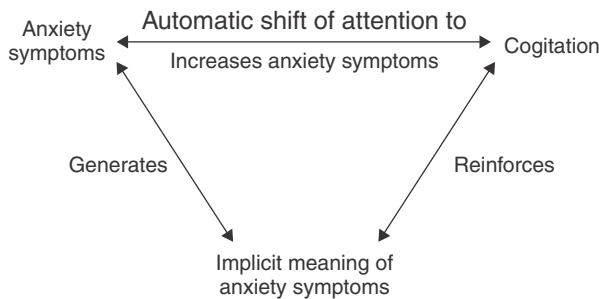


FIGURE 12.1 Schematic Model of Anxiety Disorder

have in one's life; acceptance versus denial of one's mortality; how much to trust people in one's life; acceptance of personal responsibility for one's thoughts, feelings, and actions; and acceptance of the inevitability of the loss—of loved ones, relationships, careers, and physical capabilities.

All of these views suggest a perception of self as one who cannot cope with—and therefore needs protection from—the rigors and realities of everyday living. Because these realities are unavoidable, the anxious individual must create indirect strategies for coping with these realities that protect them from intolerable emotions while at the same time keep them from facing these realities head on. Such strategies range from behavioral avoidance to cognitive ritual to emotional constriction; they usually produce unintended interpersonal consequences that have the paradoxical effect of reinforcing the patient's core beliefs about the self.

### Development of an Anxiety Disorder

Although this model acknowledges that certain patients may have a genetically transmitted predisposition for developing an anxiety disorder, the bulk of the causative weight is placed on the patients' damaging life experiences, the self-wounds that those experiences generate, and the ineffective "protective strategies" that are employed to prevent the exposure of those wounds. These damaging experiences stem from a variety of sources, including traumatic experiences, shaming or toxic ideas, betrayals by significant others, emotional miseducation, and ineffectual responses to the realities of ordinary living. In our field's drift toward a more biomedical view of mental illnesses, the extent of damaging life experiences and their role in the generation of emotional disorders have been seriously underestimated.

In response to the initial anxiety, patients typically engage in cogitating about being anxious (i.e., self-preoccupation), avoiding the fear-inducing objects and situations, and/or engaging in negative interpersonal cycles. These strategies result in the temporary reduction of anxiety and the reinforcement of the patient's

underlying maladaptive self-beliefs. Psychological defenses in this model serve as self-defeating efforts to protect one's self-image.

### Maintenance of an Anxiety Disorder

A number of cognitive and emotional processes automatically spring into action to protect the self-wound from exposure. Instead of confronting the self-wound head-on, anxiety patients typically engage in strategies designed to keep them hidden from one's self and from others. There are three categories of strategies that anxiety patients typically employ: (a) cogitation, (b) avoidance, and (c) negative cycles of interpersonal behavior. These strategies or psychological defenses usually produce unintended interpersonal consequences that have the paradoxical effect of reinforcing the patient's painful core beliefs about the self (i.e., self-wounds). When we observe the consequences of these self-image protective strategies, we see that the wound analogy breaks down, because these protective processes do not allow the self-wound to heal, but rather guarantee that they will not heal. Unhealed self-wounds are the primary reason for the maintenance or continuation of an anxiety disorder.

### Integrative Model Applied to Specific Anxiety Disorders

This integrative etiological model is applicable to all anxiety disorders. The details, however, shift slightly from disorder to disorder. Space limitations allow only a brief description of the model for two separate anxiety disorders: social phobia and panic disorder.

Social phobias develop in a matrix of destructive hypercriticism from primary caregivers. When individuals are severely criticized for revealing a vulnerability or weakness, they are likely to internalize toxic opinions of the self. Typically, these opinions suggest that individuals are defective or inferior. These opinions produce self-wounds, which are characterized by feared self-appraisals that they are socially inadequate, unlovable, or unworthy. As a result, social situations and public-speaking



opportunities produce the experience of self-endangerment. The associated anxiety protects the individual from painful feelings of inadequacy. The extreme humiliation is unbearable and is thus avoided by experiencing the panic/anxiety instead. The anxiety or panic leads to an automatic shift of attention to a preoccupation with one's social limitations and with the imagined rejection from a hostile or disdainful audience. This self-preoccupation degrades social performance, and the vicious circle is then completed when the degraded social performance reinforces the feared negative self-appraisals.

The disorder is basically maintained by three separate processes: (1) the self-diminishing opinions (i.e., self-wounds), (2) avoidance of social occasions or public speaking engagements, and (3) *impression management*, which involves behaving in ways that patients believe will bring them approbation from others. The difficulty with impression management strategies is that the behavior feels inauthentic.

Typically, social phobics fear several interrelated catastrophes, including being exposed as a fraud or imposter, being unacceptable or inferior, being rejected, and losing status. Social phobics also fear the associated emotions of shame and humiliation.

Panic disorder with or without agoraphobia is rooted in an unconscious self-wound. Patients suffering with panic disorder and agoraphobia learn early on that it is dangerous to live autonomously in an unsafe world. They secretly believe that they cannot cope with life's unavoidable realities. Although the feared catastrophes vary from person to person, they generally concern the inability to accept such ontological givens as death, loss, increased responsibilities, intense negative emotions, autonomy, and interdependence. Past self-endangerment experiences, however, have been "zipped" and are now unconscious except for a somatic trace of the original experience. These somatic traces (i.e., bodily sensations of anxiety) lead to an automatic shift of attention to cogitating about the implications of these sensations, which, in turn, produces more anxiety. This process may spiral upward until the patient has a panic attack. In an effort to control

the panic attacks, the individual, associating the location of a panic attack with its cause, begins to avoid the panic locations. This process can become so extensive that the person may become housebound.

Panic disorder is maintained by agoraphobic avoidance, the continuation of the unhealed self-wounds, and the inability to experience the implicit meanings of the panic attack. As with other anxiety disorders, panic patients cannot tolerate the experience of certain painful emotions. In my experience, the emotions that panic patients seek to avoid at all costs include anger/rage and humiliation/shame.

## INTEGRATIVE TREATMENT MODEL

Since the publication of this chapter in the earlier edition of the *Handbook*, my treatment model has moved closer to a more seamless integration. The treatment attempts to synthesize elements of psychodynamic, behavioral, cognitive-behavioral, and experiential therapies. The model defines ultimate and intermediary treatment goals. The core intermediary goal is the reduction or resolution of the symptoms of an anxiety disorder. The achievement of this goal is a necessary prelude to the ultimate goal of healing the self-wounds that presumably generate the anxiety symptoms. There are a number of subsidiary goals associated with this healing process, including (1) enhancing the individual's sense of agency or self-efficacy, (2) increasing the individual's tolerance for emotional experience, particularly negative affects, (3) identifying and modifying the various cognitive and affective defenses erected against emotional experience, (4) restructuring toxic views of the self, and (5) increasing the patient's ability to engage in authentic relationships.

The reduction of anxiety symptoms necessarily involves an increasing ability to tolerate painful affects. This is achieved through a painstaking focus on the individual's direct, in-the-moment experience. Once the patient has achieved a sense of control over the anxiety symptoms, he or she is invited to explore the

underlying determinants of the anxiety symptoms.

### Phase I: Establishing the Therapeutic Alliance

This integrative treatment conceptualizes the treatment process in terms of four phases (Wolfe & Sigl, 1998). Phase I involves establishing the therapeutic alliance. Therapy with anxious patients is often characterized by a difficult beginning because of their self-protecting interpersonal style. The life histories of anxiety disorder patients are replete with experiences of betrayal, empathic failures, mistreatment, and difficulties with attachment. Thus, the negotiation of trust is typically the first task of therapy. From the first session onward, the therapist will typically encounter fears of trusting, humiliation, and of being known. The process of repairing the wounded self begins here by attempting to enhance the client's ability to trust both the therapist and him or herself, and with desensitizing the client's fear of being known.

A frequently occurring phobogenic conflict in agoraphobic patients, for example, involves the bipolar dimension of freedom versus security. Each pole possesses both a positive and a negative valence. Freedom connotes autonomy and isolation; security connotes being cared for and being controlled. With such patients, therapists will be called upon to pass specific tests of trustworthiness (Friedman, 1985; Weiss & Sampson, 1986). Can therapists care for without controlling agoraphobic patients? By the same token, can therapists allow patients to function autonomously without abandoning them? Unless therapists pass such tests, agoraphobic patients cannot make use of any of the therapeutic techniques and tasks, including imaginal or in vivo exposure. The first therapeutic task, then, is for therapists to establish their trustworthiness, *and for patients to receive this trustworthiness*.

To the extent that the therapist is being trustworthy, he or she is providing the patient with important information to be assimilated. But because of past disillusionments and resul-

tant fears of disappointment, the patient may find it difficult to acknowledge and accept the therapist's care and concern. Part of the alliance-building phase of therapy will identify the various strategies by which the patient interrupts his or her immediate experience of the therapist's trustworthiness. As these defenses are identified and found to be inapplicable in the current context, the patient may begin to experience and "take in" the therapist's trustworthiness. The resurrection of immediate experiencing will begin to lead to a corrective emotional experience regarding the dependability of a significant other.

The direct experiencing of the therapist's trustworthiness indirectly contributes to the rebuilding of the patient's sense of self-efficacy. With the therapist as ally, the patient feels more confident of his or her ability to face the anxiety-inducing objects or situations and to endure the automatically occurring anxiety. The provision of a safe relationship that is empathic, genuine, and nonjudgmental serves as a therapeutic bulwark against which the patient leans as he or she negotiates the specific therapy tasks (Rogers, 1957).

### Phase II: Treating the Symptoms of an Anxiety Disorder

By the third or fourth session—although there are many instances where it may take longer—most clients suffering with an anxiety disorder are ready to begin phase II, which focuses on the symptom layer of the disorder, including the bodily symptoms of anxiety and the obsessive catastrophic cogitating about the symptoms. The primary focus of this phase is to help the patient achieve some measure of control over the symptoms of an anxiety disorder. Cognitive-behavior interventions are in the ascendency during this phase. Relaxation strategies, exposure to fear stimuli, and the cognitive restructuring of conscious catastrophic thoughts surrounding the fear stimuli are the primary interventions during this phase of treatment.

It is extremely important to monitor the state of the therapeutic alliance as the patient begins to carry out the phase II interventions.

The introduction and implementation of these therapy techniques possess meaning for the patient in terms of his or her feelings toward the therapist. If they are presented in an authoritarian manner, for example, the patient may rebel either directly or implicitly and may refuse to carry out the treatment or terminate it prematurely. The patient may resist the treatment because its nature or manner of presentation activates unconscious conflicts regarding authority.

Sometimes the conflict may be conscious. I once treated a patient suffering with obsessive-compulsive disorder (OCD) by presenting him with a self-initiated program of exposure plus response prevention. Two weeks in a row he returned to therapy without having started the program. When I asked him why he had not been able to carry out the potentially helpful therapy, his reply was as follows: "I cannot stand to be told what to do by a male authority figure." This revelation not only uncovered a potential rupture in the therapeutic alliance but also led to a temporary shift in therapeutic focus to the exploration of his painful relationship with his caustically critical father.

### Phase III: Eliciting the Tacit Self-Wounds

Once an anxiety patient achieves some measure of control over his or her anxiety symptoms, the therapy is at a decision-point. For some patients, the therapy is complete. They have received what they came for and are ready to terminate the therapy. Many other patients, however, wish to explore the roots of their anxiety and are willing to undergo a shift in therapeutic focus and technique. The therapeutic goal of phase III is to elicit the tacit self-wounds and the feared catastrophes and emotions associated with them. The major technique employed during phase III is Wolfe's Focusing Technique, a form of imaginal exposure (Wolfe & Sigl, 1998).

The patient is first told to relax and to engage in the previously taught diaphragmatic breathing for about 2 minutes. During this induction process, the patient is primed to allow him or her to be open to whatever thoughts or feelings may arise during the exercise. The

patient is subsequently instructed to focus all of his or her attention on the anxiety-inducing cue and simply to notice whatever thoughts, feelings, or images appear. In the case of phobias, the patient is asked to imagine the phobic object or situation. In the case of panic disorder, the patient is asked to identify the most prominent bodily sites of anxiety or fearful bodily sensations and to maintain a strict attentional focus on these sites. For OCD patients, the strict attentional focus is on the obsessive thought that is causing anxiety. Typically, within one or two sessions, this procedure results in the appearance of several thematically related and emotionally laden images. It usually takes longer with panic-disorder patients because they have great difficulty contacting emotion-laden imagery. Despite this, however, the procedure is almost uniformly successful in eliciting the catastrophic imagery reflecting a specific self-wound.

The imagery is imbued with themes of conflict and catastrophe that the patient is helpless to prevent or terminate. These memories of self-endangerment reflect specific self-wounds. For example, memories of parental betrayal may shape a painful view of oneself as unwanted, unlovable, or unworthy, which in turn produces fears of abandonment. These memories are usually accompanied by powerful and painful emotions, which also become fear stimuli.

This technique often segues into a guided-imagery procedure that allows us to explore the network of interconnected ideas, feelings, and associations that constitute the implicit meaning of anxiety.

One interesting feature of applying this procedure with panic disorder patients is that whereas, consciously, their fears are often about *physical* destruction, the tacit catastrophic imagery is most often about *psychological* destruction. The goals of the modified imaginal exposure depart somewhat from the original behavioral version. The experience of anxiety is not only for the purpose of learning that the feared disaster will not take place or that the anxiety will habituate but also for the patient to uncover the underlying self-wound and its associated felt catastrophes.

Though Wolfe's focusing and guided imagery are the major techniques for eliciting self-wounds, they also may be elicited on occasion through interpretive insight-oriented techniques. Socratic questioning has also been successful, on occasion, in pursuing a fear to its ultimate catastrophic end, which will reveal the specific self-wound in question. Whether one initially employs imagery, interpretation, or questioning depends on what is determined to be the most acceptable or congenial *access point* for the patient. Some patients are most comfortable beginning with behavioral techniques; others prefer more cognitive interventions to start with; still others prefer insight-oriented initial work. In rare instances, patients begin with experiential or imagery-based interventions.

#### Phase IV: Healing the Self-Wounds

The healing of the activated self-wounds involves a variety of interventions, focused on a number of separate but interrelated goals. For self-wounds to heal, a number of processes must be set in motion, including (a) identifying and modifying the patient's defensive interruption of his or her organismic experiencing, (b) enhancing the patient's self-efficacy (Bandura, 1977) or sense of agency, (c) resolving discrepancies between self-beliefs and immediate self-experiencing, (d) increasing tolerance for—and ownership of—negative affects, (e) resolution of conflicts that prevent the patient from a complete commitment to a particular self-focus, (f) the emotional processing of painful realities, and (g) increasing the patient's willingness to engage in authentic relationships.

Often, this phase of therapy begins with the identification of the patient's defenses against emotional and visceral experience. This is often done in conjunction with the application of Wolfe's Focusing Technique. Occasionally, patients are unable to carry out this technique, and the immediate therapeutic task is to understand why. Typically, one finds variations of the same theme, an intense fear of feelings. These fears are desensitized gradually, which then allows the patient to engage in the imagery techniques previously described.

The enhancement of the patient's self-efficacy actually begins with phase II, the symptomatic treatment phase. By achieving some control over their anxiety symptoms, patients begin to feel more confident and hopeful not only about "beating their disorder" but also about solving the basic difficulties of their lives. That self-efficacy increases as they begin to allow themselves to experience and accept their tacit fears and disavowed emotions.

Often, the imagery work will uncover tacit catastrophic conflicts to be resolved. Conflict resolution essentially involves the creation of a synthesis between incompatible aims. The steps involved in resolving conflict include (a) identifying the poles of the conflict, (b) employing the two-chair technique in order to heighten the experience of each pole, (c) beginning a dialogue between the two poles in an effort to create a synthesis, and (d) making a provisional decision to take specified steps toward change. Once a decision has been made regarding specific behavioral changes, the next step is to take action and allow one's immediate experience to inform the patients of the results of the change steps taken. Successful outcomes from these self-fashioned choices increase the likelihood of a change in dysfunctional self-representations. As the patients try to change, they will encounter the specific ways in which organismic experience is defensively interrupted, and additional work will be necessary to limit the impact of these defenses and increase the patients' ability to accept their immediate-in-the-moment emotions.

#### ASSESSMENT AND CASE FORMULATION

A clinical interview is the primary means of assessing anxiety disorders. On occasion, this might be supplemented with a standardized instrument, such as the Anxiety Disorders Interview Schedule (ADIS-R; DiNardo et al., 1985), which may be useful in the differential diagnosis of an anxiety disorder as opposed to another Axis I disorder. However, a clinical interview not only can produce a clear symptom picture, but it can also supply some clues regard-

ing the underlying determinants of an anxiety disorder.

The major diagnostic tool for uncovering the implicit meaning of anxiety symptoms is Wolfe's Focusing Technique. It involves a strict attentional focus on the anxiety-inducing cue. For panic patients, the attentional focus is on the frightening bodily sensation. For OCD patients, it is the disturbing obsessional thought. For the specific phobic, it is the feared object or situation that is imagined. This approach to diagnosis and case formulation results, I believe, in a more comprehensive description of a patient's anxiety disorder by delineating the specific symptom cluster associated with a given anxiety disorder and the underlying self-wounds that presumably generate the symptoms.

The assessment of anxiety disorders focuses on six key elements: (1) the nature of anxiety symptoms, (2) the intensity of the anxiety, (3) the extent of interference in the patient's life, (4) the underlying catastrophic events and conflicts (if any) and the self-wounds they reflect, (5) other physical and psychological problems, and (6) the degree of connection between the auxiliary problems and the anxiety symptoms. The anxiety symptoms become the first targets of treatment. Once patients feel that they have some control over the symptoms, they will be asked if they would like to explore the possible underlying issues governing their anxiety symptoms. At their option, we would then proceed with the focusing work in an effort to uncover these presumed underlying issues.

Focusing typically will uncover the substantial network of ideas, images, and feelings connected to specific self-wounds. For example, one driving-phobic patient remembered an early panic attack while driving with his wife when she announced that their marriage was over. This attack was associatively connected to a panic attack that he had when he was only 9 years old. He had been left alone and in charge of two siblings while his alcoholic parents went out drinking. Self-wounds around attachment and self-care apparently began to develop here. Exposure therapy was helpful in that it allowed him to drive up to 8 miles from his home. Here, he stymied in his progress, and we ad-

ressed the self-care and attachment issues in a more exploratory approach.

## APPLICABILITY AND STRUCTURE

As the title of the chapter suggests, this integrative treatment is most relevant for patients suffering from an anxiety disorder. My clinical experience, however, suggests that many aspects of this approach are relevant for patients suffering from mood disorders, somatoform disorders, and milder forms of personality disorders. It may be less useful for severe forms of borderline and narcissistic personality disorders, which might best benefit from other approaches (Koerner & Linehan, 1992). In general, this approach is most relevant with those disorders for which the inhibition of emotional processing and organismic experiencing play a central role.

For the most part, psychotherapy is conducted once per week for 45–50 minutes. During the symptom-focus phase, the therapy sessions tend to be more structured. Homework is typically assigned and then reviewed during the early part of the session. The in-session work then will typically focus on specific symptoms. When therapy progresses to a focus on the roots of the disorder, the therapy is more exploratory and experiential and therefore less structured. In-session markers serve as cues for specific experiential techniques. If the patient is struggling with a particular issue, therapy may involve exploration and interpretations. On occasion, the exploratory work may uncover or activate an underlying self-wound for which specific cognitive techniques may be employed. At this juncture, the therapy resumes a more structured cast. The alternation between periods of more and less structure is particularly characteristic of this integrative approach.

## PROCESSES OF CHANGE

Psychotherapy researchers by and large have concluded that the debate about whether in-

sight or behavior change is the fundamental mechanism of therapeutic change is a sterile one. Insight without behavior change often results in a new way of talking about one's problems, but behavior change without a change in the person's "central processing unit" (i.e., cognitions, emotional processing, attitude, or perspective) is not likely to endure. Each mechanism, however, seems to point to a particular truth about change. Behavior change implies a proactive engagement with the world in which one makes a decision to act, implements that decision, and experiences the consequences of that decision. Whatever else is included in a concept of therapeutic change, the element of behavior change as proactive engagement seems to be a necessary one (Wachtel & McKinney, 1992).

The concept of insight, however, points to the necessity of change in the way we perceive, think, and feel about the world and ourselves. Thus, insight implies some kind of cognitive-emotional change in the way we construe self and world. What has been sundered by the polemics between psychoanalysts and behavior therapists needs to be (re)integrated. An integrative concept of change must, on the one hand, involve behavior, cognition, and affect, and, on the other, encompass both behavior change and "deep structure" change. With respect to anxiety disorders, this translates into symptom reduction, on the one hand, and the healing of the underlying self-wounds, on the other.

Change in this model is construed as an oscillating process between engagement with the world and the articulation of emotional experience resulting from that engagement. Change results from the emotional processing of experiential contact with the world. The anxiety patients who can remain anxious when confronting the feared situation will eventually begin to experience the disavowed emotions connected to past catastrophic situations. When patients can do this, they come to see that they are actually not being threatened in the present. Once the discrimination can be made between past catastrophe and present reality, anxiety patients eventually gain a sense of safety in the

feared situation. There is therefore a dialectical tension between one's immediate experience of the world and the ideas that we have already stored in memory. The tension that permeates problematic moments and the painful memories that seem ineluctably associated with them are at the heart of the therapeutic modification of anxiety disorders.

In this model, direct experience is the mediator of all change. It is a necessary ingredient in the modification of behavior, cognitions, affects, and underlying self-beliefs. Different patients, however, possess different *access points* for the process of change. For a variety of reasons, patients differ in their comfort level in the initial focus of therapeutic work. Behavior change is the initial access point for many patients. For some patients, cognitive change is the initial point of access. For a very few patients, therapeutic work may begin with a focus on bringing about *corrective emotional experiences* (Alexander & French, 1946). Research data and clinical experience both confirm that behavior change is the simplest and easiest locus of change; cognitive change tends to be more difficult; and changes in the core self are the most difficult to effect and require treatment of the longest duration (Howard, Kopta, Krause, & Orlinsky, 1986). Changing core self beliefs and healing internal wounds require corrective emotional experiences and the emotional processing of painful as well as positive meanings.

One can view an anxiety disorder as a two-tiered disorder. Tier 1 includes the anxiety symptoms and the patient's catastrophic cogitations about the symptoms. Tier 2 includes the implicit roots of an anxiety disorder that generate the bodily symptoms of anxiety. Change can also be thought of as a two-tiered process (a) the reduction of anxiety symptoms and the patient's cogitating about them and (b) changing the underlying determinants of an anxiety disorder (i.e., healing the self-wounds).

The treatment of Tier 1 anxiety symptoms tends to be cognitive-behavioral in nature. The cognitive-behavioral treatment of anxiety disorders attempts to reconnect patients to their direct experience of the world while simultane-

ously trying to change their threat-laden interpretations of that experience (i.e., cogitation). Once patients achieve some control over their symptoms, they may be willing to explore, and attempt to modify, the underlying determinants of their anxiety disorder.

Change at the level of the implicit roots of anxiety (Tier 2) is achieved by having the patients confront, process, and ultimately revise the extremely painful self-views they morbidly fear. The healing of self-wounds proceeds by first analyzing and gently confronting patients' defenses against their immediate, organismic experience. Once patients recognize and are willing to modify their defensive strategies, the way is opened to experiential work that allows them to emotionally process their feared self-views. The emotional processing may also involve Socratic questioning designed to help patients experience their feared emotions around the self (i.e., self-wounds). This work will also include behavioral experiments designed to help patients enact a new sense of self.

The process of therapeutic change rarely runs as smoothly as may be implied by the above description. The dynamics of change appear to be characterized by oscillations between old and new patterns of functioning (Mahoney, 1991). Any change will be experienced by the patient initially as dissonance relative to the individual's current level of self-organization. Accordingly, change tends to be resisted, not because of pathology, but rather because of, as Mahoney puts it, "individuals' healthy caution about embarking upon or embracing experiences that challenge their integrity, coherence, or (felt) viability as a living system" (p. 329).

Resistance to change, therefore, is viewed as a precondition to change. The therapist attempts to work toward identifying the sources of resistance and endeavors to help patients understand its necessary functions. The patients need to accept that they will resist change as much as they need to accept other aspects of their current functioning (i.e., painful emotions and self-views). *The acceptance of "who they are" at the moment is an enabling condition of change* (Beisser, 1970). In-the-moment self-acceptance allows people to focus atten-

tion on their immediate self-experience. And it is organismic self-experiencing and its symbolization that provide the necessary information for human change. For anxious patients, resistance to change is manifested by avoidance of situations and feelings that appear to threaten the viability of self-experience. Whenever patients try to enter a particular context of fear, they experience the growing presentiment of self-annihilation. Therapist empathy and patient acceptance of this experience are prerequisites of change.

## THERAPY RELATIONSHIP

All therapeutic change is predicated on the development of a strong, supportive non-judgmental therapeutic alliance. As mentioned above, the safety of the therapeutic alliance allows the patient to tolerate the intimate and sometimes painful exploration and expression of his or her most tender thoughts and feelings. The therapeutic relationship is now viewed by all therapy orientations as a critical element of the change process; it is an integrative common factor of all psychotherapies (Horvath & Greenberg, 1994).

When one explores the details involved in the establishment and maintenance of a strong therapeutic alliance, one finds that many of the issues emphasized by the psychodynamic perspective are involved. In this integrative model, it is critically important for the therapist to stay in touch with transference and countertransference as well as the characteristic interpersonal defenses revealed by the patient during the therapy session. The monitoring of the therapeutic alliance is particularly important when a therapist attempts to implement a specific therapeutic task (e.g., exposure therapy). The therapist needs to remain cognizant of what the task means (explicitly and implicitly) to the patient particularly with respect to his or her feelings about the therapist. How the therapist relates to the patient may activate the patient's in-session defenses, which can impede or even undermine his or her ability to carry out any of the therapeutic tasks, including the initial symptom-reduction strategies.

## METHODS AND TECHNIQUES

The cognitive-behavioral methods used in the treatment of Tier 1 anxiety symptoms include relaxation strategies such as diaphragmatic breathing, imaginal and in vivo exposure to the fear stimuli, and cognitive restructuring of the threat appraisals. Tier 2 techniques include the analysis of defenses against immediate experiencing and resistance to change. This task includes the techniques of clarification, confrontation, and interpretation. The analysis of defenses is followed by Wolfe's Focusing Technique, which typically leads to the surfacing of avoided feelings. When these feelings emerge, the patient becomes aware of the intuitive, tacit, catastrophic appraisal of specific past or present events. These tacit appraisals may represent the recovery of repressed veridical memories or of constructed prototypes of catastrophe or catastrophic conflicts. These catastrophic appraisals emanate from various wounds to the self.

When the powerful and painful feelings emerge, the therapy focuses on helping the patient to allow and accept these feelings (Greenberg, Rice, & Elliott, 1993). As these feelings become more acceptable to the patient, they can be explored through imagery and metaphor. One patient suffering from OCD, for example, described his disorder as a metallic suit of clothes that imprisons his body. We metaphorically (through imagery) helped him to find a way to remove his restrictive suit of clothes, which helped loosen the hold that the disorder had on him.

The emerging disavowed feelings are often directed toward significant others in the patient's life. He or she may be invited to engage in empty-chair work to express these feelings to the appropriate individual (even if only in fantasy). The uncovered catastrophic conflicts often reveal *self-splits* (i.e., the simultaneous holding of two incompatible views of the self), which serve as an in-session marker for two-chair dialogues. These dialogues are designed to bring about a synthesis of the conflicting views of the self (Greenberg et al., 1993).

This is a sample rather than a comprehensive list of the techniques that I may employ in my therapeutic work with patients with anxiety

disorders. It should be noted that they include techniques from four of the major psychotherapy orientations: behavioral, cognitive-behavioral, experiential, and psychodynamic.

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## CASE EXAMPLE

A 45-year-old economics professor with a successful academic career presented to therapy with a public-speaking phobia. He experiences a great deal of anticipatory anxiety regarding a pending talk that often begins as soon as he makes the commitment to speak. The anticipatory anxiety increases significantly as the day of the talk approaches. On the day of his talk, he becomes preoccupied with fantasies of what the audience may think if he has a panic attack during his talk. These cogitations continue up until the time that he actually begins to speak. Once he is a few minutes into his talk, however, he is usually fine and relatively anxiety-free. Further probing revealed that his central fear is of having a panic attack during his talk. To panic in such a situation would be extremely humiliating, and he fears that others would begin to view him as intellectually inferior, if not pathetic.

Glen remembers an early panic attack when he was teaching. He had been particularly critical of a student. The student told Glen that he was leaving before he said something that he would regret. Glen remembers a panicky feeling welling up in him and he was afraid he was going to cry, which also would have been very humiliating. This panic attack primed him to fear panic ever since.

Glen's describes himself as coming from a southern Italian family in which shame was a major catastrophe. His father was a CPA and his mother was the homemaker who served as the primary caregiver for Glen and his two younger siblings, a brother 2 years his junior and a sister who was a year younger. Though he was never close with his sister, he felt a special kinship with his brother. But his younger brother was eventually diagnosed with mental retardation. His brother's retardation had a profound effect on Glen. By familial association, it made him doubt his own intellectual potential. This doubt has haunted him throughout his career.



His relationship with his father was apparently troubled. His father seems to have been disappointed in Glen's lack of athletic talent and in the fact that Glen eventually chose to become an academic, which, in his father's mind, was unmasculine. Glen has many memories of trying to talk to his father who would never give Glen his full attention. His father would read the newspaper while claiming he was listening. This infuriated and humiliated Glen and led him to believe that he was not "interesting enough" or "good enough" for his father. Glen also had an uncle who could be vicious in his ridicule of Glen, particularly with respect to Glen's "unmasculine" pursuits. In addition, Glen experienced his mother as cold and unnurturing.

The initial therapeutic work was symptom focused. The sequence of his anxiety disorder followed the basic model above. His anticipatory anxiety around giving his talk led to his cogitating about the audience's reaction to his panic attack. The more he cogitated, the less he was able to focus on the talk and on the ideas that he wished to communicate to the audience. The initial part of therapy, therefore, involved teaching him a relaxation skill and on retraining his attention to focus on the task at hand rather than on his fantasies regarding the audience's response to his "shameful display" of panic. I taught him diaphragmatic breathing, which he practiced on a daily basis. We also engaged in frequent behavioral rehearsals during which he worked on shifting his attention away from invidious cogitations toward a focus on the task at hand. We also employed imaginal exposure: I had him imagine having a panic attack and to try and tolerate some of the feelings of humiliation that automatically arose. The exposure work also helped him to see that he would survive if he does panic. The diaphragmatic breathing showed him that he could achieve some control over the level of anticipatory anxiety that he experiences. After 2 months of the symptom-focused treatment, he was much improved. He gave a talk without significant anticipatory anxiety.

Glen, however, wanted the therapy to continue in order to deal with the underlying "drivers" of the public speaking anxiety. At this point, imaginal exposure converted to Wolfe's focusing technique, during which he dipped into whatever

thoughts or feelings that automatically arose as he imagined preparing for and giving a talk. As he began to experience intense humiliation as he imagined his having a panic attack in the middle of his talk, he became aware that his "illusion of superiority" was beginning to disappear. Instead, he began to see himself as an intellectual imposter, a fraud that the audience would surely discover and ridicule. Not only was it becoming clear that his implicit self-view was that of an intellectually inferior "poseur," but that his defense against this extremely painful self-view was an attempt to project a self-image as an intellectually superior academic. This defense of *impression management* is very common among people with interpersonal anxiety, but it is particularly characteristic of persons with a public-speaking phobia. The basic elements of the defense are to project an image to others that will merit approval while at the same time hide from others and from himself his actual self-view.

The implicit meaning of panic for Glen is that he is a pathetic, worthless imposter who does not belong in the company of the presumably intellectually superior audience that he is addressing. As we explored the meaning of his self-wound of inferiority, Glen eventually discovered that as intellectual pursuits represented his self-chosen alternate path to masculinity (in contrast to his family's view of masculinity), to be intellectually inferior was also to be insufficiently masculine. Panic was now seen as the ultimate emasculating experience. As the guided imagery work continued, a generalized self-wound emerged, which involved Glen seeing himself as "not good enough," "not masculine enough," not smart enough, "not worth listening to," and, ultimately, "not a good enough human being."

There seemed to be at least two experiential conflicts that Glen needed to resolve. The first was to detoxify the meaning of panic; the second was to convey to his family that he was in fact a successful adult man (in his own terms) who had achieved some prominence in his chosen line of work and that he was worth listening to. By "convincing" them, he would convince himself. In approaching the first task, we worked on accepting himself as he is and to forego the need to engage in impression management. Part of this work involved his imagining having a panic attack and

redefining the significance of such an event. He first imagined telling the audience straightforwardly that he was having a panic attack and he needed to pause for a moment (thus defusing the power of his secret). He then imagined resuming his talk. After the talk, he imagined the audience supporting and nurturing him rather than ridiculing him for panicking. This imaginative redefinition of the meaning of a panic attack began to chip away at his earlier view that having a panic attack meant that he was pathetic.

It became clear to Glen that when he could let go of the need to project an inauthentic image of superiority, his anxiety would dissipate. But often, as he negotiated the oscillations of the change process, he would return to his old defensive strategy of impression management and the anxiety would return. This struggle between old and new patterns of presenting himself during the talk went on for many months. Over time, he was able to allow himself to be vulnerable and to avoid the strategy of the poseur more often than not. With this change came a diminution of the anxiety.

The second major experiential task was being able to “own” his accomplishments and maturity in the presence of his father. This task presented some difficulties because his father had been dead for many years. Yet, the relationship with his father was very much alive in his mind. I invited Glen to engage in an empty-chair dialogue with his father and to tell him that he has been a “good enough” adult, accomplished, mature, and sufficiently masculine. Here we ran into another piece of the puzzle. Initially, he was unable to carry out the dialogue for fear of emotionally damaging his father. Glen had always sensed an emotional fragility in his father that made it impossible for Glen to speak his mind. In order to protect his father (and to keep him on the paternal pedestal), Glen needed to remain insufficient in his father’s eyes. Now we see the catastrophic conflict clearly. If he owns his accomplishments, he may damage his father. If he doesn’t, he remains chronically anxious and fearful of being thought a fraud. Glen felt he was damned if he does and damned if he doesn’t.

After many months, Glen was able to carry out the dialogue as planned and he was able to tell his father of his maturity and his competence. He was also able to express his anger at his father for

not listening, for not teaching him things, for his unending litany of criticism and disappointment. After 2 years of therapy, Glen’s public-speaking phobia is gone. Moreover, Glen has gone a great distance in healing his self-wound. He is able to put his intellectual strengths and weaknesses into proper perspective. He feels that he is sufficiently masculine, mature, and smart.

The symptom-focused treatment was basically successful in a few months, but the healing of the self-wounds took 2 years. Glen still has work to do because every now and again, panic can take on some of its prior toxic meaning and the wounds to the self, though mostly healed, can open up again under stress.

This case illustrates how the symptom-focused treatment is necessary but insufficient for treating the underlying determinants of an anxiety disorder. For a more comprehensive and durable treatment, one has to confront unconscious conflicts that involve powerful, painful emotions. The therapist also has to observe, identify, and help modify the patient’s self-defeating self-protective strategies that, in the long run, cause more anxiety.

One interesting transference issue occasionally arose in therapy that laid bare the nature of Glen’s self-wound and its eventual healing. Our appointment was typically late on a Friday afternoon. If the stress of the week was heavy upon me, or if I did not get sufficient sleep the night before, I would become heavy-lidded as Glen was talking. I would struggle to keep my eyes open. Early on, Glen’s characteristic response—without a hint of sarcasm—was “I’m sorry that I am not a more interesting patient today.” Toward the end of our therapy, he had totally dropped his placatory manner, and was able to express his annoyance with me for nearly falling asleep on him.

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## EMPIRICAL RESEARCH AND FUTURE DIRECTIONS

Because this model of psychotherapy integration has not yet been subjected to empirical research, the key future direction for this approach is to find ways to do so. However, there are certain features of the model that present

great difficulties for the researcher. As I have tried to show, self-experiencing in both its organismic and conceptual modes is the crucial focus of therapeutic change. The existing research literature on self-schemas and self-representations has contributed—and will continue to contribute—much to the development of this model (e.g., Markus & Wurf, 1987; Segal & Kendall, 1990; Wolfe, 2003). But research on organismic or direct experiencing is a bit more challenging.

Immediate experiencing revives an old dilemma for psychotherapy research, the dilemma of trying to be objective about subjective experience. For the therapist/researcher, the experience of one's own subjectivity is a reality as palpable to us as persons as it has been invisible to us as scientists. As researchers, we are painfully aware of the measurement difficulties presented by any conception of the subjective self. As therapists, however, we are also keenly aware that a patient's subjective experience, and his or her struggle with it, is integrally involved in the formation, maintenance, and alleviation of psychological disorders.

The evolving cognitive perspectives attempt to capture certain aspects of the experiencing self, but their efforts have focused mainly on what is available to us in conceptual awareness; namely, our self-representations and concepts (Segal & Kendall, 1990). The research of Greenberg and Elliott has begun to help us get a handle on immediate self-experiencing, but this work is still in its infancy (Elliott, Greenberg, & Lietaer, 2003). A significant future direction, therefore, is to develop measures for assessing various aspects of organismic experiencing.

A major impediment to therapeutic change involves the myriad ways in which an individual interrupts his or her organismic experiencing in an effort to defend against the acknowledgment of painful or self-threatening information. Thus, in addition to measures of organismic self-experiencing, measures need to be developed for assessing various types of defensive interruptions of self-experiencing.

A third research need is to develop a reliable measure of the tacit catastrophic imagery

elicited by imaginal and interoceptive exposure. Wolfe's Focusing Technique is now ready to be tested as an imaginal probe for catastrophic imagery. Its potential for rapidly uncovering painful tacit issues needs to be put to the test.

A final research need is to systematically evaluate the efficacy of this integrative treatment model for anxiety disorders. In particular, my conviction that this integrative treatment produces more comprehensive and durable outcomes than cognitive-behavioral treatment alone should be subjected to empirical test. The standardization of this treatment package presents some formidable difficulties, however, because substantial flexibility is required in the choice and timing of the operations employed in the individual case. Similar concerns have been expressed by fellow eclectics or integrationists, such as Lazarus (1992), Beitman (1992), and Prochaska and DiClemente (1992); individually tailoring treatments to unique clients compounds uniform standardization of "the treatment." I have tried to present the guiding principles of this approach, as well as the modal sequence of treatment, but individual differences seem to undermine any standardization operational paradigm.

Clinically, I am extending the scope of the integrative model to other disorders (e.g., mood disorders) in order to determine (1) if similar cognitive-affective processes operate in the acquisition and maintenance of these disorders, and (2) whether this integrative treatment will be effective in changing more than just the manifest symptoms of these disorders. Another clinical priority is to develop effective procedures for the more intractable cases of anxiety disorders. Some people are so frightened of their feelings or so convinced of the veracity of their catastrophic ideas that it is difficult for them to expose themselves to their organismic experiencing. Exposure therapy has been too frightening for them to continue. Finally, I hope to develop new procedures that will help patients process their painful self-related emotions and integrate the resulting information with their preexisting network of core self-beliefs.

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## Cognitive Behavioral Analysis System of Psychotherapy (CBASP) for Chronic Depression

JAMES P. McCULLOUGH, JR.

### THE INTEGRATIVE APPROACH

My long-standing interest in chronic depression and in finding a treatment to modify the patient's psychopathology stems from multiple sources. These include (1) my own struggles with the disorder; (2) patients presenting with a chronic course of depression; (3) my reading of Seligman's (1975) book, *Helplessness*; (4) as an ardent behavior therapist, early in my career, a desire to operationalize patient change (rate of response), as well as demonstrate the utility of single-case designs to illustrate patient change; (5) the contributions of Bandura, Beck, Kiesler, and Piaget; and (6) finally, my interest in studying the diagnostic nomenclature for chronic depression.

### Personal Depression Struggles

During early adolescence, I experienced an early-onset dysthymic disorder that was followed periodically by several episodes of mild-

moderate major depression. Today, I would be diagnosed "double depression" (Keller, Lavori, Endicott, Coryell, & Klerman, 1983; Keller & Shapiro, 1982, 1984). During my mid-twenties, I underwent a multiyear quasi-psychoanalysis involving free-associating "on the couch." The cognitive-emotive-behavioral morass was resolved after several years, and the process of recovery influenced my construction of Cognitive Behavioral Analysis System of Psychotherapy (CBASP). For example, in CBASP (McCullough, 2000), I placed high value on the "disciplined personal involvement" role of the therapist, a characteristic of my therapist. Disciplined personal involvement is emphasized so that the intrapersonal learning deficits in the patient can be addressed. Many patients have never had precedent emotional experiences that are necessary for interpersonal fulfillment. One requisite precedent is being able to generate interpersonal trust toward one's caregivers or other significant others. If an individual has never been able to trust another human being,

interpersonal failure is guaranteed. In such cases, learning to trust one's therapist becomes an essential goal of treatment.

### Seligman's *Helplessness*

Even though Seligman's aim was to describe the etiology of "generic" depression, he presciently described the helplessness phenomenology of the chronically depressed individual in exciting new ways. This book challenged me to find a means by which I could overthrow the patient's refractory and long-standing helplessness dilemma.

### Behavior Therapy

I graduated from the University of Georgia in 1970, at the height of the behavior therapy revolution and became an ardent behavior therapist. Skinner (1953) provided the means to operationalize patient change (rate of response) as well as demonstrated the utility of single-case designs to illustrate patient change. Subsequently, my practice and research activities have always included systematic measurement of patient change (e.g., McCullough, 1984a, 1984b, 1984c, 1991; McCullough & Carr, 1987). From Skinner (1968), I also learned how to teach therapists to arrange in-session contingencies so that the lessons of psychotherapy are learned. This is accomplished by systematically creating negative reinforcement conditions during the session. When adaptive behavior changes are accompanied by felt reductions in discomfort and distress, behavior is strengthened.

### Other Theoretical Models

Several models have also influenced my construction of CBASP. During the late 1970s, I read Bandura's (1977) *Social Learning Theory* and Beck's treatment manual, *Cognitive Therapy* (Beck, Rush, Shaw, & Emery, 1979), as well as many of Beck's other writings. CBASP construction also reflects the interpersonal psychotherapy views of Kiesler (e.g., Anchin & Kiesler, 1982; Kiesler, 1983, 1996). Kieslerian interpersonal theory as well as his experimental

data strengthened my view that the therapist role could be used as a major interpersonal change variable. Finally, Piaget's (1926/1923, 1967/1964, 1981/1954) theory of cognitive-emotive development, elegantly described in *Intelligence and Affectivity* (1981/1954), provided the conceptual foundations for my etiological views concerning the structural dilemma of early- and late-onset chronic depressives.

### Diagnostic Nomenclature

The nomenclature in *Diagnostic and Statistical Manual of Mental Disorders II (DSM-II)* (APA, 1968) describing affective chronicity coupled with the field's conclusions about the patient being nonresponsive to treatment, particularly psychotherapy, were inadequate and wrong. Robert Spitzer's creative work with the Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1978) was a step in the right direction. Two years later, the first chronic Axis I affective category (viz. dysthymia) appeared in *DSM-III* (APA, 1980). Since the 1970s, my research program has been divided between constructing an effective treatment for the chronically depressed patient and developing an accurate diagnostic nomenclature for the chronic disorders (e.g., Keller et al., 1995; McCullough et al., 2000; McCullough et al., 2003).

Summarily, CBASP is a conceptual-methodological model derived from multiple sources: Psychoanalysis emphasizing early developmental influences and the patient's interpersonal transfer of learning from significant others to the person of the therapist (implicating what was learned as well as what was not learned); Skinnerian Psychology with its reinforcement and empirical priorities; Social Learning Theory with its crucial theoretical unification of thinking, behavior, and environmental consequences as the requisite unit of analysis for behavior change; Kiesler's Interpersonal Theory and particularly his Impact Message Inventory (Kiesler & Schmidt, 1993), which measures the patient's stimulus value and enables therapists to define their corresponding interpersonal role; and finally, the Cognitive-Emotive Maturational Theory of Piaget, which clarified the un-

derlying structural problems of the patient as well as the etiological sources of the disorder.

## ASSESSMENT AND FORMULATION

### Diagnosis of Chronic Depression

It is no longer acceptable to speak of depression in the “generic” sense (McCullough, 2003b; McCullough et al., 1996). In spite of 20 years of research demonstrating many qualitative differences between the chronic depressions and acute/episodic major depression, the field still uses the word “depression” to describe the unipolar disorders as if they were one unitary phenomenon. They’re not. The clinical course of the chronic disorders, modal age of onset, outcome of treatment, time-to-response, recurrence and relapse rates, psychosocial functioning, concomitant Axis III involvement, family history among first-degree relatives, developmental history and abuse, and the prevalence rates of Axis II comorbidity have all been well documented as differentiating variables separating the depressive subtypes. Last, but certainly not least, is the fact that the chronic depressions are lifetime disorders with low rates of spontaneous remission. This is not the case with episodic major depression which is usually a time-limited disorder that frequently remits within 9 months even without treatment (Tollefson, 1993).

When the CBASP clinician sees a depressed patient, he or she must first determine whether the disorder is chronic or episodic. The therapist training manual for CBASP (McCullough, 2001) describes a course graphing procedure that can be used to identify the historical course of chronic depression as well as determine single or recurrent episodes of episodic major depression where the interepisode periods are symptom free. The major questions that must be answered at intake are (a) is the current disorder chronic or episodic? (b) and if the disorder is chronic, is antecedent dysthymia in the course?

One reliable method for diagnosing chronic depression is the *Structured Clinical Interview for DSM-IV Axis I Disorders—Patient Edition*

[SCID-I/P, Version 2.0] (First, Spitzer, Gibbon, & Williams, 1995). The SCID provides a current as well as lifetime history of psychopathology. Recommended assessment procedures for the initial CBASP sessions are as follows:

### Assessment During Early Sessions

#### Screening Session Interview.

1. SCID (The Mood Disorder section is administered again at treatment termination).
2. BDI-II (Beck, 1996) is administered at every session.
3. Rotter Internal-External Locus of Control Scale (I-E: Rotter, 1954, 1966, 1978) is also administered at the ninth and final session to assess the acquisition of the perceived functionality learning set (McCullough, 2000).
4. Ways of Coping Questionnaire-Research Edition (WCQ-R: Folkman & Lazarus, 1988) is also administered at the ninth and final session to evaluate the quality of social coping skill functioning.
5. The therapist asks the patient to “tell his/her story” describing why they came to therapy.
6. The therapist explains the Significant Other History procedure (McCullough, 2000), which will be administered during session 2. The history will help the therapist generate Causal Theory Conclusions material for Transference Hypothesis construction.

#### Session 2 assessment:

1. BDI-II.
2. Significant Other History (postsession construction of 1–2 Transference Hypotheses).
3. The therapist completes the Impact Message Inventory postsession (IMI: Kiesler & Schmidt, 1993). The IMI is administered again at the midpoint and the end of treatment to evaluate modification of the patient’s “stimulus value” for therapist.



4. Patient given the *Patient's Manual for CBASP* (McCullough, 2003a).
5. Patient given multiple copies of Coping Survey Questionnaire (CSQ; McCullough, 2000). One is completed prior to every session.

Session 3 assessment:

1. BDI-II.
2. Patient begins their Situational Analysis training (SA; McCullough, 1984a, 2000).
3. Patient scored on their SA performance during every session using the Patient Performance Rating Form (McCullough, 2000).

### Two Types of Dependent Variables Are Assessed in CBASP

CBASP is, in part, an acquisition learning model of psychotherapy. The first type of dependent variable (DV) assessment involves determining the degree to which patients have learned the social problem solving algorithm taught throughout treatment. The Patient Performance Rating Form (PPRF) is used for this purpose. Early data on the PPRF were reported in 14 single-case replications (McCullough, 1984a, 1991), in which therapy was terminated when patients performed the problem solving procedure to criterion twice in a row meaning that their PPRF ratings were perfect for two successive sessions. Data derived from the Keller et al. (2000) study evaluated the relationship of PPRF performance to treatment outcome. The responding patients scored higher on PPRF performance than nonresponding patients in both the CBASP-only and combination treatment cells (Manber & McCullough, 2000). The data also revealed that the PPRF scores predicted outcome of treatment independently of either medication status or the severity of depression at baseline (Manber et al., 2003).

A second level of DV illustrates how treatment influences the generalized treatment effect variables (McCullough, 2000, 2002). As noted above, CBASP uses several measure-

ment indices: the SCID, BDI-II, Rotter I-E, WCQ-R, and the IMI. We want patients achieving *DSM-IV* diagnostic remission status by the end of acute treatment; to report zero or no depression intensity levels; to move toward an internal locus of control orientation; to enact Planful Problem Solving as the modal coping strategy (Folkman & Lazarus, 1988); and to increase their scores on the IMI in the Dominant, Friendly-Dominant, and Friendly octants.

### APPLICABILITY AND STRUCTURE

CBASP (McCullough, 1984a, 1991, 2000, 2001, 2003) was developed specifically for the treatment of the chronic depressive disorders found in *DSM-IV* (APA, 1994): dysthymia, double depression, chronic major depression, recurrent major depression without interepisode full recovery, and a new chronically depressed course type, chronic major depression with antecedent dysthymia. In addition, several *DSM-IV* comorbid Axis II personality disorders have also been successfully treated: avoidant, dependent, obsessive compulsive, and mild-moderate borderline (Keller et al., 2000).

CBASP has not been successful with *severe* borderline patients presenting with chronic suicidality, self-mutilation patterns, extreme cognitive-splitting, and frequent hospitalizations (McCullough, 2002). Seven successive failures are reported with these patients (McCullough, 2002). Marsha Linehan has opined that CBASP is not capable of managing and finally controlling the severe borderline patient's variegated emotional behavior and extreme emotional lability (Marsha Linehan, personal communication, July 3, 2002). The author concurs.

Data are available concerning the recommended number of acute phase sessions needed to obtain a positive treatment response. Intent-to-treat data from a recent national study (Keller et al., 2000) showed that the average number of sessions received among 216 responding psychotherapy-alone patients and 226 responding patients who received combination treatment was 16.0 ( $\pm 4.7$ ) and 16.2 ( $\pm 4.8$ ) sessions,

respectively. However, a better indicator of the typical number of required sessions for a positive treatment response was seen with the patients who “completed” the 12-week acute phase of treatment. Ninety responding patients in the psychotherapy-only cell and 152 responding patients in combined treatment received a mean number of 18.2 ( $\pm 1.9$ ) sessions; among the nonresponders, 83 psychotherapy alone and 27 combination patients averaged 17.9 ( $\pm 1.9$ ) sessions. The optimal number of acute phase sessions needed for a therapeutic response seems to be 18–20 sessions.

One exception to the optimal number of sessions are adults who are diagnosed with early-onset dysthymia without major depressive involvement (pure dysthymia). Pure dysthymia, although described in *DSM-IV* as a milder disorder than major depression, is one of the most difficult chronic disorders to treat to remission. Eighteen to 20 sessions will probably not be enough. I have reported outcome data on 10 pure dysthymics who completed CBASP treatment (McCullough, 1991). Patients were seen for an average number of 31 ( $\pm 9.34$ ) sessions. The mean treatment duration was 8 months with cases seen on a weekly basis. Sample patients were followed for 16–96 months after treatment termination. One hundred percent of the patients responded to treatment, and all but one remained in remission at the follow-up visit.

## PROCESSES OF CHANGE

I will briefly describe three psychopathology domains that therapists confront when treating the chronically depressed patient (McCullough 1984a, 2000, 2003).

### Structural–Perceptual Psychopathology

Chronic depression denotes structural–perceptual psychopathology whereby patients are unable to generate formal operational cognitive-emotive behavior (McCullough, 2000; Piaget, 1981/1954) in the social–interpersonal sphere.

Patients enter therapy functioning interpersonally and socially in a preoperational mode, and they think in a prelogical and precausal manner. In essential ways, their cognitive-emotive functioning mimics the behavior of 4- to 6-year-old preoperational children.

Overestimating the cognitive-emotive abilities of this patient a universal dilemma for clinicians. Therapists overestimate patient abilities because it is difficult for us who function on a formal operational level (e.g., planning ahead; thinking that if I do this, then that will happen; having the capacity to generate empathy) to work with patients whose phenomenological view of self and world is primitive and qualitatively different than our own.

The patient’s view of the world is described in the following statements: (a) “The world is the way it is simply because I believe it.”; (b) “Time has stopped for me, and my life looks like a ‘snapshot’ picture of reality which is going nowhere” (i.e., the negativity of today is the same as yesterday, and tomorrow only means more of the same); (c) “My life is summed up by one theme: ‘Misery and being hurt by others.’”

Clinicians are also frustrated by these phenomenological characteristics as they realize that many aspects of the patient’s worldview are appropriate (and valid) given their abusive/traumatic developmental histories. Frustration also results when our modification tools such as interpersonal acceptance and feedback, experiment exercises and homework, logical disputation, and/or causal reasoning tactics fail to modify the patient’s negative view of self and others.

Preoperational patients are interpersonally isolated, caught in a time warp without a future, feeling hopeless about things ever being different, feeling helpless and unmotivated to change, and unable to perceive that their behavior produces destructive interpersonal consequences. Teaching patients to learn to recognize (Harlow, 1959) the consequences of their behavior must be accomplished first. Once this learning set is acquired and the patient can now view his/her life in a *perceived functional manner* (i.e., recognizing the consequences of his or her behavior), then and only then does

he or she, the therapist, as well as others in the patient's life gain control over the patient's behavior. When patients are positively affected by the environment and can produce what they want by enacting adaptive cognitive and behavioral strategies, several intrapersonal changes will have occurred: primitive preoperational functioning has been replaced by formal operations thought. Rotter I-E externality scores decrease; mood control is obtainable; the patient is learning how to generate interpersonal empathy; social coping skills will have improved and be reflected in the WCQ-R Scales, particularly in the Planful Problem Solving subscale; and finally, the SCID Mood Disorder subsection will reflect changes in the diagnostic status of the patient.

How does the preoperational problem arise? Severe early trauma (early-onset chronic depression) and chronically heightened, out-of-control emotionality (late-onset chronic depression) are the etiological causes of chronic depression. In the early-onset case, cognitive-emotional (maturational) retardation is the result of a developmental history of maltreatment where "surviving the hell of the family," not growth, was the major goal (Cicchetti, Ackerman, & Izard, 1995; McCullough, 2000; Piaget, 1981/1954; Spitz, 1946). Recent data from the Keller et al. (2000) study (Nemeroff et al., 2003) revealed that one-third of the outpatient sample reported abuse. Thirty-four percent of 681 outpatients reported parental loss, 44% reported physical abuse, 16% said they had been sexually abused, and 10% said they were neglected. All categories described abuse that occurred before 15 years of age.

In contrast to the early-onset patient, late-onset patients usually describe a milder developmental history (Horwitz, 2001; McCullough, 2000). One or more significant other relationships have frequently played a salutary role. Late-onset individuals also report that their first major depressive episode occurred about 25 years of age (McCullough & Kaye, 1993). Current research shows that >20% of late-onset adults who are treated for their first major episode do not fully recover; thus, they go on to develop a chronic course (Keller & Hanks,

1994; Keller, Lavori, Rice, Coryell, & Hirschfeld, 1986). The catastrophic, phenomenological consequences of the unremitting major depression is seen as the person progressively adopts the attitude: "It really doesn't matter what I do, I will always be depressed." Perceptual structural deterioration follows as the "heightened-chronic emotionality" washes away the late-onset individual's normal cognitive-emotive regulatory functions (Cicchetti, et al., 1995; McCullough, 2000; Piaget, 1981/1954). The result is a return to preoperational functioning in the social-interpersonal sphere.

### Inability to Generate Authentic Empathy

The second pathological feature of the chronically depressed adult is seen in their inability to generate *authentic empathy*. Empathy requires one to use language in a reciprocal manner in order to understand another individual as well as to make oneself understood. Being able to generate empathy also assumes that one can use formal operational thought. Extreme egocentrism, not empathy, is one of the hallmarks of preoperational functioning. As noted above, egocentrism is symptomatic of the patient's perceptual disconnection from the environment. One of the major goals of CBASP is to teach patients to generate empathy with their therapists as well as with others.

### Gross Interpersonal Skill Deficits

Third, patients begin therapy with *interpersonal skill deficits*. For example, many have difficulty saying what they need, want, and don't want. Assertive training is universally required with this patient. We turn now to a discussion of the techniques of CBASP.

## METHODS AND TECHNIQUES

Situational Analysis (SA), the Interpersonal Discrimination Exercise (IDE), and Social Skill/Role Rehearsal Training (SS/RRT) constitute the three major techniques used in

CBASP. All techniques are designed to move patients to formal operational functioning, to assist them to generate authentic empathy, and to insure that they have the necessary social skills to manage their lives effectively. Only the first technique will be described below. The IDE will be discussed in the Therapy Relationship section and the skills training procedures will be described.

### Situational Analysis

SA is a multistep social problem solving exercise designed to (1) move the patient from pre-operational functioning to a formal operations cognitive-emotive level; (2) target maladaptive cognitive and behavioral patterns that are then revised; (3) teach the patient to recognize the consequences of his or her behavior; and, (4) attack the helplessness/hopelessness perspective of the chronically depressed patient by demonstrating repeatedly that one's misery is produced and maintained by the patient himself or herself. The impact of this message becomes a paradoxical word of hope: If you don't like what you're producing as well as the miserable way you feel, then you must change your behavior! Patients begin to assume radical responsibility for their lives when they recognize their behavior has consequences. What started out during session 1 as a helplessness/hopelessness statement that "nothing I do matters" is transformed by SA into a self-affirmation that "everything I do matters." It cannot be stated strongly enough that making behavioral consequences explicit in SA moves the patient to this perceptual stance—not the charismatic and logical persuasive power of therapists. This is the reason why CBASP therapists are rigorously trained to arrange in-session contingencies to modify the patient's behavior rather than rely on personal influence tactics (McCullough, 2000).

### Elicitation Phase

The goal of teaching SA is to have the patient complete the exercise without assistance from the clinician. It is a structured contingency

procedure requiring the individual to engage, in a programmed learning manner, in formal operations problem evaluation and resolution. Patients begin treatment talking globally about their problems and being unable to focus on one problem at a time. During the Elicitation Phase of SA, they approach an interpersonal problem by pinpointing one event when the difficulty occurred (e.g., Therapist: "Tell me when this last happened to you"). Once the event is targeted, the person describes the slice of time in terms of a beginning point, an exit/end point, and the story in-between. During the exercise, patients are *not* allowed to move "outside" the slice of time and talk about other things. Rigid patterns of psychosocial functioning, when analyzed carefully in one situation, often turn out to be a microcosm of the universe of interpersonal problems the person confronts in all relationships. Thus, the single SA is easily generalized to other areas of the patient's life. The generalization and transfer of learning step constitutes the last step of the SA exercise.

SA highlights specific behavioral consequences (exit/end point of the situation) that are labeled the Actual Outcome [AO]. After pinpointing the AO, patients are then asked to construct a Desired Outcome [DO] for the exit/end point. During the early sessions, DO formulation highlights the fact that the AO was not what the person wanted. This is made explicit during SA when the patient is asked: "Did you get what you wanted here?" Discrepancies between what one produces (AO) and what one wants (DO) often noticeably increase felt discomfort. Distress at this point is desirable.

### Remediation Phase

Now, the administration of negative reinforcement becomes possible (reducing the distress by substituting more appropriate behavior) during the Remediation Phase when the mismanaged situation can be "fixed." When patients see what must be done cognitively and behaviorally to produce their DO, they often feel better. The therapist must then assist the individual to recognize that the alleviation of discomfort is connected to the solution strategies.

In this way, patient learning is reinforced (Skinner, 1968).

### Successful SAs

Over time, patients begin to bring in situations where the AO = DO. Such successes are cause for celebration, particularly when they first occur. Successful situational management will be subjected to the same intensive scrutiny as has been the case with mismanaged situations. SA also prevents patients from overlooking consequences resulting from successful behavior.

## THERAPY RELATIONSHIP

### Interpersonal Discrimination Exercise

Preoperational patients habitually reconstruct psychotherapists into perceived, "hurtful" significant others. Patients are, for the most part, unaware of these tendencies; thus, their misconstruals don't represent explicit knowledge; instead, they strongly suggest tacit patterns of behavior (Polanyi, 1966). Regardless, the consequences are the same for the therapist because his or her motives, behavior, thoughts and feelings can be seriously misinterpreted. Clinicians are often expected to reject, punish, abandon, or abuse. Viewing therapists unrealistically not only decreases the probability of change, it can also decrease the patient's motivation to change. Left unaddressed, these perceptual distortions often preclude successful treatment.

The Interpersonal Discrimination Exercise (IDE) is designed to correct interpersonal distortions and heal early traumatic experiences by adding a dose of interpersonal reality to the patient's experience. It teaches patients to make accurate discriminations between the positive qualities of the therapist and the negative characteristics of significant others. Unless patients are systematically and repeatedly guided to make their misperceptions explicit, important distinctions between hurtful significant others and the clinician are not learned (McCullough, 2000). Said another way, persons can-

not sustain their newly acquired cognitive-emotional alliance with the therapist *vis-à-vis* powerful connections with a negative past. They need specific and robust assistance; the IDE provides such assistance.

During the IDE exercise, patients must first recall a specific event where a significant other reacted to them in a hurtful way. The content of the event must fall in one of four content domains and must describe actual encounters with one or more significant others: (a) an *intimacy* situation that occurred between the patient and a significant other; (b) a time when the patient *requested emotional help/assistance* or asked for material goods; (c) an occasion when the patient *made a mistake* or broke some rule; or (d) an encounter where the individual *felt or expressed negative emotions* toward a significant other (e.g., frustration, anger, fear, guilt, shame, regret, etc.). Patients are then asked to describe how the significant other reacted as well as recall how the reaction affected them. As in the SA comparison between the AO and DO, recalling negative past events often potentiates emotional discomfort. Highlighting the patient's aversive emotions during recall makes it possible to create a negative reinforcement condition. The aversive state frequently diminishes when the patient's attention is directed to the therapist's positive reactions. Thus, the interpersonal bonding with the therapist is strengthened.

Once the encounter is described, the therapist reviews how the significant other reacted during an intimacy moment (father to his son: "You don't tell another man that you love him! Do you want other people to think you're queer?"). The clinician now asks the patient how he reacted when he told him that he felt really close to him (same intimacy content domain, different authority personage). The clinician's present reactions are then compared and contrasted to the father's. When patients, after repeated discrimination exercises, come to see that therapists are not going to punish or reject them during intimacy moments, relief is often expressed either verbally or nonverbally. The final IDE step moves to a discussion of what the new interpersonal relationship offers the patient.

Several desirable consequences occur over repeated exercises: (1) the IDE highlights the positive reality of the dyadic relationship and makes it explicit knowledge; (2) the IDE proactively replaces negative emotional attachments with new emotional connections to the therapist; (3) the IDE strengthens the person's awareness that his or her therapist is qualitatively different from significant others and demonstrates experientially what a normal interpersonal relationship should be; and finally (4) patients are freed from the growth-inhibiting trauma inflicted by significant others. Summarily, CBASP therapists use the IDE to strengthen their personal involvement with patients and to impart requisite emotional experiences that lead to greater interpersonal fulfillment.

The therapist role is defined by the clinician after session 2, and two sources of data are used. The first source stems from the transference hypotheses that clinicians generate and the second from data obtained when therapists complete the Impact Message Inventory (IMI; Kiesler & Schmidt, 1993) on the patient.

### *Significant Other History*

A Significant Other History (McCullough, 2000) is obtained during the second session. Patients are asked to provide a list of 6–7 significant others who have shaped them to be the kind of person they are. These must be major life players and individuals who have left their “stamp” on the individual. The valence of the contribution may be either positive or negative—it's usually negative for early-onset patients. Patients are asked to describe the stamp or legacy in one or two sentences, and these descriptions are called Causal Theory Conclusions. Some patients have considerable difficulty drawing Causal Theory Conclusions about significant others. Examples of Causal Theory Conclusions might be the following: “From my mother I learned that I could never trust a man”; “Both parents taught me that I must always be self-sufficient, that it is wrong to need anything from anyone”; “Growing up around my father left me with the feeling that I always had to be perfect—I should never

make a mistake”; “I can't ever get mad or feel any anger, even today. This comes from my mother. She always punished me for being angry.”

### *Transference Hypotheses*

Following session 2, the therapist reviews the Causal Theory Conclusions and uses the material to construct one or two transference hypotheses. One or two consistent themes usually characterizes the Causal Conclusions. The modal themes are used for Transference Hypothesis construction. With most patients, one hypothesis is usually sufficient to capture the major interpersonal issue needing to be addressed.

Using an example where the therapist was male and the patient's mother had taught her daughter that she shouldn't trust a man, the following hypothesis was constructed: “If I get close to Dr. Samuels, *then* he will hurt/reject me.” Notice the functional way the hypothesis is stated: *if this happens . . . then that will occur*. The hypothesis also states the name of the therapist to personalize the patient's expectancy. Patients rarely come to therapy thinking this way. As stated above, the transference hypothesis, when used in the IDE, makes explicit what has previously been tacit knowledge. Whenever the therapist and patient experience moments implicated by a transference hypothesis, for example during a moment of closeness or intimacy, the occasion is labeled a “hot spot” transference area. The hot spot area signals the clinician that the IDE exercise should be administered.

### *The Impact Message Inventory*

The Impact Message Inventory (IMI) is the second source of data that informs the therapist role definition. The IMI assesses interpersonal impacts on 8 octants, all of which represent subdivisions within the interpersonal circle (Kiesler, 1983; Kiesler & Schmidt, 1993). Kiesler's interpersonal circle contains two intersecting axes. Each axis represents an interpersonal impact dimension characterized by constructs that are polar opposites. The Dominant (D) → Submissive (S) vertical axis desig-

nates a power dimension, whereas the Hostile (H) → Friendly (F) horizontal axis signifies the affiliation dimension. Power and affiliation impacts are essential stylistic variables that define the patient's stimulus value for therapists. These two impacts are always present in all interpersonal relationships and exert their influence on the quality as well as the direction relationships take.

One can further divide the quadrants into octants by moving counterclockwise around the circle after starting at the top of the circle with the Dominant (D) octant. The next octant is Hostile-Dominant (H-D) which divides the upper left quadrant. Continuing down are the Hostile (H), Hostile-Submissive (H-S), and Submissive (S) octants. Moving over to the friendly side of the circle, we continue up to the Friendly-Submissive (F-S), Friendly, and Friendly-Dominant (F-D) octants. In earlier studies (McCullough et al., 1988; McCullough et al., 1994a,b), we found that chronically depressed adults obtained highest scores in the Submissive and the Hostile-Submissive octants. This means that these individuals were typically submissive and compliant (S) and remained detached and anxious (H-S) in interpersonal encounters. S and H-S persons naturally "pull" others into assuming a Dominant (D) take-charge role, and frustration, impatience, and outright hostility (H-D) often accompany the reactions of others to these adults. More importantly, S and H-S patients pull therapists into Dominant ("I'll take charge") and Hostile-Dominant ("You can't do anything, I'll have to do it for you") roles. Even when therapists successfully resist falling into D and H-D roles, these particular pulls from patients are omnipresent. Identifying the stimulus value of patients using the IMI determines the interpersonal role the clinician must assume if he or she is to help the patient move to other interpersonal impact domains (McCullough, 2000; chapter 8).

In CBASP, the therapist role consists of (a) identifying the transference hot spots that must be addressed by the IDE and (b) making explicit the interpersonal impact pulls (IMI peak octants) that must be resisted so that patients can be assisted to increase functioning in other

octants. The optimal IMI profile for CBASP therapists is to remain in a mild impact position on the Dominant-Submissive axis on either the D or S octants and to avoid being rated as hostile.

### *Disciplined Personal Involvement*

As noted earlier, many chronically depressed adults describe a disorder that began during mid-adolescence. Such a beginning point provides strong evidence that the individual has been interpersonally damaged by significant others. *These patients have learned that reality is harmful, and they bear the scars to prove it.* As noted above, many popular cognitive and behavioral tactics such as disputation, logical reasoning, reality testing experiments, and social skill training, used by themselves, will not free the person from the overwhelming power of a harmful past. What will spring the patient loose are therapists who create interpersonal relationships that challenge and finally overthrow the old negative interpersonal realities.

The goals for creating a personal relationship are threefold. First and foremost is to modify behavior; second is to help patients make stable discriminations between harmful significant others and the person of the therapist, and third is to teach interpersonal behaviors that are congruent with the new interpersonal reality existing between therapist and patient. The logic of the strategy can be summed up this way: This is who your father was/is versus who I am; this is who your mother was/is versus who I am. Now, given who I am and the fact that I'm not rejecting, punishing, abandoning, or abusing you, what are the implications of this new interpersonal reality?

For almost 100 years, our profession has prohibited and discouraged therapists from becoming personally involved with patients. It's time we rethink this taboo. All techniques don't work equally well with all disorders. Likewise, enacting the same therapist role with all patients will not work in every case. Chronically depressed patients quickly identify the mental health workers who are not being themselves but instead are "playing" a professional role. Interpersonal reciprocity is missing.

It's no wonder that many patients remark that psychotherapy has nothing to do with the real world.

One example, taken from my earlier therapeutic efforts, will illustrate the point that just being human rather than playing a professional role is the best strategy.

PATIENT: "Dr. McCullough, you look tired this afternoon."

MCCULLOUGH: "We're not here to talk about me, we're here to talk about you. How have you been doing?"

PATIENT: "Oh, I forgot. Let me tell you what happened to me this afternoon."

The patient's reaction to my obvious fatigue was an example of empathy. She read my non-verbal behavior accurately and commented on it. Her behavior also denoted formal operational functioning as well as a focus on someone other than herself (which suggests an overthrow of preoperational egocentricity).

Now, let's look at a more human response that I could have made that would have reflected genuine personal involvement.

PATIENT: "Dr. McCullough, You look tired this afternoon."

MCCULLOUGH: "You surely read me right. I'm very tired. This has been a long day."

PATIENT: "Would you like to reschedule our appointment?"

MCCULLOUGH: "Yes, but I don't want to because there is something very important that we must address."

PATIENT: "What's that?"

MCCULLOUGH: "The way you're talking to me now. You're reading me correctly! You're concerned about me and how I feel. This is a change. It's what we've been talking about for several weeks. That is, you learning how to read others to identify what's going on with them before you act. No, I don't want to reschedule. Thanks for the offer. I've just experienced a new burst of energy. Let's talk about how your new empathic behavior has been affecting your life."

I could have been candid with the patient about my fatigue and used it to strengthen a behavior that will endear her to others. I spend considerable time in supervision teaching CBASP therapists to relax, to be themselves, and to quit trying to be a professional psychotherapist—instead, just be a human being. I feel strongly that in our day the most appropriate word to therapy trainees is not "be professional"; rather, a more appropriate admonition is "be human."

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## CASE EXAMPLE

### DEMOGRAPHIC DATA

Susan was a 41-year-old, divorced, part-time employed, above average intelligence, single-parent with an adolescent daughter. She had been depressed "for as long as I can remember" and in addition to her early-onset dysthymia, she recalled 4 or 5 major depressive episodes during the past 25 years. Her index major depressive episode (onset of the last major depressive episode) began 3 months prior to the screening interview and followed the breakup with a boyfriend. Her first husband had been an alcoholic, and her last relationship ended when she discovered the man was also seeing another woman. Susan and her father lived in the same city and saw each other at least once a week. They had a stormy, conflictual relationship that she always felt had been largely her fault. Susan's mother died 8 years previously. The mother abandoned the family for another man when Susan was 10. She had a brother 2 years younger and a sister 5 years her junior; the mother took the sister when she left home. She didn't hear from or see her mother or sister for 20 years. Her brother committed suicide when Susan was a senior in high school. She lived with her father until she went to college at age 18. The father severely criticized the patient for every mistake, and his criticism continued up to the present time. Based on her descriptions of their confrontations, he still treated her like a child. During adolescence, he frequently accused her of "being a whore," "a slut," "a junkie," and many other negative labels. She made As and Bs during



high school and graduated on time, but she did admit that she ran with a “wild crowd” and did anything that would keep her out of the house.

#### DIAGNOSIS & ASSESSMENT

The SCID was administered during the screening interview. Susan was diagnosed, early-onset double depression and, as noted above, met criteria for major depression. She obtained a BDI-II score of 35 and a Rotter I-E externality score of 15. Using the WCQ-R, her predominant coping strategies were Escape-Avoidance (wishful thinking and efforts aimed at avoiding the problem) Accepting Responsibility (acknowledging one’s role in the problem and trying to make things right), and Seeking Social Support (seeking informational, tangible, and emotional support).

#### SESSION 2

Susan obtained a score of 34 on the BDI-II at the beginning of session 2. The Significant Other History was administered. Six significant others were listed in the following order: mother, father, maternal grandmother, college professor, first husband, and her brother. The Causal Theory Conclusions centered around two salient themes: No one will be able to care for me or love me if they really get to know me; and I’m a screw-up, and I can’t do anything right. From her Causal Theory Conclusions, two Transference Hypotheses were constructed:

*Intimacy:* “If I get close to Dr. McCullough, then he will reject me in disgust.”

*Making mistakes:* If I make a mistake around Dr. McCullough, then he will ridicule me and make me feel like a child.

I also completed the IMI and plotted Susan’s stimulus value for me on Kiesler’s Interpersonal Circle. She obtained moderate peak scores on the Hostile-Submissive, and Friendly octants. Profiles of this type can be confusing. Her moderate Hostile-Submissive score denotes a detached and anxious interpersonal impact (“I’m nervous being with you”), but it is accompanied by a similar Friendly peak score suggesting a sociable, “I like being with you,” impact. A peak score on the

Submissive octant describes someone who is compliant and who pulls others to tell her what to do. My confusion comes with her sociability, which I hypothesize is *not* genuine, though on the surface it looks authentic. The detached and anxious H-S impact “trumps” her sociability and makes it suspect. To me, this means that I must not be seduced by her friendliness (F); rather, I must attend more to her obvious interpersonal distrust (H-S), which is congruent with her Causal Theory Conclusions as well as with the content of my transference hypotheses. The S pattern is a warning me that I must avoid the lethal trap of assuming a Dominant (D) role in the session. More specifically, I must resist enacting a “take-charge” role but instead encourage Susan to take the in-session lead.

Now I’ve defined my therapist role with the patient: The interpersonal hot spots have been identified with two transference hypotheses, and I’m clear about what interpersonal pulls I must resist (viz. viewing her friendliness as representing progress and inadvertently assuming a dominant therapist role).

At the end of session 2, Susan was given the *Patient’s Manual for CBASP* (McCullough, 2003a) as well as several Coping Survey Questionnaires (CSQ) for doing her Situational Analysis homework (McCullough, 2000). I asked her to complete one CSQ for session 3. The patient began taking sertraline (Zoloft) following session 2 and remained on 150 mg for the next 6 years.

#### SESSION 7

Her BDI-II score was 26, and the content of Susan’s 5th in-session SA is shown below:

#### ELICITATION PHASE

Situational Description (What happened?)

“I was in the house washing clothes and helping my daughter with her algebra homework. I had not gone to work because she was sick. I stayed home from work that day to be with her. The doorbell rang, I got up, and answered it. It was the air-conditioning repairman who had come to replace the filter in our unit. I told him this was

not a good time for him to do the work. I asked if he could come back. He insisted that he would not be long. Again I protested and asked that he come back, but I opened the door, and he walked in. He went to the utility room, replaced the filter, left his bill, and walked out. I didn't even speak to him when he left."

Situational Interpretations (What did the situation mean to you? or, What thoughts or feelings did you have during the event?)

1. "I can never control what happens to me." [Global interpretation that doesn't address the problem-at-hand.]
2. "Big corporations are unfair to homeowners." [Global interpretation.]
3. "My life is out of control." [Global interpretation.]

Situational Behavior (What did you do in the situation?)

"I answered the doorbell and asked the repair man to come back at a better time. I asked him twice. Oh, I almost forgot, I held the door open for him. I didn't speak to him when he left."

Actual Outcome (How did the situation come out for you?)

"The repair man replaced the filter and left."

Desired Outcome (How did you want the situation to come out for you?)

"I wanted the repair man to come back at a more convenient time."

AO-DO Comparison (Did you get what you wanted here?)

"No!" (Susan begins to cry while saying what a failure and screw-up she is.)

Why Didn't You Get What You Wanted Here?

"Because I'm stupid! I can't do anything right!" (more crying).

REMEDIATION PHASE ("FIXING" THE SITUATION)

Revising the Situational Interpretations

All three interpretations had to be revised. They did not accurately describe what was going on; in fact, no interpretation dealt specifically with the problem at-hand. Because they were irrelevant (not anchored to the event) and inaccurate (did not correctly describe the ongoing action), we had to modify them so that they would meet criteria for relevance and accuracy. With considerable assistance, Susan revised her interpretations in such a way that the probability of obtaining the DO was increased:

1. "I don't want the filter replaced at this time" [accurate & relevant introspective interpretation].
2. "I've got to work out another appointment time with the repairman" [Action Interpretation that leads to assertive behavior].

Repairing the Situational Behavior

MCCULLOUGH: "Had you interpreted the situation this new way, how would your behavior have changed?"

SUSAN: "I would have been more assertive and definite with the repairman. And, I certainly would not have held the door open for him!"

MCCULLOUGH: "Had you managed the situation this way, do you think you would have gotten what you wanted here—that is, for him to re-schedule and come back?"

SUSAN: "I surely would have had a better chance of getting what I wanted than I did the first time through." (Her crying stopped, and Susan is showing more signs of having energy and conviction about what would have happened.)

Space limitations do not permit us to discuss the final two steps of SA: the Wrap-up/Summary and Transfer of Learning/Generalization Steps. But before leaving the SA, the reader should note how Susan's global cognitive interpretations precluded problem resolution; and, when the cognitive errors were combined with her lack of assert-

ive behavior, situational failure and frustration were guaranteed. Her life really was out of control in this situation; and, without realizing it, she inadvertently produced the failure she described during the Elicitation Phase.

I administered an IDE following the SA exercise because the situation implicated a hot spot that was covered by the second Transference Hypothesis (viz. If I make a mistake around Dr. McCullough, then he will ridicule me and make me feel like a child). Here's the way the IDE exercise was administered:

MCCULLOUGH: "Susan, let me ask you a question. Had you told your dad about the way you first handled this situation, how would he have reacted?"

SUSAN: "He would have laughed out loud at me and made me feel like a stupid idiot. He would have gone on and on about how I can't do anything, how I'm always screwing up." (Susan is beginning to tear up.)

MCCULLOUGH: "How would your first husband have reacted had you told him about your experience with the repairman?"

SUSAN: "He would have poured himself a drink and told me I had driven him to drink. He was just like daddy. He would have called me stupid, dumb, an imbecile, and the biggest loser he had ever known. (Susan is crying softly now.)

MCCULLOUGH: "Now, I want you to describe for me what my reaction was to the way you dealt with the repairman?"

SUSAN: "It was okay, I guess."

MCCULLOUGH: "Think back, what did I do, how did I look throughout, what did I say? I want you to think carefully about how I behaved with you a few moments ago."

SUSAN: "You certainly didn't make me feel stupid. You helped me see what I could have done better, you encouraged me, and then you were pleased when I said that the second way would have probably gotten me what I wanted."

MCCULLOUGH: "Now, I want you to compare and contrast my reactions to you with those of your father and ex-husband. Tell me how they were similar and how they differed."

We must stop here, but you can see how the IDE exercise attacks proactively the negative reactions of significant others by focusing attention on the salubrious behavior of the therapist. The stable reality of this new interpersonal relationship must be nurtured and strengthened over time so that it will acquire the capacity to compete with and finally overthrow the old interpersonal realities and the hold they have had on Susan's life.

Susan ended weekly treatment after 21 sessions. Her Rotter I-E externality score was a 7 at session 21 (indicating internal locus of control) and on the WCQ-R, Planful Problem Solving (describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem) became her modal coping style. Susan learned to self-administer SA to criterion (using the PPRF as the rating scale) without assistance from me by the end of session 21. At session 21, she obtained a BDI-II score of 9, though the Mood Disorder Section of the SCID showed that she continued to meet criteria for dysthymic disorder. She and I saw each other during the next 12 months on a twice per month and then on an as-needed basis. Six months after the weekly sessions ended, Susan achieved remission from dysthymia.

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## EMPIRICAL RESEARCH

CBASP has recently been tested with medication in a large, national 12-site study lasting 19 months (Keller et al., 2000). The study, the largest psychotherapy-medication clinical trial ever conducted, provides a unique perspective from which we can evaluate the efficacy of long-term treatment for a large sample of chronically depressed outpatients. The Keller et al. (2000) study, where the majority of the 681 outpatients had been depressed for more than 20 years, contributed treatment data in three ways: (1) finding that combination treatment was significantly more effective than monotherapy in the treatment of the chronically depressed adult; (2) demonstrating that patients who improved after 12 weeks of acute treatment and who remained in the same treatment

modality for 4 additional months continued to improve; (3) provided an opportunity to investigate recurrence rates among CBASP-only patients during a 12-month maintenance period (Klein et al., 2004).

Intent-to-treat response rates were 73% for the combination cell and 48% for both the medication-only and CBASP-only cells. Among completers of the acute phase, combination treatment produced a response rate of 85% and a 55% and 52% response rate for medication and psychotherapy patients, respectively. One of the major outcomes of the Keller et al. (2000) study was the conclusion that combination treatment should be the treatment of choice for the chronically depressed patient. This conclusion was drawn in spite of the fact that nefazodone (Serzone) is the only medication to be tested to date with CBASP. The reason for the conclusion is that Serzone produced a faster-acting symptom-decrease effect than psychotherapy alone in reducing the symptoms of major depression (Keller et al., 2000). There is no reason to think that other serotonergic medications would not act similarly. In the CBASP-only group, symptom reduction did not match the medication-only cell decreases until the end of the eighth week. Rapid symptom decreases (e.g., major depressive symptoms such as diminished ability to think or concentrate, indecisiveness, diminished interest in current activities, hopelessness) at the outset of psychotherapy are highly desirable. Because psychotherapy requires patients to learn, that is, to think clearly, concentrate and focus, generate interest in the task at-hand, make decisions, and be able to experience hope in the outcome of treatment learning in the combination group appeared to be enhanced with the early medication gains. In the absence of symptom decreases, patient motivation is likely to remain low, and the effectiveness of psychotherapy may be significantly compromised.

In order to assess the continuing status of patients after the end of the acute phase, the three treatment groups (Combination Treatment, Medication-only, CBASP-only) were compared at the continuation phase (4 months) exit point. Analyses showed a significantly

greater proportion of combination patients achieved *partial* or *full responder* status at the continuation exit-point than did either the medication-only or CBASP-only groups. The data in Table 13.1 show that the percentages of *full responders* in the three treatment groups increased consistently across all groups when treatment was continued.

In summary, CBASP outcome data demonstrate the need for long-term treatment for the chronically depressed patient. I feel strongly that the more our mental health field prospectively compares the outcome efficacy of short-term versus long-term care, the more we will move away from cost-effectiveness priorities toward a position that constitutes the foundation of the healing professions; namely, the well-being of the patient.

At the end of the Continuation Phase, 82 patients who responded to acute and continuation phase CBASP-only treatment were randomized to monthly CBASP or assessment-only groups for 12 months. Estimated recurrence rates were 11% and 32% in the CBASP and assessment-only groups, respectively. The CBASP-only patients benefited significantly from continued treatment contact (once per month) with their therapists. Even among those randomized to assessment-only, CBASP had a moderate prophylactic effect (68% survived) (Klein et al., 2004).

## FUTURE DIRECTIONS

During the next decade, CBASP must be dismantled to identify the active change ingredients operative within the model. Second, it must be compared to Cognitive Therapy (Beck, Rush, Shaw, & Emery, 1979) and Interpersonal Psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) to determine its relative efficacy with chronically depressed patients. Finally, the question of its efficacy with other psychological disorders should be explored.

A dismantling investigation was launched in 2002 in a 9-site national NIMH Study treating 910 chronically depressed outpatients. CBASP is being compared to Brief Supportive Psychotherapy (Markowitz et al., 1995, Markowitz,

TABLE 13.1 Comparative Percentages of “Full Response Subjects” (Ss) at the End of the Acute and Continuation Phases in the 3 Treatment Groups

	End Acute Phase	End Continuation Phase
<i>Combination group</i>		
Percentage full responders	48% (109/226Ss)	62% (92/148Ss)
<i>Medication-only</i>		
Percentage full responders	29% (62/220Ss)	62% (59/90Ss)
<i>CBASP-only</i>		
Percentage full responders	33% (72/226Ss)	63% (54/86Ss)

Ss = Subjects in the study

Spielman, Scarvalone, & Perry, 2000) to control for the nonspecific factor of therapeutic alliance. We want to determine what additive effects Situational Analysis (the social problem solving algorithm of CBASP) might have on treatment outcome. Comparative clinical trials have not been undertaken to date nor have investigations with other psychological disorders been carried out.

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## Integrative Therapy for Borderline Personality Disorder

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Psychotherapy integration synthesizes different theories and techniques to develop a maximally efficacious therapy. In this way, the goal and process of psychotherapy integration parallels the goal and process of psychotherapy itself. Psychotherapists from various schools strive to foster synthesis within their clients, whether by targeting the incorporation of new skills into a client's behavioral repertoire or by guiding the client toward the integration of disparate aspects of the self. In Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b), the emphasis on observing and creating syntheses within the process and content of the therapy has developed into an integral part of helping clients achieve their ultimate goals. DBT is integrative in the "dialectical/developmental" sense of the word (Stricker & Gold, 1993), meaning that it emphasizes the "open-ended dialogical process in which differences are examined and novel integrations are welcomed" (p. 7). Thus, while at any given moment DBT constitutes a single, unified psychotherapy, it is

also in a continuous process of change in which new developments are accepted rather than avoided, rather like a client effectively participating in therapy.

This chapter elaborates on the various integrative aspects of DBT by describing its application to individuals who meet criteria for borderline personality disorder (BPD), the population on which the treatment was originally developed. First, it identifies the primary theoretical and philosophical principles of the approach and the history of their integration. It discusses "dialectics" in greater detail and describes some of the ways in which the dialectical philosophy performs multiple integrating roles throughout the therapy. The chapter describes the initial assessment, case formulation, and treatment modalities. It focuses on the strategies and process that occur within a therapy session, as well as how the therapy relationship contributes to change. A case example illustrates the integration of the various strategies. Finally, the chapter summarizes the results of



outcome trials that examine the efficacy of DBT for BPD and considers future directions for the treatment approach.

## INTEGRATIVE APPROACH

### Development of Approach

Linehan (1993a, 1993b) originally developed DBT as an outpatient cognitive-behavioral intervention for individuals meeting criteria for BPD and engaging in parasuicidal behavior. To explain the etiology and maintenance of problematic behaviors associated with BPD, she combined capability deficit and motivational models of behavioral dysfunction. Individuals who meet criteria for BPD lack important skills (e.g., emotion regulation, interpersonal effectiveness), and personal and environmental factors both inhibit skillful behavior and reinforce problematic behavior. Linehan further proposed a transactional theory of the etiology and maintenance of BPD that combines biological, social, and developmental causes.

To change the problematic behaviors, Linehan applied the principles of behaviorism (e.g., Pryor, 1984; Skinner, 1974) and the traditional practices of cognitive-behavior therapy (CBT; e.g., Barlow, 1988; Masters, Burish, Hollon & Rimm, 1987; Goldfried & Davidson, 1976; Wilson & O'Leary, 1980) that had led to the development of efficacious treatments for many other disorders. To facilitate case conceptualizations and interventions capable of addressing the multiplicity and complexity of behaviors associated with BPD, she integrated and adapted traditional problem-solving strategies such as skills training, exposure, and contingency management. Clinical experience, however, suggested that these practices alone would prove insufficient when treating BPD clients. Compared to most clients who successfully complete behavioral programs, these clients had significantly more behaviors to target, poorer treatment compliance, and higher treatment dropout. Developing and maintaining a collaborative relationship and a stable set of treatment goals while encountering high suicidality, conflict in therapy, and other crises

made the application of CBT in a straightforward way extremely challenging.

Therapy-interfering behaviors occur as a result of CBT's perceived focus on changing behaviors, ranging from emotions and cognitions to overt behavior. She suggested that the focus on change was experienced by the client not only as invalidating specific behaviors but as invalidating the client as a whole. Research by Swann (Swann, Stein-Serussi, & Giesler, 1992) may explain how such perceived invalidation leads to problematic behavior in therapy. Their research revealed that when an individual's basic self-constructs are not verified, the individual's arousal increases. The increased arousal then leads to cognitive dysregulation and the failure to process new information. The bio-social theory would suggest that BPD clients are particularly sensitive to any potentially invalidating cues and more likely to become highly aroused.

To balance the emphasis on change, Linehan began to integrate the principles of Zen (e.g., Aitken, 1982) and the associated practice of mindfulness (e.g., Hanh, 1987), which describe "acceptance" at its most radical level. Zen encourages radical acceptance of the moment without change. Practice includes focusing on the current moment, seeing reality as it is without "delusions," and accepting reality without judgment. The practice also encourages students to let go of attachments that obstruct the path to enlightenment, to use skillful means, and to find a middle way. Zen teaches that each moment is complete by itself and that the world is perfect as it is (Aitken, 1982). Zen focuses on acceptance, validation, and tolerance instead of change. Finally, in contrast to the experimental evidence required in psychology, Zen emphasizes experiential evidence as a means of understanding the world.

Recent outcome research examining the effects of practicing mindfulness supports the integration of the practice into DBT. Kabat-Zinn (1990, 1994), who defines mindfulness as "paying attention in a particular way: on purpose, in the present moment and non-judgmentally" (1994, p. 4), has developed a mindfulness-based approach to treat stress. Research has provided favorable initial evidence of the treat-

ment's efficacy in treating chronic pain (Kabat-Zinn, Lipworth, Burney, & Sellers, 1986) and anxiety disorders (Kabat-Zinn et al., 1992). More recently, Segal, Teasdale, and Williams (Segal, Teasdale, & Williams, 2002) have adapted Kabat-Zinn's approach and integrated it with aspects of CBT for depression to develop a treatment, Mindfulness-based Cognitive Therapy (MBCT), designed to prevent relapse prevention from major depression. A randomized control trial suggested that the addition of MBCT to treatment as usual may reduce the likelihood of relapse for some clients (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000).

The tensions arising from Linehan's attempt to integrate the principles of behaviorism with those of Zen required a framework that could house opposing views. The dialectical philosophy, which highlights the process of synthesizing oppositions, provides such a framework. Through the continual resolution of tensions between theory and research versus clinical experience and between Western psychology versus Eastern practice, DBT evolved in a manner similar to the theoretical integration model described by psychotherapy integration researchers (Arkowitz 1989, 1992; Norcross & Newman, 1992).

### Dialectical Principles

Dialectics describes the process by which the development and progress of therapy occurs and by which conflicts that impede progress are resolved. The American Heritage Dictionary (1979, p. 363) defines dialectics, in part, as "The Hegelian process of change whereby an ideational entity (thesis) is transformed into its opposite (antithesis) and preserved and fulfilled by it, the combination of the two being resolved in a higher form of truth (synthesis)." Linehan's application of dialectics was influenced by evolutionary biology (Levins & Lewontin, 1985), cognitive development (Basseches, 1984), and the evolution of self (Kegan, 1982). Based on such sources, Linehan draws several assumptions about the nature of reality that are particularly relevant to psychotherapy with BPD clients. Three of these assumptions—that

reality is (1) interrelated or systemic, (2) oppositional or heterogeneous, and (3) continuously changing—are discussed in greater detail.

### *Interrelatedness*

Dialectics stresses the fundamental interrelatedness and unity of reality by emphasizing relationships within and between systems. Levins and Lewontin (1985, p. 3) describe this aspect of dialectics: "Parts and wholes evolve in consequence of their relationship, and the relationship itself evolves. These are the properties of things that we call dialectical: that one thing cannot exist without the other, that one acquires its properties from its relations to the other. . . ." Behaviorism and Zen both recognize the importance of interrelatedness. Though all CBT therapists are trained to include the external environment in their search for controlling stimuli and to evaluate the effect of behavioral antecedents and consequences, the contextualist position described by Hayes (1987) most clearly resembles the dialectical emphasis on attention to interrelatedness and the whole. Zen and other Eastern practices (Wilber, 1979) highlight the experience of connectedness to the universe and letting go of personal boundaries.

One of the most pervasive ways in which the principle of interrelatedness influences treatment is that it encourages a systemic approach to the analysis of behavior. Within the systems that influence behavior, the DBT therapist considers two basic levels at which the client may experience dysfunction. The first level encompasses mutually influential systems within the individual such as biochemical systems, affective regulation systems, and information processing systems. For example, if a client's serotonin uptake is dysregulated, this may lead to affective instability. Affective dysregulation often interferes with cognition. If the cognitive dysregulation includes a disruption of problem-solving abilities, then this disruption could lead to a crisis that further dysregulates affect. Though multiple dysregulations may require multiple treatments, a systemic approach also foresees how any single intervention may influence multiple systems. For example, effec-

tive pharmacotherapy may regulate serotonin intake such that the chain described above never begins. Alternatively, enhancing emotion-regulation skills may help the client to cope effectively with biological changes such that information processing and problem solving are not impaired.

The second level of systemic dysregulation involves the interpersonal systems, such as family and culture, and other environmental systems. To obtain an accurate understanding of the client's behavior, the DBT therapist must assess these influences as well as biological and psychological factors. Many clients live in or interact with systems that reinforce problematic behavior or punish skillful behavior. For example, the hospitalization of a client for suicidal behavior may actually reinforce the behavior if the hospitalization provides desirable consequences such as more warmth and caring from staff than the client received elsewhere or fewer onerous responsibilities (e.g., finding housing) that the client cannot otherwise avoid. Decreasing the suicidal behavior may involve, in part, the therapist and client working to diminish the likelihood that hospitalization leads to such desirable consequences. Alternatively, a client's attempts to search for employment may be punished by a family in which everyone else lives on unemployment benefits. One of the most critical interpersonal systems is, of course, the therapeutic relationship, which will be discussed later.

### *Opposition*

Dialectics also highlights the complexity of nature by suggesting that reality is composed of opposing forces, the thesis and the antithesis, in tension with each other. Development occurs as these oppositions proceed toward synthesis, and as a new set of opposing forces emerges from the synthesis. In psychotherapy, tensions can arise within the client, within the therapist, between the client and therapist, or between the client and/or therapist and the larger treatment system. Here we focus on what Linehan has identified as the central opposition for the therapist: the tension be-

tween accepting the client and changing the client.

The relationship between change and acceptance forms the basic paradox and context of treatment. Therapeutic change can occur only in the context of acceptance of what is, and the act of acceptance itself is change. The ability of the DBT therapist to balance change and acceptance is enhanced through combining aspects of CBT and Zen practices. Though CBT provides the technology of change, Zen provides the technology of acceptance. To maximize therapeutic progress, the DBT therapist continuously interweaves acceptance strategies, which acknowledge the client as is in the moment, and change strategies, which attempt to alter the client's behavior. The therapy strives to help the client understand that certain behaviors may prove both valid and problematic. For example, a client who fears not having sufficient skills to cope when the therapist leaves town for a holiday is a valid response from a client who has few coping skills and functions better when the therapist remains in town. On the other hand, the client must learn new skills to cope with the separation because the therapist will leave town. To validate the client while also solving a problem, the therapist may offer the client an extra session prior to the holiday and then focus exclusively during that session on skills to help the client cope with the therapist's absence.

### *Change*

Dialectics stresses change as a fundamental aspect of reality. All therapies foster change, but they differ in the type and degree of change they promote. As noted above, both behaviorism and Zen discuss change, though in slightly different ways. CBT promotes change by using interventions that require the client and/or the therapist to actively change emotions, thoughts, overt behavior, or the environment. In contrast, neither the Zen student nor the master tries intentionally to change but instead mindfully observe experiences as they occur. Whereas the behavior therapist teaches the client how to actively decrease dysfunctional behavior, the

Zen master helps the student learn to observe how emotions, cognitions and urges, both pleasant and aversive, naturally come and go without any attempts to change them. According to Zen, everything is impermanent and comes and goes like waves in the ocean.

Behavior therapy and Zen practice thus offer two approaches to change. For example, whereas behavioral procedures can reduce suicidal behavior by teaching the client how to actively reduce suicidal urges, Zen practice can reduce suicidal behavior by teaching the client how to allow and observe the urges without acting on them. These behavioral and Zen approaches to parasuicide reciprocally enhance each other. On the one hand, an important step in reducing suicidal urges is to increase awareness of those variables that control the urges. On the other hand, if one observes the urges without reinforcing them through action, the urges will naturally decrease over time.

In addition to promoting change in the client's behavior, DBT allows therapists extensive freedom to change their own behavior and some aspects of the treatment's structure. For example, as the therapy relationship develops, the therapist may become willing to expand various limits (e.g., willingness to accept phone calls, using examples of self as a coping model) as one would expand limits in any other relationship over time. This natural change is allowed to occur so that the therapeutic context matches, as closely as possible, the "real world." Alternatively, such limits may also contract as a result of changes in the therapy relationship (e.g., client begins to phone the therapist too often or shares the therapist's self-disclosure with other clients) or the therapist's life (e.g., therapist has a baby, is studying for exams). The therapist does not try to protect the client from natural change but instead tries to help the client learn to cope with such change, viewing such changes as opportunities for the therapy to actively address deficits in the client's ability to adapt. For example, when group skills trainers rotate into and out of an ongoing group, the trainers may directly target the clients' distress by helping them to practice some

of the relevant skills that they have learned during skills training.

## APPLICABILITY

DBT was originally developed as an outpatient treatment program for women who met criteria for BPD and had a history of parasuicidal behavior. Clients committed to an initial year of treatment, which included weekly individual therapy, weekly group skills training, and after-hours telephone consultation as needed. Initially, the treatment excluded individuals who met criteria for schizophrenia, bipolar disorder, substance dependence, and mental retardation, but included individuals who presented with comorbidity for other disorders. Because treatment programs for substance dependence often excluded borderline individuals, Linehan (Linehan & Dimeff, 1997) decided to develop an adaptation of DBT to treat BPD women who also met substance dependence or abuse criteria. The randomized controlled trials (RCT) demonstrating the efficacy of these treatments will be discussed at the end of the chapter. It is worth noting here, however, that these RCTs all focused on women, so the applicability of the treatment to men remains an empirical question. Clinical experience suggests that, perhaps with some treatment adaptations, men can benefit from DBT as well.

Other clinicians and researchers have focused on adapting DBT for various treatment settings. Pilot studies have examined the effectiveness of DBT when applied to borderline patients on psychiatric inpatient units (Barley et al., 1993; Bohus, Haaf, Stiglmayr, Pohl, Bohme, & Linehan, 2000) and in a high security, forensic hospital (Low, Jones, Duggan, Power, & MacLeod, 2001). Though the results of these studies generally favor DBT, the findings must be replicated in more tightly controlled trials before clear interpretations can be made. Treatment developers are also beginning to investigate adaptations of DBT for non-BPD psychiatric populations, including suicidal adolescents (Miller, Rathus, Linehan, Wetzler, & Leigh, 1997), men with histories of

domestic violence (Fruzzetti & Levensky, 2000) and the elderly with comorbid depression and personality disorders (Lynch, 2000). The adaptation with the most empirical support thus far is group DBT for binge eating disorder, which has reported positive results in a pilot study (Telch, Agras, & Linehan, 2000) and an RCT (Telch, Agras, & Linehan, 2001).

## ASSESSMENT

Regardless of the setting, pretreatment assessments begin with a thorough diagnostic assessment. Though DBT emphasizes the importance of such assessments, however, the treatment maintains a behavioral view that suggests that a diagnosis of BPD is simply a term that summarizes a particular pattern of behaviors. If the behaviors cease, so too does the diagnosis. Furthermore, DBT therapists approach the application of the diagnosis of BPD from a utilitarian perspective. That is, DBT does not “believe in” the diagnosis per se but uses it because it has been demonstrated to be effective. A diagnosis of BPD functions to predict the prognosis of various types of treatments and allows the therapist to develop a treatment plan.

After establishing the individual’s diagnostic suitability, pretreatment assessments focus on obtaining histories of the individual’s most severe behaviors. Borderline individuals often present with severe behavioral dyscontrol, engaging in multiple unsafe and or destabilizing behaviors. A single individual may be parasuicidal, abuse substances, physically threaten others, and dissociate. Because BPD clients often engage in behaviors that either directly interfere with therapy (e.g., not attending, not completing homework, remaining mute) or that lower the therapist’s motivation to provide treatment (e.g., insulting the therapist, threatening to complain about the therapist to management, stalking the therapist), an assessment of the individual’s past treatment experiences may prove valuable as well.

For clients at this stage of dysfunction, DBT focuses on moving from severe dyscontrol to behavioral control. The initial assessment of the severe behaviors enables the therapist to

develop a hierarchy of behaviors to target. These target behaviors are as specific and as clearly defined as possible. The target hierarchy is as follows: (1) decreasing suicidal (e.g., parasuicide, suicidal urges, suicide threats) and other imminently life-threatening behaviors (e.g., homicidal behaviors); (2) decreasing therapy-interfering behaviors of both patient and therapist; (3) decreasing severe quality of life interfering behaviors (e.g., other diagnostic disorders, impulsive spending leading to bankruptcy, behaviors leading to homelessness); and (4) increasing behavioral skills such as distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness in order to bring about skillful coping. The target hierarchy guides the agenda of each session. Once the therapist and client have identified an episode of a behavior to target during a session, they will conduct a thorough assessment of that episode.

The identification of treatment targets highlights a tension between behavior therapy and Zen and a paradox within Zen itself. Whereas the behavior therapist helps the client to define where the client wants or needs to go, the Zen master helps the student to realize that the student is already there. The paradox within Zen is that, although one enters the practice to achieve enlightenment, the more one focuses on enlightenment as a goal during practice, the less likely one is to experience it. The DBT therapist balances requiring the client to work on treatment targets with appreciating the client’s inherent strengths. Of course, the therapist must also attend to the many ways in which attention to treatment targets can interfere with achieving them. For example, the client’s fears of not being able to stop drinking may actually cause anxiety that leads to more drinking.

## CASE FORMULATION

Formulation in DBT may be viewed as occurring on two overlapping levels, a general case formulation and specific behavioral formulations. The therapist first develops a formulation of the case as a whole. Based on behavioral and

dialectical principles and the bio-social theory, the case formulation provides a general understanding of the development of the client's behaviors and general guidelines for treatment. This formulation slowly evolves across sessions as the therapist first addresses the same problem in various contexts and then moves on to address other problems. Within a single session, a therapist first selects an episode of the client's most severe behavior (e.g., cutting, bingeing, dissociating) to target and then develops a behavioral formulation for that specific episode. If the behavior reoccurs the following week, the therapist will develop a behavioral formulation of the new episode, incorporating information from both an assessment of the current episode and from past formulations. Thus, the DBT therapist develops a single case formulation that slowly evolves and a series of behavioral formulations that may change more quickly from session to session.

### Bio-Social Theory

To explain the development of the behaviors associated with BPD, Linehan (1993a) proposes a bio-social theory in which BPD results primarily from a disorder within the system of emotion regulation. She hypothesizes that the problems with emotion regulation result from a dialectical transaction between a biologically based proclivity toward emotion dysregulation and an invalidating social environment(s). This hypothesis suggests that not only does the interaction of the individual's biology and environment lead to problematic behaviors, but also that the biology and environment reciprocally influence each other such that the emotional dysregulation creates more invalidation and vice-versa.

The pervasive emotion dysregulation experienced by borderline individuals results from a biologically based emotional vulnerability combined with insufficient emotion regulation. Emotional vulnerability refers to a physiological predisposition to be highly sensitive to emotional stimuli, to respond intensely to such stimuli, and to return slowly to a less emotional baseline. Emotional vulnerability alone would not necessarily prove problematic if the individual

managed the emotions well. To conceptualize emotion regulation, Linehan has incorporated the work of Gottman and Katz (1990), who have suggested that emotion regulation requires the ability to (a) inhibit inappropriate behavior related to strong negative or positive affect, (b) self-soothe physiological arousal induced by the affect, (c) refocus attention away from the affect, and finally (d) organize one's behavior toward coordinated action to achieve the external goal (i.e., solve the problem that initially elicited the affect).

Though emotion dysregulation may cause some form of psychiatric problems by itself, only when such dysregulation transacts with an invalidating environment over a period of time does BPD develop. An invalidating environment is "one in which communication of private experiences is met by erratic, inappropriate and extreme response" (Linehan, 1993a, p. 49). Such environments chronically reject or otherwise punish the individual's communication of private experiences (e.g., emotions, cognitions, physical sensations) or self-generated behaviors and oversimplify the ease of resolving problems. For example, in response to a child's sadness and tears over a lost teddy bear, an invalidating environment might respond with "What are you crying about? It was just a toy. If you want to cry, I'll give you something to cry about." Furthermore, these environments then intermittently reinforce the escalation of emotional behavior. For example, an invalidating environment may ignore expressions of distress until it leads to suicide attempts, substance dependence, or bulimic behavior. Though borderline individuals first encounter invalidating environments during childhood, many find themselves in such environments (e.g., marriages, employment, treatment systems) during adulthood as well.

The potential consequences of continual invalidation include difficulties in effectively labeling and regulating emotions and distrusting one's own experiences as valid responses. In such environments, individuals learn to invalidate their emotions, cognitions, urges, and other experiences and to scan the environment for cues about their own internal experiences. Additionally, the environment fails to adequately

teach the individual how to solve problems, to self-regulate, and to tolerate distress. Instead, the environment teaches the individual to set unrealistic personal goals and standards and to respond severely to any perceived failure. Finally, the intermittent reinforcement of escalated emotional reactions teaches the individual to fluctuate between inhibition of emotions and extreme emotional behavior.

DBT requires formulations that employ problem solving and other strategies to address the emotion dysregulation and the invalidating environment, as well as the resulting problematic behaviors. DBT particularly focuses on teaching and improving the motivation to use skills that foster emotion regulation. All clients attend skills-training sessions on emotion regulation and distress tolerance. Meanwhile, therapists attend to validating and otherwise reinforcing the use of such skills, while trying to extinguish extreme emotional displays and associated behavior. These strategies are discussed in greater detail in the section on problem solving.

## STRUCTURE

To enhance its adaptability, DBT is organized around the tasks or functions addressed by, rather than the modes employed by, the treatment. There are five primary treatment tasks based on the capability deficit/motivational model. These tasks consist of (1) enhancing client capabilities, (2) improving client motivation, (3) generalizing client capabilities, (4) structuring the environment, and (5) treating therapists. The therapy's dialectical model suggests that although tensions may arise amongst the various tasks, the successful completion of any task depends on how well it is integrated with the others.

### Enhancing Client Capabilities

To address the assumed capability deficit, the treatment first requires a modality that enhances the client's capabilities. Various modalities, ranging from self-help books and videos to pharmacotherapy, may address this task. Standard DBT employs psychoeducational

skills training groups (Linehan, 1993b) as the primary modality of enhancing capabilities. In general, the groups meet for 2½ hours per week during the initial treatment year. The DBT skills trainer teaches modules or sets of skills that can be divided into those that promote change, consisting of the emotion regulation and the interpersonal effectiveness modules, and those that promote acceptance, consisting of the mindfulness and the distress tolerance modules. In skills training, the client first learns a wide variety of skills and then works to integrate these skills into a repertoire. The client's job resembles that of a technically eclectic psychotherapist who may select from a variety of techniques to solve a therapeutic problem. For both, the key question is what is effective in this situation.

From an integrative perspective, the mindfulness skills may be of particular interest. These skills teach clients to observe, describe and participate without judgment, with a focus on the present moment and with an emphasis on being effective. These skills help clients to enhance their awareness of reality and are an inherent part of the other skill modules. Before one can change what is, one must first be aware of what is. As one of their early assignments in the emotion regulation module, for example, clients practice observing and describing the prompting event, interpretations, facial expressions, actions, and so forth, associated with a particular emotional episode. Becoming aware of the many factors contributing to a single emotional episode facilitates learning skills to change those factors and thus better manage the corresponding emotion.

### Enhancing Client Motivation

In addition to having a repertoire of skillful behavior, one must also have sufficient motivation to engage in skillful behavior. DBT thus requires a second modality that focuses on improving motivation. Again, a variety of modalities, including inpatient milieus (e.g., settings that provide incentive systems, peer support/pressure) and couples therapy and pharmacotherapy (e.g., anxiolytics may decrease fear that inhibits interpersonal skills), may address this

function. For example, DBT for substance abusers (Linehan & Dimeff, 1997) replaces illegal drugs with legal medications (e.g., methadone for heroin users) to decrease the motivation to use the illegal drugs.

Standard DBT primarily addresses the task of improving in individual psychotherapy, where the therapist conducts an extensive analysis of the factors that motivate the client's behavior and employs various strategies to improve the client's motivation. The individual therapist also integrates the skills training described above into the individual therapy (e.g., suggesting skills as solutions to problems, rehearsing the implementation of those skills and reinforcing the use of skillful behavior). Also, if the client has a problem with the skills training group (or any other modality), the individual therapist consults with the client as to how the client can best solve the problem. Similarly, the client could seek consultation from the group therapist regarding a problem with the individual therapist.

### Ensuring Generalization and Structuring the Environment

Just as the DBT therapist does not assume that the client will have sufficient motivation to apply new skills, the therapist also does not assume that skills practice will automatically generalize from therapeutic settings to real-life settings. The context of applying skills may differ substantially from the context of learning skills, particularly in terms of the client's degree of emotional dysregulation and the environment's likelihood of providing a reinforcing response. As a behavioral treatment, DBT emphasizes the need for in vivo treatment so that learning will generalize beyond the therapeutic context. Possible treatment modalities include inpatient milieu, occupational therapy and in vivo practice/exposure with the DBT therapist or a case manager. Standard DBT provides clients with the opportunity to phone or otherwise contact a designated member of the DBT team for brief coaching interventions between individual therapy sessions. These coaching interventions generally function to help the client apply skillful solutions to an immediate problem.

Similarly, the treatment's fourth function focuses on helping the client to structure their environment in a way that promotes progress in other contexts.

### Enhancing Therapist Capabilities and Motivation

Finally, dialectical principles guide the treatment to also attend to the capabilities and motivation of DBT therapists. With difficult clients, in particular, the transaction between client and therapist may be such that the client punishes therapeutic behavior and rewards iatrogenic behavior. Treating the therapist as well as the client thus reinforces the dialectical frame of the therapy by attending to the two primary subsystems within the therapeutic context. Supervision or consultation meetings among therapists usually address these issues.

In the community, one of the frequent consequences of such a complex network of treatment modalities and care providers is that tensions arise amongst the providers. Therapists on DBT consultation teams adhere to a set of agreements that seem to reduce the likelihood of such tensions. For example, the consultation-to-the-client agreement states that therapists do not instruct each other about how to interact with a client; instead, they coach the client on how to interact effectively with members of the team. This removes one of the greatest causes of tension—psychotherapists or other treatment providers telling each other how to do their jobs. The consistency agreement states, in part, that all team members need not have a consistent response to a client. For example, a therapist covering for an individual therapist on leave may provide more hours of phone availability but may hospitalize more quickly if the client threatens suicide. Such inconsistencies offer the client an opportunity to learn, with the therapist's coaching, how to cope with the inconsistencies and changes occurring outside of therapy.

### METHODS AND TECHNIQUES

DBT is a technically integrative therapy that embraces many different techniques adapted



from a variety of sources. Each technique, however, must fit within the therapy's theoretical framework. The primary techniques or strategies are organized into sets of pairs, with one member of the pair most strongly emphasizing change and the other most strongly emphasizing acceptance. A dialectical set of strategies facilitates the synthesizing of the other strategies. The relationship between the strategies resembles a figure skating pair in a rink. The members of the pair have different steps, but the steps must flow together and balance each other, with one member's moves enhancing, not competing with, the moves of the other. Attaining balance is difficult, of course, particularly as the balance point continuously changes across clients and across time for a single client. That the session is no longer progressing is the primary indicator that one or more of the pairs of strategies have become imbalanced. The most frequently used strategies, which consist of problem solving, validation, stylistic and dialectical strategies, are described below.

### Problem-Solving Strategies

DBT views the problem-solving strategies as the central strategies for changing dysfunctional behaviors. Within DBT, problem solving targets a specific problematic behavior, applies behavioral principles to understand that behavior and focuses on current variables that maintain the behavior. Furthermore, problem solving applies empirically supported interventions to treat the problematic behavior, integrates multiple CBT procedures, and emphasizes behavioral rehearsal. Problem solving can be divided into two interconnected components: (1) a behavioral analysis, which assesses the presenting problem(s), and (2) a solution analysis, which generates and implements more effective solutions in response to the problem(s).

#### *Behavioral Analysis*

As described above in the section on case formulation, DBT emphasizes the development of a behavioral formulation within each session. To achieve this formulation, the therapist

conducts a behavioral analysis, which involves defining a behavior to target, conducting a chain analysis of that behavior, and identifying the function and other variables that control that behavior. Using the target hierarchy, the therapist and client choose a specific incident of a defined behavior for a chain analysis. When conducting a behavioral chain analysis, the therapist addresses in detail all the links in the chain from the environmental event that prompted the behavior through to the consequences that followed the behavior. Links of interest include the client's cognitions, emotions, sensations, urges, and overt behaviors. Because of the bio-social theory, emotional links are of particular note. With respect to assessing the consequences of the behavior, the therapist is interested in both the short- and long-term psychological and environmental consequences.

The following is an example of a brief chain analysis of an overdose. A client asked her husband to spend more time with her. His refusal precipitated an argument followed by his departure. The client's anger began to decrease and be replaced by a sense of loneliness. This sense elicited thoughts that the husband would never return and that she would not be able to cope by herself. These thoughts then prompted fear, which escalated over time as the client continued to ruminate. The escalating fear led to thoughts that she might go crazy, which led the client to having suicidal thoughts and urges and eventually to overdosing on prescribed medication. Later, her husband found her unconscious and rushed her to the hospital. During her stay in the hospital, the nursing staff was very validating, while her husband visited her often and apologized profusely for having left during their argument. The client enjoyed her husband's visits and hoped that things would change when she returned home.

In the chain analysis, the therapist will attempt to identify variables that control the behavior. Behaviorists particularly focus on factors maintaining the behavior in the current context as opposed to factors that initially developed the behaviors. DBT therapists also attend particularly to the impact of affect, such as the anger, fear, and joy in the example

above. Most importantly, chain analyses help the therapist and client to gain insight into the function of the target behavior. The client above overdosed with the intent of escaping from extreme fear and the behavior functioned in this way. She did not expect the nurses to validate her, nor her husband to visit and apologize; she had expected to die, after all. This couple, however, had a pattern of fighting, overdosing and repairing, such that overdosing increased the time spent with her husband more effectively. Over time, the husband's attentive response to the suicidal behavior had become a secondary function. Once the function(s) is identified, along with other controlling variables in the chain, then the therapist and client can generate alternative solutions that will help the client to more effectively achieve their goals. The behavioral analysis should not stand alone but always be followed by a solution analysis.

### *Solution Analysis*

A solution analysis involves generating, evaluating, and implementing more effective responses to problems. The first step, generating solutions, requires the therapist and client to identify as many potential responses as possible. Borderline clients frequently have a tendency to generate solutions that require someone else (e.g., therapists, social services, family) to solve the problem for them (Linehan, 1993a). For example, one client's only proposed solution to his drinking problem was to ask his psychiatrist for mediation, and another's only suggested solution to forgetting therapy appointments was to ask staff to remind him. To solve this problem, solution generation should particularly search for options that require the client's involvement.

DBT also searches for the opportunity to integrate a variety of CBT interventions. These interventions include skills training, exposure, contingency management, and cognitive restructuring. If the client does not have the requisite skills to solve the problem, the therapist would teach the necessary skills. Alternatively, if skillful behavior in the client's repertoire is inhibited by unwarranted emotions, then the

therapist would apply exposure procedures. If the skillful behavior has been either punished or not reinforced in the client's environment or problematic behavior has been reinforced, the therapist would apply contingency management procedures. Finally, if maladaptive cognitions interfere with skillful behavior, then the therapist would use cognitive modification procedures. A single behavioral analysis usually offers an opportunity to use several CBT interventions.

Solution generation itself presents a problem for many borderline clients. As a result of growing up in an invalidating environment, some clients never received adequate modeling of how to generate solutions. Other clients have acquired the basics of solution generation, but the behavior remains weak or inhibited because in the past their solutions have failed or have been punished by others. For example, when one client suggested higher education as a way to improve her quality of life, her uneducated parents responded by asking "Who do you think you are? Do you think that you are better than us?" To shape solution generation, the DBT therapist reinforces any reasonable attempt by the client to generate solutions and encourages the client to generate as many solutions as possible before trying to evaluate potential solutions.

The behavioral analysis offers an opportunity to demonstrate how a therapist and client may generate multiple solutions for a single episode of behavior. Interpersonal effectiveness skills may increase the likelihood that the client's husband agrees to spend more time with her when she initially asks. To manage that anger if the husband refuses, the client might use emotion regulation skills and, to decrease cognitions that perpetuate the anger, mindfulness skills. The therapist may also use cognitive restructuring to change problematic cognitions. Distress tolerance skills may decrease the sense of loneliness, while mindfulness and/or cognitive restructuring may decrease the subsequent worry thoughts. With respect to addressing the fear, which provided the primary motivation for the overdose, the therapist might suggest a combination of additional emotion regulation skills and exposure. If these strate-

gies fail and the client has urges to overdose, having aversive contingencies in place may help to prevent the client from acting. For example, in standard DBT, clients lose their telephone privileges for 24 hours following an episode of self-harm. Finally, in case the client does overdose, the therapist and client might want to change the current contingencies, particularly the husband's response to the overdose. Through consultation with the husband, they may try to change the husband's behavior such that he becomes more attentive when she engages in skillful behavior and less attentive when she engages in suicidal behavior.

After generating solutions, the therapist and client must evaluate the potential efficacy of the various solutions. The solution evaluation should attend to long-term as well as short-term solutions. For example, many clients report that they parasuicide because it so immediately reduces their negative affect. In the long term, however, parasuicide creates more problems that lead to more negative affect. The evaluation should also identify potential obstacle to implementing solutions. Like suicidal clients (Williams & Pollock, 2000), borderline clients seem to emphasize the potential negative outcomes of potential solutions. Though this emphasis may result from an information processing bias, the client's worries may also result from an actual lack of skills related to the solution, the anticipation or experience of extreme affect, or the fact that the client's natural environment will punish or at least not reward adaptive solutions. CBT interventions can again be used to resolve these obstacles.

Finally, the client and therapist select a set of solutions and then implement those solutions. If the solutions include new or difficult skills, the client rehearses those skills during the session. This rehearsal strengthens the skills, challenges the client's expectations of failure, and allows the therapist and client to identify and solve problems that might interfere with the successful implementation of the skills outside of therapy.

If the solutions include any of the other CBT interventions, the therapist conducts the appropriate procedures during the session. DBT generally interweaves these procedures infor-

mally into the treatment rather than following the more structured formats of traditional cognitive and behavioral therapies. For example, if a client avoids asking the therapist for help because the client fears that the therapist will respond with rejection, exposure would probably serve as the primary intervention. Prior to the exposure, however, some interpersonal skills training might increase the likelihood that the client asks for help in a way that the therapist can reinforce, while a cognitive modification of expectations might increase the client's collaboration with the exposure procedure. Finally, the therapist would reinforce the client's appropriate request for help.

### Validation Strategies

Balancing the focus of problem-solving strategies on change, validation strategies focus on acceptance. Validation occurs when "the therapist communicates to the patient that her responses make sense and are understandable within her current life context or situation" (Linehan, 1993a, pp. 222–223). There are at least six levels of validation: (1) listening and observing, (2) accurately reflecting, (3) articulating the un verbalized, (4) validating in terms of sufficient causes, (5) validating as reasonable in the moment, and (6) treating the person as valid or being radically genuine (Linehan, 1997a).

Levels 5 and 6 are most definitional of validation in DBT. Level 5 validation requires the therapist to communicate how a client's response makes sense or is normal in terms of the current context, rather than in terms of the client's psychiatric disorder or learning history. For example, in a response to a new client who indicates some distrust of the therapist, the DBT therapist might say, "It makes sense that you have difficulty trusting me considering that we have just met and you don't know me well." Level 6 requires the therapist to interact with the client simply as a fellow human being, rather than as a fragile or volatile individual who is incapable of learning. For example, a therapist may notice that a female client, who complains that the male clients in her skills training group stare at her, wears very revealing

clothing to group. If the therapist hypothesizes that the clothing contributes to the stares, a radically genuine response would require the therapist to share this hypothesis with the client. The therapist may then validate both the client's "right" to dress as she wants and the normalcy of the male clients' responses to her dress. These last two levels of validation most clearly reflect the Zen emphasis on the current moment, on searching for truth, and on the inherent capability of discovering it.

Though validation is an end in itself, it also facilitates change. The theoretical development of validation was strongly influenced by recent research indicating that the verification of an individual's beliefs about the self tends to enhance the processing of new information (Linehan, 1997b; Swann, Stein-Seroussi & Giesler, 1992). This research indicates that interweaving problem solving with validation might increase the likelihood that the client will process the information provided by the problem solving. For example, a therapist may validate the function of a target behavior ("It makes sense that you want to stop feeling so anxious, and drinking is very effective at immediately numbing your feelings"), challenge the use of the target behavior ("But drinking perpetuates your anxiety in the long run"), and then suggest alternative skills to achieve the same function ("We must find more effective ways to help you decrease your anxiety"). In addition to balancing problem-solving strategies, validation may function directly as a change strategy by providing information about what is valid, modeling how clients can self-validate and reinforcing skillful behavior.

### Stylistic Strategies

Stylistic strategies refer to the manner in which the therapist interacts with the client. These strategies attend to the how, as opposed to the what, of the therapist's communications to the client. The therapist balances the tension between two opposing sets of strategies, reciprocal communication and irreverent communication.

The reciprocal strategies refer to those that communicate the therapist's interest in and at-

tachment to the client and that foster a collaborative relationship. Part of reciprocal communication requires mindfully attending to the client by noticing even subtle responses by the client and by not allowing preconceptions or judgments to interfere with the attention. Zen applies a similar responsive approach to achieving a state of the mind at rest: "Nothing carries over conceptually or emotionally. . . . we do not react out of a self-centered position. We are free to apply our humanity appropriately in the context of the moment according to the needs of people. . . ." (Aitken, 1982, p. 42).

In contrast to the reciprocal strategies, the irreverent strategies include techniques designed to attract the client's attention and temporarily "unbalance" a client engaged in dysfunctional behavior. Procedures include reacting matter-of-factly to a client's extreme communication and directly confronting dysfunctional behavior. Therapists also reframe behaviors and situations in unorthodox ways. For example, if a client commits to decreasing frequent judgmental thinking, the therapist might respond to in-session judgmental statements by lightheartedly saying "Did you notice that you were judging? We know that you already have that skill, so you don't need to practice it any more. Let's practice a skill that you don't have yet. Try just describing what happened." The irreverent strategies integrate techniques from Whitaker's (1975) irreverent style in family therapy and were influenced by Ellis's (1962, 1987) style in his rational emotive therapy. The irreverent strategies also reflect the style of unorthodox responses employed by Zen masters with their students (Braverman, 1989). Such responses function to interrupt habitual thinking patterns that interfere with a student achieving enlightenment.

### Dialectical Strategies

The dialectical strategies permeate the application of all other DBT strategies. Dialectical strategies refer both to a specific set of techniques, which inherently include elements of acceptance and change, and to strategies that facilitate dialectical processes within the session (i.e., the development of syntheses in

place of tensions). With respect to developing syntheses, the therapist and client must attend to the entire context of a problem, frequently asking what has been forgotten or ignored. As discussed above under dialectical assumptions, when tensions arise, the therapist and client search for the validity of various viewpoints and the syntheses between them. The therapist also responds to dialectical tensions by interweaving change strategies with acceptance strategies (e.g., problem solving with validation, irreverence with reciprocal communication). Furthermore, the therapist must balance adherence to the treatment manual with responsiveness to the client, just as dancers must follow both the steps of the dance and the movements of their partners.

Dialectical techniques all share an inherent synthesis of acceptance and change. Though some of the techniques, such as metaphor (Barker, 1985; Rosen, 1982) and “playing devil’s advocate” (Goldfried, Linehan, & Smith, 1978), are traditional psychotherapy interventions, other techniques are adapted from Eastern practices. For example, extending is a translation of a technique used in Aikido, a Japanese martial art (Saposnek, 1980; Windle & Samko, 1992). The therapist produces change by “extending” or taking more seriously than the client a problematic position originally taken by the client. The intent is to unbalance the client so that the therapist can shift the client away from the problematic position without direct confrontation that could produce conflict. The therapist joins with the client, allows the behavior to progress naturally to the point intended by the client, and then extends the behavior beyond the point intended by the client. For example, a client may say, “You are a horrible therapist, I’m going to write a complaint about you,” with little intent of writing a complaint but with the expectation that the therapist will resist the client’s threat and will focus on repairing any damage to the therapy relationship to prevent the client from writing. A therapist using extending, however, would accept the client’s desire to write such a letter and, extending the client’s threat, may offer to spend the session time helping the client to write the letter because it is the therapist’s

job to help the client to be as effective as possible.

## PROCESSES OF CHANGE

As in other aspects of DBT, a dialectical perspective influences the understanding of the processes of change. Indeed, dialectics itself may be viewed as a theory of change. As described earlier, change occurs continuously. Thus, an individual’s behaviors will change, for better or worse and regardless of whether the individual receives treatment or not. The role of treatment is to direct and propel change along the most effective path toward a client’s long-term goals and to facilitate the client’s acceptance of such change.

Dialectics highlights the occurrence of oppositional positions and the creation of syntheses between these positions. Indeed, the creation of such syntheses may be viewed as one mechanism of change. DBT itself was created by integrating behavioral principles of learning with Zen principles of acceptance. Insight and behavioral rehearsal are two specific mechanisms of change that sometimes have been polarized. One or the other may prove sufficient (e.g., interpersonal contingencies often shape behavior out of awareness), but more often, the DBT therapist interweaves them to enhance the impact of each. For example, insight about self-blaming thoughts may increase the client’s motivation to rehearse more effective ways of thinking. Finally, DBT incorporates several theories regarding principles of learning (e.g., classical conditioning, operant conditions), as well as each theory’s corresponding techniques (e.g., exposure, contingency management). Though the theories could compete with each other, in DBT each theory and its techniques solves a particular part of the clinical puzzle. Principles to determine which solution fits where were described in the section on solution analysis.

The emphasis in dialectics on the transactional nature of development underlines the importance of attending to the interdependence of mechanisms of change, as well as to their opposition. The success of problem-

solving strategies, for example, depends partly upon interweaving them with validation strategies. Problem-solving strategies also rely upon, or at least support, each other. For example, a client's tolerance for behavioral and solution analyses depends on one following the other. Either alone is experienced as invalidating or otherwise aversive. Examples of interweaving the solutions themselves was described in the section on solution analysis.

## THERAPY RELATIONSHIP

Adhering to dialectical principles, the DBT therapist attends to the system of the therapy relationship and to the tensions and the consequent therapy-interfering behaviors that can arise. Although all psychotherapies, including behavioral therapies (Meichenbaum & Turk, 1987; Shelton & Levy, 1981) attend to the therapeutic relationship, they vary in terms of how they view the role and nature of the relationship (Linehan, 1988). Dialectical principles specifically direct the therapist's attention toward transactions that occur within the therapeutic context and accept that the therapist is part of and, therefore, influenced by the therapeutic context. The DBT therapist views therapy as a system in which the therapist and client reciprocally influence each other. Thus, the client's experience of and behavioral responses toward the therapist are examined for their validity within the context of the current relationship and not only as transferences from past relationships.

Just as the therapist shapes the client's behavior, so the client shapes the therapist's behavior. For example, one can easily imagine that if a client became verbally aggressive every time the therapist tried to address a presenting problem, the therapist may become less likely to target that problem. In this scenario, the client would have punished the therapist's therapeutic behavior, and the therapist may have reinforced the client's aggressive behavior. It is the borderline client's tendency to shape the therapist's behavior in a detrimental direction that necessitates the integration of therapist supervision/consultation into the treatment as a

whole. In this way, DBT reflects a crucial element of Zen that requires the student to practice overcoming the delusions that interfere with practicing Zen or attaining enlightenment (Aitken, 1982). DBT therapists do not view therapy-interfering behaviors simply as obstacles to be avoided or removed so that therapy can proceed, but instead view them as examples of the very behaviors that occur in clients' lives outside of therapy and as the most immediate opportunities to change problematic patterns.

As within any system, tensions will arise between the therapist and client. Three examples of tensions that occur between the therapist and the client are the client's belief that taking drugs is the solution, and the therapist's belief that taking drugs is the problem; the client's belief that only hospitalization will prevent suicide now, and the therapist's belief that hospitalization may increase the probability of a future suicide; and the client's wish for more contact with the therapist, and the therapist's wish to observe natural limits. To resolve such conflicts, the therapy searches for syntheses. The most effective syntheses are generally those that validate some aspect of both sides of the debate and move toward more effective behavior. For example, in the first example above, if the client considers drugs as a solution because they decrease overwhelming anxiety, the therapy may achieve a synthesis by identifying anxiety reduction as a valid therapy goal. With this as the accepted goal, drug abuse would no longer be a valid solution, as it will tend, directly and indirectly, to increase, not decrease, anxiety in the long term. The therapy would instead focus on the client developing more skillful means to prevent and manage anxiety.

When therapy tensions have not been successfully resolved they often result in therapy-interfering behaviors. For example, if a therapist simply confronted a client about the use of drugs but never offered alternative solutions that could achieve the client's goal of regulating affect, the client may begin to lie to the therapist about drug use. When such behaviors occur, the therapist targets the behavior and applies the problem-solving, dialectical,

and other strategies described in earlier sections.

Though balancing, integrating, or synthesizing may prove the most effective ways forward, how to balance or integrate in any particular situation is not always obvious or easy. Success requires comprehensive and detailed assessments, rapid movement among the strategies, and rigorous application of the therapy as a whole. Such demands can be intellectually and emotionally exhausting for the therapist and client alike. The therapy can stop or even reverse if the therapist then becomes emotionally dysregulated or cognitively distracted by worries of what may happen next, by beliefs that the therapist should be able to find a synthesis more easily, or by judgments that the client should not have placed them in this situation in the first place.

Perhaps the most crucial element in not becoming overwhelmed by the demands of therapy is conducting therapy as mindfully as possible. Mindfulness requires the therapist to nonjudgmentally focus on the moment and what is effective, to be aware of unmindful thoughts and urges, and to refocus on solving the problem at hand. Also drawing from Zen practice, the therapist strives toward balancing compassion and detachment. Of course, therapists also use for themselves any or all of the skills and interventions that they teach their clients.

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### CASE EXAMPLE

"C" is a woman in her late twenties who met criteria for BPD. She had completed college and at the beginning of therapy was a married homemaker with no children. She was referred for treatment following a suicide attempt by overdose. C reported a history of overdosing with varying degrees of suicidal intent during the previous 3 years. On average, she overdosed every other month, but only half of these required medical treatment. Early in her history of overdosing, most episodes requiring medical treatment also led to brief psychiatric inpatient stays, but during the year prior to entering DBT, the client had only

been hospitalized twice. C reported no other types of parasuicidal behavior but did meet criteria for recurrent major depressive disorder, panic disorder, and subclinical bulimia. C described a history of supportive therapy as helping "me to feel better but nothing really changed." She stated that she had not had any problems with the therapy, but her past therapist had described her as "dependent" and "occasionally manipulative" within the therapy context.

C identified several goals for therapy, including no longer being suicidal, having a "better relationship" with her husband, and "feeling better" about herself. She initially contracted for 1 year of treatment. The DBT therapist and client developed the following target hierarchy: (1) decreasing suicidal overdoses and urges to overdose; (2) decreasing therapy-interfering behaviors; (3) decreasing bingeing and purging, panic attacks, and depression; and (4) increasing skills, including mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness skills. The therapy-interfering behaviors emerged over time and included frequently phoning the therapist prior to the therapist's out of town trips, missing the session following the therapist's trips, sobbing when the therapist challenged passive problem solving, and impulsively responding with "That won't work" to suggested solutions.

Several factors may have initially transacted to shape C's problematic behavior. She was an only child, whom her mother described as "colicky" and difficult to soothe as an infant. Her mother had recurrent episodes of major depression throughout the client's childhood. C described her relationship between her mother and father as "conflicted." Her father left the family when C was 8 years old, though he maintained regular but infrequent contact with her. Her mother accused the father of being an alcoholic, but C believed him only to be heavily drinking. She also described occasional outbursts of anger. After father departed, mother became more depressed and irritable and less tolerant of any emotions expressed by C, though she never abused or neglected C.

Though it would prove difficult to differentiate the relative impact of nature versus nurture, some of the sequelae of their transactions are clearer. The client presented as emotionally vulnerable,

with a particularly high reactivity to emotional stimuli. Her mother failed to model coping with emotions and tended to either ignore or otherwise punish C's emotional communications unless they became extreme (e.g., sobbing). C believed that her father used alcohol to manage his emotions but also remembers that he did try "to reassure" her when she worried. When possible, he would also solve problems for her (e.g., financial). C learned to inhibit her emotions as much as possible, to become extreme when she failed to manage them, and to depend on others to solve problems. Also, she did not learn either to tolerate or to resolve interpersonal conflict. These patterns were maintained in her relationship with her husband.

The client received all of the traditional DBT modalities during the first year of treatment. She attended individual psychotherapy and group skills-training regularly, missing approximately eight sessions of each modality during the course of the first year. She also regularly used after-hours phone contact for skills coaching. When the therapist became aware of the extent to which the husband's responses influenced C's motivation, the therapist and C arranged several couple sessions with the husband. These sessions focused on changing the husband's responses that reinforced target behaviors, particularly overdoses and panic attacks. These sessions appeared effective, in part, perhaps, because the husband shared his wife's treatment goals and was motivated to help. Her psychiatrist had prescribed a variety of antidepressants and anxiolytics prior to C's entry into DBT. By the end of the treatment year, C had stopped using anxiolytics.

During each individual therapy session, the therapist and client targeted the highest behavior in the hierarchy that had occurred during the past week. If C had not overdosed or had strong urges to overdose during the past week, the therapy usually focused on one of the quality-of-life-interfering behaviors. Therapy-interfering behaviors topped the agenda only in the case of missing a session or phoning beyond the therapist's limits. Other therapy-interfering behaviors, such as sobbing or passive problem solving, usually occurred while targeting suicidal or quality-of-life-interfering behaviors. If these behaviors occurred, the therapist would briefly shift the focus to the in-

session behavior, solve the problem, and return to the original target. For example, when the client sobbed in session, the therapist would usually coach the client on mindfulness and emotion regulation skills until the client had stopped sobbing and would then proceed with engaging the client in actively solving problems related to the original target. This response not only encouraged the client to use skills, but it also functioned as a contingency management intervention in which the therapist did not reinforce the client's avoidance (via sobbing) of active problem solving.

After selecting a target behavior, the therapist and client completed behavioral and solution analyses of the target behavior. An example of a behavioral analysis and the corresponding solution analysis for one of C's overdoses is provided above in the section on problem solving. Most of her overdoses were precipitated by a disagreement with her husband that led to strong emotions, with fear as the predominant emotion. Solution analyses included the full range of skills and other interventions, with mindfulness and emotion regulation seemingly the most crucial skills. Major therapy-interfering behaviors and quality-of-life-interfering behaviors received similar treatment. For example, panic attacks sometimes occurred in the chain leading to overdosing, and if so they received treatment like other links in the chain. In the absence of overdosing or strong urges to overdose, panic attacks often served as the primary target. Analyses of this behavior revealed a similar chain of events. Standard behavioral treatment, interwoven with mindfulness skills, served as the main intervention for the panic attacks themselves, while a range of skills and interventions, similar to those used to treat overdosing, addressed the other links in the chain.

By the end of 1 year of treatment, C had become notably more stable. She had not required hospitalization at any time during the year. During the last 4 months of the year, she only infrequently had a strong urge to overdose and never acted on this urge. C stopped missing sessions in response to the therapist's traveling and very seldom exceeded the therapist's limits on telephone calls. The frequency of panic attacks decreased from weekly to monthly, and their intensity and duration were significantly less. Bingeing and



purging decreased in a similar way. By the end of the year, C reported a notable decrease in depression, as measured by the BDI, though her score remained within the clinical range. C decided to renew her treatment contract for another year, and during this second year the treatment focused on continuing to decrease quality-of-life–interfering behaviors and to increase skillful behavior. By the end of the year, the bingeing, purging, and panic attacks had stopped. C no longer met criteria for major depression but did have occasional periods of “low mood.” The therapy also moved into a more advanced stage of treatment where targets included emotionally processing issues from her childhood, finding and maintaining employment, and improving the way she related to her husband. Therapy ended after 2 years because the therapist relocated.

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## EMPIRICAL RESEARCH

The initial randomized, controlled trial (RCT) of standard DBT compared 1 year of the therapy to treatment-as-usual (TAU) in the community (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Tutek, Heard & Armstong, 1994). The participants were women who met criteria for BPD and had a recent history of parasuicidal behavior. The results suggested that after 1 year, participants receiving DBT had significantly fewer parasuicides, less medically severe parasuicides, higher treatment retention rates (DBT = 83% vs. TAU = 42%), fewer psychiatric inpatient days, lower anger, and higher social and global functioning. The two groups did not differ, however, with respect to depression or suicidal ideation. Additional analyses have suggested that DBT may also be a cost-effective treatment (Heard, 2000). Outcome results were weaker but generally maintained during a 1-year follow-up (Linehan, Heard, & Armstrong, 1993). Linehan and colleagues are currently attempting to replicate the initial trial, though with a more rigorously designed controlled condition.

Four other RCTs examining the efficacy of DBT for BPD have been completed. First, Koons and colleagues (Koons et. al., 2001)

conducted an RCT comparing standard DBT to a predominantly CBT control condition. The participants were female veterans who met criteria for BPD, only 40% of whom had a recent history of parasuicidal behavior. After 6 months of treatment, DBT participants had a significantly greater reduction in suicidal ideation, depression, hopelessness, and anger expression than TAU participants. The two conditions did not differ with respect to treatment retention (DBT = 77% vs. TAU = 82%), parasuicidal acts, anger experienced, and dissociation.

Second, Linehan and colleagues (Linehan, Schmidt, Dimeff, Craft, & Kanter, 1999) conducted an RCT to compare the efficacy of modifications to standard DBT for the treatment of substance abusers. The participants in this trial were women who met criteria for BPD and either substance abuse or substance dependence. After 1 year of treatment, DBT participants had significantly greater reductions in substance abuse compared to TAU participants. The treatment retention rate was 55% for DBT and 19% for TAU. The conditions did not differ with respect to psychiatric inpatient treatment, anger, social functioning or global functioning. During a 4-month follow-up, however, DBT participants had significantly greater gains in global and social adjustment, as well as significantly greater reductions in substance abuse.

Third, Linehan and colleagues (Linehan et al., 2002) completed an RCT that examined the efficacy of DBT for women who met criteria for BPD and opioid dependence. All participants received levomethadyl acetate hydrochloride (LAAM) as replacement medication, while half received DBT and the other half received a control treatment consisting of Comprehensive Validation plus 12-Step program (CVT+12S). The control treatment consisted of individual therapy and Narcotics Anonymous meetings. Individual therapists used all of the DBT acceptance-based strategies (e.g., validation, reciprocal communication, and environmental intervention) as their primary strategies and used problem solving only to reduce imminent suicide risk and to ensure treatment attendance and medication compliance. The

control treatment also encouraged participants to meet weekly with a 12-Step sponsor and to attend as many NA meetings as possible. The results of this trial suggested that both treatments effectively reduced opioid use. Interestingly, the Validation plus 12-Step participants were more likely to remain in therapy (DBT = 64% vs. CVT + 12S = 100%), but the DBT participants were more likely to maintain treatment gains.

Finally, van den Bosch and colleagues (Verheul, van den Bosch, Koeter, de Ridder, Stijnen, & van den Brink, 2003) examined the efficacy of 12 months of DBT versus treatment as usual for borderline women referred through either addiction or psychiatric services. At the end of this trial, DBT participants had significantly higher treatment retention rates (DBT = 63% vs. TAU = 23%) and greater reductions in self-mutilating and self-damaging impulsive behaviors (e.g., substance misuse, binge eating, gambling) when compared to TAU participants. Additional analyses suggested that DBT had the greatest impact on self-mutilating behavior among those patients who had reported higher baseline frequencies for the behavior.

## FUTURE DIRECTIONS

Future directions for DBT may be roughly divided into three pathways: development of the treatment, dissemination to clinicians, and delivery in clinical settings. With respect to treatment development, research will need to occur in several areas, including continued evaluation of the treatment's efficacy, examination of the mechanisms of change, and determination of predictors of outcome. Efficacy research should include RCTs evaluating the efficacy of DBT for BPD in inpatient and forensic settings. Pilot studies have provided promising results, but without randomized controls those results remain open to numerous interpretations. It may also prove useful to examine the efficacy of DBT in treating some of the comorbid disorders (e.g., eating disorders, dissociation) with which BPD clients present.

Though no studies have examined the mechanisms of change in DBT, the results from

some outcomes studies suggest possible avenues for future exploration. For example, the positive outcome for the CVT+12S condition in the RCT for BPD heroin addicts (Linehan et al., 2002) suggests that validation may be an important mechanism of change, either directly or indirectly by increasing the likelihood that the client remains in treatment long enough for other mechanisms to have an effect. Similarly, an early RCT (Linehan, Heard, & Armstrong, 1995) revealed that simply adding DBT skills training to standard community psychotherapy produced no more improvement than standard community psychotherapy alone. Though this indicates that therapists should not abstract DBT skills training from the rest of the treatment, it also highlights the need for research regarding the relative importance of skills training within DBT as a whole.

Although DBT has become widely disseminated, little research has been conducted to examine the efficacy of the dissemination. One study (Hawkins & Sinha, 1998) examined the impact of introductory and advanced education in DBT on clinician's DBT conceptual knowledge. The study reported that performance on an examination of DBT knowledge correlated specifically with DBT training. The study also reported that background education generally did not predict performance, except that psychologists scored significantly higher than other professions. More research is needed to determine which types of training (e.g., workshops, consultation, supervision) produce the most adherent therapists and which therapists will most likely benefit from the training.

Finally, the delivery of DBT in clinical settings offers many research opportunities to consider the effectiveness of the treatment. Related to the issue of dissemination, effectiveness researchers must ask whether therapist or program adherence predicts outcome. The completed RCTs have adherence data, but it is correlational rather than experimental and does not provide a clear picture. Effectiveness researchers must also consider the cost implications of DBT. The first RCT provided favorable cost-effectiveness data (Heard, 2000), but subsequent studies have not analyzed this type of effectiveness. More problematic, none of the

RCTs have included male participants. Because men who meet criteria for BPD do present in clinical settings, they should be included in effectiveness studies. Finally, research should attend to the impact of the treatment on therapists as well as on the clients. In the long run, a therapy will succeed only if therapists are motivated to apply it.

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## Integrative Psychotherapy with Culturally Diverse Clients

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The purpose of this chapter is to describe an integrative approach to psychotherapy with culturally diverse clients. Although the psychotherapy integration movement and the multicultural counseling movement have developed along parallel paths during the past few decades, there has been relatively little dialogue between the two groups. One of the few descriptions of integrative multicultural psychotherapy was written by Franklin, Carter, and Grace (1993), who proposed an integrative multisystem/racial identity perspective for working with Black/African Americans. This multisystems approach took into account the role of intrapsychic dynamics, family systems, socio-cultural influences, economic resources, and community. These authors concluded that both a client and therapist's racial identity development has a crucial impact on their therapeutic interaction. The current chapter will embrace these themes of culture, identity, and integration by exploring two interrelated lines of thought related to psychotherapy with cul-

turally diverse clients: multicultural therapy and multicultural development.

### INTEGRATIVE APPROACH

#### Multicultural Therapy

Multicultural Counseling and Therapy (MCT) is a theory about working with culturally diverse clients and understanding the role of culture in human development and behavior. In the 1970s, many writers in the mental health field concluded that, "counseling has failed to serve the needs of minorities, and in some cases, proven counterproductive to their well-being" (Atkinson, Morten, & Sue, 1979, p. 11). This conclusion was based on the observation that "minorities are diagnosed differently and receive 'less preferred' treatment than do majority clients" (Atkinson, Morten, & Sue, 1979, p. 11). In 1982, Sue and colleagues proposed the first set of multicultural counseling compe-

tencies that described specific beliefs, skills, and knowledge that culturally competent therapists should possess. In 1991, Pederson hailed multiculturalism as a fourth force in psychotherapy, complementing the three traditional forces of psychodynamic, behavioral, and humanistic psychotherapy. In 1995, the *Handbook of Multicultural Counseling* (Ponterotto, Casas, Suzuki, & Alexander, 1995, 2000) summarized the progress of the field. In 1996, MCT was described as a formal theory with six propositions, each with numerous corollaries (Sue, Ivey, & Pederson, 1996).

Our description of MCT in this chapter will be organized around the six propositions described by Sue et al. (1996). The first proposition of multicultural theory describes MCT as a metatheory:

MCT theory is a metatheory of counseling and psychotherapy. A theory about theories, it offers an organizational framework for understanding the numerous helping approaches that humankind has developed. It recognizes that theories of counseling and psychotherapy developed in the Western world and those helping models indigenous to non-Western cultures are neither inherently right or wrong, good or bad. Each theory represents a different worldview. (Sue et al., 1996, p. 13)

When MCT is used as a metatheory, each theoretical orientation can be seen as embedded in a distinct cultural context. Because of the cultural values that are reflected in each theory, approaches that were developed within one cultural context may not readily translate to another. Using MCT as a metatheory helps psychotherapists recognize the cultural values that are inherent to different theories and to make conscious choices about intervention strategies that match the cultural values of individual clients.

Integrative psychotherapy with culturally diverse clients synthesizes important concepts from psychotherapy integration with key propositions from multicultural theory. This includes efforts to address the role of culture within integrative models of psychotherapy and to integrate MCT with other approaches to psychotherapy. Many of the ideas about how

to integrate multicultural ideas and strategies with other theoretical approaches are drawn from a new model of psychotherapy integration called, *Multitheoretical Psychotherapy* (MTP; Brooks-Harris, in press). MTP identifies cultural contexts as one of seven elements in a multidimensional model of human functioning that can be used to establish an interactive focus in psychotherapy.

## Multicultural Development

Developmental Counseling and Therapy (DCT; Ivey, 1986/2000, 1991/1993; Ivey, Ivey, Myers, & Sweeney, 2004) is an integrative method for understanding and facilitating the process of cultural identity development. DCT is an integrative approach to psychotherapy organized around Piaget's stages of development: "Developmental therapy focuses on both the process and outcome of development and suggests specific therapeutic techniques that may be employed to facilitate growth and change" (Ivey, 1986/2000, p. 11). DCT was one of the first integrative models to address culture as a central concern of psychotherapy: "One of the important tasks we as helpers face is sorting out what are the individual and what are the cultural artifacts of the developmental process" (Ivey, 1991/1993, p. 200). In this chapter, DCT will be described as a method for facilitating cultural identity development, which is a crucial aspect of integrative psychotherapy for culturally diverse clients. Therefore, DCT provides a complementary and very practical approach that is useful in implementing many aspects of MCT.

## ASSESSMENT

Multicultural theory insists that assessment in psychotherapy must take into account the cultural experiences and contexts that shape clients' identities. From the perspective of multicultural integration, a psychotherapist should assess the way that cultural contexts interact with other dimensions of functioning.

Individuals develop within a cultural context. Consciousness of self in social context is

central and essential. The individualistic word *self* is replaced by *self-in-context*, *self-in-relation*, *person-in-community* (Ogbonnya, 1994), and *being-in-relation* (Jordan, Kaplan, Baker-Miller, Stiver, & Surrey, 1991). MCT points out that internal emotional distress is often related to external stressors. So-called disorder is often a reaction to disordered social conditions such as racism and oppression (Ivey & Ivey, 1998). Until psychotherapy recognizes the centrality of contextual issues and reconstructs the idea of the self, it will be difficult to work with the underlying oppression faced by many of our clients. MCT's proposition in this area states:

Both counselor and client identities are formed and embedded in multiple levels of experiences (individual, group, and universal) and contexts (individual, family, and cultural milieu). The totality and interrelationships of experiences and contexts must be the focus of treatment. (Sue et al., 1996, p. 15).

This important proposition of MCT reminds us that we need to see the individual in social context. Another way to think about this issue is whether or not the problem is *in the person* or *in the social context*. MCT argues that we cannot understand the person without an appropriate balance of person and environmental issues. Therefore, assessment with culturally diverse clients must focus on the external environment as well as the individual's experience of the environment.

From the perspective of multicultural theory, one of the most important contextual issues is oppression. Locke (1992) pointed out the centrality of racism and prejudice in counseling and defined racism as the combination of prejudiced beliefs with the power to enact those beliefs. Therefore, multicultural assessment should include looking at clients' experiences with prejudice and racism. For example, what may appear as dysfunctional behavior in the dominant culture may best be understood as a reaction to prejudice or racism.

Multicultural assessment can be used to understand clients' worldview or to ensure that traditional assessment instruments are appropriate. In order to understand a client's world-

view, cultural variables that should be assessed (for both clients and their families) are psychological mindedness, attitudes toward helping, and level of acculturation, as well as the family's attitude toward acculturation (Grieger & Ponterotto, 1995). Multicultural assessment should include measurement of group identity variables, like cultural orientation, in order to decide whether culture-specific assessment technologies are appropriate for a particular client (Dana, 1993). By assessing these cultural variables, integrative psychotherapy can be adapted to the cultural needs and expectations of diverse clients and psychotherapists can assure that assessment has been sensitive to the cultural background of individuals.

Multicultural therapy involves locating culture within a multidimensional model. The MCT proposition that therapist and client identities are formed and embedded in multiple levels of experience can be compared to the recognition of multidimensionality found in some models of psychotherapy integration. For example, Lazarus's (1997, this volume) Multimodal Therapy describes seven modalities of functioning: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and biological processes. Similarly, Prochaska & DiClemente's (1992, this volume) Transtheoretical Approach describes five levels of change: symptom/situation problems, maladaptive cognitions, current interpersonal conflicts, family systems conflicts, and intrapersonal conflicts. Although these models of integration are organized around important dimensions of human functioning, neither recognize the role of culture. In order to integrate MCT with other forms of psychotherapy, culture needs to be recognized as a crucial dimension that shapes human functioning and can be the focus of psychotherapeutic interventions.

Figure 15.1 depicts a multidimensional model of human functioning drawn from *Multitheoretical Psychotherapy* (Brooks-Harris, in press). Acknowledging the relationship between cultural contexts and other dimensions of human functioning creates a way for integrative therapists to assess the impact of culture on clients. Once cultural variables such as worldview and acculturation have been assessed, multicultural



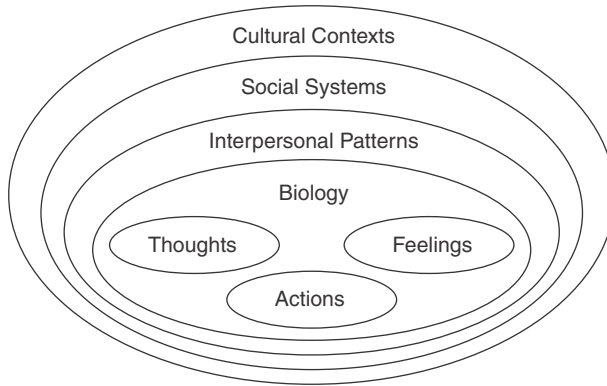


FIGURE 15.1 Multidimensional Model of Human Functioning

integration involves assessing the way that culture impacts psychological dimensions such as thoughts, actions, feelings and the way culture interacts with other contextual dimensions such as biology, interpersonal patterns, and social systems.

The therapist must remember that identity is shaped by contextual dimensions such as family, community, and society (Franklin, Carter & Grace, 1993; Ivey, Ivey, Myers, & Sweeney, 2005). Multicultural therapy involves assessing the impact of culture on all other dimensions of human functioning. A multidimensional, multitheoretical perspective acknowledges the impact of microsystems, like interpersonal patterns and social systems, and the cultural macrosystem on the current experience of humans (Bronfenbrenner, 1979).

## FORMULATION

An essential part of multicultural formulation is to understand the development of cultural identity. The third proposition of multicultural theory highlights the importance of identity development:

Cultural identity development is a major determinant of counselor and client attitudes toward the self, others of the same group, and the dominant group. These attitudes which may be manifested in affective and behavioral dimensions, are strongly influenced not only by cultural variables,

but also by the dynamics of dominant-subordinate relationships among culturally different groups. The level or stage of racial/cultural identity development will both influence how clients and counselors define the problem and dictate what they believe to be appropriate counseling/therapy goals and processes. (Sue et al., 1996, p. 17)

The developmental framework for multicultural theory rests in cultural identity theory (Cross, 1971, 1991, 1995; Thomas, 1971). Cross and Thomas independently generated cultural identity theory as they observed cognitive/emotional development among African Americans who experienced the Black identity movement of the 1960s. They both recognized a Black consciousness or racial identity starting in a naïve embedded awareness that was then shaken by the discrepancies encountered in a racist society.

The most influential model has been that of Cross, who describes the following states and/or stages.

- *Preencounter*. The individual may be locked into a White perspective and devalues and/or denies the vitality and importance of an African American worldview. The goal of some African Americans who take this perspective may be to be as “White” as possible.
- *Encounter*. The African American meets the realities of racism in an often emotionally jarring experience. This perturbs

one's former consciousness and often leads to significant change.

- *Immersion-emersion.* The discovery of what it means to be African American and valuing blackness become important, while often simultaneously denigrating Whites. Emotions can run strong with pride in one's culture and anger at others. This is often a stage of action for African-American rights.
- *Internalization.* A more internalized reflective sense of self-confidence develops and emotional experience is more calm and secure. This is often featured by "psychological openness, ideological flexibility, and a general decline in strong anti-White feelings" (Parham, White, & Ajamu, 1999, p. 49). However, the strength of commitment to the African-American world may even be stronger. Later, Cross (1995) suggested a fifth stage, very similar to internalization with the addition of a commitment to action and social change.

A large number of researchers have validated the sequential stages of cultural identity development in many cultural settings and extended it to other groups. Important among these have been Atkinson, Morten, and Sue's (1993) general theory of cultural identity development; Hardiman's (1982) description of White identity development; and Helms's (1990, 1995) model of African-American and White identity development. Although the language varies, the general sequence of development identified by Cross remains consistent in these emerging models.

Initially, cultural identity theory focused its central effort on expanding awareness of one's racial/ethnic identity. Increasingly, we are finding identity theories focused on other multicultural issues. Cass (1979, 1984, 1990), Marszalek (1998), and Marszalek and Cashwell (1998) have developed theories of gay and lesbian identity development. Ivey, D'Andrea, Ivey, and Simek-Morgan (2002) suggested that many groups (e.g. women, cancer survivors, the people with disabilities, and Vietnam veterans) go through parallel issues of identity as they discover the power of context in their individual

lives. Therefore, a multicultural formulation based on a description of a client's stage of identity development can be an important foundation for integrative psychotherapy with culturally diverse clients.

Because development of identity and awareness is such an important part of a multicultural formulation, it is helpful to include a developmental formulation to complement the multicultural formulation. Developmental Counseling and Therapy's cognitive/emotional development rests in a postmodern interpretation of the Swiss developmental epistemologist, Jean Piaget (see especially Piaget, 1926/1963). DCT emphasizes that development occurs over the life span, that Piagetian constructs reappear in adolescent and adult learning but always in social context. Whereas cultural identity theories tend to focus on specific groups, DCT takes a narrative approach to the evolution of consciousness. Individuals (and families and groups) have life stories that they tell about themselves, guiding the way they think and behave.

DCT theory asserts that clients come to psychotherapy with varying levels of consciousness or meaning-making systems used to understand their world. These consciousness orientations lead to different styles of thinking and behaving. No one type of consciousness is best, although more states and stages permit more possibilities for thought and action. Meaning-making can be equated with the development of consciousness. DCT describes four epistemological styles or stages of consciousness that have interesting parallels to cultural identity theory.

- *Sensorimotor consciousness.* The client is often embedded in direct experience. What is seen, heard, and felt is central. External reality can direct inner experience with little or no reflective consciousness. Cognition and emotion are often not separated. The person may not be fully able to separate self from situation.
- *Concrete/situational consciousness.* People again are focused on external reality but can talk about their issues with a "subject-object" orientation. Expect concrete, detailed stories of issues. Emotions are

now separated from cognition, but reflection is not prominent.

- *Formal/reflective consciousness.* The client is able to reflect on experience, cognitions, and emotions. Much traditional psychotherapy theory rests here (e.g., “reflection of feelings”). Individuals are able to notice and think about patterns. Action on the world, often associated with the concrete and dialectic styles, tends to be overlooked. Reflective people are often as sure of what they think and feel as those who are concrete—while both may fail to think about the assumptions on which their thoughts and actions are based.
- *Dialectic/systemic.* Two major concepts illustrate this style of meaning-making: multiperspective thought and awareness of self-in-context. People who think from this perspective are able to view information and emotions from several points of view and to examine and challenge their own assumptions. Though it is possible to become enmeshed in complex thought, action on oneself and systems is often important.

A formulation based on multicultural development involves assessing and understanding cognitive/emotional ways clients make sense of what is happening. Once a client’s preferred level of meaning making has been identified, the psychotherapist “joins clients where they are” in their cognitive/emotional understanding and assists expansion of development both vertically and horizontally. These levels of identity development and cognitive/emotional consciousness will be revisited later as a way to guide the choice of methods and techniques.

## APPLICABILITY AND STRUCTURE

Early descriptions of multicultural therapy focused on improving mental health service for ethnic minorities (e.g., Atkinson et al., 1979). This emphasis shifted when Pederson (1991) proposed a broad definition of culture that included demographic variables, affiliations, and ethnographic variables. Using this broad defi-

nition of culture helped the field recognize that multiculturalism is applicable to all clients and that psychotherapy should always address the role of culture. Although MCT suggests ideas that are applicable to all psychotherapy relationship, it does not suggest a prescribed structure. Therefore, integrative psychotherapy with culturally diverse clients can take many forms. Most multicultural therapists have concluded that multiculturalism should complement rather than compete with traditional theories (Corey, 1996; Pederson, 1991). In describing integrative psychotherapy with African Americans, Franklin, Carter, and Grace (1993) concluded that psychotherapists should integrate various theoretical models when treating Black clients. Therefore, the only prescription is an ongoing attempt to see how culture impacts clients’ thoughts, actions, and feelings, as well as shapes interpersonal and systemic relationships.

In this respect, assimilative integration provides a useful way to think about integrative psychotherapy with culturally diverse clients. Messer (1992, p. 151) described assimilative integration as an approach that favors a firm grounding in one system of psychotherapy, but with a willingness to incorporate ideas or strategies from other approaches. When assimilative integration is practiced, techniques from diverse sources are adapted within the psychotherapist’s primary theoretical framework. For example, Messer (1992) described the way that a Gestalt empty-chair technique could be adapted to behavioral therapy by focusing on external behavior rather than internal experience. Other chapters in this *Handbook* describe assimilative psychotherapy based on psychodynamic (Stricker & Gold, this volume) and cognitive-behavioral theories (Castonguay, this volume). The recognition that culture is relevant to all psychotherapy relationships suggests that MCT may be used as a foundational theory for assimilative integration.

Using MCT as a foundation for assimilative integration involves recognizing the primacy of culture. “MCT theory combines elements of psychodynamic, behavioral, humanistic, biogenic, and other perspectives to the extent that the person’s culturally learned assumptions shape

the unconscious in the psychodynamic view, act as reinforcing contingencies in the behavioral view, and define the meaning of person-centeredness in the humanistic view” (Sue et al., 1996, p. 14). Culture shapes elements of human experience that are the focus of traditional psychotherapy approaches. Therefore, using MCT as a foundation for assimilative integration involves recognizing the way that culture shapes thoughts, actions, feelings, unconscious conflicts, interpersonal patterns, and family systems.

## PROCESSES OF CHANGE

### Liberation of Consciousness

Multicultural theorists have identified a variety of change processes that are frequently activated in psychotherapy with culturally diverse clients. One of the most prominent descriptions is that of *liberation of consciousness*, which speaks to helping clients understand how oppression operates in their lives. MCT theory describes this process of change in the following way:

The liberation of consciousness is a basic goal of MCT theory. Whereas self-actualization, discovery of the role of the past in the present, or behavior change have been traditional goals of Western psychotherapy and counseling, MCT emphasizes the importance of expanding personal, family, group, and organizational consciousness of the place of self-in-relation, family-in-relation, and organization-in-relation. This results in therapy that is not only ultimately contextual in orientation, but that also draws on traditional methods of healing from many cultures. (Sue et al., 1996, p. 22)

Paulo Freire’s (1972) liberation psychology has been particularly influential by emphasizing the need to actively intervene in order to transform the world. Psychotherapy focused on liberation may use a variety of methods to help bring individual and group awareness of the social context. Freire is particularly inspirational with his focus on situational and concrete change. Awareness and consciousness require

action leading toward change. The psychotherapy field, individualistic in tradition, faces a major challenge in the area of social action. Is psychotherapy interested in transforming the world? Specific methods for applying Freire’s ideas in psychotherapy have been suggested by Developmental Counseling and Therapy (Ivey, 1995; Ivey, Ivey, Myers, & Sweeney, 2004). DCT argues that any integrative model of therapy that does not inform clients of how external stressors affect client issues actually is not therapeutic in the long run. Traditional approaches, whether theory-specific or integrative, that do not include multicultural issues are very much “part of the problem” as they work within the cultural status quo.

### Common Factors

Multicultural therapy recognizes *common factors* as central change processes as well. “The common factors approach seeks to determine the core ingredients that different therapies share in common” (Norcross & Newman, 1992, p. 13). For example, Garfield (1992, 1995) described therapeutic variables that are used across theoretical approaches including the therapist-client relationship, cognitive modifications, and reinforcement. Recognizing common factors starts by recognizing liberation of consciousness as a multicultural adaptation of consciousness raising, a common factor described in many models.

Two earlier attempts at identifying common factors used in MCT represent examples of this type of multicultural integration. First, Prochaska, Norcross, and Sweeney (1999) identified a sequence of three therapeutic processes that are frequently used in MCT: consciousness raising, catharsis, and choosing. This transtheoretical analysis suggested that MCT frequently begins with consciousness raising that helps clients “understand how the dominant culture has shaped their views about themselves and their culture” (Prochaska et al., 1999, p. 422). Then, catharsis is supported in which “suppressed anger over discrimination and cultural alienation often comes to the surface” (Prochaska et al., 1999, p. 423). Finally, MCT involves choosing “how to express and

channel their new-found energy” (Prochaska et al., 1999, p. 424).

Another example of describing common factors in MCT was proposed by Fischer, Jome, and Atkinson (1998) who described four common factors frequently used in MCT that correspond to Frank’s classic model (1961; Frank & Frank, 1991). The therapeutic relationship, a shared worldview, client expectations, and a ritual of intervention were identified as common factors that could be used to organize MCT. These authors suggested that common factors could be used to integrate the universal aspects of healing with the unique cultural affiliations of individual clients. In this way, common factors would be adapted to a client’s cultural context based on cultural knowledge.

## THERAPY RELATIONSHIP

Integrative psychotherapy with culturally diverse clients should involve the development of a therapeutic relationship that is consistent with cultural expectations of clients. Multicultural psychotherapy should not be limited to traditional, Western models of helping. MCT theory describes the therapy relationship in the following manner:

MCT theory stresses the importance of multiple helping roles developed by many culturally different groups and societies. Besides the basic one-on-one encounter aimed at remediation in the individual, these roles often involve larger social units, systems intervention, and prevention. That is, the conventional roles of counseling and psychotherapy are only one of many others available to the helping professional. (Sue et al., 1996, p. 21)

MCT begins and ends with a worldview that is contextual, one that demands more than individual, family, or group therapy alone. The psychotherapist needs to work with all three dimensions, developing a network of change agents that together reverberate throughout the total system (Attneave, 1969, 1982).

MCT stresses the vitality of alternative approaches to therapy, particularly those drawn from other cultural frameworks (Nwachuku & Ivey, 1991). The women’s movement, the gay/lesbian/bisexual/transgendered movement, and the ethnic/racial identity movements have all brought us to awareness of the importance of social context in practice. Sad to say, traditional theory and practice still have a considerable distance to go to provide culturally sensitive and aware helping. Community counseling, intervention in systems, encouraging changes in the workplace—these are all examples of an effective contextual approach. Consultation, prevention, and training others become central roles of the effective, multiculturally aware professional. Alternative helping roles have been identified including adviser, advocate, consultant, change agent, and facilitator of indigenous support and healing systems (Sue et al., 1998).

Specifically, multicultural therapy embraces *relational adaptation*: adapting the therapeutic relationship to the individual needs and preferences of the client (Norcross, 1993, 2002; Lazarus, 1993). Relational adaptation allows psychotherapists to create different types of relationships and use different parts of their personality with different clients. The multicultural literature has consistently suggested that the therapy relationship should be adapted based on clients’ cultural expectations. Different cultural groups may be more receptive to certain counseling styles because of their cultural values about interpersonal communication (Sue et al., 1981).

For example, Santiago-Rivera, Arredondo, and Gallardo-Cooper (2002) suggested that psychotherapists working with Latino clients should be sensitive to Latino values about interpersonal communication that include an orientation to the person, respect, dignity, an easy-going and friendly relationship, trust and familiarity, as well as a demonstration of endearment. They make recommendations about adapting the relationship to Latino values by beginning in a formal style and using titles, allowing proximity in seating, maintaining a flexible time frame, and starting with person-

able small talk before engaging in serious conversation. Similarly, Parham (2002) suggested that counselors can connect with African-American clients by using ritual, sharing music or poetry, exhibiting congruent realness, being in the present, creating ambiance, and being willing to shift the context and setting of therapy. Hong and Ham (2001) concluded that Asian-American clients tend to expect quick and direct relief from symptoms and want expert advice. They point out the importance of setting short-term goals, discussing traditional Asian healing practices, and consulting with other professionals such as physicians or teachers. All of these recommendations are examples of relational adaptation because of the way psychotherapists are encouraged to adapt their communication style to match the cultural expectations of diverse clients.

## METHODS AND TECHNIQUES

MCT embraces the use of methods and techniques drawn from a variety of psychotherapy approaches adapted to the cultural values and expectations of individual clients. MCT describes the use of culturally appropriate methods and techniques with the following proposition:

The effectiveness of MCT is most likely enhanced when the counselor uses modalities and defines goals consistent with the life experience and cultural values of the client. No single approach is equally effective across all populations and life situations. The ultimate goal of multicultural counselor training is to expand the repertoire of helping responses available to the professional regardless of theoretical orientation. (Sue et al., 1996, p. 19)

This assumption of MCT is a culturally appropriate restatement of traditional psychotherapy theory and practice: *join the client where he or she is*. Therapists are, for the most part, deeply committed to empathy and understanding the client's frame of reference. What has been missing in traditional writing about the therapeutic

alliance is cultural context and awareness of the self-in-relation. Joining clients where they are involves diagnosing levels of consciousness and identity development, respecting that person where he or she *is*, and facilitating expansion of consciousness and culturally appropriate action in consultation with the client.

Parallels between cultural identity development stages (emphasized in Multicultural Counseling and Therapy) and cognitive-emotional developmental levels (emphasized in Developmental Counseling and Therapy) that were described in the formulation section can be used to choose methods when providing integrative psychotherapy for culturally diverse clients. Each of Cross's (1995) stages of cultural identity development corresponds to a different stage of development drawn from Piaget (Ivey & Ivey, 2000). These stages of cultural identity development and cognitive-emotional development can be used to identify focal dimensions (emphasized in Multitheoretical Psychotherapy and identified in Figure 15.1) and theoretical approaches that may be most useful in multicultural integration. By recognizing the way that different stages of cultural identity development are related to distinct patterns of cognitive/emotional development, DCT becomes a blueprint for integrative psychotherapy with culturally diverse clients. This framework for choosing multicultural methods is summarized in Table 15.1.

### Pre-encounter: Sensorimotor

During the pre-encounter stage of development, individuals are likely to focus on direct experiences related to cultural identity. Pre-encounter and sensorimotor thought and emotion can be constraining if that embeddedness is without the ability to take perspective. But, the openness to here-and-now experience can also represent a chance for growth. The focus is on sensory experiences and observations related to the client's story. The client might be asked to generate an image of the general situation just described, and this image might be fleshed out with questions like, "What are you seeing?" or, "What are you hearing?" This fo-

TABLE 15.1 Identity Stages, Development Levels, Focal Dimensions, and Theoretical Approaches

Cultural Identity Development Stages	Cognitive-Emotional Developmental Levels	Focal Dimensions	Theoretical Approaches
Preencounter	Sensorimotor	Observations	
Encounter	Late sensorimotor	Actions	Behavioral
Immersion/emersion	Concrete	Thoughts	Cognitive
Immersion/emersion	Formal	Feelings & interpersonal patterns	Experiential & psychodynamic
Internalization	Dialectic/systemic	Social systems & cultural contexts	Systemic & multicultural

cus on observations and imagery lays a foundation for other types of interventions.

### Encounter: Late Sensorimotor

When people meet oppression or difference in a dramatic encounter, they are often unable to separate self from situation and cannot distinguish between thoughts and feelings. The concrete and specific encounter with a racist incident can perturb individuals and helps them move out of sensorimotor magic thinking patterns and opens the way to concrete consciousness. During this stage of development, psychotherapy often focuses on actions, and a behavioral approach is frequently employed to help clients choose adaptive actions (Ivey, 1991/1993). Although there may be a behavioral emphasis on “what to do,” there are also strong feelings that may need to be processed.

### Immersion-Emersion: Concrete

During the time when individuals immerse themselves in their own cultural group, there is often detailed learning as well as concrete awareness of racism and prejudice, accompanied with anger—and, often, specific action to fight oppressive situations. There is frequently a focus on the thoughts that clients are using to try to understand and make meaning out of their own cultural experiences. Cognitive approaches like reality therapy, problem-solving, and decisional counseling are often helpful at this stage (Ivey, 1991/1993). In-depth experiencing of sensorimotor experience may be used to facilitate encounter and the emergence of a

new way of thinking about old ways of being. Helping clients move to new states of consciousness often is facilitated by supportive but challenging confrontation. Pointing out discrepancies and incongruities in the story or situation, particularly when the story is supported by emotionally based here-and-now experience, is often helpful in moving consciousness. It may be helpful for therapists to encourage clients to share their experience with questions like, “Could you share a story of what happened? I’d like to hear it from beginning to end.”

### Immersion-Emersion: Formal

During the latter part of the immersion-emersion stage, reflective consciousness becomes more prominent. Particularly helpful in moving to reflective thought is the summarization of two or more individual stories (which will often contain similar key words) and asking the individual or group how the stories are similar. During this stage, there may be an increased emphasis on feelings and interpersonal relationships. Experiential and psychodynamic therapies may be a useful way to encourage formal reflection. Helpful questions during this stage include, “How is your story similar to stories you have told me in the past?” and, “Do you see this as part of a pattern?”

### Internalization: Dialectic/Systemic

When people begin to internalize their own cultural values, there is often a shift to reflective consciousness—thinking about thinking

and reflecting on cultural identity. A requirement of internalization is systemic thinking and the ability to take multiple perspectives. Crucial here is encouraging people to see themselves and their group in systemic relation, often through multiperspective thought. This style of consciousness can become heavily embedded in intellectual thought and abstraction. Thus, attention to action and generalizing learning to the real world through concrete action may be essential. During this stage, there is increased focus on social systems embedded within cultural contexts. To address these dimensions, systemic and multicultural interventions are often helpful. Specific questions used to encourage dialectic/systemic consciousness include, "What rules were you operating under in this situation?" "Where did those rules come from?" and "How would external conditions, like racism or sexism, affect what is occurring with you?"

Obviously, MCT is technically eclectic—using a broad repertoire of interventions from a variety of theoretical sources. Psychotherapists can use multicultural strategies in combination with strategies from other approaches (Ramirez, 1991). Two descriptions of specific techniques for integrative psychotherapy with culturally diverse clients will be summarized next. Ivey (1995) described psychotherapy as a process of liberation and proposed four specific skills that could be used to help clients achieve critical consciousness about the cultures in which they live. First, psychotherapists can help clients understand the self-in-relation more completely and then help them move from naivete or acceptance to naming and resistance. Second, therapists can help clients expand their cultural understanding by naming the contradictions they see and resist oppressive systems. Third, therapists can help clients reflect on self and self-in-system and redefine themselves in a way that promotes pride. Fourth, therapists can help clients continue to expand a sense of multiperspective integration that allows them to integrate thought and action as well as appreciate a variety of cultural perspectives (Ivey, 1995).

Brooks-Harris and Gavetti (2001) proposed another set of multicultural techniques that in-

cluded 14 key strategies summarized in Table 15.2. In treatment planning, these strategies can be used to consider a variety of interventions that focus on culture and identity development. Describing practice indicators and expected consequences for each strategy can make these techniques even more useful in treatment planning as well as training (Brooks-Harris, in press).

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### CASE EXAMPLE

Pono is a 25-year-old, gay, Hawaiian male. After attending college and working for a couple of years in Chicago, he moved back to Hawaii 1 year ago. Pono consulted with a physician because he was having trouble sleeping and because he frequently felt "jittery and uptight." The physician referred Pono to Dr. K. for psychotherapy. Pono began meeting with Dr. K, a heterosexual, Japanese-American, male psychologist in his mid-fifties. Pono told Dr. K that he had been experiencing symptoms of anxiety and depression since moving back to Hawaii. Pono was surprised at this reaction because, when he was living on the mainland, he frequently dreamed of returning home and hoped he would feel more comfortable back in Hawaii. Pono attended a total of 18 sessions of individual psychotherapy during a 6-month time span.

Dr. K conducted a multidimensional survey of Pono's life (see Figure 15.1) and concluded that the change in cultural contexts between Chicago and Honolulu was having an impact on Pono's thoughts and feelings. One of Pono's recurring thoughts was, "I don't fit in." This perception of not belonging was associated with feelings of loneliness and despair as well as a physical sensation of agitation and restlessness. Although Pono had thought and felt this way in Chicago, he had assumed that the situation would be different if he returned home. Pono indicated he was not interested in psychiatric medication unless things did not improve in response to psychotherapy.

Dr. K was interested in Pono's identity development and gradually formulated a multicultural conceptualization. In Chicago, Pono had felt out



TABLE 15.2 Key Multicultural Strategies for Psychotherapy

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1.	Viewing Clients Culturally. Observing and understanding clients' thoughts, actions, and feelings from a cultural point of view.
2.	Clarifying the Impact of Culture. Clarifying the impact of cultural context and family background on current functioning and interpersonal relationships.
3.	Celebrating Diversity. Celebrating diversity in order to help clients accept and express their uniqueness.
4.	Facilitating Identity Development. Facilitating the awareness and development of cultural identity in order to promote self-acceptance and empowerment.
5.	Recognizing the Impact of Identity. Recognizing how identity development impacts attributions of personal success and failure.
6.	Appreciating Multiple Identities. Appreciating the intersection of multiple identities including race, ethnicity, gender, sexual orientation, class, ability, and age.
7.	Highlighting Oppression and Privilege. Highlighting the impact of societal oppression, privilege, status, and power on thoughts, feelings, and actions.
8.	Creating an Egalitarian Collaboration. Creating an egalitarian collaboration within the therapeutic relationship that highlights and subverts societal power dynamics.
9.	Exploring Societal Expectations. Exploring societal expectations and supporting informed decisions about which roles to embrace and which to discard.
10.	Integrating Spiritual Awareness. Integrating a client's spiritual awareness or faith development into holistic growth.
11.	Understanding the Psychotherapist's Worldview. Understanding your own cultural worldview and how it impacts your role as a psychotherapist.
12.	Reducing Biases. Reducing personal prejudices in order to present options with as little bias as possible.
13.	Illuminating Differences. Illuminating differences between psychotherapist and client identity and how they impact the therapeutic relationship.
14.	Supporting Social Action. Supporting clients who participate in social action in order to change oppressive societal structures or practices.

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of place as a native Hawaiian but had been able to explore his identity as a gay man. Back in Hawaii, the situation was reversed; he felt more comfortable being around other Hawaiians but did not feel comfortable about revealing his sexual orientation to his family and lifelong friends. In terms of his Hawaiian identity, Pono had moved forward from an encounter stage, in which he felt discriminated against and misunderstood in Chicago, to a stage where he was immersed in Hawaiian culture. However, as a gay man, Pono had moved backward from a stage of immersion, in which his social life centered around spending time with gay friends and going out dancing at gay clubs, to a preencounter stage in which he was hiding his sexual orientation from those closest to him.

In terms of cognitive-emotional development, Pono experienced a similar duality. When talking about his return to Hawaii, Pono seemed to be engaging in formal thinking. He was able to reflect on himself and his place in his family and community. For example, he could recognize systemic patterns in his family and could describe

his family role. When asked questions about sexual orientation, such as whether he was interested in dating, Pono seemed to be operating at a sensorimotor level. Pono was spending a lot of time carefully observing and listening to things that friends and family members said about sexual orientation that might give him clues as to how they might react if he ever came out. This conceptualization was based on clinical interviews and no formal psychological testing was used.

Dr. K tried to match his interventions to Pono's cultural and developmental levels (see Table 15.1). When exploring Pono's Hawaiian identity, Dr. K focused on feelings and interpersonal patterns to help Pono directly experience this part of his identity. When exploring sexual orientation, Dr. K encouraged Pono to move from sensorimotor to concrete thinking by encouraging actions and thoughts that were consistent with his observations.

In terms of change processes, the therapist tried to use psychotherapy as an opportunity for consciousness raising. He encouraged Pono to

recognize that the racism he experienced on the mainland was similar to the heterosexism he now feared from his family and friends. Dr. K also tried to build a culturally appropriate therapy relationship by creating a warm interpersonal relationship but also letting Pono view him as a wise elder. Dr. K tried to encourage Pono to make active choices about cultural practices and expressions that would help him resolve his distress.

A variety of culture-centered methods were used to explore the impact of cultural context on Pono's thoughts and feelings. Dr. K also focused on the interaction between Pono's dual identities as a gay man and as a native Hawaiian. They discussed the fact that the Hawaiian part of Pono liked living in Honolulu, whereas the gay part had felt more comfortable in Chicago. Dr. K illuminated differences between psychotherapist and client to help Pono realize that a heterosexual man could affirm his gay identity.

In addition to these multicultural strategies, Dr. K used interventions drawn from experiential and cognitive approaches. Experientially, Dr. K facilitated a two-chair dialogue between these two cultural parts of Pono. Cognitively, Pono modified his core belief from, "I don't fit in" to "Different parts of me fit better in different places." Understanding his thoughts from a contextual point of view helped alleviate some of the feelings of distress.

Dr. K wanted to encourage Pono to find a cultural context in which he might integrate his Hawaiian and gay identities. After discussing several options, Pono decided to learn to dance hula. Pono had always wanted to dance hula but had not pursued this as a youth. Furthermore, Pono missed going dancing with his gay friends in Chicago and thought that hula might provide a physical outlet for his anxiety. Pono's sisters were both hula dancers, and he thought the hula community might be a place where he could be more open about his sexual orientation. With the therapists' encouragement, Pono joined a hula halau and found that it facilitated new social connections as well as cultural and spiritual awareness. Pono began to realize that he had grown away from some of his old high school friends, who were not gay-affirmative, and found it useful to make new friends in his old hometown. When Pono found out that two of the dancers in his ha-

lau were openly gay, he began to explore his hope that this might be a place where he could integrate the gay part of himself with the Hawaiian part. Pono worked with Dr. K to decide how to come out to the other dancers in the halau. After doing so, the split between the gay and Hawaiian sides of Pono felt less divided.

After making gay friends in Hawaii, Pono felt more comfortable with the idea that he would eventually come out to his family. He felt more confident about his gay identity after he had discovered a congruent and creative outlet for his Hawaiian identity. This sense of cultural integration resulted in fewer negative thoughts and decreased feelings of anxiety. After completing individual psychotherapy, Pono began attending a support group at the Gay and Lesbian Community Center with the goal of coming out to his family. About 6 months after termination, Pono sent a card to Dr. K thanking him and letting him know that he had begun to talk to some family members about his sexual orientation.

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## EMPIRICAL RESEARCH

### Multicultural Counseling and Therapy

MCT outcome research has been ably summarized by Ponterotto, Fuertes, and Chen (2000). The authors make the following key points: Nine analogue studies indicated clearly that clients responded favorably when cultural issues were included. Satisfaction, willingness to return to therapy, and self-disclosure were all increased. In one of the studies (Thompson & Jenal, 1994), the same general findings occurred among 17 of 24 clients, but 7 clients were unaffected. A review of these sessions found that the therapist had avoided multicultural issues even though they were broached early in the session. The clients appeared to have followed the therapist's lead and both avoided discussing racially related issues. It is possible, even likely, that many traditional therapy sessions follow the same model. Specifically, racially related issues are simply not dealt with. However, no randomized clinical trials of MCT have been conducted.

The literature review is promising, but research in MCT still has far to go. The content of MCT constructs hold up well in analog studies and in research using instruments. The extensive work on cultural identity theory (e.g., Helms, 1984, 1995; Cross, 1995) is solid, but not a direct test of outcome. Much more work needs to be done, particularly with regard to outcome. Although MCT research also includes broader issues including gender, sexual orientation, ability/disability, and many other factors, space does not permit a more comprehensive review.

**Developmental Counseling and Therapy**

DCT argues for multistyle treatment, often with a special emphasis on the sensorimotor and dialectic/systemic levels, coupled with more traditional interventions using concrete and formal styles. In a research review, Ivey (1986/2000) noted that DCT treatment resulted in more weight loss than a cognitive-behavioral comparison group, and DCT clients maintained their weight loss for a longer period of time (Weinstein, 1994). Agoraphobia and anxiety disorders have responded well to DCT treatment procedures in case studies (Gonçalves & Ivey, 1992). Inpatient depressed clients have shown increased cognitive flexibility through DCT strategies (Rigazio-DiGilio & Ivey, 1990). Adolescent substance abusers (Boyer, 1996) and college learning disabled students (Strehorn, 1998) have responded favorably to DCT treatment. Case studies with children indicate the broad viability of the model (Ivey & Ivey, 1990; Myers, Shoffner, & Briggs, 2002). Extensive research and clinical work in Japan has revealed the cross-cultural relevance of the model (e.g. Fukuhara, 1987; Tamase, 1989, 1993, 1998; Tamase & Fukuda, 1999). Marszalek and Cashwell (1998) have shown the viability of the model with gay and lesbians’ cognitive/emotional development.

As with MCT, clearly DCT requires more research. The early findings are promising, but represent only a beginning. The MCT and DCT models hold in common a belief in cog-

nitive/emotional development in a social context. The developmental and the contextual approaches are clearly not yet at the center of the research or practice scene in psychotherapy. It is hoped that this brief introduction to some of the issues will be helpful in moving to the next stage.

**FUTURE DIRECTIONS**

An important future direction related to integrative psychotherapy with culturally diverse clients is to articulate the relationship between MCT and other theoretical approaches. Multitheoretical Psychotherapy (Brooks-Harris, in press) provides a conceptual map that lends itself to the task of integrating multicultural therapy with other approaches. The multidimensional model of human functioning depicted in Figure 15.1 provides a way to organize a multitheoretical framework. Diverse approaches to psychotherapy can be classified according to the dimension that serves as a primary focus or as a “point of leverage” to encourage change. The correspondence between major systems of psychotherapy and dimensions of human functioning is outlined in Table 15.3. By including multiculturalism as a theoretical approach in this framework, MTP prepares integrative psychotherapists for the task of attending to interactions between culture and other dimensions of functioning. In the future, multicultural and integrative psychotherapists can work together to develop a multicultural theme within psychotherapy integration (Corey, 1996).

TABLE 15.3 A Multitheoretical Framework for Psychotherapy

Theoretical Approaches	Focal Dimensions
Cognitive	Thoughts
Behavioral	Actions
Experiential	Feelings
Psychobiological	Biology
Psychodynamic	Interpersonal patterns
Systemic	Social systems
Multicultural	Cultural contexts

Psychotherapy faces a time of major change. All therapy is multicultural in nature. Bringing into the therapeutic hour dimensions of race/ethnicity, gender, sexual orientation, and disability enriches individual uniqueness. Discarding the outmoded concept of self and replacing it with self-in-context, being-in-relation, and person-in-community will enable us to think of what it means to be human in new ways. Multicultural therapy is leading us in a new direction. It is our hope that Developmental Counseling and Therapy and Multitheoretical Psychotherapy can be part of the process supporting this change toward a new future. To put all these ideas into place, the implementation of Multicultural Competencies is central (Arredondo et al., 1995; Sue et al., 1998).

Let us put ideas for future directions in the context of the next 50 years. The year 2050 will see our present world vastly changed. In the United States, people of color are predicted to be as numerous as Whites. In California, White people have recently become the minority already. White privilege will perhaps be a relic of the past (McIntosh, 1989). The challenge for Whites and our present “minorities” will be how they can live together effectively, productively, and with some sense of mutual respect and enjoyment. It may be time that we start speaking of the “joys and opportunities of multiculturalism” rather than considering it a problem to be solved.

The following ideas can lead to a more understanding and cooperative world in 2050—we need a positive approach to language understanding, gender differences, sexual orientation, spiritual and religious differences, a respect for ability/disability issues. Ivey and Ivey (2000) presented an optimistic view of the next decade and ensuing years with specific reference to MCT and DCT. Their predictions are summarized here:

1. Psychotherapy will move toward greater contextual awareness. No longer will we think within the present individualistic frame of traditional psychodynamic, cognitive-behavioral, and existential-humanistic thought. Each of these traditional

theories will remain important, but they will be enriched by MCT and other culturally focused frameworks such as DCT and MTP.

2. Oppression will be recognized as a central construct. Therapists will include in their assessment and treatment a balance of internal and external attribution. The problem no longer will be seen as “in the individual.” This will be replaced by a more sophisticated counseling in which individual, family, group, and multiple cultural factors will be considered.
3. Facilitating the development of consciousness will become an important part of each treatment plan. Therapists will facilitate movement to new levels of understanding in a cooperative, co-constructive fashion with their clients. As part of this, the liberation of consciousness will become a regular part of many counseling sessions.
4. Multiple interventions co-constructed with the client will be seen as basic to any effective treatment plan. The idea of one “right” or “best” theory will finally disappear as new ways of integrating theory and practice evolve.
5. “Disorder” will cease to frame our consciousness about the deeply troubled. Rather, psychotherapy will engage serious client “dis-stress” and not define it as “dis-ease.” This means that the *Diagnostic and Statistical Manual of Mental Disorders*, if still in use, will define clients’ issues and challenges as a logical response to developmental history and external social conditions. Rather than putting the difficulty in the client, therapists will enable them to balance personal and external attribution—and then facilitate client internal and external *action* to produce change.
6. Psychotherapists will recognize the importance of directly attacking systemic issues that affect client development. We will move toward a proactive stance rather than our present reactive position. We need not expect our clients to work

alone. Psychotherapists have an ethical imperative to work toward positive societal change.

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## **PART IV**

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# Integrative Treatment Modalities

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## Differential Therapeutics

JOHN F. CLARKIN

When we first articulated the concept of differential therapeutics (Frances, Clarkin, & Perry, 1984), there were a growing number of psychosocial and medication treatments idiosyncratically selected by individual clinicians. Our impression at that time was that the field needed an algorithm to assist in treatment planning, and such an algorithm would be useful in the education of clinicians. In the ensuing several decades, the field has progressed to more refinement in the diagnostic assessment of mental disorders at the symptom level and in the generation of treatment planning guidelines. There have been the publication of treatment guidelines for individual disorders generated by committees (e.g., APA, 1993, 2001), generated by Delphi procedures (Kahn, Docherty, Carpenter, & Frances, 1997), and lists of patient diagnoses matched with treatments manifesting empirical support (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). We agree with those individuals (Garfield, 1996; Shapiro, 1996) who find the evidence-based treatment approach to

be too general for practical clinical use, and this is the reason for the use of differential therapeutics.

In this chapter, differential therapeutics is described as the application of principles derived from research and clinical experience in matching the individual patient to the most efficacious treatment under circumstances specific to that individual (as opposed to randomization or planning from group means in treatment studies that ignore the individual). Differential therapeutics is discussed at the macro level (i.e., five areas of treatment planning) and on the micro level (i.e., the adjustment of therapeutic strategies and techniques within the treatment process itself). Finally, these principles of treatment planning are applied to a representative Axis I diagnosis (major depression) and an Axis II syndrome (borderline personality disorder) in order to illustrate how they can be used with specific patient difficulties.

It is interesting to speculate about the local environment in which a particular clinical re-

searcher or author generates notions about treatment selection and guidelines. Most probably, the various authors in this *Handbook* “live” their clinical lives in somewhat different settings, and these settings influence the range of patients they see and their views on treatment selection. Differential therapeutics arose in the setting of a major metropolitan psychiatric hospital that had emergency and walk-in services, outpatient, inpatient, and day hospital services. The different diagnoses, the range of pathology between individuals with the same diagnosis, the need for rapid assessment and action, and the variety of possible treatment settings all influenced our conceptualization of differential therapeutics.

## FIVE DIMENSIONS OF MACRO TREATMENT PLANNING

Although there is much interdependence among the various macro dimensions of treatment planning, we have found it pedagogically helpful to separate them in order to highlight the decisions that are made, either knowingly or implicitly, on each of these dimensions. The *setting* and *format* of treatment provide the environment and the ecology, both in terms of place (hospital, office, patient’s home, site of phobias) and persons involved (patient, patient and family, group of patients). The *strategies and techniques* are the technical interventions that the therapist uses to introduce change. The decisions about strategies and techniques have been the narrow, if not the sole, concern of other attempts at treatment integration. The *duration and frequency* are the aspects of how the treatment is embedded in time. Insurance companies and managed care have particular interest in this consideration due to its direct relationship to cost. The appropriate use of *medication* and other somatic treatments (ECT, light therapy) have been the focus of much clinical research.

### Setting

The settings of treatment have remained somewhat constant in the last several decades: in-

patient, day hospital, outpatient clinic, private office, treatment in the family home, and sessions at the site of disorder (e.g., systematic desensitization in vivo). However, from a practical point of view, the actual accessibility of these treatment settings has changed dramatically in the current era of health care cost containment. Inpatient care is more and more restricted in terms of who obtains it (the most severely disturbed patients in acute distress) and how much of it is available (the length of stay is becoming more restrictive). This constriction of resources is forcing clinicians to be more creative in using alternatives to hospitalization in crisis situations.

### Format

The treatment format is the interpersonal context within which the intervention is conducted. The choice of a particular treatment format is determined, in part, by the perspective from which a presenting problem is initially defined, either by the patient/family and/or the clinician. Some couples apply to a family clinic for treatment of what they perceive as an interpersonal problem or conflict. Another couple in the same situation may prompt the wife to call a clinic and ask for an appointment for herself. From the clinician’s point of view, the treatment of the partner with depression can vary, depending on whether it is viewed (etiology aside) as a current adaptation to a larger problem involving the patient’s personal adaptation to a unique biological, social, or historical situation (in which case, individual or group treatment is more likely indicated), or not. The mediating and final goals of treatment will vary accordingly. Although therapeutic strategies and techniques are influenced, in part, by treatment format, these can vary independent of format and in accordance with the particular theoretical model from which the therapist is working.

### *Individual Treatment Format*

The individual treatment format is one in which the patient and therapist meet in the privacy of the therapist’s office with the goal of

treating the patient's problem. The development of the individual format of treatment served several adaptive functions within the historical context from which it evolved. The individual was seen as the locus of difficulty, with unconscious and preconscious motives and desires viewed as a driving force in that person's psychopathology. Subsequent developments, including the behavioral and interpersonal therapy, continued to focus on the individual with his or her learning history and patterns of interpersonal behavior as the locus of difficulty and the focus of treatment.

The final goal of individual treatment, like that of other formats, is to alleviate the symptoms and conflicts that brought the individual for help. The relationship between therapist and patient is fostered and used as the framework for the application of a multitude of therapeutic techniques to assist the individual in coping with symptoms and resolving interpersonal conflicts through their replay with the therapist. The individual treatment format is the easiest (as it requires the motivation of only one person) and most versatile format for treatment. It can be used whenever the patient does not meet criteria for more economical treatments (such as group) or treatments that approach the problem in their own setting (e.g., marital and family treatment).

The individual format has the following advantages, which give it special status under certain circumstances.

- Problems of dyadic intimacy, which require the development of a relationship with a therapist for some resolution to occur.
- Patients whose character or symptoms are based on firmly structured intrapsychic conflict, which causes repetitive life patterns that, more or less, transcend the particulars of the current interpersonal situation (e.g., family, job relationships).
- Adolescents or young adults who are striving for autonomy.
- Symptoms or problems that are of such private and/or embarrassing nature that the secrecy of individual treatments is required at least for the beginning phase.

The only relative contraindications include patients who meet clear indications for family/marital treatment or patients who regress in individual therapeutic relationships.

### *Group Treatment Formats*

The group treatment format is one in which a small group of patients meets with one or several therapists on a regular basis for the goal of treating the disorders of the group members. The historical impetus for the development of the group treatment format was based, in part, on the functional advantages that it afforded: an economic mode of delivering treatment, an effective means of reducing or circumventing the resistance expressed in individual therapy, adjunctive support or ancillary therapists in the form of other patients, and a setting in which interactional forces could be played out and examined.

Group treatments fall on a continuum of theoretical assumptions, methodologies, and mediating and final goals. In our attempt to organize indications for use of a group therapy format, we do not distinguish among the different schools (which will be accomplished in the next section on strategies and techniques), but rather organize our decision tree around the distinction between the indications for *heterogeneous* versus *homogeneous* group membership. Although this distinction is not yet supported by controlled research, it has been extensively used in clinical practice.

In *heterogeneous groups*, individual patients differ widely in their problems, strengths, ages, socioeconomic backgrounds, and personality traits. Treatment in heterogeneous groups fosters self-revelation of one's inner world in an interpersonal setting where sharing and feedback are encouraged. The group provides a context in which interpersonal behavior patterns are reexperienced, discussed, and understood, and in which patients experiment with new ways of relating. The variety of interactions and misperceptions that result affords all group members an opportunity to correct their distortions about others, to discover how others regard them, and to alter their maladaptive patterns. Patients are encouraged to take interper-

sonal risks, first within and later outside the group. They learn to share the therapist and discover that they can help and be helpful to their peers.

There are two general indications for heterogeneous group therapy.

1. The patient's most pressing and salient problems occur in current interpersonal relationships. If these interpersonal difficulties are currently exhibited mainly in family relations, referral to family/marital treatment should be considered.
2. Prior individual therapy formats have failed for various reasons, for instance: (a) the patient has a strong tendency to actualize interpersonal distortions in individual therapy formats; (b) the patient is excessively intellectualized; (c) the patient cannot tolerate the dyadic intimacy of individual therapy; (d) the patient has a treatment history of eliciting harmful reactions from individual therapists.

There are, however, some contraindications for heterogeneous group therapy.

1. The situation is an acute psychiatric emergency or crisis that requires more urgent, intense, and individualized attention.
2. The patient is likely to respond to brief planned therapy.
3. The patient meets criteria for another form of treatment that may be more beneficial. For example, by becoming comfortable in group treatment, the patient is avoiding the anxiety of engaging in intense individual treatment for serious problems around dyadic intimacy.
4. The patient manifests interpersonal behavior that would disorganize the group process. This would, for example, be true of patients with severe organic brain syndrome or severe impairment in reality testing; or dishonest, manipulative, suspicious, or explosive behavior.

*Homogeneous groups* are self-help or professionally led groups in which all members share the same symptom or set of symptoms that are

the focus of the intervention and change. The goal of the homogeneous group is to change behaviors related to the symptom focus of the group. The group is highly structured and provides a social network for the patient, who previously may have felt alone and isolated with the target symptom. There may be a formal hierarchy within the group, a system of gradual promotion, as the patient improves systematically and gains new skills and, in some cases, the possibility of members eventually rising to leadership roles. The sense of commonality—of jointly fighting a common problem—provides support and self-validation.

The indications for homogeneous group treatment include the following:

1. The patient's most salient problem or chief complaint involves a specific disorder for which a homogeneous group is available. These problems fall into four general categories: (a) specific impulse disorders (e.g., obesity, alcoholism, addictions, gambling, violence, and criminal behavior among prisoners); (c) problems of a particular developmental phase such as geriatrics, childhood and adolescence, or child-rearing; and (d) specific psychiatric disorders or symptom constellations such as agoraphobia, somatoform disorders, and schizophrenia.
2. The patient experiences his or her salient problem with a sense of embarrassment and/or isolation and may benefit from sharing these problems with others who have had similar experiences.
3. The patient does not have a sustaining and supportive social network and/or has an existing social network that is composed of individuals with the same disorder (e.g., alcoholics whose only friends drink at the same bar).

The following are relative contraindications for homogeneous group therapy:

1. The patient will be harmed by associating too exclusively with others who have the same difficulties. An example would be a physically handicapped person who

needs to learn to associate with and cope with the nonhandicapped.

2. The patient resents and will not tolerate a central aspect of the homogeneous group program. For example, some people react negatively to the Alcoholics Anonymous spiritual, didactic, and mystical elements.

### *Family Treatment Format*

There are a variety of relational problems that one encounters in clinical practice, including relational problems related to a mental disorder or general medical condition in a family member, parent-child relational problems, sibling relational problems, and spousal or partner relational problems (Tompson, Miklowitz, & Clarkin, 2003). The family treatment format is one in which various subgroups of a family (a nuclear family, a couple, a couple with family of origin) meet on a regular basis with a therapist (see Feldman & Feldman, this volume). The family format was derived in large part from an emphasis on the contextual origins of the presenting problems. More recently, family and couples treatments have been applied more broadly, with greater emphasis on their practical utility rather than solely or primarily on the role of family/dyad in the etiology of the problem. Hence, we see family- and couples-based treatments (such as for agoraphobia and schizophrenia), wherein the partner or family member is enlisted to serve as adjunct therapist or to provide social support to the patient.

A review of the early trends in the development of the family treatment format suggests that it served several adaptive treatment functions. It was recognized to be an important adjunct to individual interventions with children and adolescents whose family environments contributed to their problems. It helped to diminish family resistance to continuation of the child's treatment. It was particularly well suited to brief treatment of focal problems occurring in the context of the family or marital unit.

The final goals of family and couple treatments are at times indistinguishable from those of the group and individual treatment formats. The mediating goals of family and couple

treatments are to change the rigid and repetitive interpersonal family interchanges that are in themselves the focus of complaint or are hypothesized to be related to the symptoms of one or more individuals in the family system.

The relative indications for family/couple formats include the following:

1. Family/couple problems are presented as such without either partner or any family member designated as the identified patient.
2. Couple committed to each other presents with symptoms that occur almost exclusively within the relationship.
3. Symptomatic behaviors are experienced almost predominantly within the family/couple system.
4. The family presents with current structured difficulties in intrafamilial relationships, with each person contributing collusively or openly to the reciprocal interaction problems.
5. Adolescent acting-out behavior (promiscuity, drug abuse, delinquency, vandalism, violence) is disrupting the entire family.
6. The family is unable to cope adequately with the chronic mental illness of one family member.
7. Symptoms in one family member seem related to repetitive interpersonal issues in the family or couple. For example, mild to moderate unipolar depression in a partner seems related to interpersonal conflict.
8. A partner needs to be involved in the treatment program of his or her mate in order for it to succeed. For example, the partner suffers from an eating disorder or agoraphobia, and the mate is needed to assist in behavioral treatment compliance and general support.

The following are relative contraindications for family/couple formats:

1. The presenting problem of the individual does not have a significant relationship or effect on the family system.



2. Family therapy would provide a defense through which individual responsibility for major personality or character disorders could be derived.
3. Individuation of one or more family members requires that they have their own and separate treatment.
4. Family treatment has stalemated or failed and has resolved what crises it can, but one or more individuals require additional individual treatment.
5. One or more family members is strongly motivated to be seen alone (e.g., an adolescent states emphatically that he or she has personal problems and wants private help).

### Strategies and Techniques

We have just experienced a period of proliferation of treatment strategies and techniques. Clinical research is beginning to suggest which strategies and techniques are effective with specific patient problem areas. Treatment manuals are helpful in explicating the treatments and showing similarities (despite different theories and theoretical language) and differences. In addition, technical eclecticism—which advocated the use of multiple techniques, regardless of theoretical heritage—is growing (Norcross, this volume). This *esprit* fosters consolidation of techniques across schools into useful treatment packages.

There have been volumes written comparing the various schools as related to strategies and techniques. There seems to be an unwritten consensus that the differences between treatments—differences seen as crucial for outcome—are captured at the level of techniques. We question this assumption as being incomplete, and suggest rather that psychotherapy has advanced in its specificity not through investigation of techniques but through research into the disorders that provides the key foci of the treatment (also see Wolfe, 1992). The implication is that no treatment strategy or technique can be considered in and of itself, but its value lies in the context of achieving specific mediating goals of treatment for the specific problem/patient condition. Thus, though we

discuss strategies and techniques abstractly in this section, it is only when considering specific problems/disorders in the latter part of this chapter that one matches mediating goals with specific techniques.

We review here the major treatment strategies and techniques that emerge from a survey of the existing treatment manuals. Although this is not meant to be an exhaustive review of all manuals (which increase in number each day), we have included those that cover a range of patient pathologies and schools of therapy, which enables us to make some generalizations.

### *Common Strategies and Techniques*

Despite the diversity of treatment manuals in reference to the model of the disorder, treatment strategies, and patient populations, we are struck by the methods that are repeated in many of the manuals. Indeed, the finding that most treatments are equally effective may be related to the common ingredients as noted in an inspection of the manuals (Arkowitz, 1992; Garfield, 1992). Though adherents of the various schools of psychotherapy emphasize their uniqueness, a large body of data suggests that experienced therapists of different persuasions do many things in common (e.g., Frank, 1973; Goldfried, 1982; Kazdin, 1980; Salzman & Norcross, 1990; Beutler et al., 2004).

The schools of psychotherapy deviate from one another in the mediating goals chosen and the specific focus put on these goals. Even here there are commonalities. These commonalities include (1) establishing and fostering a therapeutic alliance (e.g., conveying support for the patient's wish to achieve treatment goals, conveying a sense of understanding and acceptance of the patient), (2) managing patient resistance (e.g., identifying resistance, inviting the patient to examine the resistance), (3) structuring the treatment, (4) focusing the treatment, and (5) termination. Although the schools of therapy use different techniques, they are alike in using these common strategies. The relationship between therapist and patient is the bedrock upon which the use of any technique must be based, and the development and nurturance of that relationship is crucial.

All or most therapies encourage the patient to make certain basic behavioral changes, including confrontation of fears, in order to master them; reality testing; and practice and working through (see Grencavage & Norcross, 1990, for a review). Encouragement of behavioral change can be direct (e.g., specific behavioral assignments, homework) or indirect (e.g., modeling, questioning); but the basic message is the same; the patient must at some point begin to behave differently and to expand his or her behavior repertoire. In somewhat diverse ways, the therapist, of whatever persuasion, models the notion of behavioral risk and change.

### *Specific Strategies and Techniques*

In addition to using the strategies and techniques common to the various schools of therapy, the clinician must consider the use of more specific strategies and techniques that might be appropriate for the particular patient. In this process, one considers most carefully the mediating goals of treatment and those strategies and techniques that might be instrumental in reaching those goals.

We are conservative in our approach and emphasize those strategies and techniques that have been manualized for a specific patient diagnosis or problem area and have shown effectiveness in clinical trials. In rare instances, specific strategies and techniques have shown superiority over competing ones in comparison studies (Wampold, 2001). In addition, we have tried to classify techniques with the goal of treatment planning specifically in mind. The clinician must determine specific mediating goals for each particular patient, given his or her unique diagnosis, social environmental situation, and personality assets and liabilities. For example, psychodynamic techniques have the mediating goal of insight and conflict resolution; behavioral techniques, the mediating goals of specific behavioral changes; cognitive techniques, the mediating goals of change in conscious thought processes; and experiential-humanistic techniques, the mediating goals of increased awareness that are more fully integrated into the patient's personality.

### **Duration and Frequency**

Treatment duration is multifaceted. The major reference is to the duration of the *treatment episode*; that is, the time from evaluation to termination of a particular treatment period. Alternatively, one could consider the duration of each *aspect* of the total treatment package. For example, the total treatment for one episode of a disorder may include different treatment settings (inpatient followed by outpatient), treatment formats (individual and family therapy), medications of different classes, and diverse strategies and techniques. Finally, treatment can be over a lifetime, involving many episodes of treatment throughout the lifetime of a patient who has a chronic mental disorder, such as schizophrenia, bipolar disorder, or recurrent depression.

A number of factors make the relationship between treatment duration and outcome relatively unpredictable. The duration of the treatment episode and the frequency of sessions are related to the amount of effort and length of time needed to achieve the mediating and final goals of the intervention, which, in turn are related to the nature of the disorder and symptoms under treatment. In general, the more extensive and intensive the therapeutic goals, the longer treatment takes. Alternatively, when the goals of treatment are circumscribed, treatment can be brief. Setting the duration for a brief treatment can assist in ensuring that the goals will be reached more quickly than leaving the duration open-ended.

### *Crisis Intervention*

Crisis intervention is an intense, timely, brief (usually less than 1 month), and goal-directed treatment intended to resolve a crisis of major and urgent proportions and recent onset. The treatment often requires frequent (perhaps daily) and prolonged sessions, 24-hour staff availability, the potential use of psychotropic medications, the mobilization of family members and other community resources, environmental manipulations, and a multidisciplinary team. The intervention is focused on the presenting problem, particularly an exploration of its pre-

precipitating events. The goal is the relief of the symptoms, avoidance of further decompensation, and development of more adaptive coping skills for future crises.

Indications for crisis intervention include the following:

1. The patient's distress and risk factors must be severe enough to warrant urgent and intense attention—perhaps to require inpatient hospitalization if a crisis intervention is not offered. This degree of urgency may result from suicidal threats or acts, psychosis, severe depression, panic disorders, grief, or excited states.
2. Often a major precipitating stress provides a clear focus for the intervention. This may be accidental (injury, illness, death, job loss), interpersonal (an affair, a bitter argument), or developmental (a child is born, goes to school, marries).
3. Onset of symptoms is an indication if they occurred relatively recently.

### *Brief Therapy*

With only a few exceptions, therapy is brief, lasting some 6 to 15 sessions. Whether it is planned in advance or not, most patients now treated with psychotherapy engage in it for only a short period of time. Patients seeking clinic outpatient psychotherapy generally expect it to last no more than 3 months, and a very high percentage of patients actually remain in treatment for fewer than 12 sessions. The reimbursement system (insurance plans and managed care) limit their payments almost entirely to brief treatments.

The brief psychotherapies differ among themselves in goals, treatment techniques, strategies, format (group, family, or individual), setting (inpatient, day hospital, outpatient), and selection criteria. Certain essential features, however, characterize the brief therapies: establishing a time limit, achieving a focus with clear and limited goals, and an active therapist.

Difficulties brought by patients can be broadly conceptualized as either symptomatic or conflictual in nature (Beutler & Clarkin, 1990).

Brief treatments have been articulated for symptoms (e.g., depression, anxiety), unrecognized feelings or behaviors (e.g., phobias), and interpersonal conflicts, leaving aside for the moment the question of strategies and techniques (Clarkin & Hull, 1991; Hollon & Beck, 1986; Koss & Butcher, 1986).

### *Long-Term Psychotherapy*

The rationale for treatment of long-term duration is that some problems are so ingrained, complex, and extensive that an extended period of time is necessary for both their dissection and resolution, and for the patient to assimilate and apply the new solutions into daily life. Because regularly scheduled long-term psychotherapy is expensive and is weakly supported by available research, the prescription of this duration requires the most thoughtful assessment of indications, contraindications, and enabling factors.

Patient factors that tend to lengthen the treatment include the diagnosis of chronic mental disorders (e.g., schizophrenia, bipolar disorder, recurrent depression), multiple problem areas, poor patient-enabling factors for treatment, and relatively poor premorbid functioning and adjustment. A poor or insufficient response to brief treatment is an empirical demonstration of the need for further intervention.

A distinction can be made between a planned treatment of long duration (e.g., the year-long treatment of borderline personality disorder), and brief treatment of an episode of symptoms followed by a maintenance treatment (e.g., acute and maintenance treatment for recurrent depression).

### *Medication*

Major advances have been made in the investigation of various medications to treat symptoms and symptom constellations as related to the various Axis I and some Axis II disorders. These medications can be used as the primary intervention, or combined with a major psychosocial intervention, but should never be given alone. Noteworthy situations that call out

for a combination of medication and psychotherapy would include schizophrenia, bipolar disorder, major depression, and anxiety disorders (Thase & Jindal, 2004).

## NO TREATMENT AS THE PRESCRIPTION OF CHOICE

Most patients present with symptoms and a desire for treatment. This situation lends itself to assessment followed almost inevitably by treatment. In this situation, clinicians are not inclined to recommend no treatment and rarely do so for patients applying to an outpatient clinic (Frances & Clarkin, 1981). By way of contrast, many patients discontinue their treatment rather quickly for a host of reasons. It is helpful for treatment-planning purposes to distinguish groups of patient who might be seriously considered by the clinician for no treatment. This would include (1) patients likely to improve without treatment (“spontaneous remission”), (2) those likely not to respond to treatment (nonresponders), (3) those at risk for a negative response to treatment, and (4) those for whom the recommendation of no treatment is an intervention in itself, aimed at resistance (Frances et al., 1984). Each of these categories deserves some description.

In many ways, the most felicitous situation is one in which the clinician evaluates a person suffering from acute stress, but who has a history of effective functioning and coping. These individuals are often capable of coping with the stress by using their own resources, along with reassurance from the evaluator.

In contrast, there are those who are at risk for a negative response to the treatment itself. We are talking here of those individuals who actually become worse in clinical status and/or functioning during the treatment. The incidence of negative response to treatment ranges from 3% to 28% (Bergin & Lambert, 1978). There are many potential reasons for negative response: reasons related to the nature of the treatment itself, to further progression of the disorder, or to adverse environmental stressors. For treatment planning, it is most important to identify those people who are likely to experi-

ence a lasting deterioration because of treatment. Therapeutic factors that seem most related to negative effects include inaccurate and deficient assessment of the patient, poor therapist training and skills, therapist personality, therapist–patient relationship misapplication of therapeutic technique, and patient qualities. Those patient qualities that put the patient at risk for a negative response to treatment include negative therapeutic reactions in masochistic and narcissistic/oppositional patients. In addition, borderline patients seem vulnerable to a negative response to treatment due to their affective lability, fragile sense of self, and need to attach because of frightening fears of abandonment. Some borderline patients become psychotic in intense therapeutic relationships. They are prone to act upon their transference fantasies rather than to investigate them and often do this in a self-destructive and provocative manner. Finally, there are those patients at risk for showing no response to treatment. They are individuals who are not motivated for treatment and/or do not get involved in the interpersonal process in such a way as to foster change.

## MICRO LEVELS OF TREATMENT PLANNING

Our original approach (Frances et al., 1984) focused on the evaluation process, with the goal of appropriate referral of the patient to a most optimal treatment, along the lines of the five macro areas of treatment planning previously outlined. Since that time, there has been an integration of differential therapeutics with in-treatment modifications (Beutler & Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000). Treatment planning begins with the initial referral. Patient and therapist, whatever the original treatment goals, foci, and methods, must constantly make reevaluations and adjustments. Whereas the diagnosis and problem area focus the *content* of the intervention, the cognitive style of the patient will dictate the *process* and *style* of the intervention. Thus, two people with equal levels of depressive symptomatology may get different interventions, de-

pending on the patient's problem complexity, coping style, and reactance (Beutler, Clarkin, & Bongar, 2000).

### Problem Complexity

The patient's problem complexity relates to the breadth of treatment goals. In terms of problem complexity, we distinguished simple or habitual symptoms from complex symptom patterns. Habitual or simple symptoms are currently supported by reinforcing environments and bear a clearly discernible relationship to their original adaptive form and etiology. Complex symptom patterns, by contrast, are indicative of underlying conflicts, which can be inferred when the symptoms have departed from their original and adaptive form and are evoked in environments that bear little relationship to the originally evoking situation. Somatic treatments by definition are symptom focused. Likewise, behavioral and cognitive psychotherapies are directed most specifically to altering simple symptom presentations. In contrast, interpersonal-experiential and psychodynamic therapies are more broadly focused on symptomatic change and change in internal characteristics of the patient. Manuals for conflict-focused psychotherapies are illustrative by defining conflict-oriented therapeutic focus. Experiential (Daldrup, Beutler, Engle, & Greenberg, 1988), interpersonal (Klerman, Weissman, Rounseville, & Chevron, 1984), psychodynamic (Strupp & Binder, 1984), and family (Minuchin & Fishman, 1981) therapies all formulate treatment foci and mediating goals that are beyond the simple symptom focus itself.

### Coping Style

The coping style of the patient is central to treatment planning, as it sets the parameters on the depth of experience that can be addressed in the treatment. There is no single correct way to categorize patient coping styles, but we reduced the coping styles to four: internalization, repressive, cyclic, and externalizing (Beutler & Clarkin, 1990). The coping styles of the patient determine the depth of experience aroused and addressed in the treatment, with depth of expe-

rience ranging from overt behaviors, to dysfunctional cognitive patterns, to unidentified feelings and experiences, and finally, to relatively unconscious motivations, wishes, and conflicts. There is no implication here that for a therapy to be effective it must reach to the depth of unconscious motivations. However, the therapist must coordinate the problem complexity (symptom or conflict) with the depth of experience addressed in the treatment as limited by the coping style of the patient.

### Resistance Level

The patient's attitude toward seeking assistance from others—resistance or reactance—must be taken into consideration by any therapist in initiating the moment-to-moment interventions in therapy. We speculate that the reactance level of the patient relates to the degree of therapy directiveness. In general, patients high in reactance will not respond well to directive therapies and therapeutic strategies. Rather, more unintrusive interventions such as acceptance, empathy, encouragement, and restatement are most effective with patients manifesting high levels of reactance to the therapist's intervention. Conversely, patients low in reactance are more accepting of directive approaches (e.g., setting limits, providing guidance and advice) and use them productively. The expert therapist is constantly monitoring the reactance level of the patient, which can change in the course of a session or the course of a treatment episode, and adapting accordingly.

### DIAGNOSIS, PROBLEM AREAS, AND TREATMENT PLANNING

In our original publication (Frances et al., 1984), we did not base differential therapeutic principles on diagnosis, because we thought at that time there was too little information concerning diagnosis and treatment planning. We have since provided case books organized by patient diagnosis and have considered differential treatment planning within the context of diagnosis along with other nondiagnostic pa-

tient variables (Perry, Frances, & Clarkin, 1985; Perry, Frances, & Clarkin, 1990).

At the present, designs for clinical research, both in psychotherapy and medication research, depend on diagnosis for defining homogeneous patient groups. Any comprehensive treatment planning algorithm must make use of this accumulating data, so in this description of differential therapeutics, we extend the system along diagnostic lines, even though there are problems in this approach (Clarkin & Levy, 2004).

Although behavioral systems put weight on the specific problem area of the patient (e.g., Goldstein & Stein, 1976; Lazarus, 1992), other orientations seem to imply that the principles of treatment planning cut across the problem areas. They provide little attention to different problem areas and how these might influence treatment planning. The clinician's practice setting will influence the emphasis on diagnosis and its relative weight in treatment planning. The more symptomatically disturbed and less functional the patient, the greater is the need to specify via diagnostic criteria areas of symptomatology and dysfunction in order to begin a specific remediation process. At the other extreme, for those patients with less severe symptoms, who are functional and have clear assets, the diagnosis is less specific, and the treatment approaches can be more varied.

We employ two prevalent diagnoses/problem areas as examples of the use of the treatment-planning process. To that end, we will focus on one prevalent Axis I disorder, major depression, and one prevalent and severe Axis II disorder, borderline personality disorder. We will use these disorders as prototypes for treatment planning.

## Major Depression

The prevalence and multidetermined nature of depression makes it an important focus for treatment planning. Treatment planning for unipolar depression must take into consideration four factors in its phenomenology: (1) the phase of the illness (the acute phase or thereafter), (2) the severity of the disorder, (3) the duration of the disorder (chronic or nonchronic),

and (4) the contributory causes of the depression.

The *phase* of the disorder, either acute or between episodes, dictates both the intensity and goals of treatment. The *severity* of the disorder would include its conceptualization into subtypes, such as melancholia and psychotic depression. In terms of treatment planning, the distinction between psychotic versus nonpsychotic depression is important, dictating different medication and treatment settings. The *duration* of the mood disorder, chronic or nonchronic, influences medication strategies and may relate to the personality issues. Because of space limitations, we will discuss treatment considerations only for nonpsychotic, mild-to-moderate levels of unipolar depression on an ambulatory basis.

## Model of the Disorder

In order to conceptualize the symptoms of depression in a framework suitable for psychotherapeutic treatment, theoreticians have seen the symptoms as reflecting interpersonal problems, internalized ways of thinking about self and others that are dysfunctional, and behavioral excesses and deficits.

## Mediating Goals of Treatment

The mediating goals of the treatment of depression are related to the phase and severity of depressive symptoms and presumed causes leading to their development and maintenance (i.e., a model of the disorder). Depending on the individual patient and his or her idiosyncratic assets, liabilities, stressors, and social supports, the mediating goals of treatment will include *symptom improvement* (decrease in symptoms of depression, control and management of suicidal ideation and/or behavior); *cognitive changes* (changes in faulty or depressogenic cognitions); *interpersonal changes* (increase in social skills, social support, and positive and rewarding experiences, decrease in interpersonal conflict); and *personality/dynamic changes* (modification in interpersonal behavior, modification in intrapsychic conflict, including a decrease in overharsh standards).

### *Treatment Choices*

The severity of the depressive symptoms and/or the associated aspects of depression such as suicidal ideation or behavior may, at times, necessitate hospitalization, especially when social supports are low. Under usual circumstances, such a hospitalization would be of brief duration, but might be lengthened when the depression is accompanied by a comorbid condition such as suicidal behavior and borderline personality disorder. Other than these unusual situations, the treatment of depression can be carried out in an outpatient setting.

The manuals for the individual treatment of depression on an outpatient basis have used a range of psychoeducational, behavioral, cognitive, interpersonal, and psychodynamic strategies and techniques. In general, these treatments are highly structured, with the assessment resulting in specific foci that are negotiated with the patient. The use of homework assignments between sessions is common.

The various individual treatment strategies and techniques are effective but not differentially so for patients with mild to moderate depression. Because the treatment strategies/techniques evaluated to date are of equal effectiveness in at least the brief treatment of outpatient mild-to-moderate depressives, the clinician is faced with the dilemma of how to decide which techniques or combination of techniques to use. Although this is not clinically satisfying, the most parsimonious explanation may be that different brief therapy models draw upon common change facilitating elements (Arkowitz, 1992).

One solution is to assess each patient for the presence of difficulties in the focal areas posited by the various models of depression and target those areas where problems are noted in the evaluation. Thus, depressed patients with faulty interpersonal relations and/or poor social skills will receive treatment focused on these areas. Those patients with prominent cognitive dysfunctions may need some focus on these faulty cognitions. Those with long-standing internal conflicts will need attention in this area. In other words, the mediating goals of treatment will vary, depending on the specifics of

the individual case. In light of this clinical reality, the clinician must draw flexibly and creatively from a range of behavioral, cognitive, interpersonal, and dynamic techniques in the treatment of depression.

One important point that is emerging from research in the treatment of depression should be emphasized. It would appear that the patient must have some minimal level of competence in the area targeted for remediation for the outcome to be positive (Rude & Rehm, 1991). Without some minimal level of competence in the targeted area, the patient does not respond well to intervention, at least in brief therapies. This issue needs more investigation and may well become a central one in differential treatment planning.

Behavioral, cognitive, and interpersonal treatments delivered individually have been researched, and this may reflect the predominant treatment format in clinical use for depression. The focus of treatment in the individual format is the patient's cognitions, social-skills deficits, problematic interpersonal relations, and intrapersonal conflicts. Some of the techniques used in the individual format may be used effectively and more efficiently in the group format, but this has received less research attention.

The use of couples and family formats for the treatment of some aspects of depression is in development. Most of the studies of family treatment formats when one member is depressed have been done in the couples treatment format. In addition, however, there have been recent clinical trials using couples treatment format for both depression and mania (Clarkin, Haas, & Glick, 1988; Tompson, Miklowitz, & Clarkin, 2003).

On a practical level, the clinician must assess for common family problem areas, regardless of whether they predate, coexist with, or follow from the patients' affective symptoms. It is often impossible to sort out the time sequence and causal relations between symptoms and interpersonal stressors. Family and couple areas of prime relevance to intervention would include marital conflict, anger toward and rejection of the patient, lack of relational intimacy, poor parenting behavior, hostility and overin-

volvement (high expressed emotion) with the patient, poor medication compliance, and lack of family support for this compliance.

In addition to the focus on common problem areas when one family member is depressed, a sequence of possible levels of family interventions is available. There is a potential progression of family intervention from psychoeducation, to routine communication training and problem-solving skills enhancement, to more involved systems and psychodynamic intervention. It would appear to us that for any family in which a member has an episode of major depression, family psychoeducation is indicated. Indeed, in families who have excellent premorbid communication and problem solving, psychoeducation may be sufficient. In the majority of families, however, the insult and stress of a major depressive episode will call for at least a planned, relatively brief family/marital intervention, mainly cognitive and behavioral in strategy and focused on assisting the family in coping with the disorder. Finally, there are a subset of families in which premorbid marital conflict, interpersonal difficulties, and poor problem solving are endemic. In these situations, often the patient has concomitant Axis II pathology, and the partner may also have moderate to serious psychopathology. Then, a longer and more involved family intervention may be of assistance, although it is in these cases where small gains are long in coming.

The predominant outpatient treatment for mild to moderate depression that has been researched is a brief, 12- to 25-session psychotherapy. It is quite likely, however, that clinical practice is at variance with the brevity of the treatment in research. This is especially so with cases of more severe depressive symptomatology and where this Axis I condition is confounded with Axis II disorders, which become either an impediment to brief treatment or the focus of intervention once the depressive symptoms have been alleviated.

In many cases, a brief treatment can be negotiated with the patient at initial evaluation, but at the end of this brief intervention, further evaluation will determine the need for more extended intervention. Theoretically, it is possible to describe patients most likely to respond

to brief treatments (little character pathology, absence of previous depressive episodes, those who form a good therapeutic alliance, areas of healthy functioning); in reality, it is often difficult to predict which patients will respond to brief treatments. An empirical approach is best.

In evaluating whether brief therapy is appropriate for a particular depressed patient, the duration, severity, nature, and causes of the depression, as well as the presence or absence of a comorbid Axis II condition are important considerations. Brief cognitive-behavioral and interpersonal therapies have been shown to be effective in the diminution of mild to moderate depressions in outpatients with at least some functional capacity. Successful brief therapy has been accomplished when the mediating goal is cognitive changes (Rush, Beck, Kovacs, & Hollon, 1977), social-skills training (Hersen, Bellack, Himmelhoch, & Thase, 1984), increases in pleasant events (Thompson & Gallagher, 1984), changes in interpersonal problems (Weissman et al., 1979), and psychodynamic changes (Thompson & Gallagher, 1984).

A sizeable minority of patients do *not* respond to brief treatment. For example, in one carefully designed study (Hersen et al., 1984), female unipolar depressives responded to all four treatment conditions (social skills, social skills plus amitriptyline, amitriptyline, and psychotherapy) with marked improvement. However, when a conservative cutoff score (below 10 on both the Beck Depression Inventory and the Hamilton Rating Scale for Depression) was used, only 23% to 49% of the patients were rated as improved. This limitation of therapeutic range may be seen in many other studies. Although behavioral treatment was effective in another study (Brown & Lewinsohn, 1984), at 6-month follow-up, 25% of the patients still met criteria for depression. Low responders to this educational treatment (those who needed more treatment and/or another treatment) reported depressions earlier in life, had significant life stresses, and had greater dissatisfaction across more areas of life, especially with friends. Although there is no guarantee that depressed patients would respond better to a longer treatment, results such as these suggest that longer and more intensive treatments should be em-



ployed for patients whose depressive symptoms do not substantially remit after brief therapy.

### *In-Treatment Modifications*

Once the depressed patient is in treatment, there will likely be needed modifications in the ongoing treatment plan. With depression, the likely modifications are focus (cognitive vs. interpersonal), the level of therapist control and direction, and the length of the treatment.

Once there is some alleviation of the initial depression, attention will often be more concentrated on accompanying interpersonal behavior and personality disorder traits, which, as noted earlier, are quite common in depressed patients. These difficulties may have helped cause the depression or may have been instrumental in occasioning circumstances leading to the depression, and without intervention they may very likely cause relapse. Personality disorders accompanying depression will have an impact on many aspects of the treatment. The prognosis for recovery is not as favorable when the two are co-occurring (Clarkin & Abrams, 1998), and the treatment duration will probably be longer, with personality traits becoming the focus of treatment.

### **Maintenance Treatment**

There is a growing awareness that some patients are suffering from a more chronic depression and it brings up the practical question of which patients should get maintenance treatment? There are some indications that the nature of the response to acute treatment—(1) rapid and sustained responders, (2) delayed, but sustained responders, (3) mixed responders without sustained improvement, and (4) prolonged nonresponders—may relate to the need for maintenance treatment.

What are the patient risk factors for slow and difficult response to treatment and to relapse? There is a growing empirical literature indicating that those individuals with depression and comorbid personality disorders respond slower and more inadequately to treatment than to those patients with depression without comorbid personality disorders. It is

possible that the association between presence of personality disorders and poor response to treatment for depression may be related to the presence of interpersonal difficulties in those with personality disorders, as interpersonal difficulties could leave the individual without much social support and interpersonal joy and pleasure. It has been found, for example, that among depressed women receiving interpersonal psychotherapy (IPT) for recurrent depression, it was the women with fearful avoidant attachment profiles that had lower levels of self-esteem and more negative attitudes toward others than those women with secure attachments (Cyranowski et al., 2002). There was a positive association between high fearful avoidant attachment ratings and longer time to clinical stabilization in IPT, even though attachment classification did not distinguish between patients who did and did not remit with IPT treatment. It would appear that both cognitive-behavioral psychotherapy and IPT (Miller, Frank, Cornes, Houck, & Reynolds, 2003) are effective in the maintenance treatment of patients with depression.

### **Borderline Personality Disorder**

#### *Model of the Disorder and Treatment-Relevant Subtypes*

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic criteria for borderline personality disorder (BPD) can be considered a working definition of common difficulties presented by individuals with the diagnosis. The criteria, however, vary widely in their sensitivity, specificity, and predictive power with respect to the diagnosis (Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983). Few individuals classified as having the disorder manifest all nine criteria. Because BPD, like most DSM diagnoses, is polythetic, it is inevitable that individuals with the disorder will be quite heterogeneous with regard to the criteria and the problem areas they represent. Using cluster analysis of the BPD diagnostic criteria in a large group of patients, we (Hurt et al., 1990) found three cluster combinations that emerge from the criteria. This involves

identity problems (such as chronic feelings of emptiness or boredom, identity disturbance, and intolerance of being alone), affective problems (intense anger, instability of affect, unstable interpersonal relations), and impulsivity problems. It is one or more of these three problem areas that one is targeting in the treatment of BPD individuals.

This heterogeneity among people with BPD makes it difficult to specify treatment strategies for the group. On the one hand, designing treatment strategies for the individual criteria themselves or for the many possible combinations of criteria seems overly specific. On the other hand, a treatment strategy designed to address the entire complex of criteria would fail to address the modal individual with the diagnosis who has less than the complete set.

### *Comorbidity*

Borderline patients often have extensive comorbid conditions on both Axis I and Axis II. Many BPD patients have a comorbid Axis I diagnosis of some form of depression, and they often get into treatment because of a depressive episode. From a practical point of view, borderline patients with depression need attention for the depression at the beginning, after which the treatment can proceed to other disruptive BPD behaviors (Skodol, 1989). On Axis II, it is common for borderline patients to have overlap with narcissistic and histrionic personality disorder and/or features.

### *Mediating Goals of Treatment*

The mediating goals of treatment, in order of priority, would be (1) control of suicidal and other self-destructive behavior (e.g., serious alcohol abuse), (2) induction into treatment with normalization of in-treatment behavior (e.g., attendance at each session, reduction in multiple contacts between sessions), (3) treatment of depressive affect and other labile and uncontrolled emotions, (4) improvement in interpersonal relations and behavior, and (5) improvement in self-esteem and identity. The mediating goals of treatment will depend on the comorbid conditions of the particular BPD

patient (e.g., existence of current depression, transient psychotic symptoms), and the particular mix of BPD criteria.

### *Treatment Choices*

Under usual circumstances the borderline patient can be treated on an outpatient basis. However, because, many of these patients have episodes of serious self-destructive behavior, acute hospitalization may be needed periodically to control such behavior. The range of functioning, both psychosocial and vocational, varies widely in the borderline group, such that some of these patients may need day hospital treatment for the development of these skills.

Though the predominant clinical format is individual treatment, the most researched treatment formats for BPD are a combination of individual and group formats and group formats alone (Clarkin, Marziali, & Munroe-Blum, 1991). The group format has the advantage of diluting the BPD patient's reliance and involvement with one individual therapist and providing a group of people who can be models for coping and interaction. This format may provide one antidote to the danger of overinvolvement and iatrogenic effects of individual treatment in borderline patients (Strupp, Hadley, & Gomes-Schwartz, 1977).

There are a number of manualized treatments for BPD patients: a cognitive-behavioral approach, which combines individual and group formats supported by a clinical trial (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), a modified psychodynamic approach (Clarkin, Yeomans, & Kernberg, 1999), and an integrated approach (Livesley, 2003). In addition, two day-hospital treatments, both psychodynamic in orientation, have been described (Bateman & Fonagy, 2003; Piper, Rosie, Azim, & Joyce, 1993). Psychodynamic treatments show differences in the use or nonuse of early transference interpretation, emphasis on a holding environment versus exploring negative transference, and different conceptualizations of the therapist's role (Waldinger, 1987). Successful dynamic treatments of borderline patients suggest that early treatment goals must focus on controlling acting-out behavior around both the

destruction of the treatment and self-destructive behavior, which is then followed by other treatment goals (Waldinger & Gunderson, 1984).

It is generally agreed that substantial progress with BPD patients will take a treatment of longer duration. Linehan's dialectical behavioral treatment is 1 year in duration (Heard & Linehan, this volume), and Kernberg's (Clarkin, Yeomans, & Kernberg, 1999) manualized dynamic treatment presupposes a treatment period of some 2 years. Brief treatments, however, may be effective at times of crisis for the BPD patient, which may or may not be followed by long-term therapy. Those BPD patients who have gotten into intense and destructive treatment relationships previously may need only brief treatments in crisis.

### In-Treatment Modifications

What modifications in treatment approach must the therapist be aware of in the treatment of borderline patients? These patients present many situations (i.e., potential treatment dropout, threatening of suicidal behavior) that may call for the clinician to be flexible and change strategies in midstream. From a psychodynamic orientation (Clarkin, Yeomans, & Kernberg, 1999) the therapist may have to retreat from therapeutic neutrality at times with these patients, especially when there are suicidal threats and psychotic transferences. From any perspective, the nature and tone of the relationship between patient and therapist must be carefully monitored. BPD patients are prone to become intensely attached, both positively and negatively, to the therapist, and acting-out, self-destructive behavior will often occur in the context of this relationship and its vicissitudes.

### Summary

When planning treatment for the BPD patient, the following variables should be considered:

1. The action potential of the patient (suicidal behavior, other impulsive behaviors); these behaviors need to be controlled right from the start of the treatment.

2. The comorbid Axis I disorders; depression is common, and in about 10% of the cases, bipolar disorder is present.
3. The comorbid Axis II disorders; the continuum of antisocial, malignant narcissism, narcissism with antisocial traits, and borderline alone is relevant for treatment planning and prognosis.
4. The structure of the treatment from the start is crucial, as exemplified in the contract-setting phase of the treatment.
5. The strengths of the patient.

### CONCLUDING COMMENT

With the progression of time and the inevitable comparison with other views of psychotherapy integration, the substance of differential therapeutics in terms of its goals, content, assets, and limitations has become clearer. Differential therapeutics was originally intended as a framework (based on research and accumulated clinical wisdom) within which one could teach mental health trainees a methodology for clinical decision-making. This continues to be the main function of differential therapeutics; it is a systematic framework within which one can continually make use of new research information to reformulate guidelines for treatment planning.

Though conceived as a teaching framework, differential therapeutics can also be used as a guide for generating hypotheses for clinical research. It has been repeatedly pointed out that the number of possible combinations of patients by type, by diagnosis, by treatment, is almost infinite, and we cannot plan for research on all combinations. Rather, one must strategically plan research on the most likely fruitful combinations.

Part II of this *Handbook* is focused on systems of psychotherapy integration, and Part III pertains to integrative psychotherapies for specific disorders and populations. In many respects, differential therapeutics includes, but is not limited to a system of psychotherapy integration or to specific disorders. Integrative systems focus on what the therapist does in terms of therapy strategies and techniques at different

phases of an individual treatment. Differential therapeutics originally lacked attention to such detail in the therapy session but has been applied to these situations in more recent explorations (Beutler & Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000).

Logically, differential therapeutics comes before systems of psychotherapy. Rather than assuming that the patient is in individual psychotherapy of whatever orientation, differential therapeutics is concerned with treatment planning for the individual from the first evaluation, whether that be in a hospital emergency room, in a walk-in clinic, or in a private practitioner's office. This system does not assume that the clinician will be treating the patient, but rather that the evaluation can have more degrees of freedom if the evaluator and patient do not assume that the evaluator will be conducting the treatment. From the perspective of the initial evaluation, many avenues of treatment tailored to the individual patient are real possibilities.

Other kinds of systematic treatment *integration* place little emphasis on the use of diagnosis. We think that as data accrue on the differential treatment response of various diagnostic groups, the diagnosis will continue to provide important modifiers in the treatment planning process. There are limitations to the use of diagnosis (Beutler & Clarkin, 1990; Clarkin & Levy, 2004), but the diagnosis is the first step in specifying the nature of the patient's difficulties relevant to the focus and methods of intervention. At the extremes, this statement is clear. One does not treat chronic schizophrenics and adjustment disorders alike. In the mid-range (e.g., depressed outpatients), the nature of the disorder and its relation to differential treatment is less clear.

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## Integrating Therapeutic Modalities

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Individual, family, and group therapy have developed as separate, and often antagonistic, modalities. This rigid separation has denied psychotherapists valuable opportunities to enhance clinical assessment and treatment effectiveness by integrating the complementary benefits of each of these modalities. Individual problems stimulate and reinforce interpersonal difficulties; interpersonal problems exacerbate and reinforce individual vulnerabilities. The opportunity to address both individual and interpersonal dynamics expands the possibilities for significant and lasting change.

In this chapter, we present a model for integrating individual, family, and group therapy and illustrate this model with clinical examples. The advantages and limitations of each modality are discussed, along with general considerations and common concerns regarding the process of integration. Detailed descriptions of individual and family therapy integration and individual and group therapy integration provide the reader with a framework for practice.

A brief note about terminology: We recognize that some therapists use the term “format” instead of “modality”; we generally prefer modality, but sometimes use the two terms interchangeably. We also recognize that some therapists use “family therapy” to refer exclusively to work with multigenerational families; we use a broader definition, which includes work with couples.

### ADVANTAGES AND LIMITATIONS OF INDIVIDUAL THERAPY

#### Advantages

#### *Assessment*

Individual psychotherapy provides a particularly valuable context for assessing individual problems and strengths and for promoting intrapsychic changes. The privacy of the individual setting reduces defensiveness and facilitates discussion of feelings and thoughts about self

and significant others. Often, individuals are able to discuss in an individual session important issues that they would be too fearful, ashamed, or guilty to discuss in the less private context of group or family therapy. Examples of such issues include feelings of worthlessness, suicidal ideation, thoughts about divorce, homosexual feelings, alcohol or drug abuse, couple or parental violence, extramarital affairs, and sexual abuse. When the therapist's assessment does not include a detailed understanding of such issues, that assessment will be limited and incomplete. In some instances, such as when an individual is suicidal, potentially violent, or the victim of physical or sexual abuse, the assessment may be dangerously incomplete.

Individual therapy allows the therapist to develop an indepth assessment of one person's feelings, thoughts, and behavior. All aspects of the individual's life—family, work, friends, interests, values, hopes, and fears—can be explored. In family and group therapy, this is more difficult because of the need to assess more than one person at a time, as well as the need to track the dynamic interactions between the family or group members.

In addition to its value as a context for the assessment of intrapsychic concerns, individual therapy is also a valuable source of hypotheses about interpersonal problems and strengths and interpersonal problem stimulation and reinforcement processes. Through the individual's self-reports and the therapist's direct experience of a one-on-one relationship with him or her, valuable hypotheses about interpersonal dynamics often emerge.

### *Therapeutic Change*

Individual therapy provides a particularly valuable setting for the establishment of a one-to-one therapeutic alliance (Bordin, 1979; Safran & Muran, 2000a). By relating with empathy, respect, concern, and genuineness (Rogers, 1980), the therapist fosters the development of a safe, collaborative relationship within which difficult feelings, thoughts, and behaviors can be explored and changed. The intimacy of the individual therapy relationship contributes to

feelings of trust and hope, and a sense that the therapist “really cares about me,” “has my interests at heart,” and “is my ally.”

The privacy and focused intensity of individual therapy stimulates intrapsychic change processes. The opportunity to experience a primary relationship with a “good object” (Klein & Riviere, 1964) facilitates the process of therapeutic internalization (Meissner, 1981). Individuals are able to identify with the therapist's empathic and respectful attitude toward them, thereby enhancing their own self-understanding and self-respect.

The opportunity to explore conscious and unconscious experiences within the context of a secure “holding environment” (Winnicott, 1965) facilitates the processes of insight and working through (P. Wachtel, 1985). In this context, cognitive distortions and transference projections can be clarified, and the connections between these processes and unconscious conflict can be discovered.

The intensity of the one-to-one relationship stimulates the development of emotionally charged reactions toward the therapist. Because the therapist is the only other person physically present, cognitive and emotional responses toward him or her are particularly compelling. Individual therapy affords the therapist frequent opportunities to concentrate empathic understanding on the dynamics of the therapeutic relationship. Discussion of these dynamics in the privacy of the individual setting has the potential to produce substantial intrapsychic change (Luborsky, 1984; Safran & Muran, 2000b).

Individual therapy also provides a valuable context for promoting behavioral change (Goldfried & Davison, 1994; P. Wachtel, 1997). Within the secure environment of the individual setting, new forms of behavior can safely be explored. This exploration takes place in two ways. In direct interactions with the therapist, the individual has opportunities to experiment with a variety of new behaviors; for example, passive, compliant people can risk being more assertive because they feel that the therapist will not be judgmental or attacking. The second type of exploration takes the form of role-played interactions with the therapist (be-



havior rehearsal), which provide an opportunity to address specific problem situations that occur in the individual's day-to-day life. For instance, people who are not appropriately assertive with their spouse can use behavior rehearsal with the therapist to reduce their anxiety about developing and employing assertive behavior.

### Limitations

The limitations of individual therapy are derived from its reliance on the one-to-one relationship with the therapist as the sole context for clinical assessment and therapeutic intervention. Though this relationship is highly significant, it is also limited.

In terms of assessment, an individual may withhold important information that is essential in formulating a treatment plan. For example, a person with substance abuse may be in denial or afraid to admit having a problem in this area; a suicidal person may be ashamed to reveal self-destructive feelings; a violent person may feel too guilty to discuss his or her violent behavior. In such situations, meeting with one or more significant others is often very illuminating. At times, it may be lifesaving.

Another limitation of individual therapy is that it does not allow the therapist to directly observe the individual interacting with anyone other than the therapist. Often, people behave quite differently in different contexts. A person may, for example, be calm and cordial during an individual meeting with the therapist but may manifest a great deal of hostility during a family or group meeting. Conversely, a person may be quite hostile in an individual session but calm and cordial in a family or group session. When the therapist's observations are drawn from individual meetings only, a great deal of important information may be unavailable.

In regard to therapeutic intervention, individual therapy does not provide opportunities for the therapist to directly influence the interpersonal behavior of the significant people in the person's life or of the individual in relation to those significant others. Furthermore, there are no opportunities for anyone other than the

therapist to interact with the individual in therapeutic ways. In family and group therapy, such opportunities are readily available.

## ADVANTAGES AND LIMITATIONS OF FAMILY AND GROUP THERAPY

Family therapy, with couples or multigenerational families, and group therapy, with children, adolescents, or adults, provide particularly valuable contexts for assessing interpersonal problems and strengths and for promoting positive changes in interpersonal behavior. Interactions of family or group members with each other and with the therapist offer multiple and complementary opportunities for assessment and intervention.

### Advantages

#### *Assessment*

*Family Therapy.* By meeting with family members together, the therapist has the opportunity to join with them in a collaborative effort to understand and change their problematic interactions and to facilitate the development of more positive, intimacy-promoting experiences. In conjoint meetings, the therapist is able to observe how family members organize themselves (who sits next to whom, who speaks to whom, how close or far apart people position themselves, etc.). He or she is also able to observe their postures, gestures, and facial expressions and the quality, pitch, and volume of their voices. Sequences of nonverbal and verbal behavior are valuable sources of insight into the ways that family members consciously and unconsciously stimulate and reinforce each other. For example, a husband moves back in his chair whenever his wife begins to talk about their sexual relationship; a son interrupts when his mother and father begin to argue; a mother consistently answers questions that are addressed to her daughter.

Equally valuable are the therapist's observations of the similarities and differences among each family member's perceptions of the problems and strengths in the family and of the

constructive and destructive ways that family members discuss the problems that they have identified. Based on these observations, the therapist can directly intervene to reduce the frequency and intensity of destructive behaviors and to foster the development of constructive problem-solving interactions.

Conjoint couple or family meetings also provide an opportunity for consensual clarification of self-reported behaviors and behavior sequences. Often, family members remember the same events in quite different ways. For instance, a husband may report that he drinks once or twice a week, whereas his wife states that he drinks every day. Similarly, a teenage boy may indicate that school is “fine,” but his mother reports that she is receiving frequent complaints from his teachers about his behavior. Exploration of these differences is essential for an accurate assessment.

In addition to their value as contexts for assessing interpersonal problems and strengths, conjoint meetings are also valuable sources of hypotheses about individual problems and strengths and intrapsychic problem stimulation and reinforcement processes. Observing individuals in the context of their family provides a unique perspective from which to formulate hypotheses about intrapsychic dynamics.

*Group Therapy.* In group therapy, functional and dysfunctional behaviors, strengths and vulnerabilities, become apparent as individuals relate to each other and to the therapist. One advantage of the group context is that members may challenge or confront each other in ways a therapist would not. Behavioral and emotional responses in these stressful situations provide valuable information about coping skills, vulnerability, and resiliency.

Conscious and unconscious processes are often brought to light as group interactions stimulate cognitive distortions and transference reactions. Individuals’ self-reports and group members’ feedback are both valuable means for identifying irrational thoughts and emotions.

The shared feelings and struggles of the group members provide an important “normalizing” function. Commonality of life experiences or problem areas provides reassurance

and facilitates openness and full disclosure. The humiliation that many people report about coming for professional help—not being able to “solve my own problems”—can be diminished substantially by the shared experience of group treatment.

### *Therapeutic Change*

*Family Therapy.* Family therapy provides a particularly valuable context for the formation of therapeutic alliances with couples or families (Rait, 2000). Individual resistances are often reduced in family therapy because difficulties are identified as family problems rather than the exclusive problems of one individual. Each family member is viewed as partially responsible for finding solutions. This process minimizes scapegoating and facilitates the engagement of each person in a therapeutic effort to improve the quality of family interactions.

Conjoint meetings also promote intimacy among family members. These meetings are an opportunity for individuals to share their feelings and thoughts about themselves, each other, and their life together. The therapist helps each person to communicate constructively his or her feelings and thoughts about self and others and to listen actively as others communicate their feelings and thoughts. This process increases empathic understanding and promotes feelings of intimacy.

In family therapy meetings, family members have an opportunity to practice more constructive ways of interacting with each other. The therapist can directly intervene when dysfunctional patterns emerge, can suggest more functional alternatives, and can provide positive feedback in response to constructive changes.

The time that family members spend with each other before and after family sessions is often very therapeutic. In these times, they are able to share experiences and feelings that they otherwise might not have shared. Many families report that after leaving therapy meetings, they continue to work productively on issues that they had begun working on during the meeting. In addition, families often indicate that once the lines of communication have been

opened, they experience more free-flowing conversation on a variety of topics.

*Group Therapy.* The normalizing function of the group experience not only expands assessment opportunities by counteracting inhibitions and facilitating sharing, but also makes a significant contribution to therapeutic change. Individuals often come to treatment with low self-esteem, fueled by a sense of isolation, feeling different or “defective,” and set apart from others by “unique” problems, experiences, or family backgrounds. Group therapy provides a context in which individuals can experience consensual validation, hear others report familiar struggles, recognize similarities, and reframe elements of their personal dilemma as part of the human dilemma. Group members frequently report a sense of relief as this process unfolds (Yalom, 1985).

Group therapy is also an empowering experience. The group members serve as change agents and facilitators; there are numerous opportunities for leadership and for experiencing oneself in benevolent ways. In the group context, individuals give to one another, and in that giving, receive a renewed sense of self-worth. By offering support, encouragement, reassurance, and insight through feedback and interpretations, group members influence each other in ways that facilitate growth for themselves and for others.

At the time of termination, individuals often report the special significance of interventions by their peers. Affirmations may be less suspect because the group member “is not being paid to do the praising.” Suggestions and interpretations may be considered more credible coming from others “who have been there.” Confrontations may be easier to tolerate when they come from “one of us,” not from the “expert.” Acceptance can be relished when it seems hard won rather than a professional responsibility that “comes with the territory.”

Learning through others in the group occurs directly and indirectly. Members influence each other directly by offering suggestions, validation, affirmation, or confrontation. They influence each other indirectly by means of observing and absorbing therapeutic changes.

As a fellow group member develops insight or modifies behavior, others identify with the process. In this way, therapeutic changes become available for all. “Vicarious therapy” (Yalom, 1985) is one of the distinct advantages of group treatment.

The whole in group therapy is more than the sum of its parts. An entity develops—the group—that generates its own information and offers learning through interpersonal process. This interpersonal process provides a corrective emotional experience. If individual therapy creates an opportunity for a significant relationship with a “good enough” parent (Winnicott, 1965), then group therapy provides an opportunity to address issues involving the entire family. Sibling rivalry is often re-created in group process as individuals compete for the attention and admiration of the therapist and other members. Varying positions of inclusion and exclusion in the group often stimulate each individual’s sense of self and his or her role in the family of origin. A sense of belonging, never fully experienced in childhood, may develop as the group becomes increasingly cohesive. Interpersonal conflict, unsuccessfully resolved in the family system, may be dealt with constructively in the group setting. Empathy, acceptance, validation, and affirmation that were lacking in the individual’s first significant group experience, the family, can be found in the present therapy group experience.

### Limitations

One of the limitations of family and group therapy is that in these contexts, individuals may be too inhibited by the presence of others to raise or discuss important matters concerning themselves or their families. Examples of such matters were previously noted (see advantages of individual therapy), as was the importance of the therapist having this knowledge in order to formulate an accurate and complete assessment. Another limitation is that these modalities do not allow the therapist to observe and interact with individuals outside of the family or group context. As previously discussed, the differences between how people behave in

these contexts versus the context of individual therapy can be dramatic.

A further limitation of family and group therapy concerns the limited amount of time available for each person. Some individuals need more time, energy, and attention directed toward their specific concerns and their unique situation than can be offered in a family or group context. Other individuals, such as those with attentional problems (ADD, ADHD), may be overwhelmed or distracted in a family or group setting. For these people, the focused intensity of individual therapy is essential for healing.

In addition, family and group therapies are limited in their ability to facilitate intrapsychic change processes. The presence of other people can interfere with the empathic responsiveness necessary for the establishment of a secure environment for intrapsychic exploration. Further, the highly valuable intensity of transference reactions to the therapist can be diluted by emotionally charged interactions with family or group members.

## INTEGRATION: GENERAL CONSIDERATIONS

Individual, family, and group therapy are complementary and synergistic formats. The advantages of each modality can reinforce and expand those of the others; the limitations of each can be compensated for by the others' strengths. Integration allows the therapist to use the complementary benefits of each approach.

In this section, we discuss some general issues that are of common concern in both individual and family and individual and group therapy integration. The first of these is confidentiality.

### Confidentiality

When individual therapy is integrated with either family or group therapy, confidentiality is an important concern. Anxiety about this concern often inhibits therapists from attempting an integrated approach. We hope we can reduce

this anxiety by presenting a framework for thinking about and dealing with confidentiality.

There are a number of constructive ways to deal with confidentiality; each one has advantages and disadvantages. Whichever approach the therapist chooses, it is essential that he or she communicate that approach clearly at the outset and be consistent in its application throughout the course of therapy.

One way of dealing with the question of confidentiality is for the therapist to state that because of the importance of information exchange between the modalities, it is essential that he or she have the freedom to share information from individual meetings with the other family or group members. This position maximizes communication between the different modalities, but it limits the willingness of many people to discuss important information in their individual meetings. Also, even when individuals do agree to a free flow of information, they may still experience sharing of information by the therapist as a "betrayal of confidence."

A second approach is for the therapist to take the position that integration will be most effective when the "integrity" of each process is preserved by the strict maintenance of confidentiality. This position maximizes openness in the individual meetings but minimizes communication between the modalities.

The position that we recommend incorporates elements of both these approaches. In regard to anyone outside the family or group, confidentiality is strictly maintained, as long as doing so would not endanger anyone's safety. Within the therapeutic milieu, however, there is a dynamic interplay. Everyone is encouraged to take responsibility for introducing relevant feelings, conflicts, or insights from individual sessions into family or group sessions. The therapist refrains from sharing such information unless he or she has obtained explicit permission to do so. When such permission is requested, it is important that the therapist be clear about what will be shared and why it may be helpful. In order to avoid being placed in the position of "keeping secrets" (e.g., adolescent drug abuse, extramarital affairs, misrepresentations of important information in the fam-

ily or group setting), the therapist obtains an agreement at the outset from each person that if anything is discussed in an individual session that the therapist believes is essential to share with the family or group, the individual will either share that information or give the therapist permission to do so.

In addition to discussing the therapist's behavior regarding confidentiality, it is also important to make clear recommendations to family or group members about their own behavior. In relation to anyone outside the family or group, confidentiality is essential. In regard to sharing material from individual sessions with family or group members, it is generally best to leave the decision to each person; however, the therapist should discuss the possibility that if such information is shared, it can lead to difficulties. This is particularly true when one person shares comments that the therapist reportedly made about others in the family or group, such as: "He said that the reason we have marital problems is because you're overly sensitive" or "She said you really came on too strong when you attacked me in the last group meeting." It is important that the therapist request, at the beginning of treatment, that if individuals are told about any comments reportedly made by the therapist that are upsetting to them, they discuss their reactions with the therapist so that clarification and working through can take place.

### One Therapist or Two?

In most instances, one therapist can effectively integrate individual therapy with either family or group therapy. Indeed, there are specific advantages to a one-therapist structure: (a) the therapist has direct access to the information and observations derived from the individual and family or group meetings; (b) the therapist can form both individual and family or group therapeutic alliances; (c) there is maximal coordination of the different therapeutic modalities; (d) there is maximal flexibility in regard to structure change (e.g., increasing or decreasing the frequency or length of the individual, family, or group meetings); (e) one therapist is more cost-effective than two; and (f) there is

minimal conflict between the individual and family or group therapists.

There are times, however, when the advantages of a one-therapist structure are outweighed by the disadvantages. With individual and family therapy integration, a two-therapist structure is indicated when the number and/or severity of the presenting problems are unusually high, when a symptomatic person is extremely resistant to sharing "his or her" therapist with the other family members, when an individual therapy relationship has been firmly established prior to the introduction of couple or family therapy, or when the therapist is convinced that a couple's relationship is not likely to endure and that each person will need an individual therapist to weather the transition and move on. When two therapists are used with multigenerational families, one therapist meets with the symptomatic child or adolescent, the other meets with the parents, and both meet with the family. With couples, one therapist meets with each spouse and both meet conjointly with the couple.

With individual and group therapy integration, a two-therapist structure is indicated for those with a particularly strong need for an exclusive relationship with an individual therapist. In some instances, this need arises as a result of being in individual therapy for a considerable period of time prior to the start of integration. In other instances, individuals with significant shame or guilt may move more easily into the group context if there is a separate therapist facilitating the group with whom they have not personally detailed all episodes of a painful history.

When the integration is facilitated by two therapists, consistent communication and collaboration are essential. Conflicts and misunderstandings need to be resolved and a unified approach developed and maintained.

## INTEGRATING INDIVIDUAL AND FAMILY THERAPY

### Clinical Assessment

Individual and family interviews each provide essential and complementary information. In-

tegration of these formats allows the therapist to develop a comprehensive assessment and treatment plan (Feldman, 1992).

### *Families*

An initial meeting with the parents of a symptomatic child or adolescent provides the therapist with an opportunity to gather detailed information about the presenting problems, to place those problems in perspective by collecting information about the family history, to discuss the parents' attempts at problem solving, and to explore individual and family strengths. It also allows the therapist to begin the process of establishing a positive working alliance with the parents.

It is essential that the therapist involve *both* parents in the assessment process. Each parent's perceptions of the problems and strengths of the symptomatic child or adolescent and of the family system are of the utmost significance. In addition, it is important that the therapist establish an alliance with both parents from the outset so that each parent can be engaged as a partner in the therapeutic process.

*Clinical Illustration.* A 10-year-old girl, Alice, and her parents were referred for an evaluation in response to the parents' concern about Alice's intense fear of being separated from them. Whenever the parents tried to leave her with someone else for an evening, Alice became extremely frightened and distraught. She cried uncontrollably and begged her parents not to leave. She was also afraid to sleep over at any of her friends' houses and consistently refused their invitations. As a result, she was starting to lose her friends.

The initial meeting was with the parents, who both expressed a great deal of concern about Alice's separation anxiety. They reported that when they asked her what she was afraid of, she could only say that she was afraid something bad would happen to her if they left. They indicated that Alice's symptoms had emerged about 6 months after the death of her maternal grandmother. During that 6-month period, Alice's mother had been severely depressed and emotionally withdrawn. Once Al-

ice's separation anxiety appeared, the mother became extremely protective toward Alice. She frequently reminded her to be careful, asked her repeatedly if she felt afraid, and organized her time so that Alice was seldom left alone. If she and her husband did go out, she called in frequently to make sure her daughter was all right. If the person staying with Alice reported that she was upset, the mother strongly suggested to her husband that they return home immediately, and they usually did.

Alice's father was generally less anxious than her mother, but he was quick to anger when he felt frustrated or hurt. At the time of the referral, he was feeling quite frustrated with both Alice and her mother and hurt by what he perceived as his wife's lack of interest in spending time with him.

The second component of an integrated family assessment is an individual meeting with the symptomatic child or adolescent. This meeting is directed toward an exploration of the young person's feelings and thoughts about self, family, and individual and interactional problems. With adolescents, the meeting is generally entirely verbal; with children, verbal discussion is combined with diagnostic play activities, such as therapeutic board games, picture drawing, story telling, and doll or puppet play (Broder & Hood, 1983; E. Wachtel, 1994).

In her individual meeting, Alice was very anxious and seemed moderately depressed. During the course of a play therapy assessment, she said she was afraid that if her parents left her alone, she or her mother might die. She wasn't sure why she had that fear, but thought it might have something to do with her grandmother's death. Alice also talked about how frightened she got when her father became angry at her or her mother. She said she was mad at her father because he got angry so often.

The third element of an integrated assessment is a conjoint family meeting. This meeting always includes the parents and the symptomatic child/adolescent and may also include other family members (e.g., siblings, grandparents) if the therapist believes their presence is necessary for a comprehensive assessment. When the parents are married and/or living together,

they both participate in the same conjoint family meeting; when they are separated or divorced, it is sometimes more therapeutic to conduct separate conjoint meetings with each parent, at least initially. During the conjoint meeting, the therapist clarifies each family member's perceptions of familial problems and strengths. Requests for change are identified, and behavior change agreements are negotiated.

A week after the individual meeting with Alice, she and her parents came together for a conjoint family meeting. In that meeting, Alice's mother urged Alice to talk about why she was afraid, and she urged her husband to talk about why he was angry. Alice and her father were slow to respond, but both did eventually talk about their feelings. Alice was able to say she was afraid she or her mother might die and to connect this to her grandmother's death and her mother's subsequent depression and withdrawal. She was also able to say that when her father got angry, she felt frightened. Alice's father said he felt frustrated with Alice because she seemed unwilling to work on learning to handle being separated from him and his wife. He also said he felt frustrated with his wife because she seemed unwilling to work on learning to tolerate Alice's being upset. Alice's mother cried and said she felt overwhelmed by Alice's symptoms and her husband's anger.

Each family member was helped to translate their feelings into requests for specific behavioral change. Alice's parents asked her to work on her fears so that she could learn to tolerate separation from them. Alice asked her father to work on reducing the frequency and intensity of his anger and asked her mother to stop asking her so often if she was all right. Father asked mother to work on increasing the amount of time the two of them spent with each other, and mother asked father to work on controlling his temper.

### *Couples*

With couples, an initial conjoint meeting allows the therapist to clarify the nature, intensity, and history of the presenting problems, to discuss the couple's current and past attempts

at problem solving, to observe the couple's communication and problem-solving interactions, and to explore current and past relationship strengths. At the same time, the therapist is able to begin the process of forming a therapeutic alliance with each partner.

*Clinical Illustration.* Barbara and Bill came for couple therapy in response to increasingly frequent arguments, which were characterized by mutual blaming, name-calling, and threats of divorce. In the initial conjoint meeting, they described a chronically recurring interactional pattern: Barbara became angry when Bill behaved in ways that she experienced as inconsiderate and hurtful—for instance, coming home late and not calling. Bill became defensive when this happened and withdrew into a cold, distant silence. Barbara reacted to his behavior with increased anger, often leading to verbal hostility and/or name-calling. At that point, Bill responded with hostile and demeaning comments about Barbara. From there, the argument escalated into a shouting match. Eventually, Bill and Barbara withdrew from each other and maintained a “cold war” atmosphere, sometimes for hours and sometimes for days. After a time, one of them made a move toward reconciliation. Sometimes, this initiative was rejected, leading to another round of arguing. More often, the other person responded positively, and they entered a short-lived period of relatively satisfying interaction.

The second component of an integrated couple assessment consists of individual meetings with each partner. In these meetings, the therapist can explore each person's feelings and thoughts about the presenting problems, the relationship, the partner, the self, and the family of origin. The individual meetings can strengthen the alliance between the therapist and each partner and deepen the therapist's understanding of the strengths and vulnerabilities that each person brings to the relationship. In focusing on the presenting problems, the therapist can clarify both individuals' emotional and cognitive reactions to their partner's behavior and help them develop a better understanding of their partner's emotional and cognitive reactions to their behavior.

The therapist inquires about each person's perceptions of individual and relationship strengths. He or she explores both current strengths and those that were present in the past but are not currently in evidence.

When the problems and strengths have been clarified, family-of-origin history is explored. This exploration provides a foundation for understanding the connections between feelings, thoughts, and behaviors in relation to the partner and conscious and unconscious feelings and thoughts in relation to members of the family of origin (i.e., transference reactions).

The individual meetings with Barbara and Bill helped to clarify some of the emotional and cognitive roots of their dysfunctional interactions. Barbara talked about repeated experiences of feeling neglected by her father, who seemed much more invested in his business than in his family. Bill talked about feeling criticized by his mother, who never seemed satisfied by his performance at school or his behavior at home. The therapist pointed out that part of what seemed to be happening in their relationship was that each person's behavior (Bill's neglectful behavior; Barbara's critical behavior) touched a raw nerve in the other. He encouraged Barbara and Bill to talk about their family-of-origin experiences in the next conjoint meeting and to continue to work on their feelings about these experiences in subsequent individual meetings.

### Formulation and Treatment Recommendations

By integrating the information and observations derived from the conjoint and individual meetings, the therapist is able to develop a comprehensive formulation. This formulation includes an assessment of the nature and intensity of individual and family problems, the intrapsychic and interpersonal factors that are stimulating and reinforcing those problems, and the individual and family strengths that are limiting the severity of the problems and providing a foundation for constructive problem resolution.

Based on his or her formulation, the therapist generates treatment recommendations, which

are then discussed with the family. The therapist explains the rationale for this particular treatment plan and asks family members to share their feelings and thoughts about the recommendations. Based on their reactions, the plan may be implemented as originally described, or one or more modifications may be introduced. In either case, it is helpful to implement the treatment plan on a time-limited basis (for example, one month) and then reassess whether to retain or modify the original structure.

### Therapeutic Structure

In developing an integrative treatment plan, the therapist devises a therapeutic structure that he or she believes is most likely to promote a decrease in individual and family interactional problems and an increase in individual and family interactional strengths. The first step in this process is clarification of each family member's explicit and implicit therapeutic goals.

### Goals

Family members often identify different, and sometimes conflicting, treatment goals. For example: (a) The parents of a depressed adolescent boy identified their major goal as the alleviation of their son's depression; the boy indicated that his major goal was a reduction in the conflict between him and his mother; (b) A husband stated that his goal in coming for couple therapy was to improve the marriage; his wife stated that her goal was to dissolve the marriage. When the therapist discovers that two or more family members have conflicting goals, he or she uses individual and conjoint meetings to explore the possibility of developing treatment goals that all family members can accept. In doing this, the notion of time-limited goals is often helpful. Suppose, for instance, that a married couple comes for therapy and the wife reveals in an individual meeting that she is uncertain about whether or not she wants to stay in the marriage. The therapist can explore this with the wife and determine whether she is willing to make a time-



limited commitment (e.g., 2 months) to try to improve the marriage and then to reevaluate her feelings. If she is willing to make such a commitment, then marital therapy is possible; if she is not, then divorce therapy is the only possible option.

### Structure

After exploring each family member's therapeutic goals, the therapist recommends a treatment structure that he or she believes has the greatest likelihood of facilitating the attainment of those goals. That structure will involve either a symmetrical or asymmetrical integration of individual and family therapy meetings (see Table 17.1).

*Symmetrical integration* is characterized by an equal emphasis on each type of format. In symmetrical therapy with couples, conjoint meetings with the couple alternate with concurrent individual meetings with each partner. In symmetrical therapy with families, conjoint meetings with the family or a family subgroup (e.g., parents) alternate with individual meetings with the symptomatic child or adolescent.

With both couples and families, conjoint and individual meetings can either take place on separate visits, or each visit can be divided into conjoint and individual components. For

instance, a conjoint family meeting may be followed by an individual meeting with the symptomatic child or adolescent; individual meetings with each member of a couple may be followed by a conjoint meeting with the couple.

*Asymmetrical integration* is characterized by an emphasis on one format more than the other. In asymmetrical therapy with couples, the structure is either (a) two or more conjoint meetings in a row, followed by one set of concurrent individual meetings (conjoint-oriented integration); or (b) two or more sets of concurrent individual meetings, followed by one conjoint meeting (individually oriented integration). In asymmetrical therapy with families, the structure is either (a) two or more conjoint meetings with the family or family subgroup, followed by one individual meeting with the symptomatic child or adolescent (conjoint-oriented integration); or (b) two or more individual meetings with the child or adolescent, followed by one conjoint meeting with the family or family subgroup (individually oriented integration).

As with symmetrical integration, the conjoint and individual meetings may take place on different visits, or each visit may be divided into asymmetrical components. For example, there may be a 15-minute conjoint family meeting, followed by a 45-minute individual

TABLE 17.1 Integrating Individual and Couple/Family Therapies

Integrative Structure	Characteristics	Indications
Symmetrical	Equal use of individual and family interviews	Equally high degree of individual and family dysfunction, and no major resistance to either individual or family interviews
Asymmetrical		
Individually oriented	Individual interviews used more than family interviews	Higher degree of individual than family dysfunction, and/or major resistance to family interviews
Family oriented	Family interviews used more than individual interviews	Higher degree of family than individual dysfunction, and/or major resistance to individual interviews
Sequential	Individual and family interviews used on different visits	Constructive use of both individual and family interviews
Combined	Individual and family interviews used during the same visit	Blocks to constructive use of either individual or family interviews, and/or termination phase of therapy

Source: Feldman (1992).

meeting with the child or adolescent. With a couple, there may be 15-minute individual meetings with each partner, followed by a 45-minute conjoint meeting with the couple.

In general, a symmetrical structure is indicated when the degree of individual and interactional dysfunction appears to be equally high, and the degree of resistance to individual and conjoint meetings is equally low. When individual dysfunction appears to be greater than interactional dysfunction, or when there is a high degree of resistance to conjoint meetings, an individually oriented integration is indicated. Conversely, a conjoint-oriented structure is indicated when there appears to be a greater degree of interactional dysfunction or when there is a high degree of resistance to individual meetings.

Combining individual and conjoint components during the same visit is often indicated when family members have difficulty making good use of one of the interview formats. A highly conflictual couple, for example, may have great difficulty engaging in constructive problem-solving during a conjoint meeting unless this meeting is preceded by individual meetings with each partner. In such meetings, they can ventilate some of their hostility and then prepare themselves to listen to the other's point of view. Conversely, a child may make more productive use of an individual meeting if it is preceded by a conjoint family meeting in which family interactional problems are identified and discussed.

The combined structure is also helpful if the frequency of visits is reduced. This allows the therapist to continue using the same type of structure, even though the overall frequency of contact is less. For example, if conjoint family meetings have been alternating with individual child meetings on a once-a-week basis and the frequency is reduced to once every 2 weeks, it may be helpful to combine a conjoint and individual meeting during each visit.

During the assessment process, the therapist observes each family member's reactions to the conjoint and individual meetings and assesses the specific need for each format. Based on this assessment, a recommendation for either a symmetrical or asymmetrical integration is

made. This is discussed with the family and, based on their reactions, the structure is either implemented as recommended, or modified in one or more ways.

## Change Processes

Change has been conceptualized by individual therapists primarily in terms of processes for promoting intrapsychic or individual behavioral changes. Family therapists have focused primarily on processes for promoting interactional changes. From an integrative perspective, both individual and interactional change processes are highly significant. Each type of change process facilitates and strengthens the other (Feldman, 1992; P. Wachtel, 2004). When there is a block to change at one level, it can frequently be reduced or eliminated by change at the other level. In the following sections, the integrative use of individual and interactional change processes will be discussed and illustrated.

### *Using Individual Change Processes to Facilitate Interactional Change*

Interactional changes in family or couple systems are frequently blocked by dysfunctional cognitions and emotions of individual family members. When these intrapsychic factors are neglected, therapy often becomes bogged down in frustratingly repetitive efforts to promote change by means of interactional change processes alone. Reduction or elimination of the intrapsychic blocks allows family interactional change to proceed.

*Clinical Illustration.* A conflictual couple was unable to learn effective problem-solving skills because each person blamed the other for their relationship problems, refused to listen to their partner's complaints, and resisted initiating any behavioral changes. Each one magnified the dysfunctional aspects of the other's behavior and minimized his or her own dysfunctional behavior. Underlying these perceptual distortions were preconscious anxieties. Both partners were afraid that if they acknowledged their own role in creating and maintain-

ing the relationship problems, the other would not reciprocate, and the initial risk taker would be labeled as “the cause” of their problems. They were both afraid to make any changes for fear they would be humiliated if the other did not also change.

In individual meetings with each partner, intrapsychically oriented change processes (insight, working through, and cognitive restructuring) were used to decrease their resistance to accepting responsibility for their role in maintaining the relationship problems and to increase their ability to tolerate the anxiety associated with making behavioral changes. As their defensiveness was reduced, they were increasingly able to make use of conjoint meetings and interactional change processes (modeling and behavior rehearsal) to develop constructive problem-solving interactions.

### *Using Interactional Change Processes to Facilitate Individual Change*

Individual changes by family members are often blocked by dysfunctional interaction patterns in the family. When these interpersonal blocks are ignored, therapeutic insights are not translated into lasting individual changes. Reduction or elimination of the interactional blocks allows individual change processes to proceed.

*Clinical Illustration.* An 11-year-old boy, Carl, and his family were referred for therapy because of Carl’s failing grades in school and his oppositional behavior at home. His parents were divorced and he lived primarily with his mother. Carl’s contact with his father was infrequent, erratic, and unpredictable.

During the assessment, it became clear that Carl was extremely angry with his father for having “abandoned” him after the divorce. In conjoint meetings, Carl’s father was initially very defensive. Soon, however, he began to respond to Carl’s expressed feelings of abandonment by increasing the time and attention he gave to his son’s day-to-day activities. As he did so, Carl began to realize that he had been acting out his anger toward his father through pas-

sive-aggressive behavior at school and hostile behavior at home. He also began to recognize that this was self-defeating and, with the support of the therapist and both of his parents, he was able to translate this realization into positive behavioral change.

### *Interrupting Multilevel Problem-Maintenance Processes*

Individual and family problems are perpetuated by a combination of intrapersonal and interpersonal factors, as well as the dynamic interactions between them (Feldman, 1992). In order to interrupt the problem-maintenance process, both intrapsychic and interpersonal change processes are needed. By implementing an integrated combination, individual and interactional changes are more effectively facilitated, and intrapersonal and interpersonal blocks to change are more effectively overcome.

## INTEGRATING INDIVIDUAL AND GROUP THERAPY

### **Clinical Assessment and Treatment Planning**

Individual and group assessment are complementary and synergistic processes. Integration allows the therapist to combine the specific benefits of each process and moderate their limitations.

Individual and group therapy integration begins with one or more individual meetings. In these meetings, the focus is threefold: first, a therapeutic alliance needs to be established; second, individuals need to be understood in terms of their intrapersonal and interpersonal worlds; and third, the appropriateness of group involvement must be determined in accordance with the individual’s needs.

The question of how many individual sessions there should be before integrating the individual into a group experience is a controversial one. Some therapists recommend limiting initial contact to two or three individual meetings for assessment and group preparation (e.g.,

Amaranto & Bender, 1990). Their experience supports Yalom's (1985) earlier position that long-term individual involvement with the therapist makes the transition to group more difficult and that the inability to share the therapist with other group members is often a contributing factor to premature termination.

Other psychotherapists maintain that lengthy individual work provides the necessary foundation for individual and group therapy integration. For instance, Scheidlinger and Porter (1980) believe that 1 to 2 years of individual psychotherapy are essential to accomplish certain therapeutic tasks that are prerequisites for productive group involvement. Though it is often more difficult to offer long-term preparation in these days of managed care, it does continue to be a possibility for some individuals.

Our recommendation is to determine the number of initial individual sessions on the basis of the specific needs and resources of each particular person. Some people are ready to begin participating in an integrated therapy after only a few individual meetings; others need more lengthy preparation.

Certain people presenting in acute distress are not good candidates initially for individual and group integration. Those who are flooded with extreme anxiety, immobilized by severe depression, or lost in psychosis are often unable to respond to others in their environment. They may need individual attention exclusively for a period of time in order to alleviate some of their symptoms and become more available for group process. Severely disturbed individuals manifesting paranoia or narcissism may need significant preparation in order to be able to use the group format productively. People with borderline personality disorder are likely to respond to an integrative approach by "splitting" the modalities into the good treatment and the bad treatment, the good therapist and the bad group members, or the good group and the bad therapist. This tendency can be offset, in part, through adequate preparation. In all these instances, careful assessment during the initial meetings allows the therapist to design a treatment plan that meets the specific needs of a particular individual and is consis-

tent with the specific needs of a particular group.

In contrast to the aforementioned situations, many people struggling with a great variety of problems are able to maximize their opportunity for growth by participating in an integrated form of psychotherapy instituted after only a few individual sessions. For these individuals, the process of preparing for integration begins with an initial assessment meeting designed to explore the presenting problems and previous attempts, both successful and unsuccessful, to address these problems. Information about past and current functioning is elicited, and the therapist evaluates intrapersonal and interpersonal strengths and weaknesses. A family history and history of other group experiences provide important data.

This process continues into one or more subsequent individual meetings as the therapist formulates early diagnostic impressions and begins to develop a therapeutic alliance with the individual. The therapist's questions and feedback provide problem clarification, support, and empathic understanding. Even in this assessment phase, treatment has begun.

When the diagnostic picture is reasonably clear and a therapeutic alliance sufficiently established, the focus shifts to goal setting and the formulation of a treatment plan. The rationale for integrating individual and group therapy is discussed, and its specific value for this particular person is described in detail.

Some individuals react with curiosity and/or positive anticipation to the suggestion of an integrated approach: "How would that work?"; "That might be good . . . I've always felt so alone in this"; "Maybe the more heads the better." Others are more apprehensive, and express a variety of concerns. The time between individual meetings allows for the emergence of additional questions, anxieties, and resistances.

Anxieties frequently relate to the person's relationship with the therapist and to anticipated relationships with other group members. Individuals may interpret the recommendation for integration into the group in a variety of troubling ways: "The therapist is bored with me

and my problems”; “The therapist is overwhelmed by my difficulties and needs to draw on additional resources”; “I have failed at individual therapy”; “I am hard to be alone with.” Feelings of rejection, embarrassment, shame, or guilt often emerge. The therapist must be alert to these possibilities and provide opportunities for working through. Transference and countertransference reactions are often activated in this process and need to be dealt with constructively.

Individuals may feel angry at the prospect of sharing the therapist and apprehensive about those group members who will be part of “their” treatment. They may be concerned about “losing control in front of other people.” Fear of rejection, confrontation, and judgment are common: “I know they’ll blame me for my problems, just like my family does.” Fear of ridicule often prompts resistance: “I don’t need anybody else to make fun of me. I get enough of that at the office.” Skepticism is often present: “How can they help me if they’re in the same boat?” . . . “if they’re not professionals?” . . . if they need therapy themselves?”

Most people are able to work through their anxieties and move on to discuss possible ways to structure group and individual integration. The ratio of group to individual meetings is determined through careful assessment of the therapeutic needs and resistances of group participants. For some groups, a balanced or symmetrical integration is indicated—individual sessions alternate with group sessions. This structure is most helpful when intrapersonal and interpersonal issues are of equal concern. For others, the need for individual attention and a primary focus on intrapersonal issues is most compelling. When this is the case, an individually oriented asymmetrical integration is indicated, consisting of two or more individual meetings for each group meeting. A group-oriented asymmetrical structure is indicated when people present primarily interpersonal problems; here, multiple group sessions are held for each individual session. When any form of asymmetrical structure is employed, it is crucial that the less frequent format be offered often enough so that its unique benefits

can be experienced and the synergistic effects of integration have an opportunity to develop.

When children and adolescents are evaluated for individual and group therapy, the structure of the initial meetings is somewhat different than for adults. The first contact most frequently is a phone call from a concerned parent or parents, after which a series of assessment sessions is set up. The first of these is usually an extended meeting subdivided into child, parental, and family components. In assessing the therapeutic needs of children and adolescents, their day-to-day interactions with other family members must be considered. The therapist may decide that along with individual and group therapy, family therapy is also needed. This therapy may be conducted by the same therapist who provides the individual and group treatment, or there may be clinical indications suggesting that a different therapist should supply the family therapy component.

### Therapeutic Process

The potentiating effects of combining individual and group therapy become evident even before the first group meeting. With the introduction of integration, reactions are triggered in the individual sessions that provide valuable data. As the individual considers group involvement, thoughts and feelings surface that deepen and broaden clinical understanding and provide early opportunities for therapeutic intervention.

The initial group meeting begins with a discussion of the rules, goals, expectations, and restrictions upon the group members and the therapist. Clear guidelines and consistent adherence are crucial for successful integration. Confidentiality is discussed and decisions are made regarding member contacts outside the group. Some therapists insist upon limiting contacts to the therapy sessions; others are open to or even encourage members to socialize outside of group meetings. Whichever position the therapist takes, it is essential that this be communicated at the outset, thoroughly processed with the group, and that each group member agrees to adhere to the guidelines.

Once the ground rules are established, group members are encouraged to share whatever information about themselves, their problems, their history, or their treatment goals they feel ready to volunteer. Immediate reactions, thoughts, and feelings about being in this group at this time are often elicited. In this first group meeting, the therapist needs to inhibit the impulse to volunteer information from individual sessions. Group members need to be in charge of their own presentation of self—the content and the pace left to their discretion. They need to begin to know each other and to develop a sense of trust in the process. The therapist may stimulate group interaction by offering and inviting questions, comments, and general feedback. Her role, however, is that of facilitator; the task is to provide a safe arena and to elicit information so that some sense of common purpose begins to emerge.

Even within the first group meeting, the cross-fertilization between individual and group therapy is apparent. Group members often refer to work done in individual sessions as they identify themselves and offer their ideas for group treatment goals. For example: “My family moved a lot when I was a kid. In therapy, I figured out that all those moves are part of why I’ve always felt like an outsider. I’m wondering if anybody else ever feels like that?”

The flow of material from individual to group therapy continues throughout treatment and serves as a vital element enhancing the therapeutic process. Group treatment is enriched for all members by the input generated from each member’s individual work. The focused intensity of the one-on-one sessions produces insights that can often benefit other group members struggling with similar concerns. Moreover, sharing these insights generates trust, encourages others to take risks, promotes group cohesiveness, and may enhance the self-esteem of the person sharing the insight and those who receive it.

*Clinical Illustration.* During one group meeting, there was much discussion about painful feelings of humiliation and inadequacy that three individuals had experienced during

recent work performance evaluations. A fourth group member volunteered that in his individual therapy sessions, he had become aware of a link between feelings about his critical supervisor and feelings about his critical father. Recognizing this link had helped him understand the history of his feelings of inadequacy and the intensity of his distress in his current job situation. The group members who had initiated the topic felt understood, validated, and reassured by his identification with their plight. They were enlightened as his interpretations triggered awareness of their own transference reactions. Group process was enhanced by the empathy and insight offered through sharing the work of individual therapy.

Individual therapy also facilitates group therapy by providing a concentrated opportunity for ministering to narcissistic injuries, challenging cognitive distortions, and role-playing possible confrontations. The individual is able to bring to group sessions a heightened awareness of his or her strengths and vulnerabilities. Role-play in individual sessions provides the preparation some people need for more active group participation. Under certain circumstances, the support, understanding, and active intervention provided by individual therapy may interrupt flight from group treatment.

Individual therapy enhances group treatment by providing the therapist with a variety of valuable opportunities for cross-referencing. Aided by an in-depth understanding of each participant, the therapist is able to facilitate productive movement in group process. The therapist may use eye contact, an encouraging nod, or a knowing glance to encourage appropriate sharing in the group. In a nonspecific way, she may raise questions or invite comments on issues known to be of particular concern. On occasion, the therapist may ask permission to share relevant individual material with the group. When such a request is made, it must be general enough so that confidentiality is maintained.

Just as individual therapy facilitates group treatment, so too does group therapy facilitate individual treatment. The group provides a safe arena for testing some of the new attitudes and

behaviors developed in individual sessions. Members are able to take their heightened self-awareness into a social context, gather data about self and others, and return to individual therapy for further indepth exploration. Experiences in the group often trigger unexpected intrapsychic reactions, which may be carried back to individual therapy.

*Clinical Illustration.* A young woman brought to an individual therapy session some disturbing feelings that she had been experiencing in the group. She hesitatingly “confessed” to feeling enraged with the therapist whenever the therapist offered empathic feedback to any other group member. This data led to fruitful, indepth exploration of this woman’s role in her family of origin. As the oldest of six children, she had been forced into the role of mother’s assistant at an early age. Her dependency needs had been denied, and any efforts to be heard, supported, or understood had met with a stern rebuff. This woman’s yearning for nurturance made it difficult for her to share that aspect of the therapist with other members of the group. The depth of her rage (conscious and unconscious) created anxiety, confusion, and the impulse to flee treatment.

Group therapy provided the stimulus for these reactions; individual therapy provided an arena in which they could be explored in a concentrated way. She was able to experience the therapist as reassuring, empathic, and accepting of her, even in her fear and anger. She developed important insights, received some of the nurturance she craved, and began to understand through the therapist’s psychoeducational approach how she might glean support from the other group members, not only from the “good enough” mother.

As attachments develop with various group members, the individual’s base of support broadens. Dependency needs are met not only by the therapist but also by the other group members. As reliance upon the therapist diminishes, people become less anxious about sharing all their feelings in their individual therapy sessions. They are increasingly willing to challenge, confront, or disagree with the therapist. Supported by a sense of belonging and identifi-

cation with the group, it becomes easier to tolerate the exploration of narcissistic injuries or a break in the therapist’s empathy in individual therapy.

The group experience also enhances individual therapy by providing the therapist with valuable data. People often behave very differently in this social context, and their self-presentation, communication skills, and coping behaviors may enlighten the therapist regarding additional concerns for individual treatment. Therapists may observe attitudes and behavioral reactions to cognitive distortions that need to be challenged in the privacy of the individual session. Certain problem areas may not be on the individual therapy agenda because the individual may not be aware that these difficulties contribute to his or her dissatisfaction. In an integrated approach, the therapist can draw on material from the group to enrich the work of individual therapy. Cross-referencing by the therapist may be direct or indirect; specific reference can be made to group observations, or this information can be integrated into the therapist’s overall understanding and approach to the individual.

*Clinical Illustration.* A 10-year-old boy was referred for treatment of depression and social isolation. In the initial family meeting, the parents expressed confusion about the reasons for their son’s “lack of friends.” The boy reported feeling “sad and bored.” He insisted that his isolation was a choice; other children were “too babyish” and he simply wasn’t interested in connecting. The therapist contracted with the boy for an “experiment” in treatment involving individual and group therapy integration. She was able to draw from group observations crucial data regarding dysfunctional behaviors, attitudes, and coping skills. The boy’s yearning for peer acceptance and approval was obvious in his affect. The behaviors he employed—knowing all the answers, directing the activity, correcting others’ mistakes—alienated, rather than impressed, his peers. His defensive posture, unconsciously designed to cover his vulnerabilities and quiet his anxieties, was experienced by peers as arrogance. Aided by these observations, the therapist was able to work

more productively with this boy in individual therapy, focusing on the ways he created and reinforced his dilemma and on the intrapsychic issues that stimulated this behavior.

In general, these kinds of cross-references provide valuable therapeutic opportunities. A caution must be issued, however, because the inexperienced therapist may allow individuals to act out their resistance to one format in the "safety" of the other. When transference reactions are triggered, it is important at some point that they be addressed in the modality in which they developed. When people bring complaints about group members or group process to their individual sessions, the therapist must consider the significance of the reaction, identify the work that needs to be done individually, and then direct the person to discuss his or her feelings in the group. A simple statement, such as "This sounds like something you need to take back to group" may suffice. Similarly, those who choose to air complaints about their individual therapy in the "diluted" environment of the group need to be encouraged to work through those specific grievances in the individual meetings. The transference work of individual therapy must be preserved, even when the person experiences the therapist in both individual and group settings.

Often, themes can be extracted, generalized, and productively addressed in both formats.

*Clinical Illustration.* A young woman was frightened by another group member's angry comment. It was important that she share these feelings in the group and discuss her experience of the other group member directly with that person. In individual therapy, she explored the connection between her reaction in group and her feelings about her mother's anger and impatience with her throughout childhood. Her impulse to withdraw from the angry group member and the group itself was painfully similar to her retreats to her bedroom as a young girl fleeing a threatening parent.

In some instances, one format supplies support for the confrontation that needs to occur at the site of the working through. In the previous example, the young woman found it help-

ful to role-play in an individual session her approach to the hostile group member. Focused exploration of her phobic reaction to anger in any context facilitated intrapsychic growth and understanding, defused some of her anxiety, and prepared her for productive work in the interpersonal realm of the group setting.

Another illustration of the dynamic interplay between group and individual therapy is found in the earlier example of the man who felt criticized by his father and by his current work supervisor. In that situation, the group members' responses to this man's insight broadened his understanding of his own dilemma. His self-esteem was enhanced as group members affirmed him for his courage in sharing and expressed appreciation for his valuable input. He returned to individual therapy with a renewed sense of self-worth and a strong determination to tackle his remaining issues.

## CONCLUSION

Integration of individual therapy with family and/or group therapy has the potential to enhance the accuracy and comprehensiveness of assessment and the range and effectiveness of treatment for a wide variety of emotional, behavioral, and interactional problems. Support for this position is provided by a growing number of case reports (e.g., Feldman, 1992; Friedmann & Silvers, 1977; Heitler, 2001; Kramer, 2000; Lindenbaum & Clark, 1983; Nichols, 2001; Pfeifer & Spinner, 1985; Pinosof, 2005; Sander, 1979; Schachter, 1988; Stumphazer, 1976; Swiller, 1988; Wachtel & Wachtel, 1986) and clinical trials (e.g., Amaranto & Bender, 1990; Arnow, Taylor, Agras, & Telch, 1985; Barrowclough et al., 1999; Hogarty et al., 1991; Huxley, Randall, & Sederer, 2000; Liebman, Honig, & Berger, 1976; Ney & Mills, 1976; Rosenberg & Linblad, 1978; Waldron, Slesnick, Brody, Turner, & Peterson, 2001).

Future development of this area of psychotherapy integration will require additional controlled outcome studies and comparative studies of integrated versus nonintegrated therapies. Equally important are process studies of the most effective ways to (a) integrate different



modalities for different types of clinical problems; (b) design therapeutic structures that are maximally responsive to the specific needs of particular individuals and families; and (c) prevent or overcome potential problems during the process of individual–family or individual–group integration. Such research, combined with practitioners' accumulating clinical experience, offers the promise of increasingly effective integration of therapeutic modalities.

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## Integrative Problem-Centered Therapy

WILLIAM M. PINSOFF

Integrative problem-centered therapy, or IPCT (Pinsof, 1983, 1995, 2002), is a framework for integrating different psychotherapeutic approaches and a model for the conduct of specific psychotherapies. As a framework, it provides a set of parameters for interrelating family, individual, and biological treatments. As a model for therapy, it provides clinicians with guidelines for making decisions about what types of interventions to use at which points in therapy with specific types of patients with specific problems.

IPCT locates psychotherapy within education and human problem-solving. With the exception of involuntary patients, people come for therapy when they cannot solve their psychosocial problems. The therapist teaches the skills and knowledge people need to solve the problems for which they seek help. For some, this entails facilitating the use of skills and knowledge they already have; for others, it entails helping them acquire the knowledge and skills they lack.

### CENTRAL TENETS

A set of linked ontological and epistemological assumptions underlie IPCT. *Interactive constructivism* asserts that there is an objective reality but that it is ultimately unknowable. Our knowledge of that reality is a “construction” that derives from the interaction between that reality and our capacities to perceive, think, and feel. A construction (i.e., an assessment, hypothesis, or diagnosis) needs to work well enough to accomplish the task at hand. All constructions are not equal.

Knowledge is always partial and evolving. There are no “definitive diagnoses,” only “sufficient diagnoses.” However, though never definitive, knowledge is progressive. We can know more and more about something. As knowledge accumulates, our constructions fit objective reality better. Science is a set of rules for systematically evaluating the extent to which our constructions (hypotheses) fit that objective reality.

A second assumption, *systemic organization*, draws on the constructions of General Systems Theory (Buckley, 1968; Von Bertalanffy, 1968) and views nature as systemically organized. We are simultaneously systems composed of subsystems (psychological, biological, etc.) and subsystems of larger systems (families, communities, civilizations, etc.). Systems take on a quality of wholeness that gives them an integrity and identity—"the whole is greater than the sum of its parts." Additionally, everything is more or less connected and therefore should not be considered in isolation.

A third assumption, *differential causality*, posits that causality is at least bidirectional and, more broadly speaking, mutual. I influence my wife and she influences me. The same goes for me and my daughters and all of the other relationships in which I participate. Every event, outcome, or problem has multiple causes that derive from horizontal (same level) as well as vertical (subsystemic) systemic relations. My angry outburst at my wife derives from her behavior, my interpretation of it, my feelings, my hormonal levels, and the reactions (real and imagined) of others to her behavior. Distinct causes contribute differentially. My depression contributes more to my angry reaction to my wife's behavior than her behavior or the reactions of others.

These three assumptions and their related assertions form the underlying theoretical platform of IPCT. They inform and influence the major components of the model.

## APPLICABILITY AND STRUCTURE

IPCT applies to the full range of problems that patients bring to psychotherapy. It is a comprehensive psychotherapeutic system. Although not designed to be applied to any specific mental disorder, it can and should be applied to specific disorders. As an integrative framework, it begins the treatment of most disorders with a cognitive-behavioral treatment that has been empirically shown to be effective for the particular disorder. IPCT has been designed to deal with the treatment failures of these initial and

subsequent treatments. It is predicated upon the belief that no specific treatment will be effective for all disorders or all patients—nothing works for everybody or every disorder. To help the wide variety of patients who seek psychotherapy, therapists need an integrative model that seeks alternatives in the face of treatment failure.

IPCT is not a type of family or individual therapy. It transcends conventional modality distinctions. From the problem-centered perspective, the only difference between family, couple, and individual therapies is the location of the indirect/direct patient system boundary. In "individual therapy," the identified patient comprises the direct patient system.

## ASSESSMENT AND FORMULATION

Assessment, diagnosis, or problem formulation within IPCT is organized around four concepts: the presenting problem, the patient system, the adaptive solution, and the problem maintenance structure.

### The Presenting Problem and the Patient System

The primary target of intervention in IPCT, the *presenting problem*, and the unit of intervention, the *patient system*, are reciprocal concepts that mutually define each other. The presenting problem is the problem for which the patient system is seeking treatment. The patient system consists of all of the people who are or may be involved in the maintenance and/or resolution of the presenting problems.

The presenting problem is not the therapist's formulation but rather the patient's. Typically, there are other problems within the patient system that play a central role in causing or maintaining the presenting problem, but for a variety of reasons, the members of the system choose not to present them for therapy. Thus, Frank presents himself as struggling with panic attacks, despite his fears that his wife, Ellen, is having an affair and considering leaving him. When he calls for therapy, he does not even

mention his marital concerns. Similarly, Roxanne seeks help for her 14-year-old son, Jason, who is failing in school, disobedient at home, and probably using drugs. She fails to mention her own depression and illegal drug use, both of which have escalated since her divorce from Ray, Jason's father.

Patients implicitly or explicitly give the therapist a mandate to address the presenting problems and to not address the nonpresenting problems. The guiding principle for the problem-centered therapist is that if you are going to focus on a nonpresenting problem, it must either be discernibly (to you and key members of the patient system) linked to the presenting problem or it must threaten patient health or safety. If it fails to meet either of these criteria, the therapist should leave it alone. Thus, the therapist would need to explicitly link Frank's panic attacks and his marital problems, or Roxanne's depression and Jason's school failure, to justify focusing on these nonpresenting problems. The *link* between the presenting problem and the nonpresenting problem is an essential and defining characteristic of IPCT.

Patient systems typically include key patients who constitute the system's major problem formulators and power centers. Frank and Ellen are the "key patients" in the panic attack system; their children, parents, and friends may participate in maintaining or resolving the panic attacks, but Frank and Ellen account for most of the variance in the attacks. Similarly, Roxanne and Jason are the "key patients" in the school failure presenting problem. However, Jason's father, Ray (recently divorced from his mother), would also be a "key patient."

The presenting problem is the starting point of therapy, the anchor of the process, and its resolution constitutes a crucial outcome. In terms of a process anchor, the problem-centered therapist continually asks the key patients: What do you want to work on? Presenting problems typically evolve: what people want to address at the beginning is not necessarily what they want to address 3 months into it. Their evolving understanding of their problems and their alliance with the therapist are inextricably linked. If the therapist has a good alliance with key patients, it may be easier to integrate an obvi-

ous nonpresenting problem like Ellen's potential infidelity or Roxanne's depression into the presenting problem formulation, thereby making it a legitimate target of the therapy.

The patient system is differentiated into two major subsystems. The *direct patient system* consists of everyone with whom the therapist is working directly at this time. Direct work typically involves face-to-face encounters or telephone contact. The *indirect patient system* consists of all of the members of the patient system with whom the therapist is not working directly at this moment. The boundary between the direct and indirect systems may change during therapy. For instance, in working with a couple, the therapist may involve the parents of the husband for a series of sessions. The parents move from the indirect system into the direct system and back into the indirect system after the "family of origin episode." Changes in the location of the indirect/direct boundary during therapy are negotiated carefully and in advance with the key patients.

The indirect/direct system distinction ensures that therapists never forget that they are intervening into a system (network of relationships and causal factors) that is larger than the people with whom they are interacting directly. Historically, systemically sensitive psychotherapists, whether shamans, cognitive behaviorists, psychoanalysts, or psychopharmacologists, have recognized that they were intervening into systems that were larger than the "afflicted individual." Their "best" interventions incorporated an awareness of the existence and response predispositions of the key patients in the indirect system.

The systemic orientation of IPCT is not just applied to patient systems. Therapy is the interaction of the patient system with *the therapist system*—all of the people engaged in providing therapy to the patient system. Therapist and patient systems constitute *the therapy system*. The therapist system can also be subdivided into direct and indirect systems. Supervisors, consultants, and care managers constitute key members of the indirect therapist system. Perhaps the most important members of the therapist system are therapists, including pharmacologists, who work with other subsystems or mem-

bers of the patient system. It is as important to establish therapeutic alliances with other therapists who work with key patients as it is to establish therapeutic alliances with key patients. A fragmented therapist system can be as troublesome as a fragmented patient system.

### The Adaptive Solution

In addition to asking about the problems for which they are seeking help, the therapist needs to ask the key patients what would constitute an adaptive solution to their presenting problem. Typically, this entails identifying the solutions that key patients have attempted in their efforts to resolve the problem. This collaborative analysis of the attempted solutions is an essential step in the search for an *adaptive solution*—a sequence of actions for the key patients that has a high likelihood of resolving the presenting problem.

The therapist needs to establish a consensus with the key patients about the suitability and appropriateness of the adaptive solution. Typically, this requires delineating the steps that need to be taken by key patients in preparation for or as part of the attempted solution. For instance, Frank needs to first decide whether he wants to try to save his marriage, and if he does, what confrontational and reconciliative steps he would need to engage in to bring that about. Creating a consensus about an adaptive solution delineates major short- and long-term goals of the therapy.

An ultimate goal of IPCT is to strengthen the patient system by making it more competent, at least in regard to the problems for which it is seeking help. This typically entails teaching or helping the key patients to solve the presenting problem rather than solving it for them. The problem-centered therapist is like a coach rather than a player. Ultimately, it is the key patients who need to do what needs to be done to resolve the presenting problem. Roxanne needs to provide appropriate structure (time and space boundaries) and nurturance (support/warmth) to help Jason do the work he needs to do to be successful in school. Steps along the way might involve getting treatment for her depression and drug addiction,

involving Ray, her ex-husband and Jason's father, to support her initiatives, or educating herself about appropriate limits and boundaries with a 14-year-old. If she cannot successfully engage in these tasks, she and the therapist need to explore alternatives like decentralizing herself and centralizing Ray or other system members who can give Jason what he needs.

### The Problem Maintenance Structure

The quest to match treatments to disorders is at best quixotic. The fundamental problem with the matching quest is that it is not the surface features of a disorder that determine its treatment requirements but rather its underlying features. Within IPCT, these features constitute the *problem maintenance structure*—the set of constraints within the therapy system that prevent the key patients from successfully implementing the adaptive solution. Our primary focus in describing the problem maintenance structure will be on the constraints (Breunlin, 1992) within the patient system that prevent problem resolution. However, constraints within the therapist system or between therapist and patient systems can also play central roles in preventing successful problem resolution.

#### *The Levels of the Problem Maintenance Structure*

The possible constraints within the problem maintenance structure can be organized on six levels, as reflected in Figure 18.1. The first, top level contains constraints from the *Social Organization* of the patient system. These include boundaries—the rules that prescribe who can do what. For instance, Roxanne needs to create appropriate time and space boundaries at home so Jason can have a quiet time and place to do his homework. Additionally, she needs to communicate effectively with the school that provides her with accurate feedback about his school performance on a timely basis. Finally, she needs to reintegrate her son's father, Ray, back into Jason's life in support of her initiatives with him and as an emotional and intellectual resource for Jason.

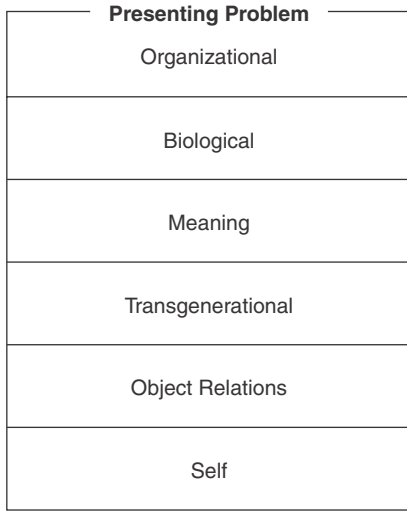


FIGURE 18.1 The Problem Maintenance Structure

The next level consists of *Biological* constraints that prevent implementation of the adaptive solutions. These constraints include the biological components of major mental disorders, learning disabilities, developmental delays, and those aspects of physical illnesses that affect behavior, cognition, and emotion. The psychomotor retardation aspect of Roxanne's depression may impede her ability to accomplish the social organization tasks outlined above. Similarly, if she struggles with an organizational learning disability, she may be unable to provide the organizational structure Jason requires. Conversely, it may be hard for Jason to use the temporal and spatial structure she provides, because he too struggles with a learning disorder.

The third level includes *Meaning* constraints that prevent implementation of the adaptive solution. They typically involve maladaptive cognitive and emotional responses on the part of key patients. Aspects of the presenting problem and/or the adaptive solution "mean" something to the key patients that prevent them from solving their problem. IPCT assumes that cognition and emotion are the intertwined components of meaning. Meaning typically emerges as a feeling-infused narrative replete with catastrophic expectations. Frank does not confront

Ellen because he believes that if he does she will admit that she does not love him and leave him. In this narrative he is unattractive, worthless, and weak. He fears abandonment and humiliation. To confront her would be to reaffirm his worthlessness. He would rather avoid that and hope that "the affair will just go away." Roxanne fears that if she confronts and challenges Jason, he will hate her and run away.

*Transgenerational* constraints compose the fourth level. They derive from the transgenerational legacies of the key patients as well as the current maladaptive involvement of their families of origin members. Transgenerational legacies are cognitive, emotional, and behavioral patterns that have characterized the families of the key patients for multiple generations. Maladaptive transgenerational legacies are patterns that prevent implementation of the adaptive solution. The belief that men are useless and weak has characterized Roxanne's family for generations. It now constrains her ability to turn toward Ray as an ally and resource in providing Jason with the structure and nurturance that he needs.

Family of origin constraints include the maladaptive involvement of family of origin members in the key patients' efforts to solve their presenting problems. Frank has spent most of his life enmeshed with his mother. She expects him to call her at least once a day and persistently depreciates Ellen. She tells him she knew that Ellen was "no good" from the first time she met her. His mother has escalated her "demands" that he call her and see her since his father's death 4 years ago. Frank feels sorry for her and afraid of her wrath if he disappoints her. He feels "caught" between his mother and Ellen.

The fifth level encompasses constraints from the *Object Relations* of the key patients. Object relations refers to the internalized and transformed representations of self and important others that derive from the early family experiences of the key patients. "Important others" are the people (or psychological objects) that were attachment figures for the key patients. Object relations become deployed maladaptively through defense mechanisms like denial,

projection, transference and projective identification.

Roxanne's mother was very harsh and punitive. Roxanne was scared of her and resented her depreciating and shaming behavior. In contrast, her father was affectionate and supportive but extraordinarily ineffective. His passivity in the face of his wife's abusive behavior toward Roxanne and her sister infuriated Roxanne. She learned that turning to him for support or protection was useless and only resulted in feeling more lonely and abandoned.

In her efforts to provide Jason with the structure he needs, Roxanne fears that if she denies and limits him, he will perceive her as an abusive mother and that he will "hate" her as she hated her mother. Roxanne bumps up against her early decision that she would never be like her mother. Additionally, Roxanne perceives Ray as being like her passive father—seeking his support will only exacerbate her feelings of loneliness and depression. Finally, her propensity to see Jason as perpetually angry is a projection of her own anger at everybody who has hurt her or let her down. She has denied, disowned, and displaced this anger much of her life, at times turning it on herself and becoming depressed.

The sixth and last level consists of *Self* constraints from the narcissistic vulnerabilities of the key patients that interfere with their ability to adaptively address their problems. Typically, these vulnerabilities derive from the failures of key attachment figures (referred to as self-objects within Self Psychology) to meet their narcissistic needs early in their childhoods. These include the need to be "mirrored" (to see oneself positively in the eyes of another), to "idealize" (look up to), and to "twin" (to feel you are like me) with key self objects. Generally, the more vulnerable the self, the more rigid and immutable the object relations.

Early in their relationship, Ellen perceived Frank as kind, sensitive, and caring. He was very different from her own father, who was aloof, critical, and impossible to please. However, as Ellen experienced Frank's growing enmeshment with his mother after his father's death, she felt abandoned. She lost his mirroring and found herself increasingly unable to

look up to him due to his childlike attachment to his mother. In the face of this narcissistic abandonment, she became enraged. However, instead of expressing that rage to him, she increasingly sought the mirroring she needed from other powerful men she could also idealize. A year and a half ago, that quest eventuated into an affair with a married man with whom Ellen works. Her narcissistic vulnerability made it difficult to tolerate Frank's withdrawal and to deal with it more adaptively. Rather than confronting his withdrawal and enmeshment with his mother, she sought support outside of the relationship.

### *The Shape of the Structure and the Power of Constraints*

Using a spatial metaphor like Figure 18.1, the problem maintenance space can be conceptualized as a rectangular shape with six different levels. Any particular problem maintenance structure can be thought of as a shape that has a certain depth and width within that rectangular space. Each problem has its own unique problem maintenance structure. One structure may be wide and relatively superficial, primarily encompassing constraints from the Social Organization and Biological levels. Another structure might be bell shaped, encompassing few constraints from the top levels and more from the lower, historical levels. Similar problems can have different problem maintenance structures, and different problems can have virtually identical structures.

Constraints within a problem maintenance structure can vary in power—how much they impede implementation of the adaptive solution. Roxanne's paternal transference to Ray constrains her reaching out to him for support with Jason. However, the mere presence of this constraint does not determine its power within the problem maintenance structure. Roxanne may be able to overcome it and reach out to Ray for support with Jason if the therapist directly encourages her to do so, or she may be so entrenched in her belief that Ray is worthless that such encouragement will fall on deaf ears.



### *On the Impossibility of Knowing the Structure in Advance*

The crucial difficulty with problem maintenance structures is that it is impossible to know their shape and the power of their constraints without directly challenging them. Problem maintenance structures reveal themselves through action—the process of working with them. Clinicians need idiographic data that helps them determine the particular treatment requirements of particular patient systems with particular types of problems. That idiographic knowledge is best obtained by helping the patient system resolve its presenting problem.

### PROCESS OF CHANGE

Because the treatment needs of the patient system are best determined through intervention, *intervention and assessment are ongoing and inseparable processes*. Within the IPCT, there are not distinct assessment and intervention phases. The two co-occurring processes begin the moment the referring patient calls for help and conclude with termination. The therapist's knowledge of the patient system and the problem maintenance structure is always partial and ongoing. The goal is a sufficient diagnosis that permits resolution of the constraints that impede implementation of the adaptive solution. That diagnosis evolves, becoming more accurate and sufficient as feedback from the therapist's interventions accumulates. The assessment/intervention process in IPCT is organized around the sequential use of different therapeutic orientations and contexts.

### The Problem-Centered Modalities/Contexts and Orientations

The 3 × 6 matrix in Figure 18.2 identifies the three primary modalities and the six generic orientations that are used in IPCT. They are listed in the order in which they are typically deployed, progressing from left to right and top to bottom. Furthermore, the figure shows how the orientations cut across the modalities.

### *Modalities: Assessment/Intervention Contexts*

IPCT uses three primary assessment/intervention contexts that specify which members of the patient system are directly involved in treatment at any particular time. Usually, these contexts are thought of as therapeutic modalities. The term “context” is used in IPCT because it is more precise and carries less assumptive baggage. “Modality” typically confounds contexts and orientations: it not only specifies who is directly involved in therapy but also aspects of theories of problem formation and change that are frequently linked to that modality.

The “first” context, *Community/Family*, is the most inclusive and directly involves at least two members from different generations of the patient system—a parent and a child. Maximally, this context can involve multiple members from different generations of the patient system as well as members of the patient system from the community. The treatment of Jason's presenting problems would employ this context, directly engaging Jason, his mother Roxanne, Jason's teachers, possibly his father, Ray, and potentially other school personnel like a social worker or guidance counselor.

The *Couple* context is usually dyadic and involves two people from the same generation within the patient system. The treatment of Frank's panic attacks would primarily involve Frank and Ellen. Similar and symmetrical role expectations are linked to the direct patients in the Couple context. Husbands and wives have equal rights and responsibilities within their marriage. Obviously, these role expectations must be “modified” in the context of different cultures. The third and last assessment/intervention context, *Individual*, directly involves just one member in the direct patient system.

### *The Problem-Centered Orientations*

An orientation specifies theories of problem formation and problem resolution—how people get into and out of biopsychosocial trouble. The six IPCT orientations are generic—they broadly address particular levels and con-

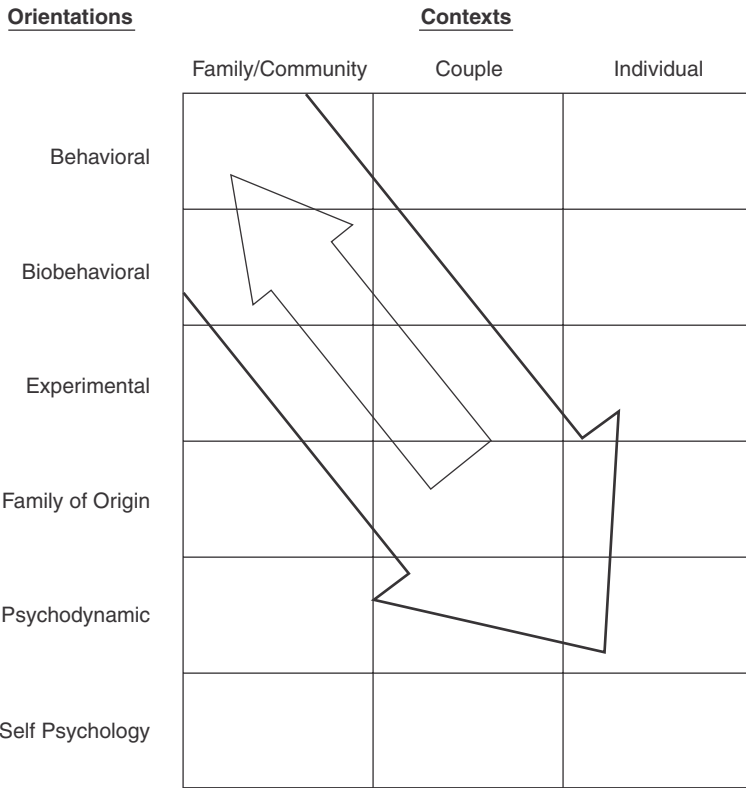


FIGURE. 18.2 Problem-Centered Orientation/Context Matrix

straints within the problem maintenance structure and contain specific orientations.

*The Here-and-Now Orientations.* The first three orientations deal with constraints that are rooted in the here-and-now. These orientations generally eschew a focus on the origins of these constraints and are somewhat ahistorical.

The *Behavioral* orientation asserts that people get into trouble because of the way they are behaving, and that they can resolve their problems by changing their behavior. It particularly attends to the social organizational constraints on the first level of the problem maintenance structure—attempting to change the boundaries that specify who can and should do what within the patient system in regard to the presenting problem. This generic orientation includes more specific behavioral orientations such as Structural Family Therapy (Fishman,

1993; Minuchin, 1974); Strategic Family (Watzlawick, Weakland, & Fisch, 1974) and Couple Therapy (Shoham & Rohrbaugh, 2002); Structural-Strategic Marital Therapy (Keim & Lappin, 2002); Solution-Focused Family (de Shazer, 1982) and Couple Therapy (Hoyt, 2002); and Behavioral Marital Therapy (Holtzworth-Munroe & Jacobson, 1991). Most of these specific orientations also address cognitive and emotional dimensions of human functioning; however, they fall within this generic orientation because they primarily focus on changing behavior.

With Jason’s problems, work on this level would involve behavioral and structural interventions to initially help Roxanne involve Ray as a coparent and then to help them implement more effective time and space boundaries around Jason. This would entail creating and enforcing a regular time and place for him

to do his homework, communicating effectively with the school about his performance, attending to and organizing his after-school and weekend time more effectively, and implementing consequences for Jason's positive and negative response. Implicit in these interventions is the goal of increasing Ray's involvement with Jason.

With Frank and Ellen, work on this level would focus on creating an appropriate marital boundary. This would entail helping Ellen assert her feelings to Frank about his overinvolvement with his mother, with the goal of decreasing that involvement and increasing his involvement with Ellen. It would also entail helping Frank express his feelings to Ellen about her affair and marital disengagement, with the goal of increasing her involvement with Frank and ending her affair. The underlying assumption of intervention with Frank on this level is that his panic attacks derive primarily from his inability to deal with his fears of and anger at his mother and his wife, and that if he can begin to deal with those feelings and those relationships, his panic attacks should decrease.

The *Biobehavioral* orientation asserts that people get into trouble because of biological constraints and that getting out of trouble entails changing those constraints. Biobehavioral interventions primarily aim to change constraints within the biological level of the problem maintenance structure. Specific orientations within this generic category include medication (Gitlin, 1990), biofeedback, meditation, and massage therapy (Moyer, Rounds, & Hannum, 2004). Certain types of cognitive-behavioral interventions for Panic Disorder and other similar disorders with major physiological dimensions also fall into this category.

With Frank, Biobehavioral intervention might involve teaching him anxiety management and relaxation techniques and/or prescribing anti-anxiety medication. With Roxanne, it might involve two components: antidepressant medication and a psychoeducational assessment for some kind of organizational learning disability. Similarly, it might be helpful to have Jason evaluated for a learning disability and to have him undergo a drug screening.

The *Experiential* orientation focuses primarily on cognitive and emotional constraints within the Meaning level of the problem maintenance structure. This orientation asserts that people are in trouble because of the way they think and feel, and the process of change must modify these cognitive and affective constraints. IPCT uses an adaptive action theory of emotion (Pinsof, 1995, 1998) that views emotions as stimuli to adaptive or maladaptive behavior. IPCT enhances emotions that are likely to stimulate adaptive action and diminishes emotions that are likely to stimulate maladaptive behaviors. Specific orientations within this generic category include Cognitive and Cognitive-Behavioral Therapies for individuals (Beck, Rush, Shaw, & Emery, 1979) and couples (Baum, Epstein, & LaTaillade, 2002); Emotionally Focused Couples Therapy (Greenberg & Johnson, 1988; Johnson & Denton, 2002); and Narrative therapies for families (White & Epston, 1990) and couples (Freedman & Combs, 2002). Most postmodern psychotherapies fall within this category due to their emphasis on the construction of meaning through culture and language.

With Frank and Ellen, intervention on this level might focus on modifying their maladaptive affective and/or cognitive patterns. Specifically, Frank fears that if he confronts Ellen about her affair, she will leave him. Similarly, he fears that if he disengages from his mother, she will become angry with him. Along with this fear, he is angry about Ellen's infidelity and his mother's selfish exploitation of him. These emotions implode in panic attacks. Frank needs to identify and own his feelings. Then he needs to use them as stimuli to adaptive action. Similarly, Ellen needs to identify her feelings of anger and loss in the face of Frank's enmeshment with his mother and learn to use them adaptively to address Frank's behavior. This work frequently entails identifying and hopefully defusing the catastrophic expectations that haunt Frank and Ellen about what will happen if they face their feelings and address their social causes.

For Roxanne and Jason, work on this level might explore their grief about the divorce and the concomitant losses each of them have suf-

ferred. Jason and Roxanne both fear that Roxanne will become more depressed if she gives in to her feelings of loss and if Jason overtly grieves his old family. This catastrophic expectation needs to be defused. Work on this level might also challenge Roxanne's strong mother/weak father narrative that impedes her efforts to reengage Ray as a coparent for Jason.

During the past 10 years, a number of approaches have emerged that integrate behavior, cognition, and emotion. Typically, they began as behavioral therapies, but incorporated cognitive and emotional variables. Jacobson and Christensen's (1996) Integrative Couples Therapy and its subsequent elaboration as Integrative Behavioral Couple Therapy (Dimidjian, Martell, & Christensen, 2002) along with Gottman's (1999) Marriage Clinic Model exemplify this new tradition. At this point in the evolution of psychotherapy, it makes less and less sense to sharply distinguish behavioral, cognitive, and emotionally focused approaches. Most therapists from behavioral or cognitive orientations have incorporated affective variables in their work, and some have even begun to consider historical or psychodynamic variables (Gottman, 1999).

*The Historical Orientations.* The remaining three orientations in Figure 18.2 address constraints that derive from the past and typically assume that some aspect of their historicity must be addressed. *Family of Origin* primarily addresses constraints from the Transgenerational level of the problem maintenance structure. It includes specific orientations that view current problems as primarily resulting from maladaptive historical legacies from key patients' families of origin and/or the direct maladaptive involvement of their families. Concomitantly, these constraints must be resolved enough to permit implementation of the adaptive solution.

Specific orientations that address historical transgenerational constraints include Bowen's (1978; Kerr, 1981) Differentiation of Self Therapy; Boszormenyi-Nagy's Contextual Therapy (Boszormenyi-Nagy & Spark, 1973; Boszormenyi-Nagy & Ulrich, 1981); and Roberto's Transgenerational Family (1992) and Marital

Therapies (Roberto-Forman, 2002). These approaches tend to use genograms (McGoldrick, Gerson, & Shellenberger, 1999) for analyzing and modifying transgenerational patterns. These approaches contextualize the current work with a family or a couple as a reaction to and attempt to transform maladaptive patterns that derive from the key adult patients' families of origin.

With Roxanne, intervention on this level might focus on the historicity of her strong mother/weak father narrative, helping her understand its impact over the generations and encouraging her to test its validity with Ray. A central task at this point is assessing the extent to which Ray is capable of functioning as an effective coparent. Roxanne's narrative legacy may or may not accurately reflect the reality of her ex-husband. If he proves to be a competent coparent, her transgenerational legacy is broken for the better. If he proves incompetent, her proclivity to play out the legacy by associating with incompetent men becomes a worthwhile therapeutic target.

A primary specific approach for engaging family of origin relatives of key adult patients directly in therapy has been articulated by Framo (1992). This approach invites the parents (or siblings) of key patients to participate in a series of sessions (a family-of-origin episode) with their adult child to address current and historical aspects of their relationship. Frequently, this work occurs in the context of couples therapy. Framo recommends excluding the spouse of the adult child during these sessions. In contrast, IPCT recommends including the spouse in most, if not all, of the family of origin sessions in order to maximize the therapeutic impact of the family-of-origin work on the marital system.

With Frank and Ellen, this work might involve working with them to invite Frank's mother into a series of sessions to address Frank's enmeshment with her. Frank would be the central actor in inviting her into the therapy sessions. Ellen's role would be primarily as an empathic witness to Frank's efforts to extricate himself from his father-replacement role within his family of origin. The goal of the sessions would be to help Frank and his mother establish a more appropriate relationship that does

not impinge substantially on his relationship with Ellen. In these sessions, the therapist is like a coach, preparing the team before the game and then coaching from the sidelines, carefully avoiding being induced into the role of player.

The next orientation, *Psychodynamic*, addresses object relations constraints in the problem maintenance structure. Specific orientations in this category assert that people are in trouble because of maladaptive object relations, and these relations must be addressed in order to facilitate the implementation of the adaptive solution. The primary specific psychodynamic orientation is the Object Relations “school” of psychoanalysis that originated in Britain after World War II (Fairbairn, 1952; Guntrip, 1969). More recent elaborations of Object Relations have emerged within psychoanalysis (Greenberg & Mitchell, 1983; Summers, 1994) and family therapy (Boszormenyi-Nagy, 1965; Scharff, 1989; Scharff & Bagnini, 2002; Slipp, 1988)

Psychodynamic intervention modifies maladaptive “defense mechanisms” that interfere with appropriate problem identification and/or implementation of the adaptive solution. Particular attention has been devoted to the mechanisms of transference, projection, and projective identification. The primary goal of psychodynamic intervention within IPCT involves helping key patients take responsibility for or “own” parts or aspects of themselves that they would rather deny, displace, and/or project onto or into other people. For instance, Roxanne needs to reown the healthy anger that she has projected onto Jason and use it to set limits and provide structure for him to succeed in school. Additionally, she needs to overcome her “weak male” transference to Jason (as well as Ray), in order to not enable his academic and social incompetence. Ellen needs to reown and adaptively use her anger to address Frank’s abandonment of her and enmeshment with his mother. In doing so, she needs to confront her father transference to Frank, realizing that confronting him will not result in the feelings of impotence and rage she felt in the face of her father’s unavailability.

The last orientation, *Self Psychology*, asserts that people get into trouble because of their narcissistic vulnerability, which constrains their ability to engage in the psychosocial tasks that are required to implement the adaptive solution. The primary specific orientation within this category is the work of Kohut and his disciples (1971, 1977, 1984). The focus of therapeutic activity is the relationship between the key narcissistically vulnerable patients and the therapist, in which the therapist becomes a “self object” for them. In doing so, the therapist becomes the recipient of the three healthy “transferences”—mirroring, idealizing, and twinning. The selves of the patients become stronger through the repeated “tearing and repairing” of these transferences. In a tear and repair episode, the therapist and the key patients overcome the “small” failures of the therapist to be empathic (to mirror), to be admirable (to be idealized), and/or to maintain a sense of identity (to twin) with the key patients.

Since Ray left her, Roxanne has felt very vulnerable narcissistically. Initially she felt like she was falling apart, but her rage at Ray has helped to organize and focus her. Inviting him to get involved as her coparent with Jason is not compatible with her need to stay narcissistically organized through her rage at Ray. However, as her alliance with the therapist has grown, she has felt stronger, and her rage at Ray has begun to abate. Initially, she was horrified and offended by the therapist’s suggestion that it might be helpful to invite Ray to get more involved in Jason’s life. It tore their relationship. However, the therapist’s empathic response and “tabling for now” of the idea of Ray’s involvement, restored her trust. Through such repeated tear-and-repair episodes, her vulnerability has diminished. Now inviting Ray in seems possible.

### Sequencing Modalities/Contexts and Orientations

A hallmark of IPCT is the sequential deployment of contexts and orientations. The process of IPCT moves from the Family/Community through the Couple to the Individual context.

Similarly, it moves from the Behavioral through the Biobehavioral, Experiential, Family of Origin, and Psychodynamic orientations to the Self Psychological. The macro context progression is from the interpersonal to the individual; the macro orientation progression is from the behavioral and the here-and-now, to the historically linked intrapsychic. In Figure 18.2, the process movement is from left to right and from top to bottom.

Figure 18.2 depicts the Context and Orientation dimensions as independent. For example, psychodynamic work can occur in Family/Community, Couple, or Individual contexts. In regard to Biobehavioral intervention, a psychiatrist could do a medication evaluation with a 60-year-old bipolar married woman in the presence of her husband and adult children, in the presence of her husband, or just alone with her. The critical context and orientation question is “What is the best context in which to use interventions from a particular orientation?” The terms “best” refers to the therapeutic impact of the intervention.

The arrow in Figure 18.2 illustrates the macro movement of the process in IPCT from the upper left quadrant of the matrix toward the lower right quadrant. Traditionally, the top three here-and-now orientations use the interpersonal contexts more than the lower three historical orientations. In fact, most people would associate the Psychodynamic and Self Psychology Orientations exclusively with the Individual context. For IPCT, this association is not essential or necessarily desirable. For instance, it may be better to talk with Frank *and* Ellen about his fears that Ellen will abandon him if he confronts her and how these fears may be linked to the way in which his mother withdrew from him whenever he expressed any anger or unhappiness with her than to explore these fears alone with Frank.

The macro process movement in IPCT is not an “ideal” but rather a necessary progression that occurs in the face of the failure of the interventions in a particular cell of the matrix to resolve the constraints that prevent the key patients from solving their presenting problem. IPCT is organized around the question of what

should a therapist do when what he or she is doing is not working. The model says: “When what you’re doing (the orientation/context combination) isn’t working, move to the right and/or down in the matrix.” The process is failure driven.

The challenge is to how to determine that something is not working and a matrix cell shift is appropriate. A shift is appropriate when the patient system is not making any progress toward resolving the constraints that prevent implementation of the adaptive solution. Usually, this lack of progress becomes of concern after a minimum of three or four weekly sessions—approximately a month of no-progress. However, if deterioration occurs, a shift may be indicated sooner.

The little arrow nested within the large arrow goes from the lower right quadrant toward the upper left. It indicates that as the therapist moves down the matrix, the links between the upper and lower levels are not lost. In moving down the matrix, it is important to continually test key patients’ readiness to engage in the constrained behaviors on the higher levels that would lead to problem resolution. With Roxanne’s paternal transference to Ray, the therapist regularly tests her readiness to engage him as a coparent. As soon as she can invite him to participate, the exploration of the paternal transference terminates. Exploration of the “deeper” constraints ceases once they are resolved sufficiently to permit resolution of the more superficial constraints and implementation of the adaptive solution. Once Roxanne can solicit and facilitate Ray’s engagement with Jason and her, the deeper work is no longer necessary.

## GUIDING PREMISES

The failure-driven progression is guided by theoretical premises. The first is the *Health Premise*, which asserts that the key patients are healthy until proven sick (incapable of solving their problems without major assistance). This premise encourages the therapist to approach the key patients as if they have what it takes to solve their presenting problem. The second

premise, *Problem Maintenance*, presumes that the problem maintenance structure is simple and superficial until proven otherwise. Its constraints are minimal, and the key patients should be able to overcome them with minimal, direct assistance. Together, these premises encourage therapists to approach patient systems from a health perspective, expecting them to engage in healthy and adaptive problem-solving behavior without “years of therapy.” However, these premises are not intended to promote psychopathological naivete. Not taking major psychopathology seriously can be a fatal error. These premises are intended to slightly tip the scales of health and pathology in the direction of health. Leaning in the direction of health, the therapist is open to feedback that disconfirms these premises.

The third premise that guides assessment and intervention is *Cost Effectiveness*. Attempting to create the most parsimonious therapy, this premise encourages therapists to use the most direct, simplest, and least expensive interventions before more complex, indirect, and costly ones. The assumption underlying the arrow in Figure 18.2 is that interventions in the upper left quadrant are more direct, simpler, and less expensive than interventions in the lower right-hand quadrant. Behavioral family and couple therapies typically presume simpler and more superficial problem maintenance structures, approach the constraints within those structures more directly, and are less expensive than individual psychodynamic and self-psychological therapies. Thus, IPCT begins with the former and progresses, if necessary, to the latter.

If the progression of treatments is driven by cost-effectiveness, why does biobehavioral intervention come after behavioral intervention? The answer has to do with the health and problem maintenance premises. In responding initially to people as if they are healthy and minimally constrained, the “pathology” of the identified patient (symptom bearer) is viewed as an appropriate response to difficult circumstances. Thus, Frank’s panic attacks are seen as an appropriate response to the “reality” that Ellen is having an affair and may leave him. Similarly, Roxanne’s depression can be seen as an

appropriate response to her divorce and the difficulties Jason has been having in school and at home.

Thus, the first therapeutic initiative focuses on alleviating the “real” psychosocial stressors stimulating the symptomatic response. If addressing those stressors reduces the symptoms, a medication intervention may not be necessary. The risk is that in moving immediately to medication, it communicates to the patient that “there is something wrong with you that should be medicated,” as opposed to “there is something going on in your environment that is upsetting you and that you need to address.” If addressing the stressors does not alleviate the symptoms, then medication may be indicated. Thus, the health and problem maintenance premises take precedence over the cost-effectiveness premise.

The fourth premise, *Interpersonal*, asserts that, if possible, it is better to do the required orientation work within an interpersonal (family/community or couple) as opposed to individual context. IPCT privileges the interpersonal. It says, “If you can, do the work that needs to be done in the presence of the other, appropriate key patients.” Therapists will generally learn more about patient systems by meeting with as many of the key patients as soon as possible. Additionally, meeting face-to-face with key patients facilitates the creation of a strong therapeutic alliance. Also, doing therapeutic work in the presence of the other appropriate key patients creates the largest possible “collective observing ego” and maximizes the impact of the work.

There are exceptions to this rationale. With abuse cases, the therapist may learn more and establish stronger alliances by meeting individually with key patients. Similarly, many patients will not be able to establish sufficiently strong narcissistic transferences to the therapist to do the self-repair work they need to do if other patients are present. For them, the private nature of the therapy is essential. Nevertheless, in most cases, the knowledge gained and therapeutic payoff are greater when the interventions occur in the largest, appropriate direct patient system.

**THERAPY RELATIONSHIP**

IPCT uses an integrative systems model of the therapeutic alliance (Pinsof & Catherall, 1986; Pinsof, 1994, 1995). This model consists of two sets of dimensions that form the 3 × 4 Matrix in Figure 18.3. The three horizontal *Content* dimensions derive from the work of Bordin (1979) and Horvath and Greenberg (1994). The first, *Tasks*, targets how much the therapist and the key patients agree about their respective tasks in the therapy. The second, *Goals*, refers to how much key patients and the therapist agree about the goals of therapy. The *Bonds* dimension taps how much key patients feel connected to the therapist—the extent to which the therapist is a self-object for them.

Different therapy systems can have different alliance profiles. For instance, if Roxanne agrees with the therapist’s initiative to help her grieve the loss of her marriage to Ray and to help her move out of her depressed and demoralized state, the contribution of *Tasks* to the overall alliance would be high. Similarly, if she agrees with the therapist’s goal of helping Jason function effectively in school, the contribution of *Goals* would be high. However, if she distrusts

the therapist, the contribution of *Bonds* to the alliance would be low. Roxanne’s alliance could be described as a high *Tasks*, high *Goal*, and low *Bond* alliance.

Quantitatively modeling the *Content* dimensions as 10-point scales, Roxanne’s *Content Alliance* profile could be described as an 8 on *Tasks*, an 8 on *Goals*, and a 4 on *Bonds*. Her *Content Dimension* score would be 20. If 20 were viewed as the viability cutoff, Roxanne’s alliance would be sufficient to sustain therapy. However, if the therapist tries to involve Ray directly in therapy and Roxanne feels threatened, the *Task* contribution to the alliance might plummet, taking the overall alliance score substantially below 20 and threatening the viability of the therapy. However, if the therapist waits to address this task until his or her *Bond* with Roxanne has grown, the reduction in *Tasks* may be offset by the increase in *Bonds*, and the viability of the alliance and the therapy may not be at-risk.

There are four *Interpersonal* dimensions. The first, *Individual*, covers the alliances between the therapist and the individual key patients. The *Subsystem* dimension focuses on the alliances among the therapist and the key

Interpersonal Dimensions	Content Dimensions		
	Tasks	Goals	Bonds
Individual			
Subsystem			
Whole System			
Within System			

FIGURE 18.3 The Therapeutic Alliance in Problem-Centered Therapy



interpersonal subsystems within the patient system. In a three-generation family system, it addresses the alliance between the parents and the therapist, between the siblings and the therapist, and between the grandparents and therapist. The third *Whole System* dimension targets the alliance between the therapist and the whole patient system. *Within System* covers alliances between the key patients.

Figure 18.3 illustrates that the Interpersonal dimensions cut across the Content dimensions. It is possible to talk about the extent to which Frank agrees with the therapist's initiative to help him get in touch with his feelings about Ellen's infidelity (Individual/Tasks), the extent to which Frank and Ellen as a couple share the therapist's goal of helping them create a more committed marital relationship (Subsystem/Goals), the extent to which Frank, Ellen, and Frank's mother trust the therapist (Whole System/Bonds), and the extent to which Frank and Ellen share the goal of repairing their marriage (Within System/Goals).

A crucial implication of the Interpersonal Dimension is the split alliance, in which the therapist has a strong alliance with one subsystem and a weak alliance with another subsystem of the patient system. Alternatively, the therapist may have viable alliances with the members and subsystems of the patient system, but the key patients may not have a viable alliance with each other. For instance, if Frank wants to save the marriage but Ellen wants out, the Within-System alliance may not be sufficient to sustain therapy.

Typically, with split alliances, the viability of the therapy hinges on whether the positive alliance is with a more powerful subsystem. For instance, if the therapist has a strong alliance with Roxanne, Jason's custodial parent, but a weak alliance with Ray, the therapy may be viable. However, if the alliances were reversed and the weak alliance was with Roxanne, the therapy probably would not work. When the split alliance is with equally powerful subsystems, like Frank and Ellen, the therapy probably will not work.

In IPCT, the *alliance takes priority over the process progression up to the point where the integrity and effectiveness of the therapy is com-*

*promised*. When the process progression (the arrow in Figure 18.2) threatens the alliance, it should be modified. This guideline views the process progression as a major component of the Tasks dimension. Thus, if Roxanne refuses to consider involving Ray directly into the therapy, the therapist should back off that initiative until one of three things occurs: (1) Roxanne gets herself together enough to provide Jason with the structure and support he needs and he becomes functional in school; (2) Roxanne's Bond to the therapist becomes strong enough to offset her resistance to including Ray and the topic can be reopened; or (3) the therapy without Ray proves ineffective, and Jason's school problems increase. If option 3 occurs, the therapist would probably confront Roxanne with the alternatives of stopping therapy or including Ray.

IPCT views the alliance as a multidimensional phenomenon that evolves over the course of therapy. Building, tracking, and maintaining the alliance is a crucial function that frequently takes priority over technical (technique) considerations. The therapist needs to consider which aspects of the alliance with which members or subsystems of the patient system need to be strengthened at crucial points in treatment. IPCT also applies alliance theory to the therapist system, looking at the alliances between supervisors and supervisees, between multiple therapists working with the same system, and between therapists and care managers (insurance providers).

## EMPIRICAL RESEARCH

Since its inception in the late 1970s, there have been two IPCT research initiatives. The first pertains to research on the alliance; the second to the Psychotherapy Change Project at the Family Institute at Northwestern University.

### Alliance Research

In developing the Integrative Psychotherapy Alliance model, Don Catherall and I (Pinsof & Catherall, 1986) developed three patient self-report scales to measure the alliance on the

same dimensions in individual, couple, and family therapy. The initial scales included the three Content dimensions presented above, *Tasks, Goals, and Bonds*, and the *Individual, Subsystem, and Whole System* Interpersonal dimensions. We operationalized the *Individual* dimension as a *Self* dimension (“Me and the therapist”), the *Subsystem* dimension as an *Other* dimension (“my partner and the therapist” or “the other people in my family”), and the *Whole System* dimension as a *Group* dimension (“the therapist and us”). When confronting the pragmatics of measuring the alliance on the Interpersonal dimensions in different therapeutic contexts, we realized the phrasing of questions to measure each dimension had to be distinct in each context, resulting in The Family Therapy Alliance Scale (FTAS), The Couple Therapy Alliance Scale (CTAS), and the Individual Therapy Alliance Scale (ITAS).

The original scales did not include the *Within-System* subdimension. In the early 1990s, I (Pinsof, 1994) expanded the theoretical model to include the *Within-System* subdimension and added a corresponding set of questions to each of the three instruments, resulting in a new set of Revised measures (FTAS-r, CTAS-r, and the ITAS-r). The reliabilities of the original and revised instruments were good, and both have been predictive of change in a number of studies conducted by different North American research groups (Bourgeois, Sabourin, & Wright, 1990; Heatherington & Friedlander, 1990; Johnson & Greenberg, 1985; Johnson & Talitman, 1997).

### The Psychotherapy Change Project

Seven years ago, we began The Psychotherapy Change Project (Pinsof & Wynne, 2000) to (1) identify how different types of patient systems change over the course of therapy; (2) identify the profiles of therapist behavior associated with successful patient change; and (3) create a methodology for feeding this information back to therapists during the course of therapy. During the initial phase of the Psychotherapy Change Project, we studied patient change from the 1st to the 8th session and from the 8th to 16th session with a battery of well-validated

instruments on a sample of cases at the Family Institute at Northwestern University.

Between 1997 and 2001, cases presenting for therapy at the Family Institute’s Clinic were offered the opportunity to participate in the Psychotherapy Change Project. If they consented, they arrived approximately 90 minutes before their first scheduled appointment to complete the Test Battery. If the case made it to the eighth session, they came in an hour before that session and completed the Test Battery. If they made it to the 16th session and to the 24th, they repeated the Test Battery procedure. For completing the Test Battery during the course of therapy, the cases received the corresponding session free of charge. The therapists administered and collected the test batteries.

The *Test Battery* was selected to predict and assess change in the major psychosocial domains of life functioning: individual adult, couple/marital, family, family of origin, and child/adolescent. The battery consisted of four instruments: the *Compass* (Howard, Brill, Leuger, O’Mahoney, & Grissom, 1995) to tap individual attitudes toward therapy, individual well-being, and problems/symptoms; the *Marital Satisfaction Inventory*, or MSI (Snyder, 1997) to assess distinct aspects of marital functioning; the *Family Assessment Device*, or FAD (Epstein, Baldwin, & Bishop, 1983) to measure distinct aspects of family functioning; and the *Child Behavior Checklist*, or CBCL (Achenbach & Edelbrock, 1983) to measure parental assessment of the behaviors and problems of one child between the ages of 3 and 17.

The initial sample consisted of approximately 600 patients presenting for individual, couple, or family therapy at the Clinic. The majority of the patients were middle class and White. More than half of the patients did not make it to the eighth session. Most of them terminated, some of them dropped out, and a small number continued but did not complete the eighth session Test Battery. This attrition rate—50%—is not unusual in a clinic population. Patients completed the questionnaires in the test batteries that were appropriate to their demographics, not their modality or context of therapy.

Approximately 45 different therapists provided therapy to the patients in this sample. The vast majority of the therapists were practicum students in the American Association for Marriage and Family Therapy (AAMFT) accredited, 2-year Masters Program in Marriage and Family Therapy that the Family Institute runs for Northwestern University. All of the therapists were trained and supervised in the Family Institute model of therapy, an integration of IPCT, and the Metaframeworks model (Breunlin, Schwartz, & Mac Kune-Karrer, 1992), a highly compatible treatment model that adds developmental, cultural, and gender emphases to IPCT. All of the students received 3 hours of weekly group supervision and 1 hour of weekly individual supervision.

Only the 1st to 8th session data analyses are reported below, as the sample sizes for the 16th and 24th data analyses were not sufficient. The average numbers of sessions by modality were: Individual, 18.5; Couple, 12.3; and Family, 11.5. More than a third of the variables showed significant change in the appropriate direction from the first to the eighth session. The major variables on which significant changes occurred are presented in Table 18.1. No significant changes occurred between the first and the eighth sessions on any of the Family (FAD) variables. We believe that this lack of results derives primarily from the low number of patients that completed this measure (Individual therapy = 10; Couple therapy = 20; and Family therapy = 12).

Problem centered *individual therapy* demonstrated significant positive changes on Subjective Well-Being, Life Functioning, Total Symptoms, Depression, and Anxiety from the *Compass*. Problem-centered *couple therapy* demonstrated significant positive changes on all of these individual indices as well as Marital Distress and Marital Aggression from the MSI. In spite of the much lower number of patients in problem-centered *family therapy*, they still demonstrated significant changes on Total Symptoms, Depression, and Anxiety from the *Compass* and Internalizing and Externalizing Child Problems from the CBCL.

Each of the major problem-centered assessment/intervention contexts/modalities was as-

sociated with significant and expected changes: individual functioning changed in individual therapy, marital functioning changed in couple therapy, and child functioning changed in family therapy. What is more intriguing is that couple therapy and family therapy were also associated with significant individual functioning changes. In fact, couple therapy was associated with as much individual functioning change as the individual therapy. Thus, it seems that the more interpersonal couple therapy had a broader impact than individual therapy—a finding that supports the Interpersonal Premise of IPCT. This finding is also supported by the results of a number of studies comparing couples therapy for depression with individual, cognitive-behavior therapy (Prince & Jacobson, 1995).

These data constitute preliminary evidence in support of the effectiveness of IPCT across a wide array of presenting problems and contexts. The research did not involve random assignment of patients to therapists, a control or comparison condition, and could not adequately account for outcomes in two groups: more than half of the patients who began therapy but did not make it to the eighth session; and a smaller proportion of patients who made it to the eighth session but did not complete the entire Test Battery.

## FUTURE DIRECTIONS

IPCT is a framework for organizing different treatments and a systemically oriented integrative psychotherapy. It derives from the desire to create a maximally effective therapy for the broad range of patients seeking psychotherapy. It assumes that failure and the search for better alternatives is an inherent feature of effective psychotherapy. It organizes that search for alternatives around certain premises that cost-effectively build on the strengths of interpersonal and individual systems.

In terms of further work, our current efforts go in two directions. The first involves writing a manual for Integrative Problem-Centered Couples Therapy and testing this manualized

TABLE 18.1 Measures, Modalities, and Outcomes in an Initial Evaluation of the First Eight Sessions of Problem-Centered Therapy

Variable (Measure)	Modality	N	Session 1	Session 8	<i>t</i> test <i>P</i> values
Subjective well-being (Compass)	Individual	57	19.1	21.4	<.0001
	Couple	74	20.3	22.16	<.0001
	Family	13	21.07	21.38	N.S.
Life functioning (Compass)	Individual	48	50.81	55.79	<.0001
	Couple	77	57.19	65.95	<.0001
	Family	9	62.56	66.89	N.S.
Total symptoms (Compass)	Individual	54	72.56	62.03	<.0001
	Couple	86	59.83	53.57	<.0001
	Family	13	58.46	50.38	<.0001
Depression (Compass)	Individual	76	20.30	16.90	<.0001
	Couple	99	16.40	14.31	<.0001
	Family	16	16.69	13.44	<.0001
Anxiety (Compass)	Individual	73	36.86	31.73	<.0001
	Couple	88	30.99	27.75	<.0001
	Family	15	31.07	26.6	<.0001
Marital distress (MSI)	Individual	17	68.00	64.47	N.S.
	Couple	83	70.46	65.55	<.001
	Family	2	64.5	50.50	N.S.
Marital aggression (MSI)	Individual	16	21.69	20.13	N.S.
	Couple	81	23.16	21.32	<.007
	Family	3	18.33	16.33	N.S.
Child internalizing (CBCL)	Individual	4	63.25	52.25	N.S.
	Couple	10	53.60	56.00	N.S.
	Family	13	75.07	58.46	<.01
Child externalizing (CBCL)	Individual	4	69.75	59.00	N.S.
	Couple	10	63.1	62.8	N.S.
	Family	13	82.00	75.27	<.01

Note. N.S., not significant.

version of IPCT in a clinical trial to alleviate marital distress. This initiative lays the foundation for the empirical validation of one version of IPCT. Our plan is to subsequently apply and tailor this therapy to the treatment of two types of couples that are currently being studied at the Family Institute: those in which one member has Generalized Anxiety Disorder and those in which one member has depression or dysthymia.

The second effort underway is to move IPCT in the direction of becoming an empirically informed integrative therapy. This initiative, linked to the Psychotherapy Change Project, attempts to ground IPCT in the study of patient change and therapist behavior. To measure patient change, we are just completing the *Systemic Therapy Inventory of Change—STIC* (Pinsof, Zinbarg, Mann, Lebow, Knobloch-

Fedders, & Friedman, 2004), a patient-self report instrument that assesses six domains: individual symptoms and well-being; adult recall of childhood family-of-origin; current couple/marital functioning; current family functioning; child well-being and symptoms; and the therapeutic alliance. The Initial STIC-I contains approximately 140 items and is administered before the first session. The Intersession STIC-IN consists of approximately 40 items (from the scales on the STIC-I) and can be administered as often as every session. To measure therapist behavior, we have just completed the *Integrative Therapy Session Report-ITSR* (Pinsof, Mann, Lebow, Knobloch-Fedders, Friedman, & Zinbarg, 2004), a self-report questionnaire that takes about 5 to 7 minutes for a therapist to complete after a session and that provides a snapshot of the major clinical foci and thera-

peutic techniques that the therapist used during the session.

As well as providing a set of instruments to study the process of change in different types of therapy, the STIC and the ITSr have also been developed to empirically ground IPCT. The STIC represents a quantitative methodology for providing therapists and patients with empirical feedback about patient progress that can be used to inform decisions about when to shift contexts and orientations within the problem-centered matrix. The ITSr provides a quantitative profile of the foci and techniques that therapists are using at any particular time. It can specify therapist behavior in each of the contexts and orientations within the problem-centered matrix, as well as the points in the course of therapy when therapists shift orientations and/or contexts. As we develop the progress research methodology (Pinsof & Wynne, 2000) to feed STIC (patient change) and ITSr (therapist behavior) data back to therapists and patients during the course of therapy, these instruments hold great promise for helping IPCT become an empirically informed psychotherapy.

Despite its prescriptions, IPCT, for mature clinicians, represents an improvisational structure for the conduct of a genuine and creative psychotherapy. Within each of the generic orientations, there is considerable room for each therapist to find the strategies and techniques that best suit his or her style, values, and beliefs. By prioritizing the alliance over technique, IPCT asserts the primacy of relationship considerations in the therapeutic process. Finally, IPCT seeks to use progress research to empirically inform and ground clinical artistry. The vision at the core of IPCT integrates art and science, and compassion and rigor, in the service of helping people learn to solve their problems and lead healthier and happier lives.

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## Integrating Spirituality with Psychotherapy

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In recent years, many mental health professionals have introduced and elaborated ways of integrating spiritual approaches with the practice of psychotherapy. This trend is consistent with the growing awareness of the importance of religion, spirituality, and spiritual experiences in the lives of many people and the relevance of religion and spirituality for psychotherapy. Two of the most well-known and clearly conceptualized approaches to integrating spirituality with psychotherapy are Richards and Bergin's (1997) spiritual strategy for psychotherapy and Miller's (2003) views on incorporating spirituality in psychotherapy.

In this chapter, I begin with these two expositions as examples of current directions in integrating spirituality with psychotherapy. This will be followed by a discussion of a number of concerns having to do with such integration. Then I present, illustrate, and evaluate six major paths of integrating spirituality with psychotherapy.

### TWO EXEMPLARS

Miller's (2003) *Incorporating Spirituality in Counseling and Psychotherapy* reviews other approaches and presents her own ideas about the integration of spirituality with psychotherapy. One path of focus is exploring or assessing the client's spirituality. Another path is the support of the client's engagement in spiritual development and encouragement of spiritual practices. A third path is that of the therapist working within the spiritual or religious viewpoint of the client. Two final paths involve working with some clients to form a more spiritual identity as a goal of psychotherapy and using specific spiritual methods within the context of psychotherapy.

In her approach, Miller expresses a good deal of awareness of possible ethical concerns having to do with integrating spirituality into psychotherapy. In fact, she has taken the useful step of including, as separate appendices, the



codes of ethics of the American Association for Marriage and Family Therapy (AAMFT), American Counseling Association (ACA), American Psychological Association (APA), and the National Association of Social Workers (NASW). She urges therapists to respect the religious views of their clients and to work within their areas of competence. The most spiritually oriented interventions include “helping clients develop a spiritual identity” (pp. 141–150) and engaging in spiritual practices such as prayer, meditation, and spiritual imagery. She also favors collaboration with religious leaders and the value of spiritual community.

Richards and Bergin’s (1997) *A Spiritual Strategy for Counseling and Psychotherapy* presents a more clear-cut spiritual approach, which they term “theistic, spiritual.” They concern themselves with religious or spiritual assessment, ethical and boundary issues, and favor the use, in some cases, of spiritual or religious practices as part of the therapeutic process. They advocate addressing the spiritual or religious dimension of psychotherapy from either an ecumenical or a denominational viewpoint. Some goals indicated by Richards and Bergin are helping “. . . clients experience and affirm their eternal spiritual identity and live in harmony with the spirit of Truth” (p. 116), helping “. . . clients examine and better understand what if any impact their religious and spiritual beliefs have on their presenting problems and their lives in general” (p. 117), and helping “. . . clients examine how they feel about their spiritual growth and well-being and, if they desire, help them determine how they can continue their quest for spiritual growth and well-being” (p. 118). They also advocate identifying spiritual resources and helping the client make choices about the role of spirituality in their lives.

Both Miller’s approach and that of Richards and Bergin indicate the importance of including spirituality as an area of psychotherapeutic assessment, support, and even therapeutic focus. Both approaches consider the utility of promoting spiritually oriented interventions such as 12-step programs and the necessity for people to develop a spiritual identity. They both indicate awareness of ethical and bound-

ary issues and the possible use of spiritual techniques, such as meditation and prayer in psychotherapy. They both speak to the necessity to respect and work within the religious framework of psychotherapeutic clients.

## CENTRAL PROBLEMS

### Defining Spirituality

I begin with an examination of some of the more problematic aspects of integrating spirituality and psychotherapy. One problem in such an endeavor is the difficulty in arriving at a clear, consensual definition of spirituality. If one is committed as a practitioner to working within the value framework of a client, then it would follow that one would have to accept the client’s definition of spirituality. It is axiomatic that, in a pluralistic society with many variations of religious and spiritual teachings, only an imprecise definition or, more accurately, a whole array of overlapping views would present themselves.

As a personal example, I grew up in a Jewish environment in which I was taught and came to believe that the essence of Jewish spirituality was an emphasis on this world and a lack of concern with otherworldly pursuits. The idea was that spirituality consisted largely of leading one’s life ethically and following God’s teachings as indicated by my teachers. Only in young adulthood did I encounter a different strain of Jewish spirituality, one more mystical and otherworldly. Moreover, these variations are only two within a given religious tradition.

My own experience with the Jewish religion, I am sure, is similar to that of many other people in a wide array of religious teachings. There are many approaches vying within most spiritual traditions. Is there a single monotheism or many monotheisms, a Christianity or Christianities, a Paganism or Paganisms, a Buddhism or Buddhisms, an Islamic religion or religions? Some spiritual approaches are more intellectual, some more emotional, and some more physical (Sollod & Shafranske, 2000). They range from the hidden esoteric depths of mysticism, through mesotericism, to

exoteric rituals. It is highly doubtful that a few common denominators of spirituality can be found in all such traditions.

Let me briefly review two definitions of spirituality, the first of these by the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC):

Spirituality may be defined as the animating life force, represented by such images as breath, wind, vigor, and courage. Spirituality is the drawing out and infusion of spiritual in one's life. It is experienced as an active and passive process. Spirituality is also defined as a capacity and tendency that is innate and unique to all persons. This spiritual tendency moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one's capacity for creativity, growth, and the development of a value system. (ASERVIC position paper as quoted in Miller, 2003, p. 6)

This definition is global: It includes almost anything positive or life enhancing that a person might term as *spiritual*. There is an effort here, as in other definitions, to distinguish *spirituality* from *religiosity*, even though some connection of spirituality with religion is recognized. This definition views spirituality as an unalloyed positive aspect of life. In fact, it is difficult to imagine much that is positive in life, outside of simple material success, that would not fall into the ASERVIC definition of the spiritual.

Richards and Bergin (1997, pp. 12–13) elaborated their definition of spirituality:

... The *American Heritage Dictionary of the English Language* (1992) defines *spiritual* as “of concerned with or affecting the soul” and “of, from, or relating to God” (p. 1938). These definitions are a good beginning but, by themselves, they are not adequate to convey our understanding of the word *spiritual*. By spiritual we also mean those experiences, beliefs, and phenomena that pertain to the transcendent and existential aspects of life (i.e., God or a Higher Power, the propose and meaning of life, suffering, good and evil, death, etc.)

Richards and Bergin (1997, p. 13) continue:

... the terms *religious* and *spiritual* are interrelated, but they can be distinguished from each other along several dimensions. Religious expressions tend to be denominational, external, cognitive, behavioral, ritualistic, and public. Spiritual experiences tend to be universal, ecumenical internal, affective, spontaneous and private. It is possible to be religious without being spiritual and spiritual without being religious.

Richards and Bergin's definition of spirituality is more articulated and definitive than the ASERVIC definition. It clearly points to transcendence, privacy, spontaneity, and emotionality as hallmarks of spirituality. Also, there is the inclusion of monotheistic beliefs, at first in the form of a Higher Being and then, specifically, of “God, the Spirit of Truth or ... Divine Intelligence. . . .” (p. 77).

Many American views of spiritual experience have followed William James' emphasis on spontaneous mystical and transcendent experiences (Sollod & Shafranske, 2000). This emphasis, shared by Richards and Bergin, appears to ignore many other legitimate approaches to spirituality, including Christian, Islamic, and Buddhist monastic traditions. Ritual and the exoteric expressions of spirituality cannot be ruled out as potentially genuinely spiritual, nor is the emphasis on developing refined intellectual or cognitive understanding. Their approach harkens back to the ideas of American transcendentalists such as Ralph Waldo Emerson. We find an emphasis on unity and divine harmony without the more particularistic or historic aspects of religions such as Catholicism, the Christian Orthodoxies, and Judaism.

These two definitions of *spirituality* have a great deal of intuitive appeal; however, it is not difficult to spot their limitations and specific emphases. Note the healthy minded aspects of such definitions. One would have to stretch rather far to find the experiences of Christian or Islamic flagellants or the sufferings of ascetic mystics. There is meager allusion to revelation, which is the core of many spiritual traditions, nor to the ideas of remorse, repentance, and retribution. The definitions of spiritual are at

once optimistic and hopeful. However attractive these definitions may be, they do not cover much of the range of what people experience and mean when they use the term “spirituality,” even within our own culture.

### Person Helper or Spiritual Director?

Another potential problem in the development of a spiritually oriented psychotherapy is the question of to what degree the approach should conform to the existing beliefs and practices of the client. It is a well-accepted ethical guideline that the therapist should normally work within the value framework of the client. There are exceptions to this, of course. For example, a client may have values that are antisocial or have destructive consequences to himself or herself or to others. In such cases, it is precisely the values of the client that become a focus of therapeutic intervention. In such cases, typically, the therapist should be explicit in outlining value discrepancies with the client. Ethical guidelines generally indicate that the therapist should respect the particular cultural or religio-spiritual traditions upheld by the client.

In traditional forms of spiritual direction, however, it is well accepted that the spiritual advisor has an obligation to point to the client when he or she is following a “wrong” path. The spiritual aspirant may have erroneous understandings of spiritual principles or may not be applying methods correctly. Meditation training in some traditions may require years of practice, emulation of elders, and correction. The spiritual director in traditional frameworks is a person who, by virtue of experience and knowledge, is able to provide guidance to a less experienced person or “novice.” At times, the spiritual director may have to demonstrate to the novice, either gently or not, the “error of his or her ways.”

One can question the adequacy of spiritual experience or spiritual discernment of a psychotherapist interested in spirituality. Such a positive attitude toward spirituality by no means indicates that the therapist is an adequate guide for spiritual development. Missing in most of the expositions of spiritually oriented psychotherapy is the absence of clear

statements about who might be qualified to guide another person in his or her spiritual quest. Can just anyone who is favorably disposed toward spirituality take on such a responsibility? Just as one might inquire about the personal psychoanalysis of an analyst, one might inquire who “trained” the spiritually oriented psychotherapist and what were the principles of such training.

How would such a therapist, who is committed to working within the client’s goals and values, be able to correct a misplaced emphasis or direction, even were the therapist able to discern it? For example, would the psychotherapist be able to correct the client’s emphasis on transcendental experience as a goal in itself if this is what the client is genuinely seeking? A spiritual director, in many traditions, needs to focus on helping the novice be alert to evidences of egoism, which can be seen as a false and superficial sense of self. The novice might be encouraged to engage in boring, monotonous, repetitive physical work for many months in order to help achieve balance and, perhaps, to overcome egoism (cf. Wallach & Wallach, 1983). During this period, the client may not have a clear understanding or a deep acceptance of the approach of the spiritual director, even a trusted one.

In summary, there is a clear distinction between psychotherapists and spiritual directors in terms of their roles, commitments and competencies. Integrating spirituality with psychotherapy may allow an interested and enthusiastic psychotherapist to assume the role of spiritual director for their clients. Both approaches warn against therapists working outside of their expertise, but one wonders to what extent many psychotherapists have had the training and knowledge to guide their clients in their spiritual development.

### Health or Holiness?

Psychology’s traditional abhorrence of explicitly spiritual approaches is not without merit. Historically, spirituality has not necessarily been correlated with what would pass for psychological health. One has merely to examine the lives of the Saints to find any number of

pathological conditions, be it depression, mania, masochism, hysteria, phobias, and obsessional behavior. The mortification of the flesh, so prevalent in many spiritual traditions, is at variance with psychology's emphasis on acceptance of physical needs and enjoyment in their satisfaction. The emphasis in many spiritual traditions on the value of repentance and suffering is hard to find in contemporary psychotherapy. In addition, many traditional spiritual teachings emphasize the value of inhibiting what most contemporary psychologists would view as normal self-assertion. Viewing spirituality as necessarily compatible with psychological health is a naively selective view of the spiritual legacy of humanity. Holiness and psychological health are not identical goals. However, a wholesale assimilation of spirituality into a mental health model, or vice versa, is not appropriate or even possible.

Imagine two overlapping circles, one indicating spiritual approaches to life and the other contemporary views of mental health. The overlapping area would indicate areas of agreement; the areas that represent positive mental health qualities only or positive spiritual qualities only would be the non-overlapping areas of the circles. The relative size of the areas in which spirituality is consistent with mental health and where it counters mental health would have to be empirically determined. No doubt, there would be differences in these areas depending on the spiritual or religious tradition involved and, as well, the model of mental health. One can easily come up with models of spirituality almost entirely antithetical to accepted notions of mental health, such as that exemplified in the behavior of castes of Indian *mysts*, or holy men, who are electively mute penniless wanderers devoted to a deity. They often spend their lives in presumed transcendental states of consciousness while foraging in dumps and wilderness areas.

### What About the Definition of Psychotherapy?

In spite of the many efforts to integrate spirituality and psychotherapy, a recent definition of psychotherapy, used as a framework for meta-

analyses of therapeutic effectiveness, seems to preclude spiritual approaches from being included in many forms of psychotherapy. Wampold (2001) has defined psychotherapy as

... a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problems, or complaint. . . . (p. 3; italics added)

Wampold further emphasizes that treatments based on nonpsychological principles cannot be classified as forms of psychotherapy. Included in this category are "... everything but the kitchen sink and overt quackery. . . ." (p. 8). He writes:

Treatments based on the occult, indigenous peoples' cultural beliefs about mental health and behavior, New Age ideas (e.g., herbal remedies), and religion may be efficacious . . . but they are not psychotherapy and are not considered in this book." (p. 5)

Wampold's definition of psychotherapy highlights the point that many methods derived from spiritual traditions have not been developed in accordance with psychological principles. This fact does not imply that psychological principles underlying a specific spiritual method might not eventually be discovered or elucidated. One could argue that, if a spiritual method is empirically effective in causing behavioral changes, there must be some psychological principle underlying its effectiveness.

## SIX PATHS TO INTEGRATION

Given this backdrop of some problems integrating spirituality with psychotherapy, I will consider and illustrate six possible paths in which spirituality can be integrated with psychotherapy:

1. Acknowledging the extant spiritual aspects of psychotherapy in general and of specific ostensibly nonspiritual psychotherapies.

2. Working in a manner consistent with clients' spiritual and religious views.
3. Psychotherapeutic use of spiritual techniques for the remediation of behavioral disorders.
4. Facilitating a spiritual approach to life, spiritual formation, as a treatment of behavioral disorders.
5. Spiritual formation as a therapeutic goal in itself.
6. The use of methods derived from spiritual traditions to facilitate the psychotherapist's effectiveness.

### Extant Integrations

One means of integration is that of the spiritual aspects of ostensibly nonspiritual psychotherapies. The assumption that psychotherapeutic approaches have been derived from scientific roots has been frequently challenged (e.g., Perez, 1989; Sollod, 1982). Originators of psychotherapies have drawn from a variety of extrascientific sources. Spiritual traditions have long been one major but largely hidden and underacknowledged source of psychotherapeutic innovation. Frank (1973) has underscored that contemporary psychotherapies have many features in common with traditional healing approaches. The underlying structure of psychotherapy itself, that is, of a person seeking help (healee) going to a specifically trained or qualified individual (healer) for the purpose of seeking some type of solace or remediation of a problem, appears to be derived either from healing traditions themselves or from aspects of human nature appreciated both by healing traditions and by contemporary practice. London (1986) has elucidated the quasi-healer, quasi-clergy role of the psychotherapist, who has become, in our society, an arbiter of morals and values.

The effectiveness of psychotherapy is thus potentiated by archetypes related to healing and spirituality. These include some of the very bases of therapeutic effectiveness: the client's belief in the value and effectiveness of psychotherapy, a specific psychotherapeutic approach, and the ability of the therapist (healer) to facilitate positive changes.

When considering the origins of many psychotherapy approaches, ranging from Freud's psychoanalysis, through Adler's Individual Psychology, Jung's Analytical Psychology, Rogers' client-centered, to Ellis's rational-emotive therapy, a fascinating pattern regarding spirituality and religiosity occurs: The therapeutic originators often were influenced by spiritual or religious approaches in their family life (see Monte & Sollod, 2003, for examples). Many innovators consciously repudiated religiosity and spirituality but nonetheless incorporated into their approaches many ideas and even methods derived from spiritual traditions. In some cases, the process consists of an unconscious transmission of religious or spiritual traditions alongside a conscious rejection of the same. Such hidden spirituality is already quite prevalent in many psychotherapies.

Sigmund Freud was brought up in a family atmosphere replete with the late-nineteenth century Jewish spirituality of central Europe. He turned away from Judaism but continued in his writings a preoccupation with religion and religious themes. Bakan (1958) has examined some of the vestiges of Jewish mysticism in Freudian thinking; and Vitz (1988) has even speculated about some undercurrents of Christianity in Freud's background. Two specific examples include Freud's awareness of the hidden meaning of dreams from Biblical sources, with which he had long been familiar, and his interpretive approach to the psyche of patients, which paralleled the interpretive methods of Talmudic scholars. In addition, it is not difficult to find pseudo-Gnostic aspects of Freudian psychoanalysis, including its quasi-religious or cult-like organizational aspects, initiation through experience with a prior initiate, and the idea of hidden understandings open only to the correctly psychoanalyzed (Sollod, 1982). The idea of the subconscious and other Freudian ideas appear to have been derived, in part, from Kabbalistic mysticism (Bakan, 1958; Fodor, 1971). All of these features are present in apparent contradiction to Freud's repeated assertions of his adherence to a scientific worldview.

Adlerian Individual Psychology is a more straightforward example. Adler rejected Juda-

ism and converted, as an adult, to Protestantism. His ethos, however, corresponds quite closely to Jewish ethical teachings. He believed that the purpose of human life was to be creative and that each person had the responsibility to make the world she finds, whether it is the social world or the people in her life, better. This Adlerian therapeutic goal is almost identical to the Hebrew *tikkun olum*, “making the world a better place.” Adler’s (1959) view of the individual as an active creator may be considered an exoteric version of mystical Jewish teachings.

Jung’s approach is another case in point. Jung was the son of a pastor in the Swiss Reformed Church, but early on he experienced visions that included pagan imagery and/or suggested that God wanted religion to take on new forms. Jung, unlike the two predecessors, Freud and Adler, was overtly interested in spirituality. However, his spirituality differed considerably from the Christian monotheism in which he was raised. The whole panoply of Greek and Roman gods/goddesses as well as Gnostic images emerge in Jungian theory as archetypes of the collective unconscious. Jung’s spirituality, though it could be termed monotheistic, is nonetheless open to a broader cast of characters and spectrum of values than typifies Western monotheisms. Jung also values what he termed “active imagination,” a type of visualization designed to access archetypes and potentiate their energies. For Jung, there was no disagreement between a scientific and a spiritual approach to understanding personality.

Carl Rogers (1978) wrote that Taoism was an influence on his development of client-centered therapy. Secularized aspects of Protestantism also are present in his approach, in particular the emphasis on each person being responsible for finding his own path and the therapist, like the Protestant minister, being a facilitator of this process, rather than a priest-like authority. According to Lynch (1997), Rogers consciously rejected the values of his Protestant parents but unconsciously assimilated them. Lynch suggested that one example is the fall–redemption narrative form of Rogers’ description of a person’s fall into incongruence

and recovery to congruence through the provision of a “saving” therapeutic relationship.

The self-styled nonspiritual and scientific approaches of cognitive-behavioral psychotherapy are deeply connected with spiritual sources. King (1996) in an insightful exposition, *The Butterfly: A Symbol of Conscious Evolution*, indicated how radical behaviorism’s model of individual behavior as completely conditioned and shaped by the environment was connected to the ideas of Uspenskii (1929), a Russian mystic and student of Gurdjieff. Ellis (1970) has cited the insights of Epictetus, the ancient Greek spiritual master, to support the validity of his rational-emotive therapy (RET). A major tenet of RET—that an individual’s thought shapes experience—is consistent with Stoicism as well as with some Christian, Buddhist, and Kabbalistic teachings. Many techniques of relaxation that were later incorporated into behavioral methods, such as desensitization were, at least in part, drawn from Hindu or Yogic practices.

The psychotherapist practicing in accord with one of the major systems of psychotherapy could benefit by looking at its ostensible philosophy, which is often denuded of spiritual content, to some of the origins of the therapeutic system. This type of grounding can provide a deeper, spiritual orientation to one’s therapeutic endeavors.

### Psychotherapy Consistent with Clients’ Spirituality

A second path of integrating spirituality with psychotherapy is when the therapist works within the clients’ spiritual and religious views. This path is the least problematic and the most agreed upon in integrating spirituality with psychotherapy. In my view, this is not an explicitly spiritual approach to therapy, but one in which spirituality is considered as one of many a number of cultural or contextual factors in the treatment process.

In this approach, the therapist is working within a standard psychotherapeutic framework and makes every effort, in accordance with ethical guidelines, to be knowledgeable about the patient’s cultural context. Such a

context usually includes race, ethnicity, social class, family tradition, and values. Shafranske and Maloney (1996) among others (e.g., Lovinger, 1984; Richards & Bergin, 1997; Tan, 1996) have persuasively argued that a client's religious background and spiritual values should also be included as a major part of the cultural context for many clients and that it would be unethical to ignore it. One frequent example is the emphasis in many spiritual and religious traditions on community and communal activities. This is often contrary to the individual self-expression and self-fulfillment valued in many therapeutic approaches. A therapist working with a client committed to an Orthodox Jewish or traditional Islamic spirituality should have a thorough understanding of the role of community in both traditions.

This path of working in accordance with the spiritual or religious traditions of a client as part of a more general psychotherapeutic process is in contradistinction to the path of spiritual formation. There, the therapist assumes the role of spiritual director and must, at times, question or challenge the client's approach to spirituality or religion.

The psychotherapist may have a client who is actively engaged on a spiritual path. One example is of a male graduate student in political science who had embarked on a serious commitment to Buddhist spiritual development and also sought psychotherapy to resolve problems having to do with his ability to relate to others. His Buddhist meditations and other practices did not enhance his interpersonal relatedness. At the same time, he indicated to his therapist that he wanted any psychotherapy to be respectful and supportive of his spiritual life. He did not want psychotherapy to undermine his commitment to spiritual development but to help him develop insights in an area that was not a focus of his developing spirituality. The therapist reassured him that, even though she was not familiar with the concepts or methods of the Buddhism, that she was sympathetic to his spiritual quest and that she hoped he would explain areas that she might not understand. The client was relieved, as his previous therapist had viewed his participation in Buddhist meditation as little more than escapism.

We could present any number of other examples in which a client is simultaneously engaged in spiritual formation and in psychotherapy. Sometimes, the psychotherapy is designed to support the process of spiritual formation and, at other times, to help with problems not addressed by the development of spiritual life. Wilber (1977) has developed a multilevel model that demonstrates the difference between developing spiritually and solving problems of a psychological level. Spiritual formation and psychotherapy are different processes with different, though at times, complementary goals.

Closely aligned with this path of integrating spirituality with psychotherapy is the therapist's competence in understanding and empathizing with a wide variety of spiritual experiences, often involving altered or visionary states of consciousness (Tart, 1969; Cardenza, Lynn, & Krippner, 2000). There may be aspects of psychopathology in such experiences, as was the case in Jung's own life history (cf. Monte & Sollod, 2003, chapter 4), but a therapist who is open to the importance of spiritual experiences will work with the client to sort out what is most relevant and meaningful from the pathological. The therapist should be accepting and open regarding communications about such experiences and develop frameworks outside of the usual categories of pathology to understand them. Familiarity with transpersonal psychology (Tart, 1975, 1992) is very helpful in such work.

In one case, a middle-aged executive reported that he had experienced ecstatic states. He expressed concerns about becoming insane or possessed, as he felt disconnected from his body during such experiences. In addition, he reported becoming clairvoyant and was partly frightened and partly intrigued by the possibility of psychic abilities. I used supportive acceptance and education about altered states of consciousness. Therapy provided a decentering approach (Sollod & Wachtel, 1980) that provided a rich context and a variety of different viewpoints from which the client could understand his experiences. The therapist addressed the client's sense of isolation and fear by describing experiences that people reported in

altered states. Mystical states and psychotic experiences were compared and contrasted. The client was given a homework assignment of bibliotherapy involving reading descriptions of mystical states. The client was encouraged to maintain his hold on the more practical and concrete aspects of his life. During therapy, the client moved from a fearful stance to a more confident exploration of new dimensions of experience. He continued to function effectively in his professional life. He became more committed to his religious tradition and began to participate in a study group to explore spiritual life.

### Use of Spiritual Techniques and Approaches for Remediating Disorders

A third integrative path is when techniques explicitly derived from spiritual traditions are used in the treatment of behavioral disorders. The goal in such instances is not spiritual formation per se, but rather the remediation of disorders or facilitation of psychotherapy. The techniques used may or may not have been empirically derived, and they may or may not contain accepted psychological principles.

Techniques derived from spiritual tradition but used to facilitate psychotherapeutic goals may have been fundamentally altered in purpose and context. Meditation, for example, in a spiritual tradition, may enable a person to experience attunement or atonement with higher levels of being. In psychotherapy, meditation might be a means of developing mental clarity, impulse control, or relaxation.

Importing a method from one approach to facilitate the goals of another therapeutic approach has been described by Messer (1986, 1992) as assimilative integration. In such a process of assimilative integration, it is essential to consider the values and the context of the respective approaches. Context can alter the significance and effectiveness of any therapeutic method imported from another approach.

What are examples of techniques drawn from spiritual traditions and integrated with psychotherapy? Affirmations, prayer, meditation, and visualization techniques have been applied in psychotherapy (Sollod, 1993). In

healing traditions, such techniques are thought to potentiate specific contents of thoughts and feelings. Meditation, for example, has been found to result in greater relaxation, disidentification, alertness, awareness, empathy, sensitivity, and openness to change (Carrington, 1977; LeShan, 1974; Shafii, 1985). Prayer also may be part of spiritually oriented psychotherapy. The therapist may pray for and/or with the client as do a small minority of therapists (Shafraanske & Malony, 1990). Richards and Bergin (1996, p. 204) have cautioned, however, about the confounding effects on the therapeutic relationship of a therapist praying with a client. Integrating spiritual techniques into psychotherapy does not invalidate other psychotherapeutic methods or the importance of additional types of insights. In this regard, there has been a history of techniques "crossing-over" from being part of spiritual traditions to becoming a psychotherapy method.

Linehan's dialectical behavior therapy (DBT) involves the use of an array of techniques, most of them behavioral in origin, in the treatment of borderline personality disorder (Koerner & Linehan, 1992). Among the techniques "imported" into this ostensibly behavioral approach is mediation training, derived from Eastern practices. Meditation is one of the "core skills" taught to clients in DBT, and it is used to help them regulate their degree of emotional arousal. In this approach, meditation enables clients to *observe*, *describe*, and *participate*. These terms indicate mindful awareness of the flow of events, emotions, and other responses without automatically reacting in habitual patterns (p. 448).

Psychotherapy may involve the use of meditation training for clients with a tendency toward impulsive behavior. Meditation, consisting of a focus on an image or sound (*mantra*), first beginning in periods of a few minutes and then, gradually, being increased to longer periods, served for this client as a type of "time-out." By developing skill in meditating, the client was able to develop some degree of control over the automatic sequence of thoughts, feelings, and impulsive actions that had previously characterized his behavior when upset.

A controversial technique that is currently being incorporated into psychotherapy by



some practitioners is that of “energy transfer” or hands-on healing. The technique of touch or near-touch is assumed to pass healing energy from the healer to the healee (Brennan, 1987). This hands-on approach may be used to help a client relax, to feel more energized, or to resolve specific problems with a somatic representation. Empirical research has documented the impact of therapeutic touch and related approaches (Grad, 1965; Krieger, 1975; Krippner, 1980; Wirth, 1989). Therapists trained in therapeutic touch, *reiki*, and related healing modalities can integrate them with a variety of verbal psychotherapies. (Kepner, 1987).

Spiritual methods need to pass through the sieve of psychological techniques, ideally those that have passed some degree of empirical validation. “Hands-on” healing as a part of psychotherapy is an example of a method in transition from healing/spiritual traditions to psychotherapy. Hands-on healing has not yet “crossed over” to a legitimate psychological technique. In order for such a transition to occur, theorists and researchers would have first to establish that psychological principles are involved, and then demonstrate the empirical effectiveness of hands-on healing in controlled research.

### Support of Spiritual Formation as Treatment for Behavioral Disorders

The support or facilitation of spiritual development or spiritual formation as treatment for behavioral disorders is another integrative path. The therapist supports the process of spiritual formation and works to facilitate recovery. In this approach, the client’s process of spiritual development does not primarily depend upon psychotherapy.

The clearest examples of this approach are Alcoholics Anonymous (AA) and the various 12-step programs, which, in conjunction with psychotherapy, have been used in the treatment of numerous disorders, most notably types of substance abuse. There are more than 80 12-step programs and 125,000 chapters, with millions of Americans involved in these groups, including those designed to help the families of those with substance abuse disorders (Hopson, 1996). The 12-step model has

been extended from substance abuse to such disorders as gambling and compulsive sexual behavior.

Carl Jung noted that spontaneous cures of alcoholism occurred because of spiritual conversions in some of his clients. Jung (1961/1987, p. 21), in correspondence with one of the eventual founders of AA, noted that the alcoholics desire for intoxication is related to

... the spiritual thirst of our being for wholeness ... You see, “alcohol” in Latin is *spiritus*, and you use the same word for the highest religious experience as well as for the most depraving poison. The helpful formula therefore is: *is spiritus contra spiritum*.

One can view the 12 steps of AA as a method of intentionally inducing a genuine spiritual transformation—as opposed to awaiting a spontaneous conversion. But such a spiritual transformation is also connected with the process of living in accordance with spiritual principles, without resort to an addictive substance.

The role of the psychotherapist *vis-à-vis* 12-step programs is usually to recommend such programs and to provide support and adjunctive psychological work. There is often synergy between the 12-step programs and psychotherapeutic practice (Sollod, 1994). Psychotherapy is not properly focused on spiritual transformation *per se*, but supports the client in his or her process of spiritual formation and recovery from the addictive pattern of behavior. The psychotherapist should be familiar with 12-step programs and supportive toward the client’s efforts to reorient his or her life in a spiritual direction. The 12-step program’s emphases on prayer, meditation, surrender to a “Higher Power,” mystical renewal, service to others, repentance, and making amends (Tonigan, Toscova, & Connors, 1999) differ considerably from the rational, agentic individualism stressed in many contemporary psychotherapies, so it may require some significant accommodation to the 12-step value system on the part of psychotherapists to work supportively with clients in 12-step programs.

Psychotherapy may complement treatment of a client in a 12-step program in a variety of

different ways. Psychotherapy is, by its nature, less programmatic than 12-step programs, and thus can lead to greater awareness of individual patterns of experiencing and relatedness. As an example, a psychologist I know, whose psychology license was suspended for presumed unprofessional behavior while intoxicated, was required to take part in AA and have regular urine tests. In addition, he participated in group psychotherapy. He informed me that he found both approaches helpful for his recovery. The 12-step program focused on his development of a new pattern of living without addictive behavior, whereas psychotherapy focused much more on his exploration of the dynamics between him, his wife, and other family members. He indicated that his abstinence resulted in many emotions surfacing that otherwise might have been suppressed or avoided through intoxication.

### Spiritual Formation as a Goal of Psychotherapy

A fifth path is one in which the focus is the spiritual development of the client. This path is properly termed *spiritual formation*. Spiritual formation may be undertaken individually or as part of a group endeavor. It may or may not involve a more or less psychotherapeutic form, but as often assumes an educational or instructional format. Miller (2003) has presented instances in which the major goals of psychotherapy were to help the client develop a spiritual identity and to engage in spiritual practices. The development of such an identity and the development of such practices are significant parts of the overall process of spiritual formation.

The distinction between a spiritual director and psychotherapist was made earlier in this chapter. They are distinguished by differences in backgrounds, training, relation to the novice/client, value system, and conception of therapeutic process. Because of such considerations, I believe the process of spiritual formation guided or facilitated by a psychotherapist within a psychological framework is necessarily an attenuated and truncated approach to spirituality.

Another reservation concerning spiritual formation within psychotherapy is the generic, “plain-paper wrapping” of such approaches. The approaches of Miller and Richards and Bergin are both nondenominational. Miller’s approach to spiritual formation is not monotheistic; Richards and Bergin’s is monotheistic but not clearly Christian. In neither approach is there a legacy of spiritual masters, role models, Saints, and wise people. The approaches are denuded of rituals that might be termed “religious” such as those that appear on the calendar of various churches.

I experienced the limitations of a generic approach to spirituality in my own work. I led a small pro bono group devoted to spiritual development for about 7 months. We focused on the development of meditation skills, the use of affirmations, reading inspirational books, and developing a more spiritual outlook on life. At the end of this period, most of the participants indicated that they wanted to pursue a deeper level of spiritual experience by working within a variety of spiritual traditions. Our group served to provide “training wheels” for the development of spirituality, but what I could provide or stimulate did not feed the deep spiritual hunger of many of the group members. One of them started to participate in Greek Orthodox rituals; another began to make a commitment to Tibetan Buddhism. Other groups members began the serious exploration of other approaches to spirituality.

### The Psychotherapist’s Own Use of Spiritual Approaches

A sixth integrative path is one in which the therapist himself or herself integrates concepts and methods derived from spiritual traditions into the therapy process: Some of these might have been legitimized as psychological processes and others simply taken more or less whole from spiritual traditions.

An example involves a therapist’s attempt, within a client-centered approach, to develop “unconditional positive regard.” He was also a practicing Christian and indicated that he found that the best way for him to develop unconditional positive regard was to see the client

as Christ-like. Even though he was practicing a conventional psychotherapy, he was doing so by using an inner attitude derived from a spiritual tradition. This type of application of one's spirituality to enhance therapeutic effectiveness would appear to be a promising path for empirical research.

A therapist from a Buddhist background used meditative techniques, with which he was already familiar as a spiritual discipline, to promote an alert, nonjudgmental therapeutic awareness to his clients. He found that his training in Buddhist meditation, "mindfulness," facilitated his ability to be an effective psychotherapeutic listener.

This sixth path is one in which the therapist accesses his or her own spirituality as a resource in facilitating the therapeutic process and reaching treatment goals. The client, in such instances, is not necessarily aware of the inner or spiritual life of the therapist. They are not the focus of therapeutic activities, even though they may contribute to the therapist maintaining a helpful therapeutic relationship.

The therapist in such an approach is ideally able to move into altered, often transcendent, states of consciousness that may benefit the therapeutic process. Such states may be similar though deeper than the empathic almost meditative awareness of the therapist in various psychotherapies. Other states of receptivity, awareness, and nonordinary consciousness also may be accessed. Such states may involve a deep feeling of unselfish love, enhanced sensitivity to the other, contact with inner resources of compassion, and perception of the client as whole or potentially whole. Within Western monotheistic healing traditions, and in a psychotherapy incorporating these concepts, the therapist believes that the client is a loved and valued being—made in the image of God.

## CONCLUSIONS

In this chapter, I have reviewed as some concerns issues involved in the integration of spirituality and psychotherapy as well as six paths to their potential integration. Greater awareness of the spiritual aspects of extant ap-

proaches is warranted. Being knowledgeable about religious and spiritual aspects of clients' lives is both appropriate and beneficial for the psychotherapy endeavor. The path of working in conjunction with a program of spiritual transformation or spiritual formation in order to remedy a disorder also appears valid. In addition, borrowing techniques from spiritual traditions and bringing them into the psychotherapeutic process may be useful, even though the spirituality of such methods can be vitiated by new contexts and purposes.

Spiritual formation or transformation, in my view, is not an appropriate primary focus for psychotherapy. The goals and methods of spiritual formation are not necessarily congruent with those of psychotherapy, the ideological context differs considerably, the methods used are different, and the psychotherapist, by virtue of training and experience, is usually not in a position to take the responsibility of spiritual direction. A psychotherapist may encourage a client to embark on spiritual development, but I am skeptical about the ethics and results of a major focus on spiritual development in psychotherapy.

I am more sympathetic toward the sixth path to of integration, that is, taking methods from spiritual approaches and using them to enhance one's effectiveness as a therapist. Access to transcendent states of conscious can result in transformed attitudes toward clients, which can be therapeutically beneficial. In addition, the use of methods to transform one's own inner experience as a therapist does not involve the same ethical and practical issues that would be involved in trying to induce clients to change in the direction of more spiritual living.

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## Integrating Pharmacotherapy and Psychotherapy

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The mind–brain dichotomy is slowly disappearing and giving way to the beginnings of integration. Effective treatment of mental illness in the twenty-first century requires a paradigm change in the traditional “mind–brain” thinking. We know now that psychotherapy influences the function of the brain and that pharmacotherapy influences the workings of the mind. It is time to recognize the reciprocal relationship between mind and brain and to put to rest the conceptual mind–brain barrier (Feldman & Feldman, 1997).

In this chapter, we address several interrelated clinical and research issues involved in the dissolution of this long-standing dichotomy. Specifically, we consider the historical background of combined treatments, the placebo response, research in combined treatments, clinical interactions between medications and psychotherapy, and the psychotherapist–pharmacotherapist collaboration (more detailed accounts of these topics can be found in Beitman, Blinder, Thase, Riba, & Safer, 2003).

### HISTORICAL OVERVIEW OF COMBINED TREATMENT

The development of psychoanalysis in the late nineteenth century introduced a major alternative treatment for mental disorders. Prior to that time, clinicians’ efforts to alleviate mental illness were based on the prevailing understanding that psychopathology reflected a disease state of the “organ of the mind”—the brain (Bodemer, 1984). Interventions were somatic or biological, albeit primitive and often pharmacologically inert if not irrational. Treatments aimed at psychosocial influences were not developed by medical practitioners.

Although Freud (1964) himself forecast the development of specific and effective pharmacotherapies, psychiatry was dominated by the study of psychosocial determinants of human mental functioning through the 1950s. Mental disorders were seen as “disorders of the mind,” and psychotherapy was the potent modality in the treatment of neurotic disorders. In the 1960s,

the efficacy of drugs discovered a decade earlier became evident, and the concept of mental disorders as “disorders of the brain” again became more tenable. The dominant concern of the literature during this time was the treatment of schizophrenia. In the 1970s, the literature focused on the treatment of affective disorders and lent themselves most easily to combinations of psychotherapy and pharmacotherapy (Karasu, 1982). Many new psychotherapies were developed (e.g., cognitive-behavioral, interpersonal, family, brief) and, in conjunction with efficacious medications available for anxiety, mood, and psychotic disorders, active discussion of the merits, indications, and contraindications of various treatment combinations was pursued.

Discussions about the combination of psychotherapy and pharmacotherapy in mental health practice today are significantly different from such discussions 20 years ago. The recognition of the efficacy of combined treatment has been facilitated by a number of changes. At the theoretical level, the doctrine of determinism or linear causality has been altered by the development of systems theory (von Bertalanffy, 1964; Schwartz, 1982). The mind-brain dichotomy of human functioning has been substantially modified by an understanding of the truly multidimensional nature of mental life reflected in the biopsychosocial model. The multiaxial diagnostic system of the *Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV)*; American Psychiatric Association, 2000) is a tangible record of interdependent, hierarchical clinical views or perspectives on any given patient.

The recently developed capabilities in neuropsychiatric research have further blurred boundaries between the heuristic but artificial “organic” and “functional” distinctions. The Axis I symptom, or “state” disorders, are not distinct from Axis II, or “trait” disorders. For example, schizotypal personality disorder may be a phenotypic variant of a schizophrenic genotype.

Clinical experience and empirical research have demonstrated the efficacy of many forms of psychotherapy—psychodynamic, behavioral, cognitive, interpersonal, couples/family, group, and brief, among others (Frances, Clarkin, &

Perry, 1984). Similarly, the well-established indications for, and responses to, medications measurable beyond placebo responses have made either—or arguments about the various treatment modalities untenable. In fact, retrospective analyses and literature reviews (Luborsky, Singer, & Luborsky, 1975; Uhlenhuth, Lipman, & Covi, 1969; GAP, 1975), which were statistically analyzed in the meta-analysis of Smith, Glass and Miller in 1980, have compared combination treatment, psychotherapy alone, and medication alone. The consensual interpretation of this research is that combined treatments have additive and, in some instances, synergistic effects. At the very best, combination regimens do not diminish the effect of one treatment relative to another.

Psychiatrists have often used combined treatments (Beitman & Maxim, 1984) but continue to struggle with the paucity of clear guidelines for the conjoint use of medication and psychotherapy. In part, this stems from the fact that designing research to study the relevant variables in combined regimens of psychotherapy and pharmacotherapy is such a daunting task (Elkin, Pilkonis, Docherty, & Sotsky, 1988a, 1988b). The list of factors to be taken into account is lengthy and could include diagnosis, severity, chronicity, treatment setting, goals, stage, and type of psychotherapy. Furthermore, research would need to control such variables as the different “active ingredients” for each modality, different mechanisms of delivery, time course of response, outcome criteria, therapist attitude, and patient expectation.

A simpler but no less important consideration has been that clinicians have struggled with “conflicting” modes of interaction with patients when prescribing medication versus conducting psychotherapy. This had been characterized by Docherty and colleagues (1977) as the problem of “bimodal relatedness” and by Gutheil (1982) as the clinician’s “mind-brain barrier.” Attention to, and awareness of, one’s shift in style from a more receptive, open-ended or tolerant manner to a more authoritarian or directive one tends to protect the therapeutic relationship and outcome. Ideally, clinicians may bring these two forms of relatedness

together by considering that pharmacotherapy may be a psychotherapeutic intervention (Beitman, 1981). Prescription itself is a dynamic intervention with transference and countertransference implications, as is any other intervention in an ongoing treatment relationship. Consideration of these and related matters is a critical requirement for successful treatment integration.

The past three to four decades have seen substantial development of psychotropic agents to treat an array of psychiatric symptoms and disorders. As understanding of these psychopharmacological mechanisms of action has increased, these medications have been prescribed in a more sophisticated and specific manner. Similarly, the proliferation of psychotherapeutic techniques has provided potentially selective applicability to different clinical problems. The additive advantages of combinations of these major treatment modalities are still not well recognized. Rational guidelines for integrated therapy will continue to be developed for individual diagnostic groups as the treatments themselves become more finely tuned.

## THE PLACEBO RESPONSE

A vast literature in single and combined treatments is developing. This section begins with a review of one of the least discussed aspects of these trials—the placebo response—a reaction that may be due in large part to factors common to psychotherapy.

The inert look-alike placebo capsule has been a standard part of controlled medication trials for many years. Its remarkable effectiveness, however, tends to be ignored except when the data suggest that the active substance was not more effective. In studies of chronic pain, the placebo response rates tend to be approximately 50% of the active drug (Evans, 1985). Similar rates seem to hold for studies of panic disorder and major depression. How are these findings to be explained?

To participate as a researcher in drug trials is to gain some understanding of the mechanisms by which patients apparently receiving no treatment are, in fact, being treated. The

following observations are based on our experiences.

Despite the seeming scientific objectivity of research reports on drug trials, investigators develop strong emotional investments in their subjects. Each subject who “counts” (fits criteria and completes minimal treatment requirements) means one more step toward the final goal. To “count” means not only that the subject is willing to take the medication but is also willing to do so for several weeks. Furthermore, candidates are recruited through a painstaking screening process that may require multiple contacts before an eligible person is found. Unfortunately, eligibility does not necessarily result in participation, and willingness to begin participation does not necessarily mean willingness to complete protocol. Therefore, the research team pays close attention to the needs of each person in the trial, especially at the beginning.

In essence, the researchers make every effort to engage eligible subjects in the research scheme. Engagement is the first stage of psychotherapy (Beitman, 1987). The team often uses common engagement techniques such as empathic reception, demonstration of specialized knowledge (diagnosis and prognosis), and the offer of something that works (the pill). In addition, potential subjects are usually graciously received and encouraged to believe that they may not only be helping themselves but also others.

Standard medication protocols prohibit the staff from doing “psychotherapy.” But often providing generic psychotherapy is exactly what they do! The protocol provides subjects/patients with a *rationale* for understanding their difficulties (a psychiatric diagnosis) and a *ritual* (the treatment protocol). The research is carried out in a *healing setting*, generally a hospital clinic where medical studies including blood and urine analysis and electrocardiograms may be performed. Patients usually form strong *relationships* with one or more clinicians. Others become strongly committed to the project itself. These four qualities of drug trials—rationale, ritual, healing setting, and relationship—are the shared features of most psychotherapies (Frank, 1976).



Many of the therapeutic functions common to most psychotherapies as described by Frank (1976) are also present in these research programs. In the following paragraphs, these functions are italicized. The researchers *instill hope* through their own beliefs in the treatment itself, because most researchers are also clinicians who have seen similar medications work effectively in patients with the same presenting symptoms. Hope also encourages subjects to return. Through the instillation of hope, specialized knowledge, and warm empathic reception, the researchers can effectively *strengthen the therapeutic relationship*. Researchers also provide *cognitive learning* about the disorder, usually in terms of a diagnostic label that implies some biological causation. The label itself provides several other important pieces of information: It implies that the symptoms are understood, experienced by others, and amenable to professional intervention. Through these effects, the label may reduce symptom intensity by eliminating the need to seek further help, as symptom intensity is in part driven by the desire for an acceptable caregiver. Patients acquire additional information by keeping diaries and answering protocol questions, through which some are able to establish connections between their symptoms and events in their lives.

Simply talking about the details of their difficulties often leads to *emotional arousal*, which supplies the motive power for attitude and behavior change. Some patients initiate *behavior change* because their repeated visits clarify the debilitating nature of their difficulties and the possible solutions.

Other patients are not “fooled” by the placebo. They know that the pill they are taking is inactive because they are not responding, and yet they decide anyway to make key changes in their lives. The repeated pill-taking and weekly visits are constant reminders that that change is necessary. Patients may find new jobs, alter their marriage patterns, or in other ways decide to act in their own best interests. Although they are called “placebo responders,” they have stopped waiting for someone or something to take care of their problems and have taken charge themselves.

Generally, drug trials, like generic psychotherapy, heighten patients’ sense of mastery through these therapeutic functions and the associated *success experiences*. Patients learn to name their nemesis and become less afraid of it through cognitive learning and behavior experimentation. In these ways, then, psychopharmacological trials may inadvertently be using common factors in psychotherapy to encourage change.

If this conclusion is valid, then the use of active medication in drug trials represents an integration of pharmacotherapy and psychotherapy, as each patient is not only affected by the active drug but is also influenced by the contextual common factors. Of further interest are the questions raised about the reciprocal relationship between active drug and common psychotherapy factors. If the active drug has a psychological effect that is sensed by the patient, does this awareness augment the common factor effects by instilling yet more hope in a positive outcome? If the patient believes the pill contains the active drug, for example, does this belief increase the likelihood of decisions leading to positive behavior change? Is placebo psychotherapy plus active drug not simply additive but synergistic?

## RESEARCH IN COMBINED TREATMENT

A rich literature describing combined pharmacotherapy and psychotherapy trials has been developing rapidly. In this section, the clinical implications of combined treatment in the treatment of several disorders are summarized. Much of the information in this section also appears in *Integrating Pharmacotherapy and Psychotherapy* (Beitman et al., 2003).

Compared to their respective monotherapies, combined treatments do not uniformly produce additive benefits. Because combined treatment is likely to be more costly than monotherapy, before combined treatment is initiated, clear evidence of potential benefit must exist. Practitioners must research and define which subsets of patients are most likely to re-

spond to monotherapy and which are most likely to respond to combined therapy.

## Depression

The treatment of depression has been the most studied of all the diagnostic entities (Manning & Frances, 1990). The many forms of psychotherapy used in these studies have included cognitive, interpersonal, psychodynamic, marital, and behavioral. Two of these psychotherapies, interpersonal psychotherapy (IPT) and cognitive-behavioral therapy (CBT), have been found to be the most efficacious among that group and to compare well against medications.

Most of the early studies suggested that combined treatment, using interpersonal or cognitive behavioral therapies and medication, was not more effective than either treatment alone. However, these studies had small sample sizes and lacked the statistical power to detect moderate additive effects (Thase, 2003). A number of more recent studies have shown that combination treatment (using CBT or IPT and medication) may be more effective than monotherapy alone. In a recent placebo-controlled multicenter trial of more than 650 patients with depression, Keller and colleagues (2000) compared a form of cognitive behavioral therapy and an antidepressant Nefazodone (Serzone). Both monotherapies were similarly effective, but the combination showed additive effects in terms of improved response and remission rates.

Studies have indicated that combined treatment may be more effective than monotherapy in preventing relapse and achieving remission. An analysis by Thase and colleagues (1997) showed that a combination IPT and pharmacotherapy achieved a better remission rate than either monotherapy alone. The combined treatment was superior to both monotherapies especially in patients with severe recurrent depression. A study by Jarrett and colleagues (2001) found that patients suffering from depression who responded to acute cognitive treatment had lower rates of relapse if they continued with that treatment compared to patients who discontinued it after the acute response.

Several studies evaluated the efficacy of combining either IPT or CBT to pharmacotherapy in the continuation and maintenance phases of depression. Reynolds and colleagues (1999) studied nearly 200 depressed patients in a double-blind, placebo-controlled, maintenance phase study comparing nortriptyline, interpersonal psychotherapy, and combination treatment. Combined treatment was superior to either monotherapy alone.

Garvey, Hollon, and DeRubeis (1985) found, in their studies involving cognitive therapy, that more severely depressed patients responded better to combined therapy than to drugs alone. Mild to moderately depressed patients did well in all therapy conditions. A family history of depression suggested better treatment outcome for combined therapy than with cognitive therapy alone. Others have suggested that combined treatment may have reduced symptoms more quickly than either treatment alone (Manning & Frances, 1990). There is some suggestion of differential effects; namely, medications help more with symptomatic symptoms, whereas psychotherapy helps in improving social adjustment and cognitions (for further discussion see Rush & Hollon, 1991; Manning & Frances, 1990).

In conclusion, there is evidence that CBT and IPT are equally effective alternatives to antidepressants in the treatment of mild to moderate depression. For severely depressed individuals, the combination is associated with a better outcome than any monotherapy. There is some evidence that patients who show partial response to either psychotherapy or pharmacotherapy alone may find the addition of the other monotherapy beneficial.

## Panic Disorder

Most antidepressants, a number of benzodiazepines, and cognitive-behavioral therapy have been shown to be effective in the treatment of this disorder. All three treatments appear to be equally effective in the acute phase. Cognitive-behavioral therapy may be better long term: some studies have shown that up to 81% of patients who received CBT remained panic-

free for 1 to 2 years after treatment. This is in contrast to patients who were successfully treated with pharmacotherapy: 54% to 70% of these patients relapsed after discontinuation of medications (Rayburn & Otto, 2003).

In terms of combination treatment, studies have been somewhat confusing and disappointing. A large study (Barlow, Gorman, Shear, & Woods, 2000) examined the outcome of 312 outpatients with panic disorder. Five treatment conditions were compared: CBT, imipramine, placebo, CBT plus imipramine, and CBT plus placebo. This study found that CBT alone and imipramine alone were superior to placebo alone. The combination of CBT and imipramine was more effective than monotherapy alone but did not outperform CBT plus placebo. In addition, when patients were reassessed at the end of the continuation phase (after imipramine was discontinued), CBT alone and CBT plus placebo both showed an advantage over combined treatment. The authors suggested that the addition of imipramine may have reduced the long-term gains of CBT.

Other studies examining combined cognitive behavioral treatment and benzodiazepine treatment against monotherapy did not show any significant additive effect (Spiegel & Bruce, 1997). There is good evidence that combined treatment with cognitive behavioral therapy is effective in reducing relapse and facilitating successful discontinuation of benzodiazepines (Otto et al., 1993; Spiegel, Bruce, Gregg, & Nazzuarello, 1994) and selective serotonin reuptake inhibitors (SSRIs) (Whittal, Otto, & Hong, 2001).

At this time, there are no good data to help us determine what patients would best benefit from a particular form of treatment (Rayburn & Otto, 2003). A number of predictors of poor outcome have been identified, such as greater baseline symptomatology, personality disorder, depression, but these predictors appear to negatively affect CBT and pharmacotherapy to an equal degree. Patients who have poor medication tolerance or who are unwilling to accept medication perhaps because of a strong desire for control are clearly candidates for psychotherapy. A significant number of patients, despite adequate pharmacologic interventions, remain

symptomatic and therefore in need of adjunctive psychotherapy to help them enhance their quality of life and improve functioning.

### Obsessive-Compulsive Disorder

In the treatment of obsessive-compulsive disorder (OCD), specific behavioral approaches and selected antidepressants with strong serotonergic activity have been established as effective treatments. Behavioral treatment is based on exposure to a feared element (e.g., dirt) and response prevention (e.g., cessation of excessive hand-washing). Although patients with OCD often appear ripe for psychoanalytic interpretations (e.g., sexual and aggressive impulses drive the washing behavior), there is no evidence that this approach does more than simply make patients accepting of medications and break the monotony of behavior therapy.

Treatment response may depend, to some extent, on the predominance of obsessions versus compulsions. Patients with obsessive thoughts and without compulsions seem to respond better to medications, particularly monoamine oxidase inhibitors (Jenike, 1991). Although behavior therapy has little to offer such patients, those with rituals appear to respond to either approach (see Jenike, 1991).

A number of studies examining the effectiveness of pharmacotherapy (SSRIs or clomipramine) and behavioral therapy have shown a response rate in OCD of less than 60%. Many patients on antidepressants have trouble tolerating the high doses that are normally necessary to treat this disorder (Griest, Jefferson, Kobak, Katzelnick, & Serlin, 1995). Several studies of outpatients with OCD have shown that patients seem to do better when treated with a combination of medication and cognitive behavioral treatment—as opposed to either treatment alone (Thase, 2003). There are several large studies currently underway that will afford a better picture of the additive value of combined treatment as opposed to monotherapy.

### Borderline Personality Disorder

Of the diagnostic categories in this section, borderline personality is the most conceptually

diffuse. Two general approaches to classification have been used. The psychodynamic approach emphasizes hypothetical intrapsychic structures: “splitting” and the “grandiose versus depreciated self” refer to the tendency of such patients to divide themselves and the world into black-and-white categories and to vacillate between these states, in their views of both others and themselves. The second approach emphasizes what can be observed, including impulsive, often self-destructive behavior; intense shifting affective states; and intact reality testing in structured situations, with “slippage” in unstructured situations. Unstable and manipulative interpersonal relationships associated with an inability to tolerate aloneness and superficial social relationships are also seen in this disorder. Although the *DSM-IV* criteria did not include vulnerability to transient psychotic episodes, this characteristic helped to form the label “borderline,” as this label was applied to patients considered to be on the “borderline” between neurotic and psychotic.

Treatment of borderline patients with medication, psychotherapy, or both is problematic. Research in integrative cognitive-behavioral therapy is described elsewhere in this volume by Heard and Linehan. Ongoing psychodynamic research has been and is currently being conducted by a number of well-known experts in the field (Koenisberg, Kernberg, Stone, Applebaum, Yeomans, & Diamond, 2000). A survey of experienced psychodynamic psychotherapists found that the average borderline patient was seen three times a week for 4½ years, and the outcome was better the longer the patient stayed in therapy. During the first 6 months of psychotherapy, however, discontinuation rates between 23% and 66% have been reported.

Conclusions from drug studies are limited for many reasons. First, there are very few controlled studies, and each has a relatively small number of patients. Second, these patients have a significantly high placebo response rate. Third, patients also manifest a high dropout rate (14% to 57% in various studies over a 6- to 12-week time period). Fourth, medication effects are generally modest; that is, medications reduce symptoms from severe to moderately severe rather than to levels of marked im-

provement or remission. Finally, medications have little discernable impact on chronic maladaptive character patterns.

No single pharmacotherapeutic agent has been established as the treatment of choice, but several agents have been found to be effective for specific borderline symptoms. It appears that low-dose neuroleptics reduce impulsive behavior, anger, anxiety, and some symptoms of depression. A monoamine oxidase inhibitor, tranylcypromine (Parnate), and an anticonvulsant, carbamazepine (Tegretol), were more effective than placebo at reducing impulsivity and anger in one study (Cowdry & Gardner, 1988). Studies have shown the low effectiveness of tricyclic antidepressants and have suggested that they may have a detrimental effect in some patients. Selective serotonin reuptake inhibitors appear to reduce anger/impulsivity, depression, and anxiety. In addition, they are relatively safe in overdose. One of the most vexing problems facing researchers is the obvious differential responsiveness of patients fitting the borderline criteria, suggesting several subcategories that will need to be elucidated.

Borderline patients present with a spectrum of symptoms that may be differentially responsive to medications. At least five types of borderline patients may present for treatment. On the basis of clinical observations and with some research, these five types, in order of decreasing responsiveness to medications, are affective, impulsive, aggressive, dependent, and empty. Psychotherapy appears to be generally useful for each type (Oldhan, 2001).

Medications, like most other major therapeutic interventions, have great meaning and may complicate the treatment of borderline patients. Effective pharmacotherapy requires an alliance that fosters accurate reporting of symptoms and side effects. Unfortunately, borderline patients are likely to provide distorted reports of medication effect because of their propensity to induce certain feeling states in their psychotherapists. When idealizing a therapist, for example, borderline patients may erroneously take personal responsibility for medication side effects, so as to maintain the therapist as an ideal protector who would never make the patient feel uncomfortable. By con-

trast, in an effort to make the therapist feel helpless, the patient may attribute a psychological or interpersonal dysphoria to the medication. Other borderline features that complicate the use of medication in these patients include splitting, need to control others, intense transference and countertransference responses, and the potential for negative therapeutic reactions (Koenigsberg et al., 2000). The recent American Psychiatric Association (2002) practice guideline for the treatment of patients with borderline personality disorder concludes that “many patients will benefit most from a combination of psychotherapy and pharmacotherapy.”

### Social Phobia

Social phobia has traditionally received less attention from researchers and clinicians than other anxiety disorders, such as panic disorder or OCD. Many people have been, and are still, unaware of the debilitating nature of social phobia. Like panic patients, social phobics have constricted lives, but these constrictions are not as apparent as those of agoraphobics. Social phobia has received a great deal of attention during the past decade or so. Studies suggest that phenelzine (Nardil), alprazolam (Xanax), clonazepam (Klonopin), and a number of SSRIs as well as the anticonvulsant gabapentin (neurontin) have been useful in the treatment of this disorder.

Five meta-analytic investigations have examined the effectiveness of cognitive behavioral therapy for social phobia. These meta-analyses have found that CBT is effective both in the acute phase but also in follow-up studies. Medications may work somewhat faster, but CBT may provide better protection against relapse.

There has been little published research on combined treatment for social phobia. There is no clear evidence that combining CBT with pharmacotherapy provides any additive effects to monotherapy alone. Currently, clinicians have little to guide their practice except to note that there are strong similarities between the pharmacological and psychotherapeutic approaches to panic disorder and social phobia.

The differences will be important to elucidate (see Uhde & Tancer, 1991).

### Bulimia Nervosa

More than any other disorder studied, bulimia nervosa research illustrates the problems of generalizing about the efficacy of “psychotherapy.” First, some evidence suggests that, in the short term, bulimia among women in their twenties tends toward modest “spontaneous” improvement. The rates were similar regardless of whether they had sought professional help. Second, treatment studies of bulimia have employed the widest range of psychotherapies, including psychodynamic, psychoeducational, cognitive behavioral, interpersonal, behavioral, family, and group, as well as various combinations such as family plus individual psychotherapy (Feldman & Powell, 1992).

Consistent among the studies is the persistent use and effectiveness of behavioral approaches that address the presenting behaviors of binge eating, self-induced vomiting, and laxative abuse. Generally, these methods include keeping detailed food diaries, goal setting, stimulus control (times and conditions under which they could eat), response delay (delay between desire to eat and actual eating), and response prevention (do something else besides eating). As with other disorders, severity of symptoms and accompanying personality disorders make the prognosis more guarded.

According to several controlled studies, antidepressants are useful in the treatment of bulimia. Many patients are prone to side effects, increasing the difficulty with compliance. Because of vomiting, some have difficulty achieving therapeutic levels even when compliant. Blood levels may therefore be useful at times to insure adequate medication levels. As in the treatment of OCD, antidepressants appear to have an antibulimic effect in patients with no clinical depression. Selective serotonin reuptake inhibitors have gained considerable popularity among bulimics because they are effective in restraining binge eating and purging and do not induce carbohydrate craving, as do the older antidepressants. Clinical experience suggests that several different medication trials

may be necessary until an acceptable side effect profile is found.

One controlled study (Mitchell et al., 1990) that systematically compared imipramine, intensive group CBT treatment, and the combination of the two found that the psychosocial treatment was superior to the imipramine alone. Adding the antidepressant to group treatment did not improve the eating disorder symptoms although it decreased symptoms of anxiety and depression more than did the group treatment alone. Another study (Walsh et al., 1997) compared CBT and psychodynamic supportive therapy with either an antidepressant or a placebo. Overall, CBT was more effective than psychodynamic supportive therapy, and medication was significantly better than placebo. The combination of CBT and an antidepressant appear to have an additive effect but not the combination of psychodynamic supportive therapy and medication.

These findings are consistent with other studies suggesting that CBT is superior to pharmacotherapy, and that combination treatment may be better than either monotherapy alone. In deciding whether to choose medications, psychotherapy, or both, clinicians must again take into consideration the patient's presentation and preference. Any choice, however, should be accompanied by educational, nutritional, and behavioral elements (see Yager, 1991).

## Bipolar Disorder

Pharmacotherapy has always been considered the mainstay of treatment for patients with bipolar disorder. Many studies have shown the effectiveness of a variety of pharmacological agents, but virtually no study has shown the effectiveness of psychotherapy alone in this disorder. A few studies of combined treatment for bipolar disorder have been conducted in the past decade, and several are currently ongoing. Patients with bipolar disorder have significant rates of morbidity and mortality. Effective pharmacotherapy usually leaves patients with a great deal of psychosocial and professional impairment. In addition, a number of studies have shown that stressful life events, high levels of family control and criticism (expressed emo-

tion), marital discord, and low social support negatively contribute to the outcome of bipolar disorder. The goals of adjunctive psychotherapy interventions in patients with this disorder include reducing rates of relapse, increasing adherence to pharmacotherapy, and improving functioning and quality of life.

Thase (2003) reviews the findings of three significant studies of adjunctive psychotherapy that have been published in the past several years. These studies consistently support the use of psychotherapy with patients who receive pharmacotherapy for bipolar disorder. The first study (Perry, Tarrier, Morriss, McCarthy, & Limb, 1999) evaluated brief individual psychoeducation focusing on information about the disorder as well as identification of signs and symptoms of relapse. This form of psychoeducational therapy had a significant impact on the rate of manic relapse. The second study (Miklowitz et al., 2000) evaluated a form of family-focused therapy. Family-focused therapy was found to benefit patients in terms of fewer depressive relapses and lower levels of depressive symptoms. Of note is that these effects were more pronounced among patients who remained symptomatic following their index episode.

The third study examined a form of interpersonal therapy, which included lifestyle management strategies (Interpersonal social rhythms therapy, or IPSRT). In this study (Frank, Swartz, & Kupfer, 2000), it was found that IPSRT did enhance the patient's lifestyle regularity but did not improve acute phase treatment outcomes or speed time to remission. In summary, Thase (2003) commented on the fact that family and interpersonal treatments seemed to protect against depression, and psychoeducation and relapse prevention training appeared to reduce the risk of manic relapse.

A number of studies have examined the role of individual or group cognitive behavioral therapy as an adjunctive treatment for bipolar disorder. These studies have found that CBT has significant antidepressant effects (Zaretsky, Segal, & Gemar, 1999) and lower relapse risk (Fava, Bartolucci, Rafanelli, & Mangelli, 2001). The American Psychiatric Association practice guideline for the treatment of patients with bipo-

lar disorder also recommends a combined treatment, especially in the maintenance phase.

### THE RECIPROCAL RELATIONSHIP BETWEEN PHARMACOTHERAPY AND PSYCHOTHERAPY

That interacting entities mutually affect each other is increasingly part of psychotherapeutic wisdom (Wachtel, this volume; Mahoney, 1991; Pentony, 1981). Following are several cases, reported by the senior author, illustrating the relationship between psychotherapy and pharmacotherapy and organized according to the stages of psychotherapy and the phenomena of transference and countertransference (Beitman, 1987; Beitman & Yue, 1999).

Psychotherapy is a process proceeding through time. It can be divided into four stages—each stage having its own set of goals, objectives, and potential resistances. The stages of psychotherapy are engagement, pattern search, change, and termination (Beitman, 1987).

#### Engagement

Psychotherapists must establish trust with patients in order to proceed to the intimate revealing and courageous behavior often required of behavior change. Among the synergistic methods available to therapists to facilitate engagement are empathic reflection, demonstrating specialized knowledge, and effective suggestions. The prescription of a medication demonstrates specialized knowledge. If it works, it becomes an effective suggestion. Accurate diagnosis, upon which pharmacotherapy usually depends, may become a form of empathic understanding, as the patient is placed in a category about which much knowledge is usually available.

Effectiveness of medications does not necessarily guarantee engagement. Some patients are satisfied with symptom relief and refuse psychotherapy. Conversely, failure of medications does not necessarily lead to termination of psychotherapy. Discussions of medication ineffectiveness and the therapist's willingness

to try them can nonetheless provide scaffolding for engagement. Effective or not, medication side-effects can become the focus of patient anger, leading to blaming the therapist for attempts to control or harm the patient.

Similarly, pills may serve as engagement transference and countertransference vehicles. For example, an effective medication may lead a patient to idealize everything the therapist does. On the other hand, a medical psychotherapist who does not want to see a certain patient may prescribe a monoamine oxidase inhibitor (MAOI) for which the dietary restrictions are quite important but neglect to tell the patient about them. More commonly, a therapist might frighten a patient away with undue emphasis upon dietary restrictions and potential side effects.

For some patients, extensive psychotherapeutic work is necessary before they will consider medication treatment. Paranoia, mistrust of medications, and the desire to avoid the social stigma associated with psychiatric medications, may foster avoidance of needed pharmacotherapy.

#### Pattern Search

Attention to patient reactions to pharmacotherapy may offer remarkably sharp illustrations of important maladaptive patterns for psychotherapeutic work. Following are some case examples from my own practice.

#### *Focus on the Negative*

A 23-year-old woman was excessively anxious. Despite her history of alcohol abuse (to control her anxiety), I carefully initiated an 8-week course of a benzodiazepine. On her return visit, she reported that the medication was ineffective in controlling her obsessive cleaning. She was quite discouraged. Only after some prompting did she report better sleeping, better functioning in school, and much less anxiety. She was highly perfectionistic in all she did and rarely felt gratified by her positive accomplishments.

### *Goodness Always Disappears in the Future*

A highly anxious 34-year-old woman refused to take an occasional antianxiety medication, although she was often severely disabled by her anxiety. "I'm afraid if I take it too often, it won't work anymore." After I suggested to her that this was an illustration of a common pattern in her thinking, she asked "Will you be leaving this city soon?" She had grown up learning that anything good will almost certainly be followed by something awful.

### *Self-Abuse Through Medication*

A 37-year-old woman with severe panic disorder failed to renew her prescription for the benzodiazepine she had been taking for several years. She had been warned not to stop it suddenly but she decided to "tough it out." She experienced severe withdrawal symptoms. As a child, she had learned to "tough out" sexual abuse by a series of stepfathers and physical abuse by her mother.

### *"Nothing and No One Can Help Me"*

A 48-year-old man was referred to a psychiatrist by his psychotherapist for pharmacological evaluation and treatment. He had been in psychotherapy since age 22. His first psychotherapy relationship was most helpful for him but ended abruptly when his graduate student therapist announced after 10 sessions that they would meet no longer. He was deeply hurt by what he perceived to be rejection and betrayal. He believed that none of his eight subsequent psychotherapists were useful to him. The psychiatrist tried him on three different types of medication, each of which was dramatically effective in the first few weeks but just as dramatically lost their effectiveness subsequently. Nevertheless, the patient insisted upon continuing with the psychiatrist in psychotherapy and in dropping the other psychotherapist. After several months of treatment, the patient declared that this psychotherapeutic relationship

was not helpful and in fact hurtful. He terminated. Each therapist had missed the patient's belief that nothing and no one could help him.

### *"If She Wants Something of Mine, I'll Give It to Her"*

A 38-year-old married man in his second psychotherapeutic relationship wanted to find a way to divorce his wife with the help of a therapist because he couldn't find a way to do it on his own. During his first psychotherapy, he had asked his psychoanalytically oriented therapist to see his wife. Because this therapist did not do couples therapy, and because his agoraphobic wife needed treatment, the patient stopped seeing this therapist so that his wife might see him. After several sessions with me, he reported that his wife wanted to see me for a medication evaluation because "you are an expert in anxiety disorders." To his amazement, I refused. My refusal required that he explain to her that I was not willing to allow him to give up yet another therapist to her and that he too was not willing to do so. He had, in many other ways, given in to most of her requests of him. This boundary construction provided him with a wedge by which to continue the process of separation. The separation and subsequent divorce, incidentally, was associated with great reduction in her agoraphobic behaviors.

### **Pattern Search: Transference and Countertransference**

Interpersonal patterns may play out in the interaction between therapist and patient about medication use. Both patient and therapist are potential contributors to medication-associated distortions.

### *The Pill Is the Therapist*

A 47-year-old woman insisted that she receive sleep medication from me but refused to discuss the thoughts she had when trying to fall asleep. Her demands escalated and we reached a stalemate. Slowly she revealed that she was unable to go to sleep because she was preoc-



cupied with sexual fantasies about me. She wanted the medication to overcome these thoughts. Although she later showed much evidence of developing erotic feelings toward me, she refused to discuss them.

### *Give the Patient a Pill to Calm Down the Therapist*

A 24-year-old woman developed a strong sexual attraction for her 28-year-old male therapist. He was disturbed by his own sexuality and denied to himself that any woman could find him sexually appealing. To reduce what he thought was her anxiety, he prescribed an anti-anxiety medication. The patient was confused by this offer, was not aided by the pills, and rightly questioned the therapist's ability to treat her (Langs, 1973).

### **Change**

Medications and psychotherapy may interact in surprising ways to bring about change. Medications may make patients more responsive to psychotherapy but may also help with the initiation and maintenance of new behaviors; for example, an antidepressant may help agoraphobic patients expose themselves to fearful situations. On the other hand, psychotherapy may uncover a medication-responsive diagnosis not considered during the initial evaluation; for example, couples therapy may later reveal a social phobia. It is likely that additional change synergies wait to be recognized.

### *Pharmacotherapy Helps to Separate a Patient From her Mother*

A 23-year-old woman had been depressed since she was 16 years old but had never sought treatment. Although she lived independently, she always asked her mother's advice about major decisions. Because she clearly met criteria for depression, she was offered an antidepressant. Her mother emphatically instructed her not to take it because "I don't want any drug addict for a daughter." The patient therefore refused. As psychotherapy proceeded, the patient real-

ized how much she was striving to please her mother while at the same time being furious with her for her emotional abuse and physical threats during childhood. After several months she was offered an antidepressant again. She accepted and decided not to tell her mother of this decision. Not only did she gain pharmacological benefit, but also, for the first time in her life, she made an important decision without consulting and reporting to her mother. This action allowed her a more objective view of their relationship, leading her to freer attachments to subsequent friends and lovers.

### *Psychotherapy Leads to Unrecognized Medication-Responsive Diagnosis*

At age 28, the patient's ex-husband entered her office at work and shot her in the head. She suffered minimal brain damage but had recurrent panic attacks with agoraphobia, continuing depression, and posttraumatic stress disorder. She had had no psychiatric problems before the shooting and was maintained on benzodiazepine and an antidepressant. Psychotherapy focused on her dependent relationship with her mother and her agoraphobia. During the many hours of litigation surrounding this incident, she was required to undergo numerous interviews by lawyers and mental health professionals. She often had panic attacks when asked about the details of the incident or about her ex-husband. The many roadblocks thrown up by the "system" infuriated her, causing her to think that "they" were trying to subvert her legal intent. I encouraged her to gradually expose herself to these situations and these ideas. Without telling me she was going to do it, she went to another interview. She became agitated. She threw furniture around. She was furious. She thought the pictures on the wall were telling her to destroy them. I inquired more carefully into her belief about the plot against her and asked her mother about other paranoid thinking. Indeed, the patient had been paranoid for many years since the shooting. Exposure instructions had revealed psychotic thinking that was subsequently re-

sponsive to a low dose of the neuroleptic thiothixene (Navane 2–3 mg/day).

### Termination

Termination may be the most predictable stage of therapy, as the range of options for both participants is relatively limited at this time. For example, the patient or therapist may independently decide to terminate, or the decision may be made together. They may terminate abruptly, set a specific date, or gradually separate by spacing out meeting intervals. Each may also have difficulty letting go of the relationship and may therefore experience various aspects of grieving (Beitman, 1987). Patient responses to pharmacotherapy may reflect general patterns of separation.

### *Refusal to Restart an Effective but Unnecessary Medication Harbingers Termination*

Laura, a 30-year-old panic-disorder patient, had discontinued her antidepressant during the later stages of therapy because of her pregnancy. As session intervals became monthly or longer, she became worried about her failure to be “cured” because she still had an occasional panic attack. These attacks tired her and her husband because she lost sleep and then spent hours analyzing them. “Could we just start the antidepressant again?” She was looking for answers from me even though she had enough information herself to make the decision. I simply handed her a prescription and asked her to decide for herself. She did not like that. Six weeks later, she returned to report that she had not started the medication. She had a panic attack the night before our session “because I just don’t want to think about this stuff anymore. Denial is a good thing.” With some prodding, she could express her anger at me for not making her completely well. She grudgingly recognized that she would need to continue to do the work of change herself, without pills and without psychotherapy. I asked her to return in 1 year to let her see how much she had changed.

### *Wish to Discontinue Necessary Medications Is a Harbinger of Abrupt Termination*

A 48-year-old woman with panic disorder and agoraphobia was struggling with a difficult marriage. Her husband would be kind to her only when she was physically or emotionally ill. She developed a strong emotional attachment to me. After 4 years of contacts at approximately 1- to 3-month intervals, she was becoming more and more exasperated with her husband. During one session, I too expressed some minor frustration about her situation. Her sensitivity to criticism triggered intense anger at me. She called me that night, threatening to stop her medications. She knew that without them she would likely spiral into depression and panic. She was able to accept my suggestion that her anger at me had driven her to this decision. Without this discussion, she would have also quit psychotherapy. She continued the medications as well. Unfortunately, her marital difficulties contributed to a suicide attempt with medication she had stored up from another physician. She did not want to use the pills she had gotten through me. Only after divorce and the beginning of a new, successful relationship was she able to reduce her medication dosages and her treatment frequency.

### PSYCHOTHERAPIST– PHARMACOTHERAPIST COLLABORATION

There are two general models for the provision of combination treatment. In an integrated model, a physician provides both psychotherapy and pharmacotherapy. In a split treatment model (sometimes also known as divided or collaborative), a physician provides psychotropic medication while a nonmedical psychotherapist (social worker, psychologist) provides psychotherapy. Early surveys indicated that approximately 65% of psychiatrists and 80% of psychologists participated in split treatment (Beitman, Chiles, & Carlin, 1984; Chiles, Car-

lin, Benjamin, & Beitman, 1991), and those percentages have certainly risen.

The practice of split treatment has increased during the past few years, and several factors have contributed to this trend. The availability of safer psychotropic medications has made nonpsychiatric physicians more comfortable prescribing and collaborating with other clinicians (Riba & Balon, 2001). The rapid growth of managed care led to a variety of cost containment measures, including the delivery of care by multiple providers. In this model, non-medical psychotherapists are used to provide psychotherapy while physicians—and increasingly, physician assistants and nurse practitioners—provide medication management. In fact, 65% to 75% of psychotropic medications are now prescribed by internists and family practice physicians.

Recently, several studies have questioned the assumption that split treatment is more cost-effective than integrated treatment (Dewan, 1999; Goldman et al., 1998). Though many collaborations work well, problems arise in others. These include the patient idealizing one clinician and devaluing the other, accusations of clinicians' "stealing" patients from colleagues, requests for fraudulent signatures on insurance forms, and psychotherapy patients acting out by surreptitiously obtaining pharmacotherapy (Woodward, Anderson, & Woodward, 1991). In addition, there is some perception of potential problems: one report indicated that 25% of collaborating psychiatrists believed collaborative treatment could alienate them from psychotherapists and 40% believed it could result in lawsuits (Goldberg, Riba, & Tasman, 1991).

There have been a number of discussions of collaborative treatment in the literature identifying both the positive and the negative aspects of this treatment model. The following is a summary of an article by Riba and Balon (2001).

One positive aspect of split treatment is the fact that patients end up working with at least two clinicians and may have more time in treatment. In this arrangement, they see a psychotherapist for 45- to 50-minute sessions and a pharmacotherapist for 15- to 30-minute ses-

sions. Having two clinicians may also make vacations and other interruptions easier on the patient who can still see one clinician when the other is away. Another advantage may be a greater choice of clinicians. Split treatment may offer patients larger opportunities to choose a clinician who more closely matches the patients' needs. This may allow patients to develop better therapeutic alliance and trust. Split treatment may also offer enhanced adherence to the treatment plan. Many patients have trouble taking their medications as prescribed, and psychotherapy may increase compliance by providing further support, education, and an open discussion of various transferences, resistances, and defenses that invariably enter the therapeutic setting.

We believe the relationship between the two clinicians is central to effective collaborative treatment; it can support the patient and both clinicians, or it can become the instrument for amplifying the patients' conflicts. Factors determining the clinicians' relationship include the treatment setting, the patient, the history of the relationship, and the ground rules for clinician communication. Collaborative treatment is most therapeutic when both clinicians understand the potential sources of tension in their relationship and when all three participants agree on and adhere to a three way therapeutic contract.

In addition, as clinicians and researchers, we need to continue to better identify when patients will best respond to pharmacotherapy, psychotherapy or combined treatment.

### The Treatment Setting

Clinicians in collaborative treatment may be peers in a hospital or clinic, or colleagues or unknowns in private practice. In any setting, systemic and interdisciplinary issues from the large system can intrude into therapeutic relationships, making the clinicians vulnerable to identifying with the patients' conflicts. Likewise, clinicians in independent practice exist in a professional community in which each maintains a reputation: they may also be linked by office proximity, shared professional activities, or even marriage.

The treatment setting often determines the administrative relationship between the two clinicians; whether it may be supervisory, consultative, or collaborative. In the absence of an employment or supervisory relationship, each is responsible for his or her own work and not for that of the other (Applebaum, 1991). Supervisory arrangements are more acceptable to some patients and can provide support for clinicians. They are also more comfortable for physicians who are not experienced in being a peer to nonmedical psychotherapists. Unfortunately, supervisory relationships also raise issues of autonomy and self-esteem, which, if not understood and monitored, may make the clinicians more vulnerable to splitting by the patient.

### The Patient

Patients hold beliefs about the nature of their problems and about the treatments they prefer, frequently expressed by their choices of whom they initially consult for help: Some patients center their hope in physicians and can initiate psychotherapy only when it is medically prescribed, whereas others believe their problems are psychological in origin and can accept medication only with the endorsement of a nonmedical therapist.

Referral to a second clinician may elicit feelings of failure, relief, inadequacy, loyalty, hope, or despair. Many patients experience referral to a second clinician as a rejection. Adding a second clinician mobilizes some patients' tendencies toward projective identification; this may be an advantage in holding some patients in treatment, but destructive splitting requires unusually close collaboration between the clinicians. Similarly, patients with potential for violence or suicide, or difficulties with treatment compliance, are likely to require closer collaboration and present a significant source of legal liability for both clinicians.

### Development of the Clinicians' Relationship

Tensions between clinicians may originate in differences in ideology (Klerman, 1991), dis-

agreement about treatment goals and methods, or interdisciplinary rivalry (Riba & Balon, 2001). Patients' conflicts may intensify these tensions. The working relationship between the two clinicians is central in managing problems from any of these sources.

Ideally, the clinicians' relationship is built on each one's skills and self-esteem and on previous experience in working together. In the absence of sharing cases, a common theoretical orientation, institutional affiliation, or supervisory relationship may facilitate the development of trust between clinicians.

The collaborative relationship may take time to develop. This can be shortened by preliminary discussions of beliefs about treatment approaches, interpersonal styles, and common problems in collaborative treatment (Corder, Cornwall, & Whiteside, 1984). In addition, it is helpful to be meticulously complete about communication the first time two clinicians work together; the goal is to build a working relationship as well as to treat the particular patient.

### Communication Between Clinicians

Successful communication is essential to the delivery of good care in split treatment, but, unfortunately, it frequently fails (Hansen-Grant & Riba, 1995). When the patient is capable of conveying the information necessary for treatment, and when the clinicians trust and respect each others' work, communication may be less regular and frequent. This has the potential advantage of reducing the intrusion of the pharmacotherapist relationship into the process of psychotherapy (Zinberg, 1987).

Communication when problems are perceived permits clinicians to share information, formulate the case together, and manage the patient's distortions of their relationship. This more flexible approach still acknowledges the boundaries of the psychotherapy relationship.

Routine communication is used in many institutional settings in the form of rounds and supervision; it is advantageous in managing complex cases, with more disturbed patients who may act out violently or not comply with treatment, and for those who are likely to in-

duce splitting in the therapeutic triad. In very difficult cases it may be helpful for the clinicians to meet together with the patient.

### The Three-Way Therapeutic Contract

Whatever arrangements for treatment are selected, it is essential that all three participants comprehend, concur, and comply with the therapeutic contract. This contract is an agreement among the clinicians and patient about the purpose of each treatment, the respective roles of the clinicians, any employment or supervisory relationship between them, policies for clinician communication, whom the patient should call in case of emergency, coverage arrangements for vacations and other absences, and any fees for initial and ongoing clinician combination. These issues should be negotiated at all beginning of treatment; in some cases, it may be helpful for all three participants to meet together to discuss the contract (Chiles, Carlin, Benjamin, & Beitman, 1991) or for the patient to have a written summary of these policies (Applebaum, 1991).

Collaborative treatment is widely practiced but inadequately discussed; we need further research on its efficacy, the optimal arrangements for collaboration, and models of professional oversight (Lazarus, 1999). It has both advantages and potential for problems. It is most therapeutic when the clinicians attend to tensions in their relationship and when all participants understand and adhere to the three-way therapeutic contract.

### CONCLUDING COMMENTS

Clinicians cannot easily judge which patient is most likely to respond to pharmacotherapy and which to psychotherapy. Combining treatments at the outset offers patients two effective options simultaneously: Medications may make patients more responsive to psychotherapy by reducing symptoms; psychotherapy may help reluctant patients become more willing to take medications over time. Psychotherapy may also permit a quicker and deeper dose reduction

that pharmacotherapy alone. After treatment discontinuation, psychotherapy may be more likely to prevent relapse than medication alone. In these and other ways, the two treatments may interact synergistically to augment the effects of each other.

Studies have shown that both pharmacotherapy and psychotherapy alter brain function. They continue to appear separate and dichotomous in part because we have been unable to develop one language to describe their actions. As clinicians and researchers, we constantly seek new terms and metaphors to begin to bridge the linguistic mind–brain barrier. The metaphors must use both neurobiological and mental terms in order to embrace both pharmacotherapy and psychotherapy.

The term *circuits* may provide a useful metaphor to connect mind and brain. A number of neuroanatomists have been increasingly focusing upon sets of interacting circuits (Alexander, DeLong, & Strick, 1986) as a way to understand brain function. Anxiety patients are able to report recurrent patterns of anxious thoughts that circle through their consciousness. The effect of psychotherapy on anxiety circuits appears to allow patients to “step back” from their anxious thoughts. Pharmacotherapy appears to diminish the intensity of these thoughts. We are not yet sure what these different phrases actually mean in terms of brain function. In order to begin the construction of a model of psychotherapy that can be mapped onto brain function, psychotherapy must be defined in clear, operational terms that offer the possibility of finding a set of brain correlates. In addition, as clinicians and researchers, we need to continue to better identify what patients will best respond to pharmacotherapy, psychotherapy, or combined treatments.

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## **PART V**

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# Training, Research, and Future Directions

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## Training in Psychotherapy Integration

JOHN C. NORCROSS AND RICHARD P. HALGIN

Once upon a time, psychotherapists were trained exclusively in a single theoretical orientation and in the individual therapy tradition. The ideological singularity of training did not always result in clinical competence but did reduce clinical complexity and theoretical confusion (Schultz-Ross, 1995). But over time, psychotherapists began to recognize that their orientations were theoretically incomplete and clinically inadequate for the variety of patients, contexts, and problems they confronted in practice. They began receiving training in several theoretical orientations—or at least, were exposed to multiple theories—and in diverse therapy formats, such as individual, couples, family, and group.

The gradual evolution of psychotherapy training toward integration or eclecticism has been a mixed blessing. On the one hand, the movement toward more integrative training addresses the daily needs of clinical practice, satisfies the intellectual quest for an informed pluralism, and responds to the growing research evidence that different patients prosper

from different treatments, formats, and relationships. On the other hand, integrative training exponentially increases the student press to obtain clinical competence in multiple theories, methods, and formats and, in addition, challenges the faculty to create a coordinated training enterprise. Not only must the conventional difficulties in producing competent clinicians be resolved, but an integrative program must also assist its students in acquiring mastery of multiple treatments and then in adjusting their therapeutic approach to fit the needs of the client.

In this chapter, we begin by introducing an ideal training model for psychotherapy integration. We then consider training in light of the four principal routes of integration—technical eclecticism, theoretical integration, common factors, and assimilative integration—as the training objectives and sequence will differ somewhat among them. Next, we address questions regarding the centrality of personal therapy and the necessity of research training in the preparation of integrative therapists. We review inte-

grative supervision, specifically problems in the acquisition of integrative competence and an improved system. We conclude with a discussion of organizational strategies for introducing changes, particularly those promoting psychotherapy integration, into training institutions.

Before proceeding to ideal training models, a few words on terminology. The term *training* can denote a mechanistic and impersonal pursuit, such as training seals to clap their flippers or training rats to run a maze (Bugental, 1987). We would prefer to retitle psychotherapy training something along the lines of *cultivating psychotherapists* or *developing psychotherapists*. But precedent is against us; when we talk about the development of a psychotherapist, many of our colleagues and students look at us quizzically. Thus, we will concede to linguistic preference and precedent in using the conventional *training* throughout this chapter, but we implore you to interpret the term in a broader and more human meaning. We try to prepare graduates who are both competent psychotherapists *and* better functioning people.

## INTEGRATIVE TRAINING MODELS

Psychotherapy trainers are immediately confronted with a crucial decision with respect to their training objectives. The major choice is whether the program's objective will be to train students to competence in a single psychotherapy system and subsequent referral of some clients to more indicated treatments, or whether its avowed mission will be for students to accommodate most of these patients themselves by virtue of the students' competence in multimethod, multitheory psychotherapy. The former choice is favored by briefer training programs and smaller faculty; the latter seems to be preferred by longer and larger training programs with more resources.

In this section, we present consensual training models for teaching both differential referral and psychotherapy integration. The introduction and implementation of these models into any program will require substantive content revisions, as well as a clinical sensitivity to

the process of successful organizational change, as described later in this chapter.

## Differential Referrals

Psychotherapists can function effectively in a single theoretical system, providing they have the ethics and ability to discriminate which patients can benefit from their preferred system and which cannot. Referral of the latter group of patients can then systematically be made to clinicians competent to offer the indicated treatment. In the words of Howard, Nance, and Myers (1987, p. 415): "Without a therapist's willingness and ability to engage in a range of behaviors and to employ a range of therapeutic modalities, the therapist, by intent or default, will have to limit his or her practice to clients who fit the specific range of behaviors he or she has to offer." The primary problem is not from narrow-gauge therapists per se, but from therapists who impose that narrowness on their patients (Stricker, 1988).

The two essential tasks in differential referral are to train students to recognize the respective contraindications of their single psychotherapy system and to educate them in making informed referral decisions. Many evidence-based compendia are now available by which to recognize indications and contraindications of particular therapies and formats (e.g., Beutler & Harwood, 2000; Frances, Clarkin, & Perry, 1984; Nathan & Gorman, 2003; Norcross, 2003; Roth & Fonagy, 1996), and the failure to make use of such information can no longer be construed primarily as lacunae in the psychotherapy outcome literature. On the contrary, difficulties in appreciating the limitations of one's treasured proficiencies are now largely emotional and organizational, not intellectual. Helping single-system advocates to relinquish patients for whom another approach is better suited will entail attention to both the prescriptions of the empirical research and the limitations of their theoretical commitments.

In order to make differential referrals, clinicians will need knowledge of available community and treatment resources. Because many students may ultimately practice in geographic

locations different from where they were trained, this information cannot readily generalize from the training location. Instead of teaching specific resources, therefore, training programs are well advised to ensure that students know how to locate resources in any community (Norcross, Beutler, & Clarkin, 1990).

Programs can provide several experiences in order to assure students' ability to develop treatment and community knowledge. First, specific instruction and course work can emphasize the value of community services and self-help resources. Second, students routinely can be provided with names, phone numbers, and Web addresses of national directories and referral services. Careful distinction must be made here between paid advertisements and credentialing organizations, particularly on the Internet. Third, visits to community mental health centers, family counseling agencies, child protective services, and substance abuse programs, among others, can give a sampling of the variety of resources available.

Practice exercises also might be incorporated into both coursework and practica. Trainees can be assigned, for instance, the task of locating treatment resources and preparing an integrated treatment plan for an actual problem presented in either case conference or a class vignette. Examples can be organized around the client's disorder, treatment goals, stage of change, therapy preferences, and the like.

In addition to course work, trainees should have extensive experience in evaluating a range of patients under close supervision in differential referral and treatment assignment. These experiences are most easily obtained in large treatment centers that offer a variety of treatment programs and specialty clinics. In such a setting, the trainee can practice assessing the patient and making differential recommendations concerning treatment setting, format, relationships, and techniques. In such clinics, the trainee is free to consider a whole range of therapies in selecting those that might be optimal for the individual. In such clinics, too, the integration of research and practice can be facilitated and reinforced (Jarmon & Halgin, 1987).

## Integrative Psychotherapy

Of critical importance in the decision to train integrative practitioners is the assumption that students have both the time and talent to acquire competence in several models. Some training programs may be too brief, or students too inexperienced, or faculty too divided to tackle the challenge. Our own training experiences during the past two decades affirm that coordinated doctoral training can produce competent integrative psychotherapists, although additional time and effort are required in light of the more ambitious goals.

An ideal psychotherapy education would encompass an interlocking sequence of training experiences predicated on the crucial therapist-mediated and therapist-provided determinants of psychotherapy outcome. Our suggested model, drawn largely from the consensus of several journal sections on training integrative and eclectic psychotherapists (Beutler et al., 1987; Castonguay, 2000a; Norcross et al., 1986; Norcross & Goldfried, *in press*), consists of six steps. Following is an ideal generic model of training integrative psychotherapists.

The first step entails training in fundamental relationship and communication skills, such as active listening, nonverbal communication, empathy, positive regard, and respect for patient problems. Acquisition of these generic interpersonal skills can follow one of the systematic modules that have demonstrated significant training effects compared to controls or less specified modules (see Baker, Daniels, & Greeley, 1990, and Stein & Lambert, 1995, for reviews). In general, the most efficient way of maximizing learning of facilitative psychotherapy skills is to structure their acquisition (Lambert & Arnold, 1987). The standard sequence involves instruction, demonstration (modeling), practice, evaluation (feedback), and more practice. These interpersonal skills are crucial to the establishment, repair, and maintenance of the therapeutic alliance.

Students would be retained in this foundation course until a predefined level of competence is achieved in these skills. Criterion-referenced situational tests, expert ratings, and

demonstration experiments can be used to confirm such competence. The point is that students should not be automatically moved forward in the curriculum simply because they have completed a course; they should be advanced because they have demonstrated competence.

The second interlocking step consists of an exploration of various systems of human behavior. At a minimum, the courses would examine psychoanalytic, humanistic-existential, cognitive-behavioral, interpersonal-systems, and multicultural theories of human function and dysfunction. Students would be exposed to all approaches with minimal judgment being made as to their relative contributions to truth. Theoretical paradigms would be introduced as tentative and explanatory notions, varying in goals and methodology. Integrative frameworks and informed pluralism would thus be introduced at the beginning of training (Halgin, 1985b), but a formal course on integration would occur later in the sequence.

The third step in the integrative training involves a course on systems of psychotherapy. The focus in this course would be in applying the models of human function and dysfunction to methods of behavioral change. At the outset, multiple systems of psychotherapy would be presented critically, but within a paradigm of comparison and integration. In our experience, courses and textbooks that only present “one theory a week” are inadequate for this purpose. Rather, the psychotherapy systems need to be presented and, at the end of the course, compared and integrated in a clinically meaningful manner. At this point, students would be encouraged to tentatively adopt a theoretical orientation that is most harmonious with their personal values and clinical preferences.

The fourth step in the training sequence entails a series of practica. Neophyte psychotherapists would be expected to become competent in the use of *at least* two psychotherapy systems that vary in treatment objectives and change processes. In each case, completion of the practicum would depend on specific criteria to ensure acquisition of the skills associated with a given system. Relevant psychotherapy handbooks, treatment manuals, and videotapes would

be used specifically to outline criteria for implementing interventions.

Following satisfactory completion of these competency-based courses, the fifth step involves the integration of disparate models and methods. The emerging consensus is that the sophisticated adoption of an integrative perspective occurs after learning specific therapy systems and techniques. The formal course on psychotherapy integration would provide a decisional model for selecting the methods, formats, and relationships from various therapeutic orientations to be applied in given circumstances and with given clients. Sample syllabi for such integrative courses/seminars are now available for psychology, psychiatry, counseling, and social work programs (e.g., Allen, Kennedy, Veaser, & Grosso, 2000; Beitman & Yue, 1999; Norcross et al., 1986; Norcross & Kaplan, 1995). This course bears the program’s responsibility for providing “a system of analysis or a framework by which a multiplicity of theories and methods could be organized into an integrated understanding” (Reisman, 1975, p. 191).

Finally and concomitantly, an intensive practicum experience, such as an internship or residency, with a wide variety of patients would allow novice therapists to practice integration and to evaluate their clinical skills. Theoretical knowledge of integration is sorely incomplete without supervised experience in applying it to the real world of patients. In fact, the principal complaint of psychotherapists following graduation is inadequate clinical experience (Robertson, 1995).

These training experiences are but the beginning steps in the development of competent integrative psychotherapists; genuine education continues far after the internship or residency. Students would be encouraged—nay, expected—to go forth to receive additional training in specialized methods and preferred populations.

“Deep structure” integration will take considerable time and probably come about only after years of clinical experience (Messer, 1992). Expert psychotherapists represent their domain on a semantically and conceptually deeper level than novices. Conceptual learn-

ing about psychotherapy integration is probably necessary to achieve deep structure integration, but is not sufficient. For a therapist to integrate at a deeper level requires that they first understand and integrate within each individual therapy and, only then, across therapies. Additional psychotherapy experience and disciplined reflection on that experience is needed to attain a mature and abiding synthesis.

Psychotherapy integration, in other words, may take two broad forms that are differentially accessible to novice versus expert therapists (Schacht, 1991). The first form, accessible to neophytes, emphasizes conceptual products that enter the educational arena as content additions to the curriculum. The second form of integration, largely limited to expert therapists, emphasizes a special mode of thinking. This form enters the educational arena only indirectly through accumulated clinical experiences that promote fluent performance and creative metacognitive skills.

### Specific Training Models

Since the first edition of this *Handbook* (Norcross & Goldfried, 1992), we have secured considerably more experience and a bit more research to inform the ingredients of integrative training. In particular, we and others have learned that the training sequence and objectives are heavily influenced by the specific type of, or route toward, psychotherapy integration. Proponents of technical eclecticism, theoretical integration, assimilative integration, and common factors (see Chapter 1, this volume for definitions) all have definite preferences in how and when the ideal training occurs.

*Technical eclectics* seek to improve our ability to select the best treatment for the person and the problem. Eclecticism focuses on predicting for whom particular methods will work: the foundation is actuarial rather than theoretical. As such, the eclectics rely on the accumulating research evidence and the needs of individual patients to make systematic treatment selections. The training emphasis is placed squarely on acquiring competence in multiple methods and formats, as opposed to pledging allegiance to theories, and pragmatically blen-

ding these methods and formats to suit the given situation.

In that they are disinclined toward grand unifying theories and more interested in pragmatic blending of methods, technical eclectics generally endorse teaching psychotherapy integration from the very beginning of training. Gradually building toward integration in mid-career is considered too tentative and theoretical. And for some therapists, learning integration after working for years in a specific orientation may prove too difficult (Eubanks-Carter, Burckell, & Goldfried, this volume). Instead, the eclectic mandate is to teach multiple therapy methods and treatment selection heuristics early on so that clients receive the optimal match of treatment, format, and relationship.

Eclectics also readily acknowledge the limitations associated with faculty composition and disposition, which results in a series of training possibilities. Graduate programs will range from those in which the faculty embrace disparate theories and goals to programs in which there is coordination of the training process and faculty consensus about an integrative model (Norcross & Beutler, 2000). It will take considerable time for many senior faculty to unlearn their own allegiance to a single, pure-form system of conducting (and teaching) psychotherapy. Yet, many new clinical faculty have been trained in, or at least favorably exposed to, an integrative perspective.

*Theoretical integrationists* blend two or more therapies in the hope that the result will be better than the constituent therapies alone. As the name implies, there is an emphasis on integrating the underlying theories of psychotherapy along with the integration of therapy techniques from each. As such, the training focus is far more on the theoretical systems and building bridges between the chasms that separate them. Wolfe (2000, p. 241), for one prominent example, asserts that an integrative training program should “expose students to the various treatment approaches that represent the orientations to be integrated, in addition to a unifying conceptual framework that integrates at the conceptual level.”

*Assimilative integrationists* similarly embrace synthesis, but in a more tentative manner.



Their approach entails a firm grounding in one system of psychotherapy, but with a willingness to selectively incorporate (assimilate) practices and views from other systems. As such, the training is primarily in a single system of psychotherapy with an understanding that the clinicians will gradually incorporate techniques from other systems during the course of a career.

The assimilative integrationists frequently argue that, in early training, students need a single theoretical system to follow. Early on, ideology provides structure, support, and direction. Trainees internalize the theory and the contributions of their supervisor. To be sure, the eventual goal of integration is introduced, but neophyte psychotherapists need to focus on a manageable amount of clinical material, be directed to a technique toolbox, and delimit their range of experiences. Otherwise, they risk being overwhelmed by the morass of choices and the hundreds of therapeutic methods. Thus, the practical benefits of adopting integration early on are outweighed by the costs. Later, students are expected to move in an integrative fashion, but from a position of single-system comfort and strength.

*Common factorists* seek to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on those commonalities. As such, the training focuses on the acquisition of transtheoretical skills that research has found to account for much of psychotherapy success, such as creating a positive alliance, mobilizing client's resources, and helping patients acquire new skills. Castonguay (2000b), for example, outlines a training model driven by a common factors strategy in which he recommends training students in "pure-form" therapies and, using general principles of change, expecting them to integrate contributions of the different orientations in their clinical work.

In reality, these specific training models are all variations on the integrative theme. In most integrative courses and seminars, students are exposed to all four routes to psychotherapy integration. They overlap considerably in how

they educate students, with the central differences being in the timing and level of integration. As yet, there is no controlled research on integrative training. We do not know, in an empirical sense, which training process works best for which situation.

Recent data indicate that program and internship directors are committed to psychotherapy integration but disagree on the routes toward it. Approximately 80% to 90% of directors of counseling psychology programs and internship programs agreed that knowing one therapeutic model is not sufficient for the treatment of a variety of problems and populations; instead, training in a variety of models is needed. However, their views of the optimal integrative training process differ: about one-third believe that students should be trained first to be proficient in one therapeutic model; about half believe that students should be trained minimally competent in a variety of models; and the remainder believe that students should be trained in a specific integrative or eclectic model from the outset (Lampropoulos & Dixon, in press).

## MODERATING EXPECTATIONS

The excitement engendered by integrative training can give rise to grandiose plans and overly optimistic predictions. We ourselves have been guilty of such unfettered optimism at times, and we hasten to correct any illusion that competency-based training in psychotherapy integration will be easily or instantly attained. At the risk of fostering the opposite reaction—that of pessimism or apathy—we will consider several reasons that may moderate expectations regarding integrative prospects in training. These considerations, it should be emphasized, apply with equal cogency to conventional psychotherapy training and not uniquely to integrative training.

To begin with, explicit training for psychotherapy has a relatively brief history, and research on training for psychotherapy has a briefer history still. In a classic review, Ford (1979) evaluated training studies published be-

tween 1968 and 1979 and concluded that these studies focused on teaching only one or two discrete interviewing skills in the context of brief and poorly described intervention. Furthermore, the dependent variables were not well-validated, the typical client sample was composed of undergraduates, and the skills imparted were simple and discrete. In a more recent review, Alberts and Edelstein (1990) revealed that therapist training studies involving more traditional process-related skills appear to have progressed little in methodological sophistication or clinical relevance.

If current training programs do relatively little to ensure competence in a single psychotherapy model, how can competency be ensured if we attempt to teach practitioners several psychotherapy models? To contemplate such questions is to understand why systematic approaches to psychotherapy integration are not taught in most mental health programs.

Then there is the challenge of novelty—integrative training is unprecedented in the history of psychotherapy. During the 1980s and 1990s, when the integrative movement was emerging, educators faced the challenge of trying to formulate integrative training curricula without the benefit of learning such approaches in a formal context themselves. As Robertson (1986, p. 416) put it: “Quite frankly, many of us who are trainers teach students pretty much the way we were trained, and most of us were not trained to be eclectic therapists.” In recent years, the situation has improved somewhat as graduate and postdoctoral psychology programs have instituted more formalized integrative coursework and practica. However, most of those who teach and supervise integrative psychotherapies did not have such experiences themselves.

As with psychotherapy itself, it is increasingly difficult to speak of psychotherapy training without reference to its demonstrated effectiveness. Although many descriptions of integrative training programs have appeared in the literature, empirical evaluations have not (for an exception, see Lecompte, Castonguay, Cyr, & Sbourin, 1993). The same can be said for virtually all programs adhering to a single theoretic

cal tradition, but this similarity is hardly redeeming. The competence of our graduates and, indeed, the adequacy of our clinical training are typically assumed rather than verified (Stevenson & Norcross, 1987).

Given questions about the feasibility of training graduate students to competencies in multiple systems of psychotherapy in a few years, the need for rigorous evaluation of training in psychotherapy integration is particularly urgent. An indisputable disadvantage of multiple competences is that they necessitate longer and more comprehensive training than a single competency. Integrative psychotherapists, similar to bilingual children and switch hitters in baseball, may be delayed initially in the acquisition of skills or in the attainment of several proficiencies (Norcross, Beutler, & Clarkin, 1990).

Even if an integrative training program is carefully implemented and thoroughly evaluated, the effects of the training would probably be complex and idiosyncratic. The findings of the Vanderbilt II project, one of the most carefully designed psychotherapy training ventures, bear this out (Henry & Strupp, 1991). This project was designed to investigate the manner in which specialized training might improve the therapeutic process and outcome of time-limited dynamic psychotherapy. The effects of training were mixed, involving potentially positive and negative effects. No linear relationship was found between technical adherence and psychotherapy outcome, although the training was successful in imparting adherence to a manualized form of therapy. The training was also found to alter some specific and general operations associated with improving the quality of dynamic therapy, but there was evidence that some elements not directly related to the imparted techniques were also improved after training. The criteria for effective training are multitudinous and individualized, no less so than possible indications of effective psychotherapy. The introduction of an integrative perspective does nothing to reduce the subtle and complex effects of training and probably enlarges the task of measuring training outcome.

## PERSONAL THERAPY AND RESEARCH TRAINING

Contributors to the earlier edition of this *Handbook* (Norcross & Goldfried, 1992) considered questions concerning the centrality of personal therapy and the necessity of research training in the preparation of eclectic or integrative therapists. In this section, we summarize their responses on these contentious matters and add our own views on the basis of 50-plus collective years of psychotherapy training.

With respect to personal therapy, the contributors agreed that its importance as a prerequisite for clinical work depends on the student's level of psychological functioning and the trainer's own experience with personal therapy. If a student's personal problems interfere with the successful implementation of psychotherapy, then all contributors concurred it is necessary to remedy the situation, probably including personal therapy. We also sensed a marked hesitancy to endorse mandatory personal psychotherapy for all students, arising in part from two cardinal integrative principles: (1) the empirical literature is inconclusive on the ability of personal therapy to enhance clinical effectiveness, and committed integrative clinicians are reluctant to oblige students to an activity with unproven efficacy; and (2) the eclectic maxim of matching the treatment to the unique needs of the student/client would be violated by insisting on a single modality for diverse students. Instead, a variety of individually tailored personal development exercises (Beutler & Consoli, 1992) and other life-enhancing activities (Lazarus, 1992) are endorsed.

In both this *Handbook* and research studies, the valence accorded to personal therapy varies as a function of whether or not the psychotherapist has undergone personal treatment himself or herself. In one representative study (Norcross, Dryden, & DeMichele, 1992), only 4% of psychologists who received personal therapy thought it was unimportant compared to 39% of those psychologists who had not received it. In their chapter, Prochaska and DiClemente (1992) reported having undergone personal therapy, and

this admittedly influenced their valuing of it for training.

What might be the benefits of personal treatment for the typical psychotherapist in general and the integrative therapist in particular? In general, the literature contains at least six recurring commonalities on how the therapist's therapy may improve his or her clinical work (Norcross, Strausser, & Missar, 1988): (1) by improving the emotional and mental functioning of the psychotherapist; (2) by providing the therapist-patient with a more complete understanding of personal dynamics, interpersonal elicitations, and intrapsychic conflicts; (3) by alleviating the emotional stresses and burdens inherent in this "impossible profession"; (4) by serving as a profound socialization experience; (5) by placing therapists in the role of the client and thus sensitizing them to the interpersonal reactions and needs of their own clients; and (6) by providing a firsthand, intensive opportunity to observe clinical methods. In particular, clinicians with integrative leanings will probably discern from personal treatment that therapy is rarely "pure-form" in practice or outcome, that good therapists routinely incorporate a variety of methods traditionally associated with diverse systems, and that the therapeutic relationship accounts for more treatment outcome than specific techniques (Geller, Norcross, & Orlinsky, 2005).

To Yalom (2002), personal psychotherapy is, by far, the most important part of psychotherapy training. He reviews his own odyssey of personal therapy during a 45-year career, emphasizing the diversity of theoretical orientations he sought. He concludes (Yalom, 2002, pp. 41–42):

It is important for the young therapist to avoid sectarianism and to gain an appreciation of the strengths of all the varying therapeutic approaches. Though students may have to sacrifice the certainty that accompanies orthodoxy, they obtain something quite precious—a greater appreciation of the complexity and uncertainty underlying the therapeutic enterprise.

Yalom is hardly alone in his experience. Across studies and across countries, psychotherapists rate their personal therapy or analysis

the second most important influence on their professional development—behind only clinical experience (Orlinsky et al., 2001). Given this and the overwhelmingly positive self-reported outcomes of therapists' personal therapy (Orlinsky & Norcross, 2005), we enthusiastically recommend (but not require) personal treatment for our trainees. A "good-enough" therapist (or multiple therapists) is necessary for the undertaking, of course. Personal therapy is viewed as one component of ongoing development and continuing education.

With respect to research training, the consensus is that it is a desirable, but not necessary, ingredient for an effective integrative therapist. None of the contributors to the earlier edition of this *Handbook* insisted upon its inclusion in clinical curricula, but several advocate a critical and searching perspective to the psychotherapy enterprise. Beutler and Consoli (1992), for instance, asserted that a research orientation assists one to perceive relationships between therapeutic strategies and subsequent changes and to be a thinking therapist. Similarly, Lazarus (1992) placed paramount importance on the multimodal therapist being trained to understand the workings of science, to appreciate the value of inquiry, and thus to become critical consumers of research—not necessarily producers of research. We concur wholeheartedly.

A scientific orientation, not to be equated with laboratory research, conveys a mode of thought that transcends the particular brand of therapy being conducted. It teaches how to be inquisitive and skeptical, how to gather data rather than opinion, how to analyze those data and draw inferences from them. These are skills that help organize clinical knowledge and help students select among the morass of competing therapy claims. Many integrative therapists credit their research training for fostering the thinking skills and methodological pluralism that enabled them to proceed toward integration (Goldfried, 2001). Good practice, like good research, depends on systematic decision making, reasoning from sufficient data, tolerance for ambiguity, and avoidance of premature assumptions (Faust, 1986; Giller &

Strauss, 1984). Whether or not clinicians ever elect to produce original research, they must learn to respect the process of knowledge acquisition, to acquire a way of thinking about therapeutic phenomena, and to critically read the relevant literature. In short, research training prepares us to question and evaluate the way psychotherapy (and psychotherapy training) is conducted (Meltzoff, 1984).

## INTEGRATIVE SUPERVISION

As beginners, most psychotherapists sought out a single theory by which they could define their approach, manage their anxiety, and solidify their identity. Beginners felt a naïve sense of security in adhering to the methods of a single, pure-form orientation; however, such reassurance was inevitably short-lived as they came to realize the limitations of any singular approach. In recent years, the lure of empirically supported treatments has led many beginners down a path of simplistic hope that manualized treatments would have all the answers. In time, of course, those who jumped on the evidence-based bandwagon quickly came to realize the limitations of manualized therapies developed within laboratory settings using research volunteers. Decades of psychotherapy research has clearly documented that patient factors and the therapeutic relationship, rather than specific technical ingredients, are most important to psychotherapy success (Norcross, 2003; Wampold, 2001). If we manualize anything, it should be flexibility and effectiveness (Beutler, 1999).

As suggested earlier, advocates of integration are certain to confront obstacles in guiding their students toward an integrative approach. On a broad level, there are the problems with curriculum and institutional change discussed elsewhere in this chapter. On a personal level, there are the predispositions of those who are educating and the needs of those who are being taught. Committed integrationists will need to find ways to help their supervisees feel comfortable foregoing the pursuit of proficiency in a single, pure-form system and instead work to-

ward the development of a comprehensive, multifaceted system. Although most supervisors respect clinical approaches that have been demonstrated to be effective in treating certain conditions, experienced clinicians are wary of overreliance on approaches that suggest that “one size fits all.”

Many beginners cling to the notion that the realm of psychotherapy is composed of a neighborhood of separate houses. Beginners tend to view themselves as house hunters seeking the home that will feel most comfortable. If educators teach psychotherapy in ways that suggest that these houses are indeed separate parcels of real estate, new generations of beginning therapists will continue to misunderstand what the real world of psychotherapy is about.

Below are eight principles of supervising integrative psychotherapy, culled from both the nascent literature and our collective experience.

### Ensure Prerequisite Knowledge

Successful integrative supervision rests on several premises, the most important of which pertain to the supervisee’s level of cognitive complexity and theoretical sophistication prior to beginning clinical work. Ideally, as delineated earlier, the supervisee has acquired a rudimentary understanding of differential treatment selection and has been exposed to the range of theories and techniques that are the underpinnings of psychotherapy integration. In our experience, if the supervisee does not possess such knowledge, then it should be taught immediately, if feasible, or the supervision should probably not aspire to be integrative. The integrative journey is arduous; it is unrealistic to expect beginners to competently plunge into integrative work early in their development.

### Understand Trainees’ Biases and Anxieties

The word is only slowly spreading to educators who have not been involved in the integration movement about the wisdom and the pragmatics of integrative training. Experienced faculty increasingly appreciate integrative training, but they may be surprised to encounter some resis-

tance in their students about such prospects. Even in the earliest stages of training, students often come with theoretical biases that limit their openness to integrative approaches. This situation may be compounded by the understandable anxiety experienced by novices who are overwhelmed by the complexity of psychotherapy, and therefore, who yearn for a simple, albeit narrow, theoretical model.

It can be both surprising and disconcerting for a supervisor to encounter the supervisee who professes adherence to a narrow model and is resistant to the possibility of becoming more broadly trained. In these situations it may not be a matter of the trainee holding onto a base of security, but rather a case of a refusal to consider alternative methods. Some trainees apparently feel no need to become informed about other models and methods; they evidence complacency with their treasured singular psychotherapy.

The choice of theoretical orientation early in training is typically made on the basis of a number of determinants, most of them accidental. In the typical undergraduate curriculum, the pedagogical approach to clinical material tends to be discrete and categorical. For example, in a course on abnormal psychology, diagnostic conditions are commonly taught as independent of other conditions; a textbook client has panic disorder or major depressive disorder, but not both concomitantly. Clinicians working with real people, however, know that most clinical presentations are multidimensional. When they learn treatment approaches, undergraduates are likely to study independent, nonintegrated approaches such as cognitive, psychodynamic, or systemic. They may prematurely leap to the conclusion that a given model is the most viable one for them to pursue in their own graduate training, not yet realizing that clinical work tends to be technically eclectic.

Supervisors will find it easier to reach beginning trainees when they approach their work with an understanding of the stages of therapist development (Halgin, 1988). In one particular stage theory (Loganbill, Hardy, & Delworth, 1982), which has become an accepted model for understanding therapist development, su-

perverse progress through three stages: stagnation, confusion, and integration. During the stagnation stage, the beginner is deceived by the illusion of simplicity in clinical work. The confusion stage follows, during which the trainee realizes that something is amiss and solutions seem elusive. It is only later in training that the supervisee attains a sense of integration during which flexibility, security, and understanding emerge. Thus, the supervisor who impatiently expects the trainee to have attained integration early in training is likely to engender dismay, frustration, and diminished self-esteem in the trainee.

### Appreciate the Difficulty of Integration

Supervisors can often lose touch with the challenging nature of learning integration. Students, when first introduced to multitheoretical approaches, are frequently puzzled by the mechanics of technique shifts and are dismayed that their own attempts might prove to be awkward and disruptive (Wachtel, 1991). Beginners are typically overwhelmed by the array of possibilities. For example, a novice may be perplexed by whether an interpretation or a directive intervention is advisable at a given point in a session; confronted with such an imposing choice, paralysis may set in. When apprised of such a moment in the therapy, an insensitive supervisor may make a difficult situation even worse for the trainee who is already feeling miserably insecure. A comment that reflects impatience or surprise about the trainee's handling of the therapy is likely to intensify the student's anxiety instead of fostering some risk-taking, which is an indispensable part of the learning process.

Experience provides clinicians with a special sense of what should be done next in the therapy; this reflects a complex, recursive decision-making process that is informed by dozens, perhaps hundreds, of bits of data related to client, therapist, and context considerations. Like the statistics instructor who may be oblivious to the fact that many students do not fully appreciate the difference between analysis of variance and correlation, the experienced su-

ervisor can lose touch with how perplexing and intimidating the psychotherapy process is for the neophyte.

### Clarify Expectations and Goals

In addition to the difficulty of mastering integration is the difficulty of becoming a supervisee. Trainees usually enter supervision with little understanding of the process, and they often do not receive formal assistance in assuming the role of supervisee. It should come as no surprise that trainee ratings and faculty/expert ratings of the quality of the same supervision session have very low correlations (e.g., Reichelt & Skjerve, 2002; Shanfield, Hetherly, & Matthews, 2001). Many supervisor and supervisee dyads are literally not on the same page.

Psychotherapy supervision, particularly of the integrative variety, requires formal preparation of students and structured orientation to supervision (Bertger & Buchholz, 1993). Such an orientation would address the participants' goals and expectations, the logistics of supervision (e.g., setting, format, boundaries, legal relationship), and its omnipresent evaluative component (e.g., grading criteria, course credit, letters of recommendations). In fact, we are among those who opt for an explicit contract for supervision (Sutter, McPherson, & Geesmen, 2002).

### Share Our Work with Supervisees

Although modeling has been shown to be a particularly effective procedure for teaching complex behaviors, this technique is used surprisingly little in teaching psychotherapy. Most clinical educators use lecture and consultant techniques to pass on knowledge about the methods of psychotherapy. Like many consultants, they act and speak like experts who are reluctant to acknowledge the problems that they themselves encounter in their work. Rather than discuss the mistakes they have committed, they are inclined to report the successes they have achieved. Rather than disclose their anxieties, they are likely to boast in ways that communicate an inflated sense of competence and self-assurance.

This situation would be quite different if trainees could actually observe the work of their clinical supervisors; yet conducting psychotherapy before the critical eyes of supervisees is an uncommon event. Consequently, trainees are deprived of the opportunity of watching their teachers struggle with the dilemmas that are so common in clinical work.

We and others (e.g., Lampropoulos, 2002; Norcross & Beutler, 2000) emphasize the enormous value of demonstrating and modeling psychotherapy to trainees. Trainees should observe the work of clinical supervisors, conduct psychotherapy with more experienced peers, and watch videotapes of seasoned clinicians conducting psychotherapy. Trainees may also benefit by reading about how seasoned therapists themselves struggled in their early attempts to develop an integrated approach to therapy (Goldfried, 2001).

Sharing our clinical work with our students can open a rich dialogue in which the supervisor is willing to be vulnerable. By being vulnerable, the supervisor can commit to a trusting and open relationship. What a wonderful opportunity for the trainee to observe the work of the expert! Supervision can focus on the difficulties encountered by the therapist/supervisor, and in this process the student can develop a greater appreciation of what takes place within the integrative therapy session. Open discussion of our own clinical work will also sensitize us to the complexity of this work. When faced with trainees asking us to explain—and defend—why a given intervention was chosen, we will assuredly become aware of how difficult practicing within an integrative approach is; and with this awareness, we will be more sensitive to the challenges that our trainees confront.

### Make Optimal Use of the Supervisory Relationship

Just as the therapeutic relationship is an essential curative factor in psychotherapy, the supervisory relationship is comparably important in fostering growth in clinical trainees. The useful concept of *parallel process* can be used to ex-

plore the parallels between what is happening in the supervisory relationship and in the therapeutic relationship (Rau, 2002).

Researchers have documented supervisory styles that are facilitative and those that are problematic (see Neufeldt, Beutler, & Banchemo, 1997). The ideal supervisor possesses “high levels of empathy, respect, genuineness, flexibility, concern, investment, and openness” (Carifio & Hess, 1987, p. 244). Like good therapists, good supervisors are those who use appropriate teaching, goal-setting, and feedback; they tend to be seen as supportive, noncritical individuals who respect their supervisees and help them understand their own responses to patients (Shanfield, Hetherly, & Matthews, 2001). The remote and uncommitted supervisory style, in particular, seems to be detrimental (Nelson & Friedlander, 2001). It tends to beget trainee struggle or extensive anger and, in such relationships, supervisees commonly lose trust, feel unsafe, pull back, and remain guarded.

Although a negative supervisory experience may be attributable to a general problematic supervisory style, sometimes the negative experience is due to more specific counterproductive events in supervision (Gray, Ladany, Walker, & Ancis, 2001). One such example is when a supervisor dismisses a trainee’s thoughts and feelings. Another example involves the supervisor directing the trainee “to be different with the client.” Research documents that counterproductive supervisory events commonly lead to a weakening of the supervisory relationship and a diminishment of the quality of work with the client (Ramos-Sanchez et al., 2002).

Integrative supervisors have an exciting opportunity to apply to the supervisory relationship some of the same methods that are effective in integrative psychotherapy. The supervisor can blend the methods of several theoretical approaches; for example supportive, directive, exploratory, and interpersonal techniques can be blended within supervision in such a way that the supervisee feels supported, understood, and well-educated (Halgin, 1985a). The supervisory relationship is an optimal context within which to model these crucial training goals.

As should now be apparent, the relationship is simultaneously a context and a process for change in supervision. We as supervisors have the opportunity of providing our students with wonderful gifts. Ideally, they will finish their work with us knowing more about therapy, more about clients, more about us, and most importantly, more about themselves. The supervision can be viewed as a laboratory in which creative experiments take place. As supervisors, we have a great deal of responsibility for ensuring that participants—the clients and the trainees—in the experiment are treated with sensitivity and care. When we, the supervisors, make it clear that we are also participants in this exciting experiment, we enhance the probability of integrative success.

### Tailor Supervision to the Individual Supervisee

Just as we ask our students to be integrative and prescriptive in their clinical work, so too should we match our supervision to their unique needs and clinical strategies. The determinants of therapist behavior are too numerous and supervisee needs too heterogeneous to provide the identical supervision to each and every student.

Not only are accidents of fate important in determining theoretical orientation, but so also are personal life experiences and personality traits. The biographies of Freud, Skinner, Rogers, and others theorists convincingly demonstrate that their personal life experiences influence their tenets and techniques (e.g., Demorest, 2004; Monte & Sollod, 2003). Similarly, the clinical approach of many beginning therapists is tremendously influenced by personal life experiences.

Integrative supervision will obviously take into account a number of trainee variables. Supervisors will assess personality characteristics, such as introversion versus extroversion or need for challenge versus need for support, and develop supervisory strategies that take these characteristics into account (Lampropoulos, 2002) in order to help the supervisee develop therapeutic skills and discover his or her own voice as a therapist (Rau, 2002). The research litera-

ture (e.g., Holloway & Wampold, 1986; Stoltenberg, McNeill, & Crethar, 1994) suggests that we can improve supervision by tailoring it to three trainee characteristics in particular: developmental stage, therapy approach, and cognitive style (Norcross & Halgin, 1997).

One of the most appealing features of integrative psychotherapy is that an individualized treatment plan can be formulated for each client. A similar principle holds true for integrative supervision: an individualized supervision plan can be formulated for each trainee on the basis of his or her style, stage, experience, complexity, and other considerations.

### Provide a Systematic Model

Ideal supervisors provide feedback to students in a variety of ways within a coherent conceptual framework (Allen, Szollos, & Williams, 1986; Carifio & Hess, 1987). A systematic model determines in large part whether integrative supervision is experienced as intelligible or bewildering. Supervision within a coherent framework is associated with a higher quality experience; conversely, less valued integrative supervisors fail to ground their clinical interventions within larger conceptual perspectives.

The task of integrating the diverse systems of psychotherapy should not be left entirely to the trainee (Hollanders, 1999). Many programs and supervisors advertise themselves as integrative, offering a nonpartisan approach that appeals to students. But what it frequently means is that the students are taught by faculty of different orientations, leaving students to try to integrate the systems on their own; or, the students are supervised by faculty who respect all systems but have no systematic way of synthesizing, sequencing, or selecting among them for a given case (Hinshelwood, 1985).

In the midst of conducting psychotherapy, a supervisee will desire immediate and concrete guidance on the “right treatment” for his or her patients. In the midst of conducting supervision, a supervisor will want to address the student’s immediate need but also provide a more general treatment selection heuristic for future patients. The most frequent integrative/eclectic



models used in this regard appear to be multimodal therapy, the common factors approach, the transtheoretical model, cognitive-interpersonal therapy, and systematic treatment selection, according to directors of doctoral programs (Lampropoulos & Dixon, in press). The preceding chapters in this *Handbook* detail these and other systematic and evidence-based models for matching treatments to patients; our point is that supervisors should offer such a systematic model as well.

## THE ORGANIZATIONAL CONTEXT

The curricular and supervision models portrayed above represent a growing consensus on the outlines of effective integrative training. In our judgment, the training need at the present time is not so much for further conceptual refinement, but for progress in institutional movement toward adopting such integrative training. In other words, the more pressing need is less curricular than systemic.

This conclusion has led Andrews (1991) and us (Andrews, Norcross, & Halgin, 1992) to contemplate the necessary systemic change processes—how innovations are adopted in organizations of higher education. This approach represents a different stream of thinking, one that complements the conceptual models described above. Our objective in this section is to outline many of the educational, political, and organizational changes that must occur in order to implement even a modestly integrative program.

### Obstacles to Implementing Integrative Ideas

In much of the literature on psychotherapy integration, nonintegrative programs are portrayed as showing rigidity in the curriculum, in those who administer it (faculty) and in those who consume it (students). Programs that teach either one orientation exclusively or a multiplicity of competing orientations are criticized as forcing students into premature closure at the risk of otherwise seeming to be a “wishy-washy” eclectic. It is argued that such pro-

grams enforce indoctrination and do not teach optimal client–therapy matching.

One difficulty with this account is that it has a judgmental flavor, as evidenced by the use of words like *rigid* to characterize the opponents of integration. When translated into interpersonal messages, such characterizations are likely to produce an antagonistic, win–lose struggle, in which the integrative “good guys” try to take over from the separatist “bad guys.” This is hardly likely to promote a welcoming attitude toward integration on the part of the “opposition”!

Moreover, one of the first principles of organizational change is to *listen to one’s opponents respectfully and seriously*; they probably have some truth on their side, and important considerations may emerge from a dialogue among those with contrasting views. Even if the obstacles to integration consist largely of rigidity on the part of current faculty and students, we must work *with* them; we are not likely, except in unusual circumstances, to be able to select a body of faculty *de novo*. It is, of course, possible to select students or interns according to explicitly integrative criteria (see Lane, Andrews, Gabriel, Holt, & Schick, 1989, for an example), but this is only likely to happen once the faculty themselves adopt integrative principles.

Those who study social change in higher education emphasize the decentralization of power in a variety of overlapping sites. Rather than a simple “line” authority structure, power and decision making are localized in many settings: the formal administrative structures involving deans and presidents; the faculty senate and its curriculum approval committees; the department chair; and the individual faculty members who, within certain limits, decide on what is to be taught in their courses. These factors make it even more imperative that we draw on a variety of change strategies in promoting integrative training.

### Principles of Institutional Change

In his thoughtful monograph entitled *Strategies for Change*, Lindquist (1978) reports the results of case studies involving curricular and institutional change on various college and

university campuses. He distills four models of influence processes that, he concludes, help to delineate the channels through which an innovation becomes accepted and stabilized. Innovation—integrative training, in the current case—is best introduced through a combination of the four change processes. The effectively stated (“rational”) idea is spread by means of informal social networks, linked to solutions by means of the problem-solving model, and finally ratified by the political process. All four models hold, in varying degrees depending on the situation and people involved. Therefore, an effective change agent will orchestrate all four of the change processes in a flexible way if he or she is to be fully effective.

Often at conferences dealing with psychotherapy integration, complaints are voiced of resistance at one’s home institution to the introduction of integrative ideas; indeed, in some settings the Society for the Exploration of Psychotherapy Integration (SEPI) member may be the only proponent of such ideas. One reason for this frustration may be that we tend to take the rational model or one of the three other models as our sole view of change processes, thereby missing the opportunity to exert influence within a combination of models. Integrative ideas are best shared and implemented by a sage synthesis of rational information, social network, problem-solving, and politics.

### Fourteen Change Strategies

How best to develop a variety of organizational change strategies? Watson (1972) offers 14 factors that induce change in higher education. The integrationist wanting to introduce such change would do well to incorporate these strategies and to match his or her proposed innovation against these criteria, asking at each step how the endeavor to introduce integrative ideas could be modified to maximize its likelihood of becoming implemented.

1. *Ownership.* The more an innovation is “owned” by those affected by it, the greater will be full acceptance. It is important, therefore, to be sure that a proposed innovation is responsive to members’ needs, diagnosed and designed with their involvement, and implemented with their participation.
2. *Reduction of burdens.* Participants in an innovation should see it as reducing their burdens, lightening their load. Adding responsibilities to already beleaguered faculty, administrators, and students is no way to gain acceptance.
3. *Support at the top.* Although pushing an innovation from the administration without a sense of ownership at other levels is unwise, few innovations can succeed without firm commitment to them at the highest administrative level.
4. *Compatibility with organizational structure.* The innovation whose implementing structure fits into the existing college or university organization has the best chance of success.
5. *Desire for new experience.* Routine can grow tedious. The opportunity to do something new and exciting can go far toward gaining acceptance of a new idea. Unfortunately, it can also cause anxiety.
6. *Respect for the opposition.* Those opposed to an innovation usually have sound reasons and legitimate concerns. Innovators need to sit down with the opposition and listen.
7. *Clear goals.* Foggy goals often lead to failure in implementation. Clear goals are prerequisite to innovation.
8. *Open, two-way communication.* Full and open two-way communication before and during the innovation is vital, not only to increase participant ownership, but also to enhance accuracy of interpretation. Full feedback from participants should be carefully maintained.
9. *Bugs inevitable.* No innovation works right the first time. Bugs and disappointments should be expected.
10. *Training for new roles.* Undertaking new roles is difficult. New skills must be learned, and a training program may need to be developed.
11. *Suitable materials.* New approaches to curriculum, teaching, and evaluation

usually require appropriate materials and facilities. Success is contingent upon adequate resources of all kinds.

12. *Unexpected effects.* Change in one part of an organization may have unexpected consequences—some desirable, others not—for other parts. These need to be taken into account in planning and implementation.
13. *Rewards.* Faculty, trainees, and supervisors cannot be expected to participate in a new program without attractive compensation. A rule of thumb is that participants should be rewarded at least as fully as are those in traditional learning, teaching, and research pursuits.
14. *Climate of readiness.* Institutional members who have an open approach to change, who are well-informed about innovations, and who have participated previously in successful innovation are more accepting of new ideas.

## CONCLUDING COMMENTS

Theoretical pluralism and psychotherapy integration are here to stay in training mental health professionals. Although the particular objectives and sequences will invariably differ across training programs, recent research demonstrates that the vast majority of training programs profess a pro-integration position. Training directors indicate that they are committed to providing their students with significant exposure to the major psychotherapy models and to encouraging their students to seek out practica that expose them to several different treatment approaches. And, in most programs, the attitudes of professors and students alike are positive toward integration (Goldner-deBeer, 1999; Lampropoulos & Dixon, in press).

Psychotherapy integration is both a product and a process. As a product, psychotherapy integration will be increasingly disseminated through books, videotapes, courses, seminars, curricula, workshops, conferences, supervision, postdoctoral programs, and institutional changes. Our hope is that educators will develop and deliver integrative products that are less paro-

chial, more pluralistic, and more effective than traditional, single theory products.

Our more fervent hope is that, as a process, psychotherapy integration will be disseminated in training methods and models consistent with the openness of integration itself. The intention of integrative training is not necessarily to produce card-carrying, flag-waving “eclectic” or “integrative” psychotherapists. This scenario would simply replace enforced conversion to a single orientation with enforced conversion to an integrative orientation, a change that may be more pluralistic and liberating in content but certainly not in process. Instead, our goal is to educate therapists to think and, perhaps, to behave integratively—openly, synthetically, but critically—in their clinical pursuits. Our aim is to prepare students to develop, if they possess the motivation and ability, into knowledgeable integrative therapists.

We firmly believe that it is *inappropriate* to demand that students adopt any single meta-theoretical perspective, integrative or otherwise. We are equally convinced that each practitioner should develop an individual clinical style within his or her chosen perspective. The goal of every training program should be graduates who are knowledgeable, broad as well as deep in their interests, and sufficiently curious to keep learning and growing professionally (Frances et al., 1984). Integration, by its very nature, will be a continuing process, rather than a final destination. The hope is that, in Halleck’s (1978, p. 50) words, our students will “approach our patients with open minds and a relentless commitment to study and confront the complexities of human behavior.”

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## Outcome Research on Psychotherapy Integration

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Studies consistently show that one-third to one-half of American clinicians consider themselves to be either “eclectic” or “integrative” in theoretical orientation (for a review see Glass, Victor, & Arnkoff, 1993). For instance, a recent study found that 36% of psychologists claim to be eclectic/integrative (Norcross, Hedges, & Castle, 2002). Psychotherapy integration is widely believed by experienced clinicians to improve the effectiveness of psychotherapy (Wolfe, 2001), and yet, despite a large theoretical and clinical literature, empirical research on psychotherapy integration has for many years lagged behind (Arkowitz, 1997; Glass, Arnkoff, & Rodriguez, 1998; Norcross et al., 1993). Fortunately, in recent years the empirical outcome literature has begun to grow considerably; nevertheless, much work is left to be done.

Our chapter reviews the existing outcome literature on psychotherapy integration, discusses the difficulties inherent in conducting this research, and suggests future possibilities. Types of integration not included in this chap-

ter include integration of psychopharmacology and psychotherapy (see Beitman, 2005) and integration of treatment formats/modalities (see Feldman & Feldman, 2005). We will primarily focus on individual psychotherapy, with a brief review on literature of family, couples, and group modalities. Additionally, most of these individual treatments are for adults, as very little empirical research exists on integrative therapy for children. Although much of the treatment for children may be eclectic for pragmatic reasons, it is rarely identified as such (Chorpita et al., 2002).

In conducting a review of empirical outcome research on psychotherapy integration, several problems are encountered. First, it is difficult to identify what constitutes integrative/eclectic therapy. We restricted our review to those therapies that explicitly describe themselves as eclectic or integrative. Thus, therapies that may acknowledge their eclectic heritage, but primarily retain a pure-form identity, are not included (e.g., feminist therapy, rational-emotive behavior therapy).



A second problem in conducting such a review relates to what constitutes outcome research. A wide range of integrative therapies have been studied with case studies and purely process studies; however, for the purposes of the current review, the standard for inclusion was set much higher. In order for a therapy to be included in the chapter, there had to be outcome research consisting of at least one group study with or without comparison group, preferably with randomization to treatment or to a control group. We identify three levels of empirical support: substantial empirical support (four or more randomized controlled studies), some empirical support (one to three randomized controlled studies), and preliminary empirical support (studies with no control group or a nonrandomized control group). Integrative psychotherapies with only case studies or process research, or with no research, are included in a later section on promising directions.

A third source of difficulty relates to the process of identifying an accessing research conducted and published in languages other than English. Although efforts were made to locate and include integrative treatments from Europe and South America, the results of our review are largely restricted to studies published in the English language.

Finally, a fourth problem in reviewing the integrative psychotherapy outcome literature is the wide variety of ways in which psychotherapists integrate. Various attempts have been made to categorize what eclectic and integrative clinicians do (see Norcross, this volume, for a review). For our purposes, we will distinguish among four types of psychotherapy integration. The first is assimilative integration, defined by Messer (2001, p. 1) as: “the incorporation of attitudes, perspectives, or techniques from an auxiliary therapy into a therapist’s primary, grounding approach.” The second is what we will call sequential and parallel-concurrent integration, in which separate forms of therapy (e.g., cognitive-behavioral and interpersonal) are given either in sequential order or during the same phase of treatment in separate sessions or separate sections of the same therapy session.

The third type of integration we will cover is theoretically driven integration. Although theoretical integration has been defined in a variety of ways (cf. Castonguay, Reid, Halperin, & Goldfried, 2003) we will consider it to be integration in which a clear theory drives the choice of techniques. Unlike assimilative integration, the theory is not necessarily derived primarily from one type of mainstream psychotherapy; it may be developed from an amalgam of many theories of psychotherapy, developed anew, or imported from a relevant field (e.g., social-ecological theory). The choice of psychotherapeutic techniques is guided by the theory and may include techniques from one or more systems of psychotherapy.

The fourth type of psychotherapy integration discussed in this chapter is technical eclecticism, which has typically been defined as the use of psychotherapy techniques without regard to their theoretical origins (Lazarus, 2005). Although a number of authors also include common factors as a type of psychotherapy integration (e.g., the use of elements identified as common to many pure-form therapies), it is only incorporated in the “promising directions” section of the current chapter due to a lack of outcome studies. More information on common factors can be found in the chapter by Miller, Duncan, and Hubble (2005).

Within each type of integration, we will distinguish between therapies originally designed for multiple disorders and those created to address a specific disorder(s). A list of all psychotherapies covered in the chapter, along with their degree of empirical support to date, is presented in Table 22.1.

## ASSIMILATIVE INTEGRATION

A variety of integrative therapies have been developed within the framework of a particular system of psychotherapy, in which integration consists of supplementing that therapy with specific techniques or theories from other systems of psychotherapy.

TABLE 22.1 Integrative Therapies with Empirical Support, Categorized by Degree of Support

Name of Therapy	Authors and References
<i>Substantial Empirical Support (4 or More Randomized Controlled Studies)</i>	
Acceptance and Commitment Therapy	Hayes, Strosahl, & Wilson (1999)
Cognitive Analytic Therapy	Ryle (1990); Ryle & Kerr (2002)
Dialectical Behavior Therapy	Linehan (1993)
Emotionally Focused Couples Therapy	Greenberg & Johnson (1988)
Eye Movement Desensitization and Reprocessing	Shapiro (1995)
Mindfulness-Based Cognitive Therapy	Segal, Teasdale, & Williams (2002)
Multisystemic Therapy	Henggeler, Schoenwald, Borduin, Rowland, & Cunningham (1998)
Systematic Treatment Selection	Beutler & Clarkin (1990); Beutler & Harwood (2000)
Transtheoretical Psychotherapy	Prochaska & DiClemente (1992)
<i>Some Empirical Support (1–4 Randomized Controlled Studies)</i>	
Behavioral Family Systems Therapy	Robin et al. (1994, 1999)
Brief Eclectic Psychotherapy for PTSD	Gersons, Carlier, Lamberts, & van der Kolk (2000)
Brief Relational Therapy	Safran, Muran, Samstag, & Stevens (2002)
CBT and Interpersonal/Emotional Processing Therapy for GAD	Newman, Castonguay, Borkovec, & Molnar (in press)
Cognitive Behavioral Analysis System of Psychotherapy	McCullough (2000, 2001)
Sequential CBT and Psychodynamic-Interpersonal Therapy	Shapiro & Firth (1987)
Integrative Behavioral Couple Therapy	Jacobson & Christensen (1996)
Integrative Cognitive Therapy for Depression	Castonguay et al. (2004)
Integrative Treatment for Agoraphobia	Chambless, Goldstein, Gallagher, & Bright (1986)
Interactive-Behavioral Training	Daniels (1998)
Process-Experiential Therapy (Individual)	Greenberg & Watson (1998)
Systemic Behavioral Family Therapy	Alexander & Parsons (1982)
Multimodal Therapy	Lazarus (1981, in press)
<i>Preliminary Empirical Support (Studies with No Control Group or a Nonrandomized Control Group)</i>	
Bergen Project (FIAT Model)	Nielsen et al. (1987)
Client-Directed, Outcome-Informed Therapy	Duncan & Miller (2000)
Cognitive Analytic Group Therapy	Duignan & Mitzman (1994)
Developmental Counseling and Therapy	Ivey (2000)
Functional Analytic Psychotherapy	Kohlenberg & Tsai (1991)
Integrative Psychotherapy for Personality Disorders	Calderón (2001)
Integrative Group Treatment	Morgan, Winterowd, & Fuqua (1999)

Note. PTSD, Posttraumatic Stress Disorder; CBT, Cognitive-Behavior Therapy; GAD, generalized anxiety disorder; FIAT, Flexibility, Interpersonal orientation, Activity, and Teleologic understanding.

## Therapies Originally Designed for Any Disorder

### *Process-Experiential Therapy*

Greenberg and colleagues have developed a process-experiential therapy that has undergone several empirical tests in different forms, including individual (Greenberg & Watson,

1998) and couple therapy (Greenberg & Johnson, 1988; Johnson, Hunsely, Greenberg, & Schindler, 1999). The couple therapy research is included in a section on that modality later in this chapter. Individual process-experiential therapy integrates process-directive and experiential interventions for specific client markers with the facilitative conditions of client-centered therapy. Greenberg and Watson (1998) com-

pared this therapy to client-centered therapy with 34 randomly assigned clients with depression. They found no difference in depressive symptoms at termination or at a 6-month follow-up, but the process-experiential treatment showed some other benefits, including fewer symptoms, better self-esteem, and fewer interpersonal problems. A more recent randomized comparison of these two approaches has been completed with a sample of 72 depressed clients (Goldman, Greenberg, & Angus, 2003). Although both treatments significantly increased self-esteem and reduced depression, process-experiential therapy resulted in significantly more improvement on most measures. Although there are only two outcome studies on the process-experiential approach to individual therapy, extensive process research has found support for the techniques incorporated in this method of therapy (e.g., Goldman & Greenberg, in press; Pos, Greenberg, Goldman, & Korman, 2003; Watson & Greenberg, 1996).

### *Functional Analytic Psychotherapy*

Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991) uses behavioral analysis of the therapeutic relationship to improve manualized cognitive therapy (Kohlenberg, Kanter, Bolling, Parker, & Tsai, 2002). The interpersonal relationship between the client and therapist is a major focus of the work, in that problematic interpersonal client behaviors are noted and elicited by the therapist, who then contingently responds to client improvement and helps the client understand the function of these behaviors (Callaghan, Naugle, & Follette, 1996; Kohlenberg et al., 2002). Several empirical case studies of FAP exist. Additionally, in a quasi-empirical nonrandomized study with a control group, Kohlenberg and colleagues (2002) compared standard cognitive therapy to FAP-enhanced cognitive therapy with 46 depressed clients. They found significant benefits for FAP at posttreatment and 3-month follow-up on measures of depression and interpersonal function, in comparison to standard cognitive therapy.

### *Bergen Project on Brief Dynamic Psychotherapy*

The Bergen Project on Brief Dynamic Psychotherapy (Nielsen et al., 1987) was based on the FIAT model, which stands for Flexibility, Interpersonal orientation, Activity, and Teleologic understanding. The therapy designed from this model added supportive, behavioral, and cognitive interventions to psychodynamic techniques. In a small pilot study, Nielsen and associates (1988) found that clients with physical disorders who received treatment with the FIAT model showed statistically significant symptom change by the end of therapy, maintained such change at follow-up, and were judged much improved by independent raters. Their improvement was equal to that of participants who received one of two short-term dynamic therapies. Those in the FIAT treatment, however, may have reached their "peak of change" later in the process of therapy (Barth et al., 1988).

A larger sample of 44 clients with a wide range of Axis I and Axis II disorders, from which the subsample for the previous study was taken, found that at the end of treatment, FIAT clients had not improved as much as clients in the two short-term psychodynamic psychotherapy groups, but that by 2-year follow-up they had "caught up" to the other groups (Nielsen et al., 1992). The conclusions are limited because the clients were not randomly assigned to treatments but assigned due to theoretical reasons. The FIAT model has also been applied to insomnia, with good preliminary results from two case studies (Nielsen, 1990).

### *Therapies Originally Designed for a Specific Disorder*

#### *Mindfulness-Based Cognitive Therapy for Depression*

Mindfulness is a technique based in Buddhist practice that has recently been applied in psychotherapy; it involves being aware of thoughts and feelings and therefore achieving a sense of separateness from them, as well as a sense of

their impermanence. Baer (2003) reviewed the literature on mindfulness interventions and found that they may be related to improvement in a number of disorders and a number of integrative therapies, including Mindfulness-Based Cognitive Therapy (MBCT; Segal, Teasdale, & Williams, 2002).

Consisting of cognitive therapy supplemented with mindfulness techniques, MBCT (Segal et al., 2002) was developed to help prevent relapse in recurrently depressed clients. Several randomized studies have examined the efficacy of MBCT. Teasdale et al. (2000) found that if clients had experienced three or more previous episodes of depression, MBCT was associated with significant reduction in relapse or recurrence of depression when compared with treatment as usual; however, this improvement was not found for clients with fewer prior depressive episodes. This study used a sample of 145 participants.

Ma and Teasdale (2004) replicated these results with a sample of 125 depressed outpatients. Additionally, Teasdale and colleagues (2002) found that metacognitive awareness, or the ability to think about thinking, increased as a result of MBCT in a treatment study with 87 participants. Williams, Teasdale, Segal, and Soulsby (2000) randomly assigned 45 clients to MBCT or treatment as usual and found that MBCT significantly reduced the number of generalized memories in depressed clients when compared with treatment as usual; recalling generalized rather than specific memories has been found to be a maladaptive aspect of depression.

### *Integrative Cognitive Therapy for Depression*

Castonguay and colleagues (2004; Castonguay & Maramba, 2005) have developed and tested an Integrative Cognitive Therapy (ICT) for depression that uses techniques from humanistic and interpersonal therapies to help repair alliance ruptures in traditional cognitive therapy. They examined this integrative cognitive therapy for depression in comparison to a waiting-list control; randomization was employed when

assigning participants to groups. Although the number of participants was small (21), the ICT group did significantly better than the controls both statistically and clinically on two measures of depression and on global functioning.

### SEQUENTIAL AND PARALLEL-CONCURRENT INTEGRATION

Two types of psychotherapy integration that are not often explored empirically are what we term sequential and parallel-concurrent. In sequential psychotherapy integration, two or more types of psychotherapy are given, each during a separate phase of time and in a specified order, with the aim of targeting specific problems during each stage. In parallel-concurrent psychotherapy integration, two or more types of psychotherapy are given during separate sessions (both in the same phase of treatment, such as during the same week) or during separate parts of one session. Sequential and parallel-concurrent integration are different from other types of psychotherapy integration in that they keep the component pure-form therapies distinct while acknowledging the importance of including both types of therapy as part of a complete treatment.

#### Sequential Psychotherapy Integration

##### *First Sheffield Project: Combining CBT and Psychodynamic-Interpersonal Psychotherapy*

One of the first significant examples of research on combining existing approaches was the Sheffield Psychotherapy Project (Shapiro & Firth, 1987). The primary goal of this study was to compare a cognitive-behavioral (prescriptive) treatment with a psychodynamic-interpersonal (exploratory) treatment in a crossover research design. (The exploratory therapy was later found to integrate psychodynamic, experiential, and interpersonal methods; Shapiro & Startup, 1992.) Forty clients with depression and/or anxiety completed 16 sessions of ther-

apy, either consisting first of 8 prescriptive sessions followed by 8 exploratory sessions, or vice versa. At the end of treatment, both groups exhibited equally significant improvement, and at 3-month follow-up there was a trend for greater symptom improvement among those who completed exploratory therapy first. A later analysis found that this may have been due to one of the therapists being more adept at cognitive-behavioral treatment (Shapiro, Firth-Cozens, & Stiles, 1989). Those who experienced exploratory followed by prescriptive therapy reported that the process of therapy seemed smoother than did those with the opposite order of treatment (Barkham, Shapiro, & Firth-Cozens, 1989). A 2-year follow-up found results similar to those at the end of treatment (Shapiro & Firth-Cozens, 1990).

### Parallel-Concurrent Psychotherapy Integration

#### *CBT and Interpersonal/Emotional Processing Therapy for Generalized Anxiety Disorder*

Newman, Castonguay, Borkovec, and Molnar (in press) have developed an emotion-focused therapy for generalized anxiety disorder (GAD). Based on findings that some clients with GAD do not improve with typical cognitive-behavior therapy (CBT), but seem to have difficulty with emotional processing, this therapy integrates work on interpersonal/emotional processing with traditional CBT for anxiety disorders. One hour of CBT is followed by 1 hour of Interpersonal/Emotional Processing Therapy (IEP), so that the therapies are kept as distinct components of the treatment.

Newman, Castonguay, and Borkovec (2002a) compared CBT with and without IEP in a small sample of clients and found that a larger percentage of clients improved in the CBT/IEP condition compared to the CBT with Supportive Listening (SL) condition; improvements were maintained at 6 months and 1 year. This study, however, was preliminary and included a small number of clients in the comparison condition. Another study with more equal sample sizes in each group had similar findings,

with larger effect sizes in the CBT/IEP group than in the CBT/SL group, and more improvement after therapy and at 6-month, 1-year, and 2-year follow-up (Newman, Castonguay, & Borkovec, 2002b).

### THEORETICALLY DRIVEN INTEGRATION

Theoretically driven integration consists of a clear theory that guides the choice of interventions. The theory may or may not be integrative; it could be developed from an amalgam of many theories of psychotherapy, developed anew, or imported from a relevant field. The interventions may include techniques from one or more systems of psychotherapy and are chosen insofar as they can potentially meet the goals set forth by the theory.

#### Therapies Originally Designed for Multiple Disorders

##### *Transtheoretical Psychotherapy*

The Transtheoretical Model (TTM; Prochaska & DiClemente, 2005; Prochaska & Norcross, 2003) posits five stages of change (precontemplation, contemplation, preparation, action, and maintenance), with specific processes of change to be used at specific stages. Treatment outcome is thought to be related to stage of change, in that clients entering therapy in later stages (preparation or action) may be more ready for change and show more progress in therapy than clients in the early stages (precontemplation and contemplation). Clients in the precontemplation stage, which is defined as being undisturbed by or unaware of problems, and not intending to change in the near future, are at risk for terminating therapy prematurely (Smith, Subich, & Kalodner, 1995). The processes of change are activities and experiences engaged in by individuals when they attempt to change, either within or outside of therapy, such as self-reevaluation and counterconditioning. Each process can be facilitated by specific therapeutic interventions (Prochaska, DiClemente, & Norcross, 1992). Certain processes

are thought to be especially beneficial or emphasized at particular stages of change or to facilitate progress from one stage of change to the next (Prochaska, DiClemente, et al., 1992).

A variety of empirical evidence has been gathered on the Transtheoretical model. Rosen (2000) conducted a meta-analysis of 47 cross-sectional studies on the process of change and found a moderate to large effect for variation in cognitive-affective processes by stage and for variation in behavioral processes by stage. The topics addressed in the studies included smoking, substance abuse, exercise, and diet. Sequencing of the stages depended somewhat on the disorder involved. Five longitudinal studies have found that stages of change are related to the amount of progress individuals make during psychotherapy (DiClemente et al., 1991; Gottlieb, Galavotti, McCuan, & McAlister, 1991; Lam, McMahon, Priddy, & Gehred-Schultz, 1988; Ockene et al., 1992; Prochaska et al., 2005).

The stages of change model has been applied to a number of areas relevant to outcome, such as predicting dropout. Brogan, Prochaska, and Prochaska (1999) used the stages of change to predict psychotherapy dropout with about 90% accuracy. Clients in the precontemplative stage tended to dropout prematurely, clients in the action stage tended to terminate quickly but appropriately, and clients who continued had mixed profiles. Prochaska, Norcross, Fowler, Follick, and Abrams (1992) also found that stages and processes of change early in psychotherapy were found to best predict premature termination in cognitive-behavior therapy.

There is evidence that the amount of progress clients make during treatment is related to their stage of change. In a study of smoking cessation for cardiac clients, Ockene et al. (1992) found that 76% of those ready for action at the beginning of the study were not smoking 6 months later, whereas only 22% of participants in the precontemplation stage achieved success. Prochaska, DiClemente, Velicer, Gimpil, and Norcross (1985) found that participants in the study who were able to move to the next stage during the first month of treatment had double the chance of successful treatment.

A number of randomized controlled studies have examined the effects of using the stages of change to create tailored interventions for smoking cessation. Prochaska, DiClemente, Velicer, and Rossi (1993) randomly assigned 770 smokers to one of four treatments: a home-based action-oriented cessation program (standardized), stage-matched self-help manuals (individualized), expert system computer reports plus self-help manuals (interactive), and counselors plus computers plus self-help manuals (personalized). Participants in the two self-help manual conditions had similar smoking cessation rates until 18 months, when the stage-matched manuals became more effective. The two computer conditions performed equally for 12 months, after which the counselor condition stopped improving, and the group without the counselor continued to smoke less. The expert system was shown to have significant benefit compared with a control group that still had received no treatment at a 6-month follow-up, and the expert system group continued to improve at 2-year follow-up (Prochaska, Redding, et al., 2001). The expert system has also been shown to be significantly better than assessment alone in large-scale studies of 5,170 smokers (Prochaska, Velicer, Fava, Rossi, & Tsoh, 2001) and 4,000 smokers (Prochaska et al., 2000). Velicer, Prochaska, Rava, Laforge, and Rossi (1999) found that computer-generated expert systems based on the TTM were more effective than noninteractive self-help manuals for smokers when assessed at 6, 12, and 18 months among a sample of 2,882 participants.

The TTM has also been investigated within the context of treatment for alcohol dependence. A large-scale study, Project MATCH, consisted of 673 outpatient and 510 aftercare clients assigned to one of three treatments: Twelve-Step Facilitation, Cognitive-Behavioral Therapy, or Motivational Enhancement Therapy. Carbonari and DiClemente (2000) found that stage of change predicted outcome and differential treatment response.

A number of randomized controlled studies have examined the effectiveness of expert system interventions based on the TTM for a number of other health problems and risky be-

haviors. In a large-scale study of treatment for stress management ( $N = 1,085$ ), Evers, Johnson, Padula, Prochaska, and Prochaska (2002) found that a program based on the TTM (involving three expert system tailored communications and a stage-based self-help manual) was more effective than a control group at an 18-month follow-up. A study of 2,460 parents of teens who were participating in similar projects in school found that a treatment consisting of a stage-based multiple behavior manual and three assessment-driven expert system feedback reports resulted in significantly more smoking cessation, avoidance of sun exposure, and reduced-fat diets than in the control group at a 24-month follow-up (Prochaska et al., 2002). In a sample of 5,545 women, Redding et al. (2001) found improved diet, reduced sun exposure, increased mammography screening, and increased smoking cessation in participants who participated in an expert-system based treatment, compared to the control group. Patients with Type 1 and Type 2 diabetes ( $N = 1,040$ ) showed improved self-monitoring for blood glucose, diet, and reduced smoking at a 12-month assessment when given a TTM program rather than a non-TTM intervention (Jones et al., 2003). The TTM program in this study was matched to the participant's stage of change and included monthly contacts with three assessments, three expert system reports, three counseling calls, and three newsletter mailings. A second study of 400 patients with Type 1 and Type 2 diabetes used a similar TTM program (minus the counselor contacts), and found results favoring TTM compared to control group. A study of about 4,000 teenagers who were engaged in multiple risky behaviors has also found support for interventions based on the TTM model compared to control (Prochaska, Redding, et al., 2001).

Most studies of the TTM have been applied to health behaviors, although a few studies have examined its applicability to mental health. Treasure et al. (1999) examined the effects of stages of change on treatment outcome in bulimia nervosa. Female clients ( $N = 125$ ) were randomly assigned to either cognitive behavioral therapy or motivational enhancement therapy. Clients in the action stage reduced binge

eating more than those in the contemplation stage, although the stage of change did not predict dropout. The authors concluded that this provided some support for the stages of change among clients with bulimia nervosa. Wilson, Bell-Dolan, and Beitman (1997) found that the stages of change interacted with responsiveness to drug treatment for generalized anxiety disorder; participants higher in contemplation or action experienced greater decrease in anxiety, whereas those high on precontemplation did not. One study, however, did not find support for the TTM among 60 psychiatric outpatients, in that clients high in precontemplation were not more likely to drop out of therapy (Derisley & Reynolds, 2000). Although TTM-based interventions have been shown to be effective for changing health-related behaviors, the evidence for its applicability to mental disorders is still in need of more exploration.

### *Acceptance and Commitment Therapy*

Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is based on a theory that rule-governed (language-directed) behavior is excessively rigid and does not adjust to changing contextual situations (Hayes, Barnes-Holmes, & Roche, 2001). Additionally, the theory hypothesizes that experiential avoidance is a natural but maladaptive phenomenon. The therapy aims to influence the client toward acceptance of experience and commitment to constructive action, and it is characterized more by adherence to the theory than by specific methods. A variety of types of intervention are consistent with different phases of ACT, including the use of metaphor, experiential exercises, meditation, and behavioral techniques.

Eight randomized controlled studies have been conducted on ACT across a variety of problems. Two have examined ACT for depression. With a sample of 18 depressed women randomly assigned to ACT or cognitive therapy, ACT led to greater reduction in depression (Zettle & Hayes, 1986). A larger randomized controlled study of 31 depressed women compared ACT to two types of cognitive ther-

apy and found that depressed women showed equally significant gains in all groups (Zettle & Raines, 1989).

Several randomized controlled studies have examined whether ACT helps reduce stress and anxiety. A study on workplace stress management with 90 workers randomly assigned to ACT, a behaviorally oriented treatment, or a waiting-list control found significantly higher gains in stress management and health for the ACT condition, but both treatment groups experienced significantly decreased depression (Bond & Bunce, 2000). Zettle (2003) compared ACT with systematic desensitization in treating mathematics anxiety. Thirty-seven clients were randomly assigned to the two conditions. Whereas both groups improved equally, a subtype of clients who tended to avoid their personal experience improved more in ACT than in systematic desensitization. Block (2003) found that socially anxious college students ( $N = 39$ ) showed more improvement when randomly assigned to an ACT workshop rather than a cognitive behavioral group therapy workshop or a waiting-list control.

Two studies of ACT with substance abusing clients yielded positive results. Gifford (2002) found that ACT produced better results than nicotine replacement therapy after a 1-year follow-up among 57 randomly assigned smokers. Hayes et al. (2002, as cited in Hayes, Masuda, Bissett, Luoma, & Guerrero, in press; data are available in Bissett, 2002) compared methadone maintenance, methadone maintenance plus individual and group ACT, and methadone maintenance plus Intensive Twelve-Step Facilitation. The 114 randomly assigned clients consisted of polysubstance abusing opiate addicts. Significantly less drug use was found following treatment in the ACT condition than in the other groups.

Other treatment studies including ACT have been conducted. Bach and Hayes (2002) compared ACT plus treatment as usual with treatment as usual alone in a sample of 80 randomly assigned clients with positive psychotic symptoms. They found significantly fewer hospitalizations in the ACT plus treatment as usual group. Finally, a quasi-experimental effectiveness study in an HMO found that thera-

pists who received training in ACT had more successful client outcomes than did a control group (Strosahl, Hayes, Bergan, & Romano, 1998).

### *Cognitive Analytic Therapy*

Cognitive Analytic Therapy (CAT; Ryle, 1990, 2005; Ryle & Kerr, 2002), a synthesis of cognitive-behavioral and psychoanalytic object relations, includes a theory of change and a specific series of interventions that can be applied in a time-limited format. The main emphasis is on the process of reformulating the client's problems (Ryle & Kerr, 2002). This occurs through the use of diagrammatic descriptions, which depict problematic patterns of relating to others and the self. The Self States Sequential Diagram is employed to visually depict the self-maintaining nature of clients' sequences of beliefs, perceptions, roles, actions, and their consequences. At the end of therapy, the therapist writes a letter to the client summarizing what he or she has learned about the client. Ryle and Kerr (2002) offer an excellent review, summarizing the research that influenced the development of CAT, controlled and uncontrolled studies, process studies, and studies on the theory of change.

Randomized controlled studies of CAT have been conducted for depression and anorexia. Brockman, Poynton, Ryle, and Watson (1987) conducted a small randomized controlled study comparing CAT to focused dynamic therapy with 48 depressed clients and found significantly larger effects for CAT on some measures. Two randomized controlled studies have examined CAT for anorexia nervosa. Dare, Eisler, Russell, Treasure, and Dodge (2001) randomly assigned 84 clients with anorexia nervosa to one of four groups: focal psychoanalytic psychotherapy, CAT, family therapy, or treatment as usual. Although all treatment groups improved, focal psychoanalytic psychotherapy and family therapy showed significant improvement compared to the control, and CAT showed nonsignificant benefits. However, the CAT treatment was only 7 months, whereas the other 2 treatments were for 1 year each, so the results may have had more to do with



the length of treatment than the type of treatment. Treasure et al. (1995) compared CAT with educational behavior therapy for anorexia nervosa in a randomized controlled study with 30 clients. Clients in both groups improved equally, although the group given CAT reported significantly greater subjective improvement.

CAT has also been found to help clients with medical difficulties. In a randomized controlled study for clients with poorly controlled asthma, Cluley, Smeeton, Cochrane, and Cordon (2003) compared CAT with another treatment and found significant improvement in the CAT group on measures of quality of life and treatment adherence. Fosbury, Bosley, Ryle, Sonksen, and Judd (1997) compared CAT and intensive education among 26 randomly assigned insulin-dependent diabetics with poor diabetic control. Both groups showed improvement, but only the CAT group continued improvement at a 9-month follow-up, whereas the education group lost their gains. The CAT group also showed a significant decrease in interpersonal difficulties at follow-up.

Several uncontrolled trials have found positive results. Some of these have been with mixed psychiatric clients. Garyfallos et al. (1998) conducted an uncontrolled study of CAT for 239 psychiatric clients with mixed diagnoses and found statistically significant improvement on many measures by the end of therapy, and at 2-month and 1-year follow-ups. A 4- to 8-year follow-up found that the gains were sustained, and some additional improvement was obtained (Garyfallos et al., 2002). Dunn, Golyukina, Ryle, and Watson (1997) found significant improvement in an uncontrolled study of 135 clients at a psychiatric hospital. Kerr (2001) found positive results in two out of four clients with post-acute manic psychosis who received CAT.

Two preliminary studies have been conducted on clients with BPD, and one on clients who were survivors of sexual abuse. Ryle and Golyukina (2000) conducted an uncontrolled study of CAT for 27 clients with BPD and found a mixture of favorable and unfavorable outcomes. Wildgoose, Clarke, and Waller (2001) conducted CAT with five clients with

BPD and found significant changes in three. In an uncontrolled study, Pollock (2001) found significant improvement on many measures among a group of 37 survivors of sexual abuse who received CAT. This treatment is also being studied with seriously disturbed adolescents (Ryle, 2005), as well as in a randomized controlled study comparing CAT, CBT, and a CAT-informed day hospital with community mental health team management for people with severe and complex psychological difficulties (G. Parry, personal communication, May 20, 2003).

### *Brief Relational Therapy*

Safran and colleagues have developed Brief Relational Therapy (BRT; Safran, Muran, Samstag, & Stevens, 2002), which combines results from their research on maintaining a therapeutic alliance and resolving alliance ruptures with elements of relational psychoanalysis, humanistic/experiential psychotherapy, and contemporary theories of cognition and emotion. The alliance rupture resolution that is the core of BRT consists of four steps: attention to markers that indicate the rupture of the alliance, exploration of the experience, examination of any avoidance of exploration of the ruptured alliance, and finally, the emergence of a wish or need. Muran and Safran (2002) randomly assigned 128 personality-disordered clients with comorbid symptoms to BRT, brief psychodynamic psychotherapy, or short-term CBT. Although clients in all groups improved equally, BRT was better at reducing dropout than the other two treatments. Both BRT and the CBT groups showed more clinical improvement than brief psychodynamic psychotherapy.

A subsample of these clients ( $n = 59$ ) received further treatment in another study (Safran & Muran, 2002). As part of this second study, clients were randomly assigned to BRT, brief psychodynamic, or short-term CBT, and clients selected as high-risk for treatment failure were subsequently offered reassignment. Those who opted to be reassigned (10) were then either placed in BRT or in one of the other control conditions (i.e., brief psychodynamic psychotherapy or short-term CBT).

Among these reassigned clients, 60% of those in BRT had good outcome, whereas 100% of those in the control conditions dropped out.

### *Developmental Counseling and Therapy*

Developmental Counseling and Therapy (DCT; Ivey, 2000) is a theory based on Piagetian cognitive/emotional theory, Erik Erikson's work on life-span development, attachment theory, and Lacan. Therapeutic interventions are matched to client developmental level and cognitive/emotional style. Preliminary empirical evidence for DCT exists; most of it in the form of unpublished doctoral dissertations (for a review, see Ivey, 2000). For instance, Weinstein (1995) compared group CBT for binge eating to a group modified to include DCT principles and found significant reduction in binge eating in the DCT group, as well as significantly improved cognitive change.

### Therapies Originally Designed for a Specific Disorder

#### *Dialectical Behavior Therapy*

Linehan's (1993; Linehan & Heard, 2005) Dialectical Behavior Therapy (DBT) for individuals with borderline personality disorder (BPD) is probably one of the most studied integrative therapies for a particular disorder, and is on the empirically supported therapies list as a "probably efficacious" treatment (Chambless & Ollendick, 2001). The foundation of the therapy is Linehan's (1987) theory of borderline personality disorder, which integrates dialectics into cognitive behavior theory (Heard & Linehan, 1994). The behavior patterns of individuals with BPD are conceptualized as running along three dialectical poles: emotional vulnerability versus invalidation of affect, active passivity versus appearing competent, and unrelenting crises versus inhibited grieving. Linehan (1987) theorizes that the borderline client vacillates between each pole, between overreaction and underreaction. DBT contains several components, delivered both in individual ther-

apy and in a group format, to target each problem of BPD.

Interventions such as mindfulness, acceptance, and focusing on dialectical processes are integrated into a framework consisting of more traditional behavioral interventions such as reinforcement and problem solving (Heard & Linehan, 1994). The erratic, disruptive, and maladaptive behaviors of borderline clients are targeted by a behavioral focus on group skills training and collaborative problem-solving interventions. Mindfulness training is included as a component of the group therapy that runs conjointly with individual therapy. The problematic interpersonal and intrapersonal processes of the clients are addressed by an emphasis on dialectical processes to resolve their tendency to vacillate between the extremes of the dialectical poles.

The first randomized clinical study of DBT was conducted with a group of 44 female clients meeting criteria for BPD and a history of chronic parasuicidal behavior (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). After a year of treatment, several benefits were found in the DBT group compared to treatment as usual. DBT clients showed greater reductions in the frequency and severity of parasuicidal behaviors, fewer hospitalizations, and more improvement in level of anger, social adjustment, and overall adjustment than the treatment as usual group. However, depression, hopelessness, and suicidal ideation were similar in the two groups. Results were maintained at a 1-year follow-up for the most part (Linehan, Heard, & Armstrong, 1993). These results were replicated with a second group of 26 borderline clients in a similarly designed study (Linehan, Tutek, Heard, & Armstrong, 1994).

Several independent randomized controlled studies of DBT have been conducted. A study in a Veterans Administration clinic compared DBT to treatment as usual with 20 BPD clients and found significant improvement in the DBT condition relative to the control group (Koons et al., 2001). Verheul and colleagues (2003) compared DBT to treatment as usual among 58 women randomly assigned to either condition. They found that DBT was more effective than treatment as usual at reducing borderline

symptomatology. Turner (2000) conducted a naturalistic randomized controlled study for 24 clients with BPD in which DBT was compared to a client-centered therapy control condition; results were found to favor DBT.

Pilot studies have also found favorable results for BPD clients given DBT in hospital settings, including psychiatric inpatient units (Barley et al., 1993; Bohus et al., 2000) and a high-security, forensic hospital (Low, Jones, Duggan, Power, & MacLeod, 2001). A variety of quasi-experimental studies of DBT also exist; for a review, see Koerner and Dimeff (2000).

A number of attempts have been made to tailor DBT to treat clients with combinations of BPD and other disorders. Linehan and colleagues (Linehan et al., 1999, 2002) developed an adaptation of DBT to treat women with BPD who also met substance dependence or abuse criteria. In a randomized controlled study with 27 outpatient women diagnosed with BPD and either substance abuse or dependence, Linehan et al. (1999) found DBT to be more effective than treatment as usual both at the end of treatment and at a 16-month follow-up. Linehan et al. (2002) also found a similar result in a randomized controlled study conducted with 23 female opiate-dependent BPD clients; in this study, DBT was compared with comprehensive validation therapy combined with a 12-step program. Van den Bosch, Verheul, Schippers, and van den Brink (2002) randomly assigned 58 BPD women with or without substance use problems to DBT or treatment as usual. They found that DBT was more effective than treatment as usual in reducing borderline symptomatology, but not substance abuse.

Several other adaptations of DBT for disorders comorbid with BPD have been developed. DBT has been modified for offenders exhibiting borderline characteristics, with favorable results from a pilot study (Eccleston & Sorbello, 2002). One randomized controlled study found significant improvement for DBT compared with treatment as usual for bulimia nervosa (Safer, Telch, & Agras, 2000); another found similarly favorable results for DBT compared with treatment as usual for clients with

binge eating disorder (Telch, Agras, & Linehan, 2001). DBT has also been modified to use with depressed elderly clients (Lynch, 2000). In a randomized controlled study, Lynch, Morse, Mendelson, and Robins (2003) found that DBT with medication resulted in significantly less depression than medication alone among 34 depressed elderly clients, with increased remission of depression at a 6-month follow-up. Other pilot studies of DBT for depressed elders have shown promising findings (for a review, see Lynch, Morse, & Vitt, 2002). Other studies are currently underway; for instance, Korman (L. Korman, personal communication, May 3, 2003) is conducting an outcome study of DBT for gamblers with anger management problems.

### *Multisystemic Therapy*

Multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Henggeler, Schoenwald, Rowland, & Cunningham, 2002) is an integrative treatment for youth with antisocial behaviors. Grounded in systems theory and social ecology, MST uses a wide range of interventions couched within a sensitivity to developmental level and a positive, present-oriented focus. Many interventions are CBT, structural, or family therapy. Systems theory is also key in developing interventions, in that interventions are designed to consider problems in their ecological context. Strengths in the client's systems are then used as levers for change. A hypothesis-testing approach is used to develop theories regarding the reasons for behavior maintenance in order to identify areas for change. Adherence is measured by following the principles, not specific methods, that are consistent in each case.

Numerous studies have found empirical support for MST. A randomized controlled study of 124 delinquent adolescents found that MST significantly improved family interaction when compared with an alternate treatment. Family interaction also improved more in the MST group than in a healthy control group that was not given any interventions, demonstrating the ability of MST to lead to greater-than-normal

change (Henggeler et al., 1986). A randomized controlled study that compared MST to usual services for 84 serious juvenile offenders found fewer arrests, fewer offenses, less peer aggression, and better family relations among participants in the MST group (Henggeler, Melton, & Smith, 1992). A follow-up study of participants over 2 years later found significantly lower rates of incarceration in the MST group (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993). A randomized controlled study comparing MST with individual therapy among 176 juvenile offenders found greater improvement in the MST group on measures of family adjustment (in areas that have been shown to be related to antisocial behavior in youth); a 4-year follow-up found significantly fewer arrests in the MST group, including violent offenses (Borduin et al., 1995).

When MST was compared with usual juvenile justice services among 155 randomly assigned youths and their families, the results showed decreased incarceration at follow-up in the MST group almost 2 years later; moreover, adherence to the MST manual was related to better outcome (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). A randomized controlled study comparing MST to treatment as usual among 118 substance-abusing juvenile offenders found that MST resulted in fewer dropouts from services (Henggeler, Pickrel, Brondino, & Crouch, 1996) and increased school attendance (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999) while being cost-effective (Schoenwald, Ward, Henggeler, Pickrel, & Patel, 1996).

MST has been applied to problems other than antisocial behavior. Henggeler et al. (1999) randomly assigned 113 youth with psychiatric problems to either MST or inpatient psychiatric hospitalization. The MST group showed significantly fewer externalizing symptoms, better family functioning, and more school attendance than the hospitalized group, but less self-esteem. A 4-month follow-up found that MST reduced the number of days hospitalized, as well as days in other out-of-home placements (Schoenwald, Ward, Henggeler, & Rowland, 2000). Another study compared MST to

parent training among 33 families with child abuse and neglect (Brunk, Henggeler, & Whelan, 1987). Although both treatment groups showed improvement in severity of identified problems, parental symptomatology, and stress, MST restructured parent-child relationships better but was less effective in reducing social problems (Brunk et al., 1987). The efficacy of MST with 16 adolescent sexual offenders found that, compared with individual therapy, there were fewer re-arrests for sexual crimes in the MST group at a 3-year follow-up (Borduin, Henggeler, Blaske, & Stein, 1990).

Two naturalistic studies have been conducted. One randomized controlled study comparing MST to treatment as usual among 118 juvenile offenders investigated whether MST could be implemented by therapists who were not supervised by MST's developers (Henggeler, Pickrel, & Brondino, 1999). The MST group showed significantly less alcohol/drug use and criminal activity, and fewer days in out-of-home placement, compared to treatment as usual. The decreases in criminal activity, however, were not as large as in studies in which the creators of MST intensively supervised the therapists. A second dissemination study with 55 rural families including adolescent offenders found that participants randomly assigned to MST showed less problem behavior, less maternal distress, and better family functioning than the treatment as usual group (Scherer, Brondino, Henggeler, Melton, & Hanley, 1994).

### *Cognitive Behavioral Analysis System of Psychotherapy*

The Cognitive Behavioral Analysis System of Psychotherapy (CBASP; McCullough, 2000, in press) was developed specifically to treat chronically depressed clients. It understands depression through a combination of developmental (Piagetian), cognitive, and interpersonal theories; interventions include a mix of cognitive, behavioral, and interpersonal techniques intended to comprehensively address the multiple targets identified by the theory.

A randomized controlled study comparing nefazadone and CBASP, alone and in combination, among 681 chronically depressed patients found greater response rates for the combined treatment than for either treatment alone (Keller et al., 2000). Combined therapy resulted in the most improvement in psychosocial functioning, and CBASP alone produced improvements independent of symptom change (Hirschfeld et al., 2002). When considering different symptoms, combined therapy resulted in the most reduction in anxiety (Ninan et al., 2002) and increased sexual function (Zajacka et al., 2002), whereas nefazodone, alone or in combination, was more effective in reducing insomnia than CBASP alone (Thase et al., 2002).

Another randomized study with 192 participants found that CBASP, alone or in combination with serzone, resulted in more planful problem-solving coping (Sokol-Opper, 2001). A variety of other studies of CBASP have been conducted with favorable results, including an experimental case study with a client with double depression (DiSalvo & McCullough, 2002), an ABAB single-case design with one man with depression (Jehle & McCullough, 2002), a naturalistic pilot study of 10 clients with dysthymia (McCullough, 1991), and a multiple case study design with four clients with dysthymic disorder (McCullough, 1984).

### *Integrative Psychotherapy for Personality Disorders*

The Instituto Chileno de Psicoterapia Integrativa (Chilean Institute for Psychotherapy Integration) has developed an integrative model of psychotherapy for cluster C personality disorders, which is based on an integrative understanding and assessment of the disorders (Calderón, 2001). This model was tested with 25 clients in an uncontrolled study. On average, all groups of clients (dependent, avoidant, and obsessive-compulsive) showed significant decreases in depression, with avoidant and dependent clients also improving on measures of marital satisfaction and needs satisfaction, as well as significantly decreasing alexithymia. Only dependent clients also showed significant

increases in self-esteem and self-image, accompanied by lowered anxiety.

### TECHNICAL ECLECTICISM

Technical eclecticism involves the use of methods drawn from different schools of therapy without an attempt to resolve theoretical disagreements among the schools (Lazarus, 2005). However, technical eclecticism is systematic in suggesting the choice of methods (Castonguay et al., 2003); for instance, Beutler (1983) uses a systematic review of research findings to select methods for intervention.

### Therapies Originally Designed for Multiple Disorders

#### *Systematic Treatment Selection and Prescriptive Psychotherapy*

Perhaps the hallmark of eclectic psychotherapy are the twin ideas that certain clients do better in certain types of treatment, and techniques can be used from different systems of therapy regardless of their theoretical origin. Several systems of client–treatment matching have been developed with the aim of improving therapy outcome. Beutler’s systematic treatment selection (STS) has the greatest empirical support of the systems of client–treatment matching (Beutler, 1983; Beutler & Clarkin, 1990; Beutler, Consoli, & Lane, 2005; Beutler & Harwood, 2000). It was originally based on a comprehensive review of the empirical literature and then subjected to several controlled studies.

Beutler and Clarkin (1990) reviewed the literature to find criteria for matching, which include diagnosis, client expectations, coping ability, personality, environmental stressors and resources, therapist–client compatibility, response to role induction, reactance level, readiness to change, and breadth of pathology. More recent research has shown that variables relevant to choosing therapeutic techniques can be grouped into four categories: client predisposing variables, treatment context, relationship qualities and interventions, and selection of the strategies and techniques that best fit the

client (Beutler & Harwood, 2000; Beutler & Martin, 2000). Beutler, Malik, Talebi, Fleming, and Moleiro (in press) discuss further areas for treatment matching: functional impairment, subjective distress, readiness for change, problem complexity, resistance potential, social support, coping style, and attachment.

Two variables for which the empirical research clearly shows treatment matching effects are the client's internalizing/externalizing coping styles and reactance level. Externalizing behavior consists of acting-out or blaming others, whereas internalizing behavior consists of a client blaming oneself and generating internal distress as a result. Several studies have found that clients who externalize do better in CBT than in insight-oriented or relationship-oriented therapies, and that clients who are obsessively constricted or who internalize do better in interpersonal therapy, insight-oriented, or relationship-oriented therapy (e.g., Barber & Muenz, 1996; Beutler, Engle, et al., 1991, Beutler & Mitchell, 1981; Beutler, Mohr, Grawe, Engle, & MacDonald, 1991; Calvert, Beutler, Crago, 1988; Longabaugh et al., 1994).

Reactance, alternatively known as resistance, is defined as a personality tendency to oppose following directives (Beutler, Moleiro, & Talebi, 2002). It has been hypothesized to affect the types of therapy that may be optimally helpful for a client, in that clients high in reactance respond more favorably to interventions low in directiveness (such as client-centered therapy), whereas clients low in reactance respond better to interventions high in directiveness (such as CBT). In a review of 20 studies that examined resistance by type of treatment, Beutler and colleagues (2002) found that 80% supported the resistance hypothesis. Of all the client X treatment interactions, this variable has the strongest support (Beutler et al., 2005).

Several outcome studies of therapy have been based on the STS model. For instance, Beutler et al. (1991) investigated the effects of two client variables, externalizing versus internalizing coping style and defensiveness (low vs. high resistance potential), on the outcome of treatment for depression. The study involved 63 clients and three treatments: group cogni-

tive therapy (CT); focused expressive psychotherapy (FEP), a form of experiential therapy; and supportive, self-directed therapy (S/SD), a set of suggested readings supplemented by telephone contact to reflect and clarify feelings. Results matched the predicted relationships to a great extent. The more externalizing clients improved more in CT, whereas the more internalizing individuals got greater benefit from S/SD. More resistant clients improved more in S/SD than in either of the two directive treatments, whereas less resistant clients benefited more from CT than from S/SD. These interactions between client variables and treatments were maintained, although to a lesser extent, at a 1-year follow-up (Beutler, Machado, Engle, & Mohr, 1993).

Beutler et al. (2003) compared standard Cognitive Therapy, Cognitive-Narrative Therapy, and Prescriptive Therapy for 40 clients with comorbid depression and chemical dependence in a randomized study. Prescriptive Therapy selectively applied interventions from the other two therapies according to the STS model, specifically using client functional impairment, coping style, resistance level, and subjective distress as variables for matching treatments. The effects of the Prescriptive Therapy were stronger than either of the two treatments. Karno, Beutler and Harwood (2002) compared treatment matching and mismatching according to four variables. Cognitive therapy or family systems therapy was given to 47 couples in which one partner was an alcoholic. Matching on theoretically predicted variables accounted for most of the abstinence outcome (76%), and mismatched treatment resulted in the worst outcomes. For a thorough review of the relationship of client-matching variables to outcome, see Beutler, Consoli, and Lane (2005), Beutler and Harwood (2000), and Beutler, Clarkin, and Bongar (2000).

### *Multimodal Therapy*

Lazarus's multimodal therapy (MMT; 1981, 2005) is probably one of the best-known systems of eclectic psychotherapy. Multimodal treatment is based on an assessment that identifies a client's problems and also predominant

modalities (aspects of functioning) from among the BASIC I.D.: Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships, and Drugs/biological functioning. Treatment is then tailored to the client's problem, needs, and characteristic modalities. Lazarus employs approximately four-dozen techniques, including medication, imagery and fantasy, client-centered reflection, and Gestalt empty-chair exercises, with an emphasis on cognitive and behavioral techniques (Lazarus, 1981).

Lazarus's approach is widely known and written about—a literature search on PsycINFO discovered a plenitude of articles and case studies written on the approach; however, little empirical research has evaluated its effectiveness. Many of the techniques are cognitive and behavioral, which are supported by other empirical studies, but this does not necessarily mean that they are effective when employed in the context of multimodal therapy. Lazarus has an extensive theory that hypothesizes that therapy addressing more modalities will be more effective and that it is important to track the client's modality firing order (e.g., affect leading to sensation, then cognition) when selecting the order of techniques. For instance, one study of 19 client–therapist pairs found support for the prediction from multimodal therapy that clients whose therapists had similar primary modalities to theirs would have better outcome (Herman, 1998). Most of the research on multimodal therapy, however, consists of unpublished doctoral dissertations on the reliability and validity of multimodal assessment devices.

Several uncontrolled group studies on the effectiveness of multimodal therapy have been conducted. For example, Kwee, Duivenvoorden, Trijsburg, and Thiel (1986) found that multimodal therapy with 84 adult neurotic inpatients helped 78% of obsessive-compulsives and 52% of phobics to improve by the time of discharge, with 64% and 55%, respectively, judged improved at a 9-month follow-up. Kwee and Kwee-Taams (1994) found similar results. An uncontrolled study examined MMT with 25 clients who had a variety of neuroses, character disorders, and psychosomatic complaints (Kertész, 1986). He found 75% improvement

in a number of multimodal symptoms on an average follow-up of 6 months, using a semi-structured questionnaire.

Some controlled studies of MMT have been undertaken in the area of school counseling. Gerler, Drew, and Mohr (1990), for instance, developed a 10-week multimodal counseling program for potential middle-school dropouts. They found that the attitudes of girls (but not boys) in the treatment group became significantly more positive, whereas the control group did not change. No significant change, however, was observed in the multimodal group on a teacher behavior-rating scale or on academic performance. In a controlled outcome study, Williams (1988) found clear support for multimodal assessment and therapy compared with other approaches for children with learning disabilities.

### *Outcome-Informed Therapy*

Duncan and Miller (2000; Miller, Duncan, & Hubble, 2005) propose a psychotherapy that is focused on tapping client resources, enhancing the therapeutic alliance, and adopting the client's worldview regarding his or her problems. Based on research that shows the importance of the therapeutic alliance (e.g., Horvath & Bedi, 2002), Miller, Duncan, & Hubble (2005) shift from a framework in which the therapist knows best to one in which the therapist asks the client for feedback regularly and incorporates the client's views about therapy into his or her approach. Any number of interventions are then used in service of meeting the client's needs, as perceived by the client.

Miller, Duncan, Brown, Sorrell, and Chalk (in press) studied the effect of using client feedback forms with a sample of 12,000 clients. Treatment dropouts and negative outcome were higher among clients of therapists who decided not to complete client feedback forms, whereas the average rate of client improvement significantly increased at an agency where therapists employed feedback forms. Although the results of this study and other studies by Lambert and colleagues (Lambert et al., 2001; Whipple et al., 2003) support the increased effectiveness of using systematic client

feedback, no controlled studies have been conducted to date on the specific system of psychotherapy.

### Therapies Originally Designed for a Specific Disorder

#### *Eye Movement Desensitization and Reprocessing*

Eye movement desensitization and reprocessing (EMDR) was developed by Francine Shapiro (Shapiro, 1995, 2002) to treat clients who have experienced trauma. It is an integrative psychotherapy that synthesizes key elements of major pure-form systems, including psychodynamic, behavioral, cognitive, and experiential components (Lyhus, Arnkoff, & Glass, 2003; Shapiro, 1995). Although Shapiro admits that she did not create the therapy based on theory or research, she now frames it within an information-processing model (Shapiro, 2002). However, some have argued that EMDR is largely exposure-based behavior therapy (Lohr, Tolin, & Lilienfeld, 1998).

EMDR has been placed on the empirically supported treatment list as a “probably efficacious treatment” for Posttraumatic Stress Disorder (PTSD) (Chambless & Ollendick, 2001). There are now more than a dozen controlled studies that lead to the conclusion that EMDR is more effective than no-treatment controls in treating PTSD-related symptoms, as well as a plethora of uncontrolled studies and case reports supporting its use. Because comprehensive reviews of this literature are available elsewhere (e.g., Maxfield & Hyer, 2002; Shapiro, 2002), these studies will not be thoroughly reviewed here. One meta-analysis conducted by Maxfield and Hyer (2002) is helpful in evaluating this wide literature. They compared controlled studies of EMDR to the Gold Standard Scale (adapted from Foa & Meadows, 1997) for outcome research and found that studies of EMDR conducted in a more scientifically rigorous way showed larger effect sizes for EMDR than studies conducted with less scientific rigor. This result provides support for EMDR as a method for dealing with PTSD.

#### *Brief Eclectic Psychotherapy for PTSD*

Gersons, Carlier, Lamberts, and van der Kolk (2000) adapted a treatment for PTSD (Gersons & Carlier, 1994) that uses cognitive-behavioral techniques (psychoeducation, imaginary guidance, homework tasks, and cognitive restructuring), focal psychodynamic work, and a farewell ritual. In a randomized controlled study of 42 police officers with PTSD, those receiving Brief Eclectic Psychotherapy showed significant improvements in PTSD and returning to work at termination and 3-month follow-up when compared to the wait-list control (Gersons et al., 2000).

### INTEGRATIVE FAMILY, COUPLES, AND GROUP PSYCHOTHERAPY

Overall, fewer attempts have been made to empirically study the outcomes of psychotherapy integration in family, couple, and group formats than in individual therapy. This literature consists of two well-studied therapies, emotionally focused couples therapy (Greenberg & Johnson, 1988) and Multisystemic Therapy (Henggeler et al., 1998), as well as a number of therapies with only one or two empirical studies.

#### *Integrative Family Therapies*

A variety of integrative therapies have been developed for families, including Multisystemic Therapy (Henggeler et al., 1998), a combination of individual and family therapies that was covered earlier in this chapter. A review of family therapy research, including literature on integrative family therapy, can be found in Sexton, Alexander, and Mease (2004).

One integrative family therapy that has been tested in two empirical studies with random assignment is Systemic Behavioral Family Therapy (SBFT; Alexander & Parsons, 1982). This approach uses techniques from Functional Family Therapy (FFT; Alexander & Parsons, 1982) and problem solving (Robin & Foster, 1989). Brent and colleagues (1997) compared SBFT



to cognitive behavior therapy (CBT) and non-directive supportive therapy for adolescents with major depressive disorder. All groups significantly improved functioning and decreased suicidality, but clients in CBT did better on remission of depression. Birmaher et al. (2000) compared the same treatments for adolescent clients with major depressive disorder and found significant improvement in all groups, with no long-term differences between groups.

Behavioral Family Systems Therapy (BFST) has also been studied in two randomized controlled trials with anorexia nervosa. In BFST, parents are first taught to control the client's eating; this is followed by cognitive restructuring and a focus on family functioning, after which eating control is returned to the client. Compared with ego-oriented individual therapy, in both studies participants in BFST improved more on measures of weight gain (Robin, Siegel, Koepke, Moye, & Tice, 1994; Robin et al., 1999).

### Integrative Couples Therapy

Emotionally Focused Couples Therapy (EFCT; Greenberg & Johnson, 1988; Johnson et al., 1999) is on the empirically supported treatments list as a "probably efficacious treatment" (Chambless & Ollendick, 2001). This approach includes an integration of the experiential tradition, emphasizing the role of affect through the use of client-centered and Gestalt methods, and the systemic tradition, focusing on communication and interaction patterns, within the context of attachment theory. A meta-analysis of studies of EFCT found a weighted mean effect size of 1.3 (Johnson et al., 1999). Overall, a number of studies of EFCT both with and without control groups have been conducted. Those with control groups are discussed here.

Johnson and Greenberg (1985a) compared an eight-session EFCT to both a behavioral problem-solving intervention and a waiting-list control group; there were a total of 45 couples who were randomly assigned to one of these three groups. At the end of treatment and at an 8-week follow-up, both treatments were shown to be more effective than the control group,

and clients in the emotionally focused treatment had higher scores on measures of marital adjustment, relationship intimacy, and reported change in the presenting problems than did those in the behavioral marital intervention. James (1991) randomly assigned 42 couples to either 12 sessions of EFCT, 8 sessions of EFCT with 4 sessions of communication training module, or to a waiting-list control. Both treatment groups improved at completion and follow-up, with the EFCT group having more improvement on target complaints at follow-up and the combined treatment group having better communication at completion. Dandeneau and Johnson (1994) compared six sessions of EFCT, cognitive marital therapy, and a waiting-list control group for 36 randomly assigned couples. At a 10-week follow-up, the EFCT group showed significantly higher intimacy and adjustment than the CBT group. MacPhee, Johnson, and van der Veer (1995) compared 10 sessions of EFCT to two control groups, using a sample of 49 couples. More women in the treatment group recovered or improved, with significant increases in sexual desire and less depression.

One study found that (EFCT) was not better than an alternative treatment. Goldman and Greenberg (1992) randomly assigned 28 couples to the emotionally focused approach, a waiting-list control group, or to an integrated systemic marital therapy, which focused on changing current interactions, prescribing symptoms, and reframing behavioral patterns. Both treatment groups were again significantly superior to the control condition, but the emotionally focused and integrated systemic therapies were not significantly different on many measures. Also, the emotionally focused therapy group did not maintain improvement on many measures at a 4-month follow-up, whereas the integrated systemic therapy did.

Two studies of EFCT used only wait-list control or a within-subjects design. Walker, Johnson, Manion, and Coutier (1996) randomly assigned 32 couples to either EFCT or to a waiting-list control group. They found that couples who received treatment had more adjustment and intimacy at completion and at 5-month follow-up; they also had significantly

less negative communication at completion. Johnson and Greenberg (1985b) examined the effectiveness of EFCT with 14 couples, using a within-subjects design, and found significant improvement after the intervention.

Finally, Integrative Behavioral Couple Therapy (IBCT; Jacobson & Christensen, 1996) is based on acceptance theory as well as behavior therapy. Jacobson, Christensen, Prince, Cordova, and Elderidge (2000) compared IBCT to traditional behavioral couple therapy. More couples in the integrative treatment improved, with significantly more marital satisfaction than the controls.

### Integrative Group Therapies

A group, couples, and family therapy intervention for agoraphobia developed by Chambless, Goldstein, Gallagher, and Bright (1986) was based on a broad conceptualization of the disorder. This therapy considered susceptibility to panic attacks, sensitivity to separation stemming from childhood experiences, current stress or conflict, catastrophizing over the consequences of anxiety, and avoidant behavior patterns as aspects of agoraphobic disorders. The group therapy developed by Chambless et al. (1986) includes cognitive-behavioral interventions such as in vivo exposure, paradoxical strategies, thought stopping, cognitive restructuring, breathing retraining, and self-reinforcement. This is supplemented by Gestalt techniques to intensify and express feelings, and an exploration of psychodynamic factors contributing to anxiety (such as suppressed conflicts and unresolved issues such as grief, childhood trauma, and present interpersonal problems). Couple and family therapy sessions were added to include clients' significant others in treatment.

The treatment developed by Chambless et al. (1986) was found to significantly lower avoidance and self-reports of social phobia, depression, assertiveness, and agoraphobic symptoms in a study with 35 clients randomly assigned either to treatment or a waiting-list control. A very low dropout rate was found compared to previous exposure or drug treatments, and more than half of the clients were

considered to be markedly or greatly improved. Though the treatment showed great promise, further studies have not been conducted.

A number of other integrative group therapies have been empirically tested. Two included a combination of CBT and group process techniques. Daniels (1998) found that such an approach (Interactive-Behavioral Training), when compared with waiting list among a sample of 40 randomly assigned clients, significantly increased social competence and reduced negative symptoms of people with chronic schizophrenia and schizoaffective disorders (also see Daniels & Roll, 1998). In a nonrandomized group study, Morgan, Winterowd, and Fuqua (1999) found that an integrative group treatment for 36 male inmates that also combined CBT and group process techniques did not show significant improvement compared to a no-treatment control group, but that participants and therapists viewed the intervention favorably.

Three types of integrative group psychotherapy have been subjected to uncontrolled pilot studies. These were an integrative time-limited group therapy for bulimia nervosa, consisting of a combination of CBT, psychoeducation, interpersonal therapy, and relational therapy (Riess, 2002), an integrated, multimodal, and psychodynamic group therapy for sex offenders (Lothstein, 2001), and an integrative feminist/cognitive-behavioral and psychodynamic group treatment for men who abuse their partners (Lawson et al., 2001). One promising group therapy is an adaptation of Cognitive Analytic Therapy (CAT) to a time-limited group format. A pilot study with seven group members indicated that outcome was of a similar magnitude to individual CAT (Duignan & Mitzman, 1994).

### PROMISING THERAPIES FOR FURTHER EXPLORATION

Quite a number of other promising integrative therapies have been developed. Although most of these types of therapy have one or more published successful case studies, they have not yet been tested empirically in group outcome stud-

ies. These integrative therapies include Benjamin's (2003) Interpersonal Reconstructive Therapy (previously named brief SASB-directed reconstructive learning therapy); Caspar and Grawe's (1989) heuristic model of therapy that combines cognitive, constructivist cognitive, and developmental psychology; Cummings' brief pragmatic psychotherapy (Cummings & Sayama, 1995); Fosha's (2000) Accelerated Experiential-Dynamic Psychotherapy; Fernández-Alvarez, Fernández, and Coppo's (2003) model that integrates psychodynamic, behavioral, humanistic existential, and systems theory within the framework of cognitive psychology; Feixas's (1990) integration based on constructivism, personal construct theory, individual, and family-systems therapy; Howard, Nance, and Myers' (1987) Adaptive Counseling and Therapy; Knobloch's (1996) integrated psychotherapy in a community milieu; Mahoney's (1991) developmental psychotherapy; Pincus's (1995, 2005) Integrative Problem-Centered Therapy; Roemer and Orsillo's (2002) integration of mindfulness/acceptance based approaches with existing cognitive-behavioral models; Safran and Segal's work on interpersonal processes in cognitive therapy (Safran, 1998; Safran & Segal, 1990); Stricker and Gold's (2005) psychodynamic assimilative integration; and Wachtel's (1997, 2005) cyclical psychodynamics. Though Stiles and colleagues' assimilation model (Stiles, Shankland, Wright, & Field, 1997) has much process research that substantiates the model, to date there is no controlled outcome research.

In reviewing the literature, we also encountered a number of integrative therapies for specific disorders. These include Allen's (2003) Unified Therapy for BPD; Johnson and Taylor's (1996) integrative treatment for eating disorders; McCullough and Andrews's (2001) short-term anxiety-regulating therapy; Mennin's Emotion Regulation Therapy for GAD (Mennin, 2004); Scaturro's (1994) integrative program for agoraphobia; and Wolfe's (2005) integrative therapy for anxiety disorders.

Finally, a number of common-factors approaches have been articulated, but none have been tested in group outcome studies. These include: Lampopoulos's (2000) prescriptive

common-factors approach; Arkowitz's (1992) common-factors therapy for depression; Orlinsky and Howard's (1987) generic model, and the common-factor approaches of Castonguay (1987).

## CONCLUSIONS AND FUTURE DIRECTIONS

Outcome research on psychotherapy integration has progressed dramatically since we reviewed this literature a dozen years ago (Glass et al., 1993), but much work is left to be done. Some of the most influential types of eclectic/integrative psychotherapy, such as Lazarus' Multimodal Therapy, still have little empirical support. Although Beutler and colleagues' (Beutler et al., 2005) systematic treatment selection (STS) is based entirely on empirical work, the number of variables on which sound empirical evidence exists is quite small compared to the possible number of treatment matching variables. There have also been a number of approaches that have been proposed for quite some time, such as Wachtel's (1997) cyclical psychodynamics, that have not yet been rigorously evaluated. Finally, it is important to note that whereas outcome research on psychotherapy integration is growing, the number of approaches that have been studied remains far less than the profusion of integrative approaches that have been presented in the theoretical and clinical literature.

There are several recurrent themes in the integrative or eclectic therapies that have been studied thus far. First, some of them, such as Dialectical Behavior Therapy (Linehan, 1993) and Multisystemic Therapy (Henggeler et al., 1998), were developed for disorders that are thought to be difficult to treat. Others, such as Cognitive-Behavioral Therapy with Interpersonal/Emotional Processing Therapy for generalized anxiety disorder (Newman et al., in press), have been developed for clients who do not benefit from the standard treatment. These appear to be particularly fruitful avenues for integrative treatments to make a contribution above and beyond pure-form therapies.

Second, it has been thought that it is particularly difficult to study the outcome of psychotherapy integration empirically if not all clients receive the same treatment (e.g., Lazarus's multimodal therapy, 1981). However, the extensive research on Multisystemic Therapy, Acceptance and Commitment Therapy, and STS have shown that it is possible, as long as there is a systematic model for choosing the interventions. In these cases, adherence to the model is measured, rather than the implementation of standard interventions.

The last time we reviewed the psychotherapy integration literature (Glass et al., 1998), we commented on what was then a relatively new movement for "empirically supported" or "evidence-based" treatments—manualized treatments for specific disorders that had been shown to be effective in well-designed and controlled outcome studies (Chambless & Ollendick, 2001). This movement has grown, now reflected by publications not only emanating from the work of Division 12 of the American Psychological Association (e.g., Nathan & Gorman, 2002), but also the APA Division of Counseling Psychology (Wampold, Lichtenberg, & Waehler, 2002), The British Psychological Society (Department of Health, 2001), and more than 12 practice guidelines from the American Psychiatric Association (2000).

The empirically supported treatment (EST) movement has been the center of much debate among psychotherapy researchers (e.g., Elliott, 1998; Persons & Silberschatz, 1998). Although some believe it is a necessary and important advancement for both the field and for graduate training (e.g., Beutler, 1998; Calhoun, Moras, Pilkonis, & Rehm, 1998; Chambless & Hollon, 1998; Davison, 1998), others criticize it as a politically motivated and/or premature misstep that could have profoundly negative repercussions (e.g., Bohart, O'Hara, & Leitner, 1998; Fensterheim & Raw, 1996; Henry, 1998). A concern has arisen that the movement toward manualized treatments for specific disorders could obstruct the progress of psychotherapy integration and could hinder therapist innovation in the matching of treatment to client problems (e.g., Fensterheim & Raw, 1996; Stricker, 1996). Some believe that an emphasis

on ESTs may lead us to overlook or de-emphasize research in such important areas as the therapy relationship, common factors, prescriptive matching, and the development of new integrative therapies (e.g., Garfield, 1998; Glass & Arnkoff, 1996). Others argue that the EST movement will have the opposite effect and may ultimately prove beneficial to the psychotherapy integration movement by encouraging empirical research on psychotherapy integration (Goldfried & Wolfe, 1998; Shoham & Rohrbaugh, 1996).

One factor that is hopeful for the future of psychotherapy integration is a growing interest in investigating empirically supported aspects of psychotherapy relationships, as evidenced by the recent book *Psychotherapy Relationships That Work* (Norcross, 2002). In addition to examining the effects of whole therapies, it is valuable to test components of therapies empirically, such as the therapeutic alliance, empathy, congruence, and a number of other factors. Because many forms of psychotherapy integration focus on integrating specific techniques or components, this focus of research may have great rewards for the psychotherapy integration field. Further, the book presents the available research on matching treatments to specific client characteristics beyond diagnosis. Because many forms of psychotherapy integration profess to match treatments to clients, this aptitude  $\times$  treatment interaction (ATI) research also holds great promise.

Finally, an area that needs further exploration is the effectiveness of psychotherapy integration as it is carried out by clinicians in private practice. This is a difficult task to accomplish, however. On one hand, outcome research on psychotherapy integration has focused on specific types of manualized integrative psychotherapies. Because it is well-known that most practicing psychotherapists do not follow manuals (Goldfried & Wolfe, 1998), the promising results of existing studies of psychotherapy integration may not apply to therapy as rendered in real life. On the other hand, studies examining the improvement of clients receiving eclectic psychotherapy in private practice (e.g., Koss et al., 1983; Tschuschke & Anben, 2000) yield minimal conclusions because they

have not clearly defined what the therapists did during treatment, and therefore the findings cannot be replicated.

This problem is central to studying psychotherapy integration as practiced. Although most “eclectic” or “integrative” therapists state that they tend to use whatever works best for the client, they use different combinations of theories and techniques, as well as different decisional processes to determine which theories and techniques to use (Garfield, 1994). For instance, when a number of integrative clinicians were asked to provide case formulations and treatment recommendations for the same client, there was little agreement among them (Giunta, Saltzman, & Norcross, 1991). This leaves a virtually infinite number of types of integration that would need to be studied. The solution is not to study each therapist separately, but to glean the principles of decision-making that substantial numbers follow.

The need for research on how psychotherapy is conducted by practicing clinicians was recently recognized in a National Institute of Mental Health (NIMH) workshop (Street, Niederhe, & Lebowitz, 2000); likewise, a report by the National Advisory Mental Health Council’s Clinical Treatment and Services Research Workgroup highlighted the importance of studying clinician decision-making (NIMH, 1999). Therapists in the trenches are constantly making decisions to integrate therapies in an effort to improve service to their clients. Although it is a challenge to study their decision-making and link it to outcome, the field can benefit from the wisdom of those who spend the majority of their time providing services. Such “bottom-up” research strategies can complement and ultimately inform the more standard “top-down” strategy of creating and studying manualized treatments.

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## A Critical Dialogue on Psychotherapy Integration

PAUL L. WACHTEL AND MARVIN R. GOLDFRIED

The Society for the Exploration of Psychotherapy Integration (SEPI) is an interdisciplinary organization of professionals interested in integrative and eclectic approaches to psychotherapy. Founded in 1983, SEPI was designed to encourage communication and to serve as a reference group for psychotherapists interested in transcending the limitations of a single theoretical orientation. SEPI also serves an educational function by publishing a journal, by holding an annual conference, publishing a membership directory, and maintaining a Web site.

The following dialogue, presented as the closing plenary session of the 19th annual meeting of SEPI in New York City, features SEPI's cofounders in a candid conversation about the purposes, status, and future of psychotherapy integration. The comments of Dr. Marvin Goldfried and Dr. Paul Wachtel are reproduced faithfully from an audio recording of the plenary session, moderated by Dr. Jeremy Safran.

SAFRAN: One of the things I remember about the first SEPI conference in 1985 was the dialogue in which Clara Hill interviewed Paul Wachtel and Marv Goldfried about their thinking regarding SEPI and psychotherapy integration [Goldfried & Wachtel, 1987]. As it is nearly two decades since then, I thought it would be meaningful to replicate that kind of interview, and see the extent to which their thinking has changed over the years—especially their thoughts and reflections about where SEPI started from and where it's heading.

As I was thinking about this dialogue, I remembered back to my first experiences with SEPI in 1985. Then, I was a young whipper-snapper and I remember Paul and Marv as being “old men.” In fact, they were considerably younger than I am right now! There are a few memories that stand out about that. One of them was that we were in Annapolis, Maryland, and it was the first time I had tasted soft-shell crab, and it was delicious.

So that was one of my most important memories of SEPI!

WACHTEL: Jeremy has been in psychoanalytic training, and begins with the oral stage.

SAFRAN: I also remember meeting Paul for the first time. I knew Marv, but Paul and I had never met before. I traveled down with Les Greenberg, and we had dinner with Paul, Marv, and others. We were staying at a very nice hotel and sharing a room, and I was struck by the fact that they put these chocolates on the pillows.

GOLDFRIED: Still at the oral stage.

SAFRAN: I'll work my way up. And the maid said to me: "Sir, would you like a turn down?" And we were speculating what she meant by that.

WACHTEL: We just jumped two stages.

SAFRAN: My other memory—and we'll see how you interpret this one as the analyst of the team—is that Les [Greenberg] and I were giving a panel on emotion and were involved in a very intense discussion over lunch with Irene Elkin. As a result, we were 10 minutes late for our panel. We walked in and apologized for being late, and the people said: "We're just glad you made it." Now, how do you interpret that one?

WACHTEL: I'll leave that one to Marv; it's about a behavior.

SAFRAN: Anyway, the first question I have for the two of you is what memories stand out for you about that first conference?

GOLDFRIED: Why don't you start, as you're much more adept at early memories than I am.

WACHTEL: Well, my first thought, especially given the way Jeremy has reevoked the experience, is to think of the Bob Dylan song "I Was So Much Older Then, I'm Younger Than That Now." But I think what I remember most of all is the incredible sense of excitement that virtually everybody at the conference felt. And I remember one thing procedurally that we did. It was partly because it was a smaller group—part of the paradox of success is as it gets bigger, it's harder to manage, but this was

a rather small group, so there weren't that many presentations, and there was a lot of time in-between sessions. And the hallways were just abuzz; I have the feeling that they are still vibrating. There was just a sense of intense stimulation and possibility. And then we were up all night in different people's rooms talking. It was just the most exciting conference I have ever been at. So I think that's the single primary memory that I have.

GOLDFRIED: I remember very much the same thing. When people come to a SEPI conference for the first time, they may experience the same kind of thing—seeing the people that you've read about. Not only seeing them, but also having a chance to talk to them, and sometimes even touch them—so there's a reality to them. And since it was the first SEPI conference, there was the reality of a beginning. I remember a couple of years earlier when the SEPI Organizing Committee—which later became the Steering Committee—came to my apartment to talk about what we should do. I recall how nervous I was, preparing coffee and different kinds of teas; I felt everything had to be just right, as I had this sense that something important may be happening.

WACHTEL: I think the other thing that strikes me, sparked by what Marv is saying, is everyone meeting the people whose work we had each been reading, and a sense of all of us starting out on the same ground, just sharing ideas and being truly interested in each other's ideas. It felt like we got off the right way right from the beginning by making this an organization that was not a hierarchical organization. I've been to conferences where people wear ribbons that indicate how many presentations they are making or what committees they are on or offices they hold, and for some "big shots" it looks as if the ribbons will end up sweeping the floor there are so many. SEPI has no ribbons. And it's not because our dues are low and we can't afford the ribbons. Ribbons aren't expensive. But hierarchy *is* costly.

Marv and I just came from a really exciting session that centered on presentations by some of our students who met together at last year's SEPI meeting in San Francisco and had fol-

lowed up on the dialogue between them that started there. The fact that the students could do this, and do it on their own initiative, feels to me so much the essence of SEPI. SEPI is the only organization I belong to that doesn't have a president. That's again part of the aim of fostering real dialogue. And I think that what probably everybody here has found is that you can be somebody who's coming to the first meeting, someone who has not published anything, someone who isn't known yet, and people have time for you. It's not the kind of organization where there are the important people and everybody else. I think that started at the very first meeting.

However successful we may have been in different respects, we were all also, in a certain sense, professional misfits; we were people who didn't fit easily within the usual boundaries and categories. We were coming together as fellow misfits, in some way, and I think that set a tone that I hope has continued (obviously those of you that are sitting in the audience are the best judges of that).

GOLDFRIED: And you recall that one of the debates we had in the Organizing Committee was whether to have different types of members—members and fellows. The fellows being the super-misfits. You'd be a fellow if you wrote X number of different things or gave so many different presentations. We decided flatly against that. So many of the debates across theoretical orientations had been hierarchical in the past, and the notion was: "We are going to have a debate, and the goal of my interaction with someone from another orientation is to prove how he or she is wrong." When each person adopts that same attitude, nobody changes and nobody learns. We therefore wanted to create a structure that would be very different, so we didn't have a hierarchy of memberships.

One of the unique aspects of SEPI meetings is that we allow time for audience participation. Some of the best meetings I've attended are when I've learned just as much or more from the audience as I did from those presenting. And in those instances where you're presenting and where you come out knowing more than when you went in because of what

you learned from the audience discussion, you know that one of the goals of SEPI has been achieved.

SAFRAN: Thinking back to the early days, to what extent do you think the two of you had a shared vision of what both SEPI and psychotherapy integration should be, and to what extent do you think there were divergences?

GOLDFRIED: It depends on how far back we go. Are you talking about our lunch meetings or our dinner meetings? During our lunch meetings, we were very much in accord. We felt we had to break out of our boxes. This was in the aftermath of an APA symposium proposal that was rejected. Was it the 1960s?

WACHTEL: Early 1970s.

GOLDFRIED: We were frustrated about that, and we thought that if they're not going to allow us to talk in front of a group, then at least we can talk with each other. At the 1986 NIMH workshop, where a group of us met for 2 days to discuss future directions in psychotherapy integration research, I recall telling the group what I would really like to see happen. And that was that the field would reach the point where we no longer functioned according to theoretical orientations, but where we had some kind of consensus. I had thought that everyone would think that this was a great idea, but recall your saying that you didn't think that was such a good idea. I think this may be a point of distinction between us that would be good to talk about: Your exploration versus my intervention; your insight versus my action.

WACHTEL: It really is interesting to go through this process because I was actually thinking almost exactly the opposite. My recollection is that when we had different views of the way our fledgling network might go that I was the one more eager to take the next step of starting an actual organization. I remember when we first had a "virtual SEPI"—it was before the days of the computer, so it was through the post office—but there was a list of about 100 people and we would contact them. The question was "Should we actually develop an organization?" I think I was a little more eager to than Marv was, as I recall.

As we moved ahead, one of the dialectical pulls for SEPI has been on the one hand, emphasizing what we're all committed to: keeping the sense of openness, not developing some new orthodoxy, even if it's an "integrative" orthodoxy. On the other hand, there's been an increasing interest for many members in moving forward to develop guidelines for integrative practice and in describing what *practicing* integratively is like and not just what the *process of integrating* entails. I think particularly as SEPI has become more and more international, people in different countries have at times had different goals from the members in North America. There is more and more interest among members in other parts of the world especially in developing a coherent integrative approach to psychotherapy, in moving from the exploration of psychotherapy integration to integrative psychotherapies. My sense has been that most of us have been interested in the dialectic between these two visions see the value in both, but that we've differed in where we place the emphasis. It's been my sense that I've been somewhat more eager to move it to developing integrative psychotherapies and that you represented more the . . .

GOLDFRIED: We may end up learning something from each other. One of the reservations that I had was that there would be a proliferation of *even more* therapies than already existed to confuse the field, as there now would also be different kinds of integrative therapies. I think that has happened. That was always a fear of mine. In my pre-SEPI publication on psychotherapy rapprochement [Goldfried, 1980], I ended the paper by saying that I would like to envision—more of a hope than a prediction—the textbook of the future that would be different from textbooks of the present. Current books have theory A, B, C, D and so forth, with the final chapter perhaps being an integration of all of these. I would rather see the textbooks of the future that describe various kinds of clinical problems and issues, together with ways in which one may intervene. More like a *Merck Manual*, reflecting a consensus in the field. That was something that I hoped SEPI would

achieve, but I now believe that it will never achieve that—at least on its own.

WACHTEL: I don't know whether it will achieve that. I think we share the need to go beyond theories A, B, C, D, and E and then integrate. We need to develop, elaborate, explore, and investigate really integrative ways of thinking from the beginning. I think that, rather than thinking of it as a manual oriented toward specific disorders, for me it would be the development of both an integrative theory and a related integrative set of principles that will be applied differently with different patients. The skeleton wouldn't be so much *The Merck Manual* as the conceptual framework

GOLDFRIED: I would certainly be delighted to see that. I don't ascribe to using the DSM model for treatment, namely if it's panic it must be this book on the shelf and if it's depression it's this other book. However, I think we need to have some structure, but not structure that is based on theory. There are too many political, economic, and social factors that cause us to maintain our theories and our institutes. I know there are people in the audience that have institutes, and realize I am saying something that is not politically correct. However, this is not going to happen very fast, but sometime in the future it would really be nice if we achieved some consensus. I don't like the way [American Psychological Association] Division 12 has gone about trying to get a consensus by coming up with a list of empirically supported therapies. Still, consensus is in the wind. Jeremy, are we dealing with your questions?

SAFRAN: That's okay. Don't worry about me. I'll just sit here in the dark.

GOLDFRIED: I think where SEPI has been incredibly successful is in changing the *zeitgeist*. There's no question whatsoever about that. If SEPI were to get royalties from book publishers every time the term *integration* was used in the title, we'd be a very wealthy organization. Integration is no longer something that one can only talk about late at night after a conference.

I think another part of the *zeitgeist* that is starting to happen is the notion of empirically

supported or evidence-based treatments. That has occurred parallel to psychotherapy integration, and it would be nice to integrate these two themes, especially since most of the work that has been done on evidenced-based therapy has involved theoretically pure interventions—cognitive-behavioral or otherwise. As a result, I believe that the starting points for the evidence-based trials have been flawed to begin with. It would be nice if SEPI could somehow influence that, but we are avowedly apolitical in our mission. Individual members of SEPI can be political, but it's not clear that SEPI will serve in that role. Still, I'm in favor of changing the name of our organization to the Society for the Evolution of Psychotherapy Integration, which would involve more than just exploring.

SAFRAN: Think back to the inception of SEPI and try to remember your fantasies, hopes and expectations of where it would be 20 years into the future.

WACHTEL: Well, it certainly didn't include me sitting in front of a bunch of people sharing my fantasies. One of the places where my fantasies have centered, and have been partly realized and partly not, was that SEPI would be a home for people who think integratively and that the identity as an integrative therapist or an integrative thinker about therapy would be as compelling and real and "filling one up" as the identity of psychoanalyst, cognitive behavior therapist, family therapist, and so on. It seems to me that those [single-theory] identities still are stronger in many ways even among most of us at SEPI. Partly because it's my child, I would say that SEPI is the single most important organization for me personally. In terms of people identifying me or in terms of living my professional life, there are other more psychoanalytic organizations that play a very powerful role too. I know that kind of dual identity is true for almost all of us here. But SEPI still has been and is a place where I can feel especially intensely like I'm among my brethren, so to speak.

The other thing that has been wonderful and unanticipated was the degree to which SEPI has been a means for developing really

close relationships and friendships all around the world, with people from other countries, who have become very important in my own life. That has been a bonus that I didn't anticipate but now, in retrospect, seems absolutely essential.

GOLDFRIED: Without using the fantasy concept—I think of it more as belief systems I had early on, some of which were realistic and others unrealistic—I similarly did not anticipate that SEPI would provide me with a good home base. I think I missed only one SEPI meeting over the years and have always looked forward to the meetings and seeing the people involved. So, from a personal point of view, it has been very gratifying, even though that was not one of my original motives. Rather, I was looking at what was going on in the field and being very frustrated in seeing all the work, time, and energy that was being put in by cognitive-behavior therapists who were being totally ignored by psychodynamic and experiential therapists. Indeed, everyone was being ignored by everyone else, but everyone was presumably putting in all their time and energy toward the goal of improving how we work with patients. I saw this lack of communication as a folly, and that something needed to be done to address this folly. Although I didn't think I'd get the personal benefit, I'm very gratified that I have.

The unrealistic belief I had was that we could achieve a consensus. Maybe it still can happen, but I have not yet seen it happen. I'm not referring to a consensus on a grand theory—I don't think that is possible—but rather on some things more specific. For example, finding agreement on a given case. We've gone through such an exercise several times. I was recently listening to the tapes of the weekend workshop we had in San Francisco in 1982, where several of us—Sol Garfield, Mardi Horowitz, Stan Imber, Phil Kendall, Hans Strupp, Paul Wachtel, Barry Wolfe, and me—tried to determine if we could agree on anything. Talk about obsessiveness! We spent 2 hours trying to agree on the goals of a particular case, and were unable to do so. I think we could get a little bit further some 20 years later, but I don't think we are where I would hope we'd be.

SAFRAN: Just to make sure that I understand, it sounds like both of you had the fantasy, belief system, or expectation that SEPI would move toward some kind of consensus, although you might have had somewhat different ideas as to what the nature of that consensus would be. Paul, your idea was that it would involve more of a theoretical consensus, whereas your thinking Marv was that the consensus would be more about practice and some principles of change.

GOLDFRIED: Jeremy, your Rogerian training has held up.

WACHTEL: I think that it's true that a good part of my interest was in a theoretical direction, but it was not necessarily seeking a consensus on a theory. Consensus would not be the word that would primarily characterize my hope. It was really more about figure/ground differences; I don't think I'd be saying anything Marv would disagree with but there would be figure/ground differences in emphasis.

GOLDFRIED: Is that a challenge?

WACHTEL: We'll see. I was trying to make it impossible for Marv to disagree.

GOLDFRIED: I recognized that, which is why I made that comment!

WACHTEL: When you have two clinicians up here and they're savvy toward each other, it's a bit rough. What I am hoping for and still am is, first of all, dialogue. I think one of the things that struck me was that there was very little dialogue among theoretical orientations. I think SEPI has been very successful, but there's still a lot of separate worlds that don't hear each other, that don't know about each other, that don't take each other seriously, and most of all don't learn from each other. So most of all I saw SEPI as a venue for that.

But I also saw it as a force for changing each of the separate schools of psychotherapy. Changing them in the sense that part of what was wrong with psychoanalysis, part of what was wrong with cognitive-behavior therapy, part of what was wrong with family systems therapy, was that they were so exclusive and so unable to see that there were important things in the other realm. My hope was that, by paying at-

tention to what has been overlooked, new integrative ways of thinking would emerge. I use the word *ways* plural intentionally. I don't know that we can ever achieve a single theory, but I do think we want to move more and more in that direction so long as the theorizing is rooted in observations rather than just ideological. I should let Marv respond to it but then I want to come back to why I used the word *observations*, because there are issues for me with words like *evidence-based* and *empirical*.

SAFRAN: Before Marv responds, I'd like to heighten things a little bit. My view of your ultimate goal is somewhat more pluralistic than Marv's. Is that right?

WACHTEL: I don't think I would say that. I wouldn't even say it is in opposition to Marv's. The way I would articulate my own view, I don't think I'd use the word *pluralistic*, because pluralism for me entails separation. I want something that's more interactive. I want a constant evolution. That's why the word *evolution* would be a very congenial one. An evolution that continues to move toward synthesis and then discovering what's been left out and trying to work it in. There will probably be more than one way to work it in, but it's not pluralism. It's not "live and let live." It's "let's live *together*, and let's *change each other*."

GOLDFRIED: Let's see if we can operationalize this. Part of my role is to make things concrete. What would the table of contents of your fantasized textbook be in 100 years from now?

WACHTEL: It would probably be written in Chinese. More readers.

GOLDFRIED: Let's assume we could have it translated into English.

WACHTEL: I don't know what it would be like 100 years from now. I can say a little bit about what it would be like today.

GOLDFRIED: I know that!

WACHTEL: I don't know. What I would hope is that the result of 100 years of SEPI would be that it would produce the table of contents *that we can't imagine right now*. What would emerge would be *new* concepts and new ways of organizing and coordinating the observations, and it would generate new observations as a result,



leading to concepts that really would be different. For example, one of my objections to the *DSM* is that it feels to me like debating whether this patient is earth, air, fire, or water. It seems to me no matter how well you refine that, it's not a set of concepts that will last.

GOLDFRIED: We don't disagree on that.

WACHTEL: I think it's true probably of all the concepts we're working with, that the spirit of what we're up to is that they will lead, hopefully, to our learning new concepts.

GOLDFRIED: I agree. Let me refine the question a bit, because I agree that the concepts will hopefully grow out of some kind of consensus that would emerge if this [integration] movement becomes successful some time in the future. What would the organization of the chapters be like? Would they talk about principles of change? Would they talk about clinical issues? Would it talk about disorders? As I see myself as immortal, I'm preparing my syllabus for my intervention class at Stony Brook 100 years from now, and I want to know what textbook to use for beginning students.

SAFRAN: What about you, Marv? Do you have any idea about what the table of contents might look like?

GOLDFRIED: Well, I kind of hinted at it before. I would hope there would be some overarching principles of change, and that these principles would be spelled out in the context of different kinds of clinical problems—how these principles get implemented clinically. In addition, it would include the evidence.

Evidence-based therapy means not only how well an intervention has fared in a clinical trial. I think the findings of clinical trials are of interest, but I don't think they have informed us as much as other kinds of research might inform us. Evidence-based also means that we know something about different kinds of clinical problems. For example, we know that if a person has had a series of losses and is experiencing various kinds of emotions, thoughts and behaviors, then they probably are having some difficulty in overcoming these losses. There would then be certain general principles of change that would be modified so as to be ap-

plied to this type of problem. The intervention would be implemented in various ways, depending on the nature of the client. There would be leeway for clinical judgment within that, but there would be guidelines that somehow give direction. The chapter would provide guidelines, not straightjackets.

WACHTEL: I think part of what we're getting at here is that we're approaching it with a somewhat different cognitive style. In order to answer your question of what the table of contents would look like in 100 years, I would have to be entering into your cognitive style, which I would try to do if you were my patient, but you're not. It's one of the nice things about someone being a friend instead of a patient. For me, the relevant question isn't what would that look like. For me the question is how will we get there. How will we go about arriving at what is now unimaginable?

GOLDFRIED: Okay. But it's not unimaginable for me.

WACHTEL: I know.

GOLDFRIED: But it's unimaginable for you.

WACHTEL: I hope it is. In other words, if I can imagine it now, that would mean it wasn't a very exciting 100 years.

GOLDFRIED: I think we have different philosophical styles, and mine is certainly much more functional.

WACHTEL: Mine is dysfunctional.

GOLDFRIED: Functional in a learning sense.

WACHTEL: I understand; I'm just playing.

GOLDFRIED: Not in a psychological sense.

SAFRAN: I know that the two of you are in the midst of something, but rather than being my client-centered self, I'm going to be an analyst and end this part of the session on time and give the audience a chance to be part of this dialogue.

AUDIENCE QUESTION: You say that SEPI has influenced therapists to think more integratively. However, my sense is that psychoanalytic organizations have not changed all that much over the years with regard to psychother-

apy integration. What are your thoughts about that?

WACHTEL: There are very great differences between people in their participation and their identities within organizations and as individuals in their own practices. In other words, I think that you're absolutely right that organized psychoanalysis, for example, has been very unreceptive to integration. But what always surprises me is that when I speak to individual analysts, they are often receptive. There are taboo ideas in public that are very common in private. One of the things that strikes me is that very, very often I get calls from well-known analysts either asking for some input about how they might actually use a cognitive-behavioral intervention or looking for a referral for a patient of theirs even if they won't integrate it directly. That was not true 20 years ago, but it's quite common now. And this includes people that you wouldn't think that about if you see their positions in the psychoanalytic organizations. But I think that you're absolutely right that in the psychoanalytic literature and in [American Psychological Association] Division 39, it hasn't yet officially emerged. But there is something happening underneath that's also interesting to be aware of.

GOLDFRIED: I certainly can't speak for the psychoanalytic community, but I have had similar experiences in interactions with individuals who are psychoanalytically oriented and know that they are much more open. I know more about the cognitive-behavioral world, which has showed increasing openness. We have representatives at this conference from that world, and the very fact that they are here and interested in this is an indication that there has been a change.

Les Greenberg once presented at the Association for Advancement of Behavior Therapy [AABT] convention on emotion and experiential therapy. We were sharing a room together, and the evaluations of his workshop were there for me to look at. They were rave reviews. That was certainly an indication of the receptivity that cognitive-behavior therapists have to integration. Now, these were done anonymously, and whether they would have been as good

had they put their names on—or whether somebody is willing to say this in print—is another story.

AUDIENCE QUESTION: Dr. Goldfried, do you think that cognitive-behavior therapists, yourself included, take an integrative approach to intervention?

GOLDFRIED: I think there are individual differences. I would say that with regard to how I practice integratively, cognitive-behavior therapy is dominant, and everything else is integrated. But that is simply a function of cognitive-behavior therapy being my primary orientation and not what I believe is the mission of SEPI. It's where we are at this point in time that leads us to this.

In listening to some of my graduate students talk about how they do clinical work, they sounded very integrative. What is of particular interest is that they label themselves as "integrative," even though I continue to label myself as "cognitive-behavioral." We are talking here about the difference between behavior and identity.

AUDIENCE QUESTION: It seems that the two of you have been focusing more on either process or outcome. Thinking ahead to the future, what orientation do you think is likely to emerge as the superordinate one?

WACHTEL: Two different thoughts are stimulated by that comment. One goes back to the earlier question. I think, for example, in the vision of many analysts, some version of psychoanalysis is the superordinate theory. But there are two different spirits in which that can be approached. One is a problematic one, which is the defensive, "we're the best." It was once dominant, and it can't abide the fact that it no longer is. And I think psychoanalysis is really struggling with that. So that's one attitude.

But a second variant is one that reflects one of the very important advances in our understanding of what's going on process-wise in integration—Stan Messer's [1992] introduction of the idea of assimilative integration. I mean, if I look at myself, even though I'm so powerfully committed to integration, I've realized

ever since Stan introduced that term that I'm engaged in an assimilative integration in that it's not equally, say cognitive-behavioral or psychoanalytic. The psychoanalytic perspective is clearly the organizing configuration for me, but not necessarily because it's better, but just because it's what my root thinking is, and I'm constantly looking to examine and question it and to bring new things in from outside. So I think those are two different spirits of doing that same thing.

SEPI is an organization of people who, almost by the very nature of being active in this organization, are not true believers. It becomes difficult and contradictory to be a true believer in not being a true believer, so we do not have the same kind of zeal, or at least we have a different kind of zeal. I think it's a kind of zeal that makes it harder for us to be exclusionary. It's not "I'm integrative, you are not." It's "I'm integrative, join me, and let us learn from each other." And that's different from the other organizations, but it makes for a less aggressive identity and in a way one that is less defined.

GOLDFRIED: I have thought a lot about that. Indeed, I've struggled with these issues, as I've felt a certain amount of disappointment. However, I think it is no small accomplishment to change a *zeitgeist*, and SEPI has been very successful in changing it. Within the context of a new *zeitgeist*, there is much work that needs to be done. Although we can use the metaphor of outcome versus process research, people who do therapy research talk about the "big O" and the "little o." The former is the ultimate outcome and the latter the interim outcomes, the subgoals that eventually lead to the ultimate goal.

My fantasy—excuse me, my expectation, a "behavioral slip"—about the textbook 100 years

from now is of a certain sort, but that will require a lot of work and a lot of action. We are not at the action stage. We have gone from pre-contemplation to contemplation as a field and SEPI as an organization, and it's going to take a while before we get to action [Prochaska & DiClemente, 1992]. As I indicated earlier, I think we must pay attention to evidence, but the evidence must be informed in a sophisticated way by clinical practice. It is essential for practitioners to be involved in any kind of consensus that is evidence based.

SAFRAN: Because of time limitations, I'm afraid that we're going to have to stop here.

I would like to thank everybody for participating in this dialogue. I would like to thank Marv for sharing his verbal behavior with us and Paul for sharing his instinctual derivatives.

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## Future Directions in Psychotherapy Integration

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Mr. P entered treatment with an empathic clinician and began to make considerable progress. He gained insight into the sources of his dissatisfaction and identified numerous ways in which he could change his life to make it more fulfilling. However, Mr. P did not begin to make any of these changes. Week after week, he identified why he was unhappy and discussed solutions that would improve the quality of his life, and week after week, nothing changed. The therapist explored why he had not made any changes, and Mr. P grew to realize that he was afraid to change anything in his life because he might make the wrong decision. Finally, the therapist received a notice from Mr. P's health insurance carrier, demanding a justification for Mr. P's continuing need for treatment and a concise summary of treatment goals. In the next session, the therapist asked Mr. P what he hoped to gain from therapy and how he wanted his life to change. Mr. P looked thoughtful. "I'm not sure," he responded. "I need more time to think about it."

Mr. P may remind you of clients you have seen. In some ways, he may also remind you of the history of the psychotherapy integration

movement. Like Mr. P, psychotherapy integration has made progress in some respects during the past two decades by recognizing the need to move beyond the boundaries of separate theoretical orientations. However, in other respects, psychotherapy integration has not yet realized its potential. The question we address in this chapter is: "What needs to be done in the future for psychotherapy integration to fulfill its promise?"

We begin by reviewing the progress made by the integration movement and noting the areas in which integration has not yet made an impact. In order to gain a better understanding of the possible directions that integration could take, we then turn to the futuristic views of a number of individuals who are actively involved in psychotherapy integration: the contributors to this *Handbook*. We summarize and comment upon their recommendations for advancing psychotherapy integration. Our hope is that by integrating a number of perspectives, we will gain a richer understanding of how the field should proceed.

## THE PROGRESS MADE BY PSYCHOTHERAPY INTEGRATION

As indicated in the introductory chapter in this *Handbook* (Norcross & Goldfried, 2005), psychotherapy integration is now an established, respected movement with an international association, regular conferences, and multiple publications. The impact of the integration movement can be seen in the areas of practice, research, theory, and training. In their clinical practices, many therapists identify their primary orientation as integrative or eclectic. In a recent survey of the membership of the APA's Psychotherapy Division, eclectic/integrative was the most popular orientation, endorsed by 35% of the respondents (Norcross, Hedges, & Castle, 2002). There is anecdotal evidence of increasing numbers of clinicians seeking advice from colleagues on how to integrate techniques from other orientations into their clinical work (Wachtel & Goldfried, 2005). Psychotherapy research has demonstrated that with the exception of focal problems such as specific phobias, panic, and obsessive-compulsive disorder, no one theoretical orientation is consistently more efficacious than the others (Luborsky et al., 2002; Stiles, Shapiro, & Elliot, 1986). A number of therapists turned to integration because they found that no single theory was adequate for explaining or treating all psychopathology (Garfield & Kurtz, 1977; Goldfried, 2001; Prochaska & DiClemente, 1992). Psychotherapy integration promises to increase therapeutic effectiveness by enabling clinicians to capitalize on the different strengths of the major therapies.

In the area of research, growing numbers of researchers are beginning to measure and document the effectiveness of integrative therapies. In this volume, Schottenbauer, Glass, and Arnkoff (2005) summarize outcome studies conducted on numerous integrative treatments, including therapies that combine techniques from different orientations and therapies based on integrative theories. Several researchers have recommended that integration efforts be guided by process research that explores the therapeutic factors that are common to many approaches (Castonguay, 1993; Elkin, 1991; Norcross,

Glass, Arnkoff, & Lambert, 1993; Wolfe & Goldfried, 1988). Researchers such as Greenberg and colleagues (e.g., Greenberg, Watson, & Lietaer, 1998) and Safran and Muran and colleagues (e.g., Safran & Muran, 2000) have demonstrated that process research can serve as the basis for effective, integrative treatments.

Interest in integration has contributed to the development and refinement of theories about therapeutic processes. For example, there is growing empirical support for the validity of the transtheoretical model of change (e.g., Prochaska, DiClemente, & Norcross, 1992), which describes the change process in terms of the five stages of precontemplation, contemplation, preparation, action, and maintenance. An understanding of these stages can help practitioners of all orientations assess and tailor interventions to the client's readiness for change (Miller & Rollnick, 2002; Prochaska & DiClemente, 1992). The integration movement has also drawn attention to the importance of the common factors that are shared by the major therapies. Once regarded by researchers as "noise" to be controlled in the evaluation of therapy (Omer & London, 1989), common factors, such as the therapeutic alliance, are now regarded as being at the core of psychotherapeutic effectiveness.

Opportunities for education and training in integrative approaches are also increasing. Organizations such as the Society for the Exploration of Psychotherapy Integration (SEPI) provide opportunities for therapists to attend workshops and annual conferences. There is growing discussion of the best ways to introduce integration to graduate students, as illustrated by a series of articles in the *Journal of Psychotherapy Integration* (Castonguay, 2000; Hayes, 2000; Norcross & Beutler, 2000; Wolfe, 2000).

## THE UNFULFILLED PROMISE

Drawing on the transtheoretical model of change, integration efforts have helped move psychotherapy from the precontemplation stage, in which we were unaware of the value of inte-

gration, to the contemplation stage, in which we think seriously about incorporating ideas from other approaches into our therapeutic work. The next stage—preparation—entails developing and committing to an action plan. Although there has been ongoing discussion about ways to advance integration, there has been little consensus, and no organized commitment to action. Like the obsessive Mr. P, who hopes that the perfect solution will become clear if only he thinks long enough, the integration movement remains stuck in the contemplation stage.

To be sure, individuals committed to integration have taken action on their own by publishing models, conducting research, and establishing training programs. However, we refer here to a collective failure of the field to develop or commit to an organized action plan. As a result of this hesitation to act, the integration movement has not produced a number of changes that many sought. One of the initial goals of the psychotherapy integration movement was that the competition among various schools of psychotherapy and their respective rival treatments would eventually be replaced with a sense of cooperation and common purpose (Goldfried, 1980; Wachtel, 1977). Although rapprochement among the orientations has increased, competition persists, best exemplified by treatment studies designed to “prove” the superiority of a particular treatment. The pervasive focus on differences has led to wasted efforts by many talented individuals. Over the years, studies have confirmed that there is no clear-cut winner to be crowned (Luborsky et al., 2002). Unfortunately, significantly less effort has been directed toward identifying common elements across different therapies and therapists—variables that might explain the Dodo bird verdict that “Everyone has won and all must have prizes” (Rosenzweig, 1936), and point to ways to improve therapists’ effectiveness.

In the absence of a consolidated action plan, the proliferation of new therapies has continued unchecked, just as some predicted and feared (Goldfried, 1980). Although reduction in the number of therapies is not an ex-

plicit goal of the integration movement, integration should help to reduce redundancy by identifying commonalities across treatments. An active integration movement could also promote greater collaboration and teamwork in the field of psychotherapy. Currently, the field of psychotherapy reinforces individuals for working independently and staking out their professional territory. As long as there is no structure in place to encourage the systematic, efficient integration of various treatments, ambitious theorists and researchers will continue to flood the marketplace with trendy treatments that often seem to reinvent the wheel.

The integration movement has also failed to challenge the dominance of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) disorder paradigm. Researchers have followed the lead of the National Institutes of Mental Health (NIMH), which only provides funding for studies that focus on manual-based treatments of clients categorized according to DSM diagnoses. Although this approach has led to an increase in knowledge of particular disorders (e.g., depression, borderline personality disorder), it has also obscured the fact that psychological problems develop and manifest in multiple ways, necessitating that treatments be tailored beyond discrete diagnoses. Furthermore, the reification of discrete disorders hinders recognition of the extent to which various clinical problems share common processes and symptoms that would respond to similar interventions.

Although a great deal has been written about integration, many fundamental questions remain unanswered. Integrative research has generally lagged behind integrative theory. Discussion of training in integration has increased, but most educators continue to train their students in much the same way as they were trained (Andrews, Norcross, & Halgin, 1992). After years of dialogue and debate about the future of integration, disagreement continues about whether we should continue exploring (e.g., Wachtel, in Wachtel & Goldfried, 2005), start actively integrating (e.g., Beitman, 1994), or find a way to do both (e.g., Goldfried, in Wachtel & Goldfried, 2005).

## THE FUTURE OF PSYCHOTHERAPY INTEGRATION: A SUMMARY OF PERSPECTIVES

In order to advance discussion about what directions psychotherapy integration should take to realize its unfulfilled promise, the contributors to this *Handbook* were asked to respond to the following five questions:

- What *practice* directions should the field take in order to improve psychotherapy integration?
- What *research* directions should the field take in order to improve psychotherapy integration?
- What *theoretical* directions should the field take in order to improve psychotherapy integration?
- What *education and training* directions should the field take in order to improve psychotherapy integration?
- What would you like the field of psychotherapy integration to look like in 25 years?

We summarize the contributors' responses to these five questions; the complete responses appear in the *Journal of Psychotherapy Integration* (Norcross & Goldfried, in press). We begin with an overview of superordinate themes that recurred throughout the responses. We then provide a more detailed summary of the responses to each question, followed by a brief commentary. Our goal is to bring readers into the dialogue among researchers and clinicians who are involved in the integration movement.

### Superordinate Themes

Three overarching themes emerged from the responses to the questions listed above. The first theme was the need to broaden the integration effort to encompass more than theoretical orientations. The second and third themes were held in tension throughout the responses: the need to actively advance the integration movement by bringing it more fully into psychotherapy research; and the need to continue

to explore, think creatively, and resist efforts to conform to the status quo.

### *A Broader View of Integration*

Many respondents emphasized the importance of continuing to integrate the best aspects of the different theoretical orientations (e.g., Feldman & Feldman) and not to lose sight of the contributions of the past (Wachtel). Respondents also suggested ways in which the integration effort should be expanded, looking beyond psychodynamic and cognitive-behavioral orientations to embrace more concepts from experiential and family systems orientations (Wachtel).

Several authors noted the need to look beyond the realm of psychotherapy and foster collaboration and integration with other areas of behavioral science, including developmental psychology (Ivey and Brooks-Harris), social psychology, cognitive psychology, and neuropsychology (Amkoff, Glass, and Schottenbauer; Burckell and Eubanks-Carter; Lazarus). Research on brain function is particularly important for expanding our understanding of pathological and therapeutic processes (Beitman, Soth, and Bumby; Halgin). A number of contributors stressed the importance of collaborating with and learning from colleagues in allied professions (Ryle), in particular the medical profession (Consoli, Beutler, and Lane; Halgin). It was also noted that integrative therapists need to know how to integrate psychotherapy with medication (Lazarus; Norcross).

Several contributors encouraged integrative therapists and researchers to look beyond the therapist's office for factors that impact clients' well-being. DiClemente observed that time spent outside of therapy is much greater and more important than the time spent in the session. Self-help resources (Consoli, Beutler, and Lane; Norcross), spirituality, and exercise (Norcross) can greatly enhance clients' psychological health. Also, in order to understand and effectively meet clients' needs, therapists should attend more to the broader social context of clients' lives, including social values (Ryle), economic realities (Wachtel), and cultural differences (Consoli, Beutler, and Lane; Ivey and

Brooks-Harris; Norcross). In addition to multicultural competence in psychotherapy practice (Ivey and Brooks-Harris), researchers need to include more diverse samples in research studies (Pachankis and Bell) and involve members of the groups studied in the design, implementation, and review of research (Ivey and Brooks-Harris). Therapists in training would benefit from exposure to ideas from non-Western cultures (Sollod). Looking beyond the traditional boundaries of individual psychotherapy might also entail proactive prevention, community, and population-based health approaches that reach individuals who have not sought out treatment (Consoli, Beutler, and Lane; Norcross; Prochaska; Ryle).

Finally, many contributors observed that integration requires humility and an open mind. As Consoli, Beutler, and Lane wrote, "Psychotherapy integration is characterized by a humble, relativistic, skeptical, and open attitude" (quoted in Norcross & Goldfried, in press). Feldman and Feldman noted that integrative therapists must relinquish the idea that their "home theory" is superior, and must become willing to learn about other orientations. Both strengths and weaknesses can provide important lessons: Goldfried called for therapists to be open to learning about the successes of colleagues from other orientations, and Stricker and Gold suggested that greater honesty about practitioners' failures and difficulties could lead to progress in integrative practice.

### *Tension Between Action and Exploration*

In addition to the theme of expanding integration, the responses also revealed a dialectical tension between the desire to actively advance integration within the current psychotherapy paradigm and the desire to resist the status quo. Reflecting the former theme, a number of contributors recommended that the integration movement focus on using randomized controlled trials (RCTs) to develop and empirically support integrative treatments for existing disorders (Arnkoff, Glass, and Schottenbauer; Feldman & Feldman; Heard and Linehan; Lazarus; Norcross; Wolfe). Integrationists could

focus in particular on developing treatments for disorders that do not respond well to existing therapies (Arnkoff, Glass, and Schottenbauer; Norcross; Wolfe) and on ensuring that therapists remain adherent to treatments that have empirical support (Heard and Linehan). Integrative treatment manuals could aid in the articulation and dissemination of such treatments (Halgin; Pachankis and Bell).

At the same time, other contributors expressed concerns about these efforts to pursue integration within the current research paradigm. Many people were drawn to integration precisely because they were dissatisfied with the status quo of practice and research (Halgin), and believed that the gold standard of the randomized controlled trial (RCT), which requires standardized treatments, homogeneous samples, and narrowly defined problems, has damaged psychotherapy (Ryle). The integration movement was attractive because it appreciated human complexity (Consoli, Beutler, and Lane) and because it was not institutionalized (Castonguay, Holtforth, and Maramba).

The call to resist conforming to the status quo was particularly evident in comments about the use of DSM diagnoses. Contributors noted that this diagnostic system is flawed; it should not be the basis for most theory and research (Arnkoff, Glass and Schottenbauer; Burckell and Eubanks-Carter; McCullough; Sollod). Client characteristics (Arnkoff, Glass, and Schottenbauer; Norcross), client strengths (Consoli, Beutler, and Lane, and interpersonal dimensions (McCullough) are more useful in conceptualizing and treating individuals. Miller, Duncan, and Hubble stressed that, rather than focusing on diagnoses, therapists would be more effective if they attended to clients' own models of their difficulties and their progress in treatment.

The founders of SEPI acknowledged the importance of creativity and exploration by naming their organization the Society for the *Exploration of Psychotherapy Integration*. However, many of the contributors to this volume asserted that 20 years of exploration is enough, and that the integration movement needs to reach consensus on some matters (Goldfried). As Halgin observed, "As members of SEPI



have continued to engage in dialogues about who we are and what we do, the clinical world has been passing us by” (quoted in Norcross & Goldfried, in press).

We will see how the contributors wrestled with the dialectic of action and exploration as we summarize their recommendations on the future of research, theory, and training. We discuss the possibility of integrating these two themes by simultaneously working within the current system and seeking to change it in order to increase our therapeutic effectiveness.

## Practice Directions

### *Summary of Responses*

There was strong agreement among contributors on the value of integration for improving clinical effectiveness. Integration enables practitioners to expand their repertoire of skills in order to meet their clients' needs (Consoli, Beutler, and Lane). However, what is unclear is how and when practitioners should integrate; the integration movement has failed to establish this prescriptive mandate (Norcross; Wolfe). Several writers expressed a sense of urgency: with pressure from insurance carriers and pharmaceutical companies, therapists need to reach consensus on the core, curative elements of psychotherapy (Beitman, Soth, and Bumby), and actively make the case for the ways in which psychotherapy helps clients to change (Halgin).

Contributors suggested a number of ways in which integration can move toward consensus in psychotherapy practice. First, there is a need for a clear, concise, jargon-free language so that therapists and researchers can communicate with each other and with allied professions (Burckell and Eubanks-Carter; Pachankis and Bell; Ryle). Second, therapists can move beyond the limitations of the medical model by focusing on the common factors that clinicians and researchers of various orientations agree are important predictors of therapy process and outcome (Feldman and Feldman; Pachankis and Bell; Sollod). These factors include the therapy relationship (Ryle; Lazarus; Norcross),

therapist factors (Consoli, Beutler, and Lane; Ivey), and client factors (McCullough). Client factors include the client's strengths (Consoli, Beutler, and Lane), the client's perspective and feedback about the therapy (Miller, Duncan, and Hubble), and the affective impact of the client's experiences (Wachtel). In particular, therapists should draw on principles of change and attend to the client's progress through the stages of change (Burckell and Eubanks-Carter; DiClemente; Prochaska), for example, by using motivational interviewing techniques to raise client expectations regarding change (Arn-koff, Glass, and Schottenbauer).

Third, integrative therapy manuals or treatment guidelines could be developed and expanded to help practitioners select and sequence specific interventions (Norcross; Wolfe). Manuals and protocols could be used to communicate integrative approaches (Halgin; Pachankis and Bell). Researchers and clinicians could collaborate to make research available to clinicians in easy-to-use formats (Burckell and Eubanks-Carter; Pachankis and Bell). Several writers expressed confidence that clinicians of various orientations could reach agreement on guidelines for treatment and case formulation (Burckell and Eubanks-Carter; Castonguay, Holtforth, and Maramba; Goldfried).

Castonguay, Holtforth, and Maramba described one response to these calls for greater attention to common factors: principles of change. Castonguay and Beutler created a task force to delineate principles of change that recognize the contributions of treatment procedures, relationships factors, and client and therapist characteristics. The efforts of this task force led to the identification of empirically derived practice guidelines for the treatment of depression, anxiety disorders, personality disorders, and substance abuse (Beutler & Castonguay, in press).

### *Commentary*

Clinicians today have access to a plethora of treatments. Indeed, this wealth of material can be overwhelming. For example, the most recent list of empirically supported treatments

endorsed by the Division 12 Task Force on Promotion and Dissemination of Psychological Procedures contains 71 treatments (Chambless et al., 1998), and this lengthy list does not even include many widely used treatments that have not yet been empirically tested. Mastering all of these treatments would require so much training that no one would have time to actually conduct therapy.

In order to treat a diverse set of clients with presenting problems that usually do not map neatly onto *DSM* categories and manualized treatments, clinicians need a solid base of knowledge that they can apply across many different clinical situations. With over a century of accumulated clinical experience, insight, and research, psychotherapy should be ready to agree on some core ideas. As noted by several contributors, common factors could provide a starting point for reaching such a consensus.

In order to further define a core consensus, we could adopt a bottom-up approach that remains close to the clinical material that all therapists encounter, using everyday language that all therapists can understand (Goldfried, 1987). We could continue and expand upon the work being done by Beutler, Castonguay, and colleagues to delineate common change principles. Demographically diverse groups of researchers and clinicians representing different orientations could develop common guidelines for assessment and case formulation, and refine them by gathering feedback from large samples of clinicians. Frances and colleagues (Frances, Docherty, & Kahn, 1996) have demonstrated one way of achieving consensus by surveying experts in the field. Therapy guidelines could be developed in a similar fashion. Thus, rather than forcing clinical practice into the Procrustean bed of the *DSM*, we could organize therapy guidelines around issues clinicians frequently encounter, taking into account the impact of client and therapist characteristics (Beutler, Consoli, & Lane, 2005). These guidelines could be made easily available to clinicians through the internet. The immediacy of the Internet would also facilitate rapid and frequent revisions as new research becomes available. Ongoing revisions would help

prevent these guidelines from becoming yet another calcified orthodoxy.

The idea of practice guidelines may not appeal to all therapists. Some therapists may fear that such guidelines would resemble existing therapy manuals. The word *manual* evokes a visceral negative reaction in many therapists, who may share one respondent's view of manuals as prescribing "the replication of a cookie-cutter method" (Wachtel, quoted in Norcross & Goldfried, in press). In our experience, manuals can be flexible tools that provide guidance while also encouraging the therapist to tailor treatment to the needs of the particular client-therapist dyad. Any book that describes a form of psychotherapy can function as a manual, and like a manual, can be misused in a rigid fashion. To prevent such misuse, practice guidelines need to be written and presented as the field's current understanding, inevitably subject to review and revision, rather than as sacrosanct laws of therapy.

Regardless of therapists' feelings about practice guidelines, some form of guidelines may be inevitable. A panel of 62 psychotherapy experts, asked to forecast psychotherapy trends for the next decade, predicted that practice guidelines would become a standard part of daily psychotherapy (Norcross, Hedges, & Prochaska, 2002), perhaps because health care companies and governmental agencies are increasing demands for accountability. Instead of waiting for external forces to dictate standards and manuals to us, we can seize the opportunity to decide for ourselves what the standards of our field will be. We can create guidelines that reflect our shared values, the consensual research, and the clinical flexibility required to meet the needs of the individual client.

Practitioners will be important partners in the effort to create and refine therapy guidelines; such an effort can only succeed with their active participation in the entire enterprise. Therapists can also advance psychotherapy integration in their own practices by forming peer supervision groups with colleagues from other orientations. These groups provide a safe environment where therapists can experiment with new ways of understanding and in-

tervening with clients. As the social psychology literature demonstrates, by working together toward a superordinate goal (Sherif, Harvey, White, Hood, & Sherif, 1961), members of different groups can learn to look beyond rivalries and to challenge long-held prejudices.

As clinicians of different backgrounds work together, they will undoubtedly encounter limits to their ability and desire to integrate. Matching clients to treatments is important (Beutler, Consoli, & Lane, 1995); matching therapists to treatments that suit their personalities, values, and life experiences is similarly important. The goal of integration is not for every therapist to be identical. Rather, the goal is for all therapists to begin with a solid core of consensual knowledge, and then to develop their own individual therapeutic style and area of expertise. As therapists, we can continue to prefer a particular orientation, as long as we recognize the limitations of that approach. By working regularly with therapists from other orientations, we will be better able to discern when a client is a poor match for our approach but a good match for a colleague from a different orientation.

## Research Directions

### *Summary of Responses*

Although the integration movement has made great strides, the majority of contributors (Arnkoff, Glass, and Schottenbauer; Consoli, Beutler, and Lane; Castonguay, Holtforth, and Maramba; Goldfried; Halgin; Heard and Linehan; Norcross; Stricker and Gold; Wachtel; Wolfe) stressed the need to demonstrate empirically the effectiveness of integrative therapies and training rather than assuming that they work simply because they are labeled “integrative.” Little research is available to indicate how a clinician should integrate, including what should be integrated or the order in which elements should be integrated (Consoli, Beutler, and Lane; Feldman and Feldman). In light of the additional training required to master integrative approaches, others noted that cost-

effectiveness research is also needed (Heard and Linehan).

Many contributors commented on the need to move beyond RCTs model by developing methods that avoid the problems associated with this research model (e.g., Wolfe). Given that current methods have often been unable to detect significant differences in outcome (Miller, Duncan, and Hubble), some advocated the use of more complex research designs to capture interactions among client, therapist, and relationship variables (Consoli, Beutler, and Lane; Norcross) and behavior change (DiClemente). Arnkoff, Glass, and Schottenbauer noted that research on complex treatments such as multisystemic therapy (Henggeler, Schoenwald, Rowland, & Cunningham, 2002) and acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999) demonstrate that it is fruitful to study treatments in which clients receive different interventions. Many mentioned the need to integrate process research with outcome research in order to understand how change occurs rather than focusing exclusively on what has changed (Burckell and Eubanks-Carter; Feldman and Feldman; Goldfried; Pachankis and Bell; Ryle; Wolfe). Others noted that marrying qualitative and quantitative research designs (Burckell and Eubanks-Carter; Consoli, Beutler, and Lane), employing single subject designs or case studies (Burckell and Eubanks-Carter; Halgin; Lazarus; Ryle; Wolfe), and incorporating relational/interpersonal perspectives in research designs (Ryle) may also yield valuable information.

Prochaska observed that traditional clinical trials are too selective, excluding participants with comorbid diagnoses and requiring high levels of compliance. Some authors (Arnkoff, Glass, and Schottenbauer; Norcross) suggested that investigating those clients who do not benefit from empirically supported or pure-form therapies may provide avenues for the development of integrative treatments. Along these lines, Castonguay and colleagues (Newman, Castonguay, Borkovec, & Molnar, in press) have developed a treatment for generalized anxiety disorder that addresses factors that the current treatment package lacks. Follow-up

studies that track relapse may indicate paths for treatment (Feldman and Feldman) and expand our understanding of disorders and dysfunction (McCullough).

The contributors also called for changes in the types of research questions integrative researchers address. Some asserted that the research agenda for psychotherapy integration should focus on common principles of human change (Burckell and Eubanks-Carter; Consoli, Beutler, and Lane; DiClemente; Goldfried; Pachankis and Bell; Wolfe). Wolfe recommended moving beyond measures of therapist adherence to develop measures of therapeutic skill. Beitman, Soth, and Bumby stressed the importance of focusing on brain function, including the neurobiological processes of both clients and therapists. The formation of theoretically diverse research groups could facilitate the development of more innovative research questions (Pachankis and Bell).

Many respondents also indicated the need for increased collaboration between researchers and clinicians. For example, some respondents (Norcross; Ryle) stressed that researchers need to understand how to make research more useful to practicing clinicians by addressing questions that have relevance to clinical practice. One of the ways researchers and practitioners can collaborate is through the creation of practice-research networks. Castonguay, Holtforth, and Maramba proposed that these networks provide an effective forum for researchers to solicit input from clinicians and for clinicians to contribute to research in significant ways. Collaborations between clinicians and researchers can also occur by focusing research on in-session processes, such as clinical decision-making (Arnkoff, Glass, and Schottenbauer). This bottom-up approach may be particularly suited to identifying the in-session markers effective therapists use to guide their clinical decisions.

Contributors noted the importance of effectively disseminating research findings to practitioners. Single-case studies (Lazarus; Wolfe) and practice-research networks (Goldfried) can be particularly effective tools for dissemination. Research is also needed on how to effectively

train and supervise clinicians (Burckell and Eubanks-Carter).

Reflecting the tension between acting within current paradigms versus exploring outside of those paradigms, contributors expressed contrasting views of the use of manuals in research. For example, Lazarus stressed the need to develop better manual-based procedures. Wachtel, however, expressed concern that manuals tend to constrict therapists and are poorly suited to demonstrating the efficacy of integrative treatments. He advocated the development of alternative research tools, such as the use of raters to evaluate treatment fidelity. A third alternative was proposed by Goldfried, who called for improving manuals by basing them on the findings of process research delineating the mechanisms of change.

Finally, several authors drew attention to the fact that systemic changes may be needed in order to facilitate advances in psychotherapy research. Goldfried noted that the NIMH can stimulate important work in psychotherapy integration by setting aside funding for integration research.

### *Commentary*

Researchers complain that clinicians do not attend to research findings. Clinicians complain that research is conducted in a vacuum and does not apply to their clients and circumstances. Bridging this gap between research and practice may well produce treatments that are rooted both in clinical reality and empirical validation. One promising effort to make progress toward this goal is the statewide practice-research network established by Borkovec and colleagues (Borkovec, Echemendia, Ragusea, & Ruiz, 2001), and the efforts being made by Castonguay to establish a national network. These networks have the potential to enhance the usefulness and effectiveness of our treatments.

There is also a need for more partnerships between researchers of different theoretical orientations. Cross-orientation collaborations could capitalize on the fact that researchers from different orientations generally possess expertise

in different research methods (e.g., quantitative methods in cognitive-behavioral research, qualitative methods in psychodynamic research, process methods in experiential research, and systemic methods in family and group therapy). These methods could be supplemented by research on brain function and the ways in which psychotherapy impacts the neurobiological processes of both patient and therapist (Beitman, Soth, and Bumby). Combining different research methodologies would help researchers come closer to capturing the complexity of clinical phenomena. In addition, the use of multiple methodologies would help researchers present their findings in multiple ways that appeal to clinicians with different epistemologies and criteria for evaluating research (Castonguay, Holtforth, and Maramba).

We concur with the contributors who recommended greater emphasis on process research. The work of process researchers has highlighted the impact of moment-by-moment processes on therapy outcome (Greenberg & Pinsof, 1986). Although process and outcome research have often been conducted separately, combining them should increase our understanding of what works and the specific mechanisms associated with change. Furthermore, the findings from both outcome and process research should be used to develop more effective treatments and treatment guides.

## Theory Directions

### *Summary of Responses*

A number of contributors noted the current and future value of theory. Well-articulated theoretical models have clinical utility (Consoli, Beutler, and Lane); Wachtel's (1977) seminal theoretical work on integrating psychodynamic and behavioral therapies is a prime example of how theory can advance integration. Many contributors argued that theory is needed in order to address the weaknesses of the eclectic approach, in which practitioners use techniques separate from their theoretical origins. Heard and Linehan observed that without an understanding of theory, eclectic practitioners risk inappropriately abstracting tech-

niques from one therapeutic context and applying them to another. Ryle wrote that eclecticism "is no longer a viable position" (Ryle, quoted in Norcross & Goldfried, in press); in the future, integrated practice must be based upon an integrated theory. Theoretical work can help the integration movement become more intentional, and thereby move from "intuitive eclecticism toward more purposeful integration" (Ivey & Brooks-Harris, quoted in Norcross & Goldfried). Several contributors (Feldman and Feldman; Pachankis and Bell; Wolfe) expressed the hope that integrative clinicians would be able to integrate the strengths of existing theories to develop one unifying integrative theory.

In contrast, a number of contributors expressed concerns about theory and advocated for less theoretical exploration and more active research. Norcross defended the eclectic approach as pragmatic and helpful for clients and, along with Miller, Duncan, and Hubble, observed that there is little empirical evidence that theory increases the effectiveness of therapy; the future emphasis should be squarely placed on more research rather than more theory. Attempts to integrate existing theories have often produced tensions that hindered further innovations (Heard and Linehan). Goldfried argued that striving for a grand theory is a futile task that tends to lead to the proliferation of institutes and devotees. Lazarus concurred, observing that too often theorists "have not behaved like detached, impartial scientists but like itinerant proselytizers" (quoted in Norcross & Goldfried).

Although contributors expressed conflicting views on the future value of theorizing, their responses also included suggestions for ways to reach theoretical consensus by focusing on specific theories that are close to clinical experience, rather than pursuing a grand integrative theory. Several contributors recommended the development of theories that seek to explain specific aspects of the change process (DiClemente; Goldfried; Norcross). Arnkoff, Glass, and Schottenbauer suggested developing empirically derived theories of therapists' decisional processes. Several contributors recommended focusing more on client characteristics (Arn-

koff, Glass, and Schottenbauer; Castonguay, Holtforth, and Maramba) and clients' perspectives (Miller, Duncan, and Hubble). Goldfried also noted that closely linking theoretical principles to clinical observables will facilitate empirical testing of theories, which several contributors stressed as essential (Burckell and Eubanks-Carter; Lazarus; Pachankis and Bell).

### Commentary

The first step toward achieving greater integration in the area of theory is to clarify the function of our theories. The jargon of each orientation can form a language barrier that prevents us from recognizing areas of agreement (Goldfried, 1987). If our goal is clear communication, not intellectual intimidation, we may be surprised by how many theoretical concepts are shared by the major orientations. We may also be surprised by the diversity within each orientation that becomes apparent when we state our theories in common language.

As we strive to develop new theories, we should be guided by basic research in psychopathology and neuropsychology. Our ideas about how therapy works should be consistent with our empirically derived knowledge of human behavior and brain function (Beitman, 1994). The concept of basing theory on research is often associated with cognitive and behavioral approaches. Laboratory findings were the foundation of behavior therapy, and current psychotherapy research is dominated by studies of cognitive-behavioral treatments. However, research does not "belong" to the cognitive and behavioral orientations. Freud began his career as a researcher and developed psychoanalysis as a "science based upon observation" (Freud, 1925/1959, p. 58), proceeding by closely observing clinical phenomena, formulating hypotheses, and then testing those hypotheses through further observations. Research findings provide support for a number of constructs that are central to psychodynamic theory, such as unconscious processes (Westen, 1998) and the function of transference in our everyday lives (Andersen & Berk, 1998). Greenberg and colleagues (Greenberg, Rice,

& Elliott, 1996) have integrated basic research on emotion with tenets of experiential therapy.

In addition to basic research, we should draw on clinical wisdom when we develop new theories. The intuition of skilled clinicians is often years ahead of our research findings. But the tools of research can help us to access clinical wisdom in a systematic way. Instead of allowing the most forceful personalities to dominate the discussion, we can use systematic reviews of the literature (e.g., Grencavage & Norcross, 1990), surveys of experts (Frances, Docherty, & Kahn, 1996), and studies of master therapists (e.g., Goldfried, Raue, & Castonguay, 1998) to bring together the clinical wisdom of a diverse sample of therapists.

To develop new integrative theories, we can begin at an intermediate level of abstraction. As Goldfried (1980) has noted, if we begin at the highest level of theoretical frameworks (e.g., psychodynamic, experiential, cognitive-behavioral), language barriers and philosophical differences can obscure areas of agreement. If we begin at a lower level of specific interventions, topographical differences may obscure functional similarities. By beginning at the level of clinical strategies or principles (e.g., a therapeutic relationship, encouraging corrective experiences), we can recognize strategies on which we agree and can analyze differences and similarities between the interventions we use to achieve those strategies.

A greater focus on intermediate strategies will also yield more insight than our current focus on *DSM* disorders. Thinking in terms of clinical principles helps us to recognize ways of categorizing clinical material that in many cases may be more useful than diagnoses. For example, Beutler (Beutler, Consoli, & Lane, 2005; Beutler & Harwood, 2000) emphasizes matching clients, therapists, and treatments based on dimensions such as interpersonal resistance, coping style, and treatment objectives. Prochaska and DiClemente's (2005) transtheoretical model of change, which is based on the assumption that integration would most likely occur at the intermediate level of change processes, encourages therapists to tailor interventions based on the client's stage of change. Wachtel's cyclical psychodynamics (1977; Wach-

tel, Kruk, & McKinney, 2005) integrates concepts from psychodynamic, behavioral, and systems theories by focusing on current interpersonal patterns and highlighting the interaction between an individual's expectations, affective and behavioral responses, and the respective responses of others.

As we develop new theories, we should not only be grounded in research, but should also use research as a tool to test and revise our theories. Although there is romantic (and narcissistic) appeal to the idea of having an epiphany while sitting in one's armchair, the more realistic path is what Rice and Greenberg (1984) describe as a rational, idealized model: we develop hypotheses, then closely observe clinical phenomena, and modify our hypotheses. This bottom-up, empirical approach can also aid our understanding of current theories. For example, in his development of cognitive analytic therapy, Ryle (2001, 2005) has sought to describe the traditional goals of dynamic therapy in ways that permit outcome research. Using the tools of research to refine and build upon our clinical wisdom requires humility—a willingness to expose oneself to being proven wrong in the service of the greater goal of increasing our knowledge. As Beutler and Consoli (1992) observe, “It is often as important to be wrong as to be right, as long as theories are constructed in such a way as to allow one to tell the difference through empirical research” (p. 265).

## Education and Training

### *Summary of Responses*

Virtually all of the contributors believe that a less orthodox and more integrative training will facilitate the integration movement. Still, significant disagreement persists surrounding integrative training, including when integration should be introduced and what the content should include.

A central debate regarding training in integrative practice is whether it should occur after trainees have acquired a solid foundation in pure-form therapies, or whether individuals should be trained integratively from the start.

Based on the assumption that “. . . one can only integrate what he/she knows very well” (Castonguay quoted in Norcross & Goldfried, in press), several contributors advocated that trainees master one approach before they begin to practice integration (Arnkoff, Glass, and Schottenbauer; Castonguay, Holtforth, and Maramba; Norcross; Stricker and Gold; Wolfe). For example, Norcross suggested that training begin with fundamental relationship and communication skills and exposure to the major systems of psychotherapy. Students would then focus on learning the skills and theories of one or two orientations. Once students had mastered one approach, they would study models of integration. Throughout training, students should be encouraged to be open and respectful of other perspectives (Stricker and Gold; Wolfe). Norcross contended that the ultimate goal is not for students to identify as having an integrative orientation but rather for students to develop an integrative perspective, independent of the theoretical label they select.

In contrast to advocating thoroughly training beginning therapists in one school of thought, a number of contributors (Burckell and Eubanks-Carter; Consoli, Beutler, and Lane; Feldman and Feldman; Halgin; Ivey and Brooks-Harris; Pachankis and Bell; Ryle; Wachtel) supported training students in the theories and methods of multiple orientations from the beginning of training. Integrative concepts could even be introduced at the undergraduate level (Arnkoff, Glass, and Schottenbauer; Halgin). Early integrative training would enable students to avoid the difficulties of trying to unlearn years of work and practice within a single paradigm (Burckell and Eubanks-Carter; Norcross; Wachtel). As Wachtel observed, when therapists commit to one orientation, the numerous institutions and organizations they then join reinforce maintaining a single paradigm, so that “temporary” habits of thought and practice become permanent.

Respondents also expressed concern that introducing integration after students have mastered one model would result in inadequate exposure to integration. Programs may offer only one course on integration (Consoli, Beutler, and Lane), and may teach an integrated ap-

proach that remains primarily rooted in a single school of therapy to which other ideas are added. Thus, the challenging task of integration would be left to the individual trainee (Ryle).

Regardless of when integrative training occurs, many questions persist regarding how training should be conducted and what specifically should be taught. As Goldfried observed, there is no single integrative therapy or superordinate theory of change that can be taught. In the absence of such guidelines, he proposed that training should teach students to use general principles of change and to be open-minded. Several other contributors similarly emphasized the importance of teaching students to be broadminded, flexible, and innovative (Lazarus; Miller, Duncan, and Hubble; Norcross; Prochaska).

Contributors provided a number of general recommendations concerning the content and scope of integrative training during graduate training. Some stressed the need for training to move beyond a basis in a single orientation and a focus on treating DSM disorders (Consoli, Beutler, and Lane; Feldman and Feldman; Sollod). Some proposed that such a shift could result in the designation of effective *therapists* rather than effective therapies (Miller, Duncan, and Hubble). Others suggested that integrative training should focus on teaching therapists when to emphasize single methods and when to combine multiple methods (Ivey and Brooks-Harris). Several contributors (Consoli, Beutler, and Lane; McCullough; Miller, Duncan, and Hubble; Norcross) also noted the importance of training students to use and maintain the therapeutic relationship. Finally, a number of the contributors asserted that training should provide individuals with the breadth of skills and knowledge that individuals need to adapt successfully to societal changes and future challenges (DiClemente; Prochaska).

Several contributors emphasized that students need faculty and supervisors who can model integrative practice (Feldman and Feldman; Pachankis and Bell). Halgin contended that the most effective way to teach integration is for students to observe the work of integrative

therapists. However, Heard and Linehan observed that different students may benefit from different forms of training and that new technologies may provide training methods that are more effective and efficient than traditional supervision and workshops. Several contributors also noted that different methods may be needed for training new therapists than for teaching integration to experienced therapists (Arnkoff, Glass, and Schottenbauer; Goldfried; Heard and Linehan). Ultimately, these questions about training can only be adequately addressed through research (Arnkoff, Glass, and Schottenbauer; Burckell and Eubanks-Carter).

### *Commentary*

We consider training to be the most important means to achieving real change in the field of psychotherapy. We agree with the contributors' consensus that openness to integration needs to be fostered from the beginning of training. A number of contributors (Arnkoff, Glass, and Schottenbauer; Castonguay, Holtforth, and Maramba; Norcross; Stricker and Gold) recommended that further work on integration should be reserved until later in training, after students have established a firm foundation in one or two orientations. Consistent with this view, Schacht (1991) has maintained that training individuals integratively is analogous to training someone to play jazz: The fundamentals need to be learned before one can truly integrate. Messer (1992) has also cautioned that integration across orientations can only occur after one has thoroughly integrated concepts within a particular orientation. Others further caution that students may become anxious and confused without having a single system to rely on as a secure base (Loganbill, Hardy, & Delworth, 1982; Wachtel).

We, however, firmly support the idea of learning and practicing integration from the beginning of training, under the guidance of a diverse faculty of clinicians who identify with different orientations. To be sure, there are individuals who received their training before the existence of the integration movement, and only later embraced integration (see Goldfried, 2001). However, we contend that it is more dif-



difficult to successfully integrate different theories and techniques *after* working for years in a specific paradigm. Integrative training allows students to develop fluency in multiple approaches without needing to “unlearn” biases from one original approach.

Although the lack of a single “secure base” orientation may sound anxiety-provoking, we believe that training in multiple orientations is excellent preparation for the challenging, complex work of therapy. Integrative training can promote the very skills that contributors emphasized as critical: flexibility, open-mindedness, creativity, awareness of the limitations of a single perspective, and sufficient resourcefulness to cope with future changes and challenges. Even if some amount of fine-tuned expertise in one orientation is lost in integrative training, this may be outweighed by what is gained. A versatile therapist with numerous resources at his or her disposal may provide better care to the majority of clients than one who has thoroughly mastered only one approach. Although we strongly support integrative training from the beginning, we recognize that our perspective is shaped by our own experiences (Burckell and Eubanks-Carter) of early exposure to integration. Ultimately, research is needed to answer these questions.

## The Next 25 Years

### *Summary of Responses*

In their responses to this question, many contributors restated the main points from their responses to the previous questions (e.g., the need to bridge the gap between research and practice). We will not reiterate those points; rather, this summary focuses on new issues that were raised in contributors’ comments about the next 25 years of integration.

The contributors’ predictions of the future of integration varied greatly. Some contributors expressed pessimistic views of the next 25 years. Beitman, Soth, and Bumby predicted that the mental health field will continue to engage in turf battles among psychology, psychiatry, social work, and medicine. DiClemente expressed the fear that mental health care could become

even more fragmented and specialized than it is currently. Halgin proposed that psychotherapy may be extinct in 25 years, having been superseded by interventions targeting the physical body.

In contrast to such anticipations of a bleak future, other contributors optimistically proposed that in the next quarter century, psychotherapy integration will be thoroughly integrated into the mainstream (Arnkoff, Glass, and Schottenbauer; Feldman and Feldman). Some expressed hope that psychotherapy integration will be so accepted that the term would be rendered meaningless and vanish (Arnkoff, Glass, and Schottenbauer; Lazarus; Stricker and Gold). Moreover, some hoped that there will be no competing schools (Lazarus), therapists will no longer be characterized or evaluated based on their orientation (Norcross; Pachankis and Bell), and organizations centered on theoretical orientations will play a diminished role in mental health (Ryle). Consistent with this perspective, others hoped that psychotherapy integration will be an essential component in graduate (Ivey and Brooks-Harris; Lazarus; Ryle) and postgraduate (Wolfe) training, with integrative training courses, both academic and practicum, central to the curriculum (Stricker and Gold). McCullough described a continuing education model in which predoctoral training programs maintain a relationship with their graduates. He contended that this model could strengthen the link between research and practice by fostering collaborations between researchers and clinicians.

Several of the respondents (Arnkoff, Glass, and Schottenbauer; Ivey and Brooks-Harris; Norcross; Stricker and Gold; Wachtel) hoped that 25 years from now there will be a substantial research base supporting the effectiveness of integrative treatments and a dramatic increase in the number of people conducting research in this area (Arnkoff, Glass, and Schottenbauer). Some even ventured to hope that psychotherapy can enjoy the success and dramatic advances that medicine has enjoyed during the past 25 years (Heard and Linehan). Finally, several respondents (Consoli, Beutler, and Lane; Ivey and Brooks-Harris; Wachtel) hoped that the movement will increase its

focus on cultural diversity and multiculturalism.

Questions remain as to what needs to be done to help integration move forward. Several respondents (Burckell and Eubanks-Carter; Goldfried) suggested that achieving consensus is essential for the movement to advance. These contributors contended that the field does not have to agree on a single theory of human behavior or change processes. Instead, it needs to focus on agreed upon principles of change and move toward consensus regarding how these principles can be implemented. Taking a different stance, Miller, Duncan, and Hubble argued that consensus involves agreeing on outcome rather than buying into a common process or central beliefs on which we will never agree: "People believe what they will believe. Almost all, however, believe in the final outcome: salvation" (quoted in Norcross & Goldfried, *in press*). Regardless of the form consensus takes, one contributor (Prochaska) noted that the field cannot spend the next 25 years deciding how to integrate; instead, integration needs to move forward based on current knowledge.

### *Commentary*

We believe that consensus is essential to advancing psychotherapy. Consensus does not necessitate reaching unanimity on every point or stamping out dissenting opinions. Rather, consensus means agreeing on a basic approach to integration and exploring differences in systematic ways, rather than agreeing to disagree or dismissing others' perspectives. In this vein, we need to be curious rather than judgmental regarding alternative hypotheses; differences are questions to be addressed rather than markers for bunker building. Twenty-five years from now, we could be working from consensus guidelines and continually refining them as we gain more information from research and clinical experience. These guidelines could be the basis of training as well, so that all practitioners begin their careers with a solid core of consensual knowledge on which to build.

We also hope to see the emphasis on process research continue, with the goal that pro-

cess and outcome research will be conducted simultaneously to guide intervention. In addition, we support cross-theoretical and cross-disciplinary approaches. It is crucial that we acknowledge that other disciplines can contribute to our field. For example, we can learn a great deal from religious and spiritual approaches. Frank (1961), an early voice for integration, contended that spiritual traditions serve to instill an expectation for change or improvement, a process that is central to effective therapy. We are encouraged that many new treatments are actively incorporating practices like mindfulness in order to capitalize on the strengths of these nontraditional strategies. Along these lines, we also hope to see increased integration of constructs from positive psychology (Seligman & Csikszentmihalyi, 2000) and its focus on clients' strengths.

Although individual therapists can obviously contribute to change, there are also significant systemic problems that need to be addressed. Psychotherapists, just like clients, respond to reinforcers. During the next quarter century, we hope that systemic changes in grant funding, higher education, and reimbursement policies will encourage increased collaboration and consensus building. We also hope to see increased focus on integration though special issues of journals and recognition by faculties when making hiring decisions. These infrastructure changes will provide fertile ground for the integration effort.

### CONCLUSION

Since the beginning of the integration movement, there has been a dialectical tension between calls for action and calls for continuing exploration. Some have argued that it is past time for the integration movement to take action to influence mainstream psychological research and practice by reaching a consensus on key issues (Beitman, 1994). Others, however, have expressed concern that such a consensus will be premature and will hamper innovation (Wachtel, *in* Wachtel & Goldfried, 2005). This tension was reflected in the contributors' responses to questions about the di-

rections psychotherapy integration should take. Some contributors called for active efforts to advance integration within the dominant research paradigm through randomized controlled trials of manualized integrative treatments. Others emphasized the need for continuing open discussion and exploration of integrative ideas. For example, Wachtel expressed the hope that he will never be able to imagine the future of psychotherapy integration, because the ability to predict its future would mean that it had failed to innovate. Contributors expressed concern that integration should not conform to the flawed RCT paradigm and risk recreating the rigidity and parochialism of the major orientations that many in integration sought to escape. In fact, several contributors (Castonguay, Holtforth, and Maramba; McCullough; Miller, Duncan, and Hubble) noted that the very way in which the questions about the future of integration were phrased presupposed that integration has in fact become an end in itself, a movement seeking to advance its own agenda, rather than a means to an end, the goal of improving psychotherapy.

What should be the future of psychotherapy integration? To answer this question, we embrace Castonguay, Holtforth, and Maramba's description of integration: "Perhaps integration should be less of an orientation and more of a perspective—a way of thinking (in terms of convergence, divergence, complementarity, synergy, synthesis, and anti-thesis) aimed at constantly challenging our conceptualizations and improving our clinical practice" (as quoted in Norcross & Goldfried, *in press*). This view of integration as a dialectical process was also described by Heard and Linehan and has been discussed by several other writers as well (Mahoney, 1993; Stricker & Gold, 1993). A dialectical view acknowledges the value of both sides and encourages attempts to resolve issues while still remaining humbly aware that any obtained synthesis will eventually be replaced in a continuous developmental process. With this perspective, the question is not whether we should take action or explore, but rather how we can integrate the two.

At the individual level, therapists can integrate action and exploration in their own prac-

tices by forming supervisory groups with colleagues from other approaches. They can obtain continuing education in alternative orientations or integration. They can participate in practice-research networks. At the systemic level, our institutions and organizations need to recognize and reinforce efforts to collaborate and build a consensus. This consensus can draw on both clinical wisdom and clinical trials and should involve diverse groups of clinicians and researchers. This consensus can be disseminated in the form of guidelines that possess the clarity of manuals while still allowing for flexibility and creativity. This consensus can provide a foundation for therapists in training and a starting point for continuing dialogue and exploratory research.

As a field, psychotherapy has wasted a great deal of energy to date. Ironically, although we are a profession of listeners, we have not been listening to each other. In our rush to defend our own ideological turf, we have traditionally ignored voices from other orientations. In our hurry to remain cutting edge, we have disregarded contributions from the past. Researchers, wrestling with funding agencies, and clinicians, wrestling with complex cases and inflexible insurance carriers, have failed to listen to each other's needs and contributions. Beutler (1998) has observed that during the past 40 years, millions of tax dollars have been spent on psychotherapy research, and yet the profession still cannot agree on what forms of psychotherapy are effective. He warns that our reluctance to reach a consensus on what works could well give the public the impression that as psychotherapists, we lack confidence in our own field—the result of which may be a withdrawal of funding for practice, research, and training.

The ideas expressed in this chapter are not new. However, there are signs that the field of psychotherapy is finally nearing the point of readiness to commit to an action plan. During the past 20 years, the major schools have demonstrated a growing openness to new ideas from other orientations, from basic research, and from other disciplines such as spiritual practices. More than ever, we are in a position to make progress toward consensus if we are willing to try.

Our hypothetical Mr. P was afraid to make a change because he could only think about how he might make a mistake, not recognizing that the failure to change was the greater mistake. He did not recognize that it was possible that taking a risk might result in success. He also did not recognize that doing nothing was a decision. The psychotherapy integration movement is itself taking a risk: by remaining stuck in contemplation, we allow external forces to define how we shall practice. By not publicly articulating a coherent understanding of how we as therapists are able to help people, we risk becoming obsolete; we risk remaining on the path to confirming the old stereotype that therapy is nothing but talk. We believe that it is time for us to take a different risk—the risk of moving forward.

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