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14 INTEGRATIVE PSYCHOTHERAPIES[1]

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OVERVIEW

Rivalry among theoretical orientations has a long and undistinguished history in psycho-therapy, dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention, affection, and adherents. Clinicians traditionally oper-ated from within their own theoretical frameworks, often to the point of being blind to alternative conceptualizations and potentially superior interventions. An ideological "cold war" reigned as clinicians were separated into rival schools of psychotherapy.

As the field of psychotherapy has matured, integration has emerged as a mainstay. We have witnessed both a decline in ideological struggle and a movement toward rap-prochement. Clinicians now acknowledge that there are inadequacies and potential value in every theoretical system. In fact, many young students of psychotherapy express surprise when they learn about the ideological cold war of the preceding generations.

Psychotherapy integration is characterized by dissatisfaction with single-school ap-proaches and a concomitant desire to look across school boundaries to see how patients can benefit from other ways of conducting psychotherapy. Although various labels are applied to this movement—eclecticism, integration, rapprochement, prescriptive therapy,

[1] Portions of this chapter are adapted from Norcross (2005) and Norcross, Beutler, & Caldwell (2002).

treatment matching—the goals are similar. The ultimate goal is to enhance the efficacy and applicability of psychotherapy.

Applying identical psychosocial treatments to all patients is now recognized as inappropriate and probably impossible. Different folks require different strokes. The efficacy and applicability of psychotherapy will be enhanced by tailoring it to the unique needs of the client, not by imposing Procrustean methods on unwitting consumers of psychological services. The integrative mandate is embodied in Gordon Paul's (1967) famous question: *What* treatment, by *whom,* is most effective for *this* individual with *that* specific problem and under *which* set of circumstances?

Any number of indicators attest to the popularity of psychotherapy integration. *Eclecticism,* or the increasingly favored term *integration,* is the most popular theoretical orientation of English-speaking psychotherapists. Leading psychotherapy textbooks routinely identify their theoretical persuasion as integrative, and an integrative chapter is regularly included in compendia of treatment approaches. The publication of books that synthesize various therapeutic concepts and methods continues unabated; they now number in the hundreds. Handbooks on psychotherapy integration have been published in at least eight countries. This integrative fervor will apparently persist well into the 21st century: A panel of psychotherapy experts predicts the escalating popularity of integrative psychotherapies (Norcross, Hedges, & Prochaska, 2002).

Basic Concepts

There are numerous pathways toward integrative psychotherapies; many roads lead to an integrative Rome. The four most popular routes are technical eclecticism, theoretical integration, common factors, and assimilative integration. Research (Norcross, Karpiak, & Lister, 2005) reveals that each is embraced by a considerable number of self-identified eclectics and integrationists (19% to 28% each). All four routes are characterized by a desire to increase therapeutic efficacy and applicability; all look beyond the confines of single approaches; but all are also distinctive and focus on different levels of patient–therapy process.

Technical eclecticism seeks to improve our ability to select the best treatment techniques or procedures for the person and the problem. This search is guided primarily by research on what specific methods have worked best in the past with similar problems and patient characteristics. Eclecticism focuses on predicting for whom interventions will work; its foundation is actuarial rather than theoretical.

Technical eclectics use procedures drawn from different therapeutic systems without necessarily subscribing to the theories that spawned them, whereas theoretical integrationists draw their concepts and techniques from diverse systems that may be epistemologically or ontologically incompatible. For technical eclectics, no necessary connection exists between conceptual foundations 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).

In *theoretical integration,* two or more therapies are integrated with 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 techniques from each. Treatment models that integrate psychoanalytic and interpersonal theories, cognitive and behavioral theories, or systems and humanistic theories illustrate this path.

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 therapies. Integration aspires to

more than a simple combination; it seeks an emergent theory that is more than the sum of its parts.

The *common factors* approach seeks to identify core ingredients shared by different therapies, 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 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, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003).

Assimilative 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, 2001). 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 cognitive therapist, for example, might use the gestalt two-chair dialogue in an otherwise cognitive course of treatment.

To its proponents, assimilative integration is a realistic way station on the path to a sophisticated integration; to its detractors, it is a waste station of people unwilling to commit themselves to a full evidence-based eclecticism. Both camps agree that assimilation is a tentative step toward full integration: Most therapists gradually incorporate parts and methods of other approaches once they discover the limitations of their original approach. Inevitably, therapists gradually integrate new methods into their home theory.

Of course, these four integrative pathways are not mutually exclusive. No technical eclectic can disregard theory, and no theoretical integrationist can ignore technique. Without some commonalities among different schools of psychotherapy, theoretical integration would be impossible. Assimilative integrationists and technical eclectics both believe that synthesis should occur at the level of practice, rather than theory, by incorporating therapeutic methods from multiple schools. And even the most ardent proponent of common factors cannot practice "nonspecifically" or "commonly" on their own; specific techniques must be applied.

In some circles, the terms *integrative* and *eclectic* have acquired emotionally ambivalent connotations because of their alleged disorganized and indecisive nature. However, much of this opposition should be properly redirected to *syncretism*—uncritical and unsystematic combinations. This haphazard approach is primarily an outgrowth of pet techniques and inadequate training. It is an arbitrary blend of methods without systematic rationale or empirical verification (Eysenck, 1970).

Psychotherapy integration, by contrast, is the product of years of painstaking training, research, and experience. It is integration by design, not default; that is, clinicians competent in several therapeutic systems systematically select interventions and concepts on the basis of comparative outcome research and patient need. The strengths of systematic integration lie in the ability to be taught, replicated, and evaluated.

Our own approach to psychotherapy is broadly characterized as integrative and is specifically labeled *systematic eclectic* or *systematic treatment selection*. We intentionally blend several of the four paths toward integration. Concisely put, we attempt to customize psychological treatments and therapeutic relationships to the specific and varied needs of individual patients as defined by a multitude of diagnostic and particularly nondiagnostic considerations. We do so by drawing on effective methods across theoretical schools (eclecticism), by matching those methods to particular clients on the basis of evidence-based principles (treatment selection), and by adhering to an explicit and orderly (systematic) model.

Although some integrative therapies, particularly those identified with technical eclecticism, provide menus of specific methods, we are committed to defining broader change principles, leaving the selection of specific methods that comply with these principles to the proclivities of the individual therapist. Accordingly, our integrative therapy is expressly designed to transcend the limited applicability of single-theory or "school-bound" psychotherapies. This is accomplished by integrating research-based change principles rather than through a closed theory or a limited set of techniques.

In other words, our integrative therapy ascertains the treatments (and therapeutic relationships) of choice for individual patients rather than restricting itself to a single view of psychopathology and/or change mechanisms. We believe that no theory is uniformly valid and no mechanism of therapeutic action is applicable to all individuals. Thus, we strive to create a new therapy for each patient. We believe that the purpose of integrative psychotherapy is *not* to create a single system or a unitary treatment. Rather, we select different methods according to the patient's response to the treatment goals, following an established set of integrative principles. The result is a more efficient and efficacious therapy—and one that fits both the client and the clinician.

On the face of it, virtually all clinicians endorse matching the therapy to the individual client. After all, who can seriously dispute the notion that psychological treatment should be tailored to the needs of the individual patient in order to improve its success? However, integrative therapy goes beyond this simple acknowledgment in at least four ways.

1. Our treatment selection is derived directly from outcome research rather than from the idiosyncratic theory of the clinician. In our view, empirical knowledge and scientific research are the best arbiters of theoretical differences when it comes to health care.

2. We embrace the potential contributions of multiple systems of psychotherapy rather than working from within a single system. All psychotherapies have a place, but a specific and differential place.

3. Our treatment selection is predicated on multiple diagnostic and nondiagnostic client dimensions, in contrast to the typical reliance on the single, static (and often global) dimension of patient diagnosis. It is frequently more important to know the patient who has the disorder than to know the disorder the patient has.

4. Our aim is to offer treatment methods *and* relationship stances, whereas most theorists focus narrowly on methods alone. Both interventions and relationships, both the instrumental and the interpersonal—intertwined as they are—are required, indeed inevitably involved, in effective psychotherapy.

Other Systems

Integrative psychotherapies gratefully acknowledge the contributions of the traditional, single-school therapy systems, such as psychoanalytic, behavioral, cognitive, experiential, and other unitary systems. Such pure-form therapies are part and parcel of the foundation for integrative approaches. Integration, in fact, could not occur without the constituent elements provided by these respective therapies—their theoretical systems and clinical methods. Integration gathers, in the words of Abraham Lincoln, "strange, discordant, and even, hostile elements from the four winds."

In a narrow sense, pure-form or single-school therapies do not contribute to integration because, by definition, they have no provisions for synthesizing various interventions and conceptualizations. But in a broader and more important sense, they add to the 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.

The goal of integration, as we have repeatedly emphasized, is to improve the efficacy and applicability of psychotherapy. Toward this end, we must collegially recognize the valuable contributions of pure-form therapies and collaboratively enlist their respective strengths.

Even so, it is important to remember that most single-school therapies also manifest several weaknesses. First, the creation of most psychotherapies is more rational than empirical. Originators developed their therapies without, or with little regard to, the research evidence on their effectiveness. Perhaps as a result, many traditional systems of psychotherapy (classical psychoanalysis, Jungian, and existential, to name a few) have still amassed little controlled outcome research. We highly value empirical evidence, not as an infallible guide to truth, but as the most reliable means to conduct and evaluate psychotherapy, integrative or otherwise.

Second, single-school therapies tend to favor the strong personal opinions, if not pathological conflicts, of their originators. Sigmund Freud found psychosexual conflicts in practically all his patients, Carl Rogers found compromised conditions of worth in practically all his patients, Joseph Wolpe found conditioned anxiety in practically all his patients, and Albert Ellis found maladaptive thinking in practically all his patients. However, patients do not routinely suffer from the favorite problems of famous theorists. It strikes us as far more probable that patients suffer from a multitude of specific problems that should be remedied with a similar multitude of methods.

Third and relatedly, most pure-form systems of psychotherapy recommend their treasured treatment for virtually every patient and problem they encounter. Of course, this simplifies treatment selection—give every patient the same brand of psychotherapy!—but it flies in the face of what we know about individual differences, patient preferences, and disparate cultures. It is akin to seeking the remedy for all ills in a hardware store, simply because it is a "good store." The clinical reality is that no single psychotherapy is effective for all patients and situations, no matter how good it is for some; relational-sensitive, evidence-based practice demands a flexible, if not integrative, perspective. Psychotherapy should be flexibly tailored to the unique needs and contexts of the individual client, not universally applied as one size fits all.

Imposing a parallel situation onto other health care professions drives the point home. To take a medical metaphor, would you entrust your health to a physician who prescribed the identical treatment (say, antibiotics or neurosurgery) for every patient and illness encountered? Or, to take an educational analogy, would you prize instructors who employed the same pedagogical method (say, a lecture) for every educational opportunity? Or would you entrust your child to a child care worker who delivers the identical response (say, a nondirective attitude or a slap on the bottom) to every child and every misbehavior? "No" is probably your resounding answer. Psychotherapy clients deserve no less consideration.

A fourth weakness of pure-form therapies is that they largely consist of descriptions of psychopathology and personality rather than of mechanisms that promote change. They are actually theories of personality rather than theories of psychotherapy; they offer lots of information on the content of therapy but little on the change process. We believe integrative theory should explain how people change. (Specific criticisms of 15 therapy systems from an integrative perspective can be found in Prochaska & Norcross, 2010).

We are convinced of the clinical superiority of a pluralistic or integrative psychotherapy. Among the advantages of integrative psychotherapies are those inferred from the foregoing criticisms of pure-form therapies: Integrative therapies tend to be more empirical in creation and more evidence based in revision; case conceptualization is predicated more on the actual patient than on an abstruse theory; therapy is more likely to be adapted or responsive to the unique patient and the singular situation; and treatment is more focused on the process of change than on the content of personality. In other words, integration promises more evidence, flexibility, responsiveness, and change.

HISTORY

Precursors

Integration as a point of view has probably existed as long as philosophy and psycho-therapy. In philosophy, the 3rd-century biographer Diogenes Laertius referred to an eclectic school that flourished in Alexandria in the second century (Lunde, 1974). In psychotherapy, Freud consciously struggled with the selection and integration of diverse methods. As early as 1919, he introduced psychoanalytic psychotherapy as an alternative to classical psychoanalysis in recognition that the more rarified approach lacked univer-sal applicability (Liff, 1992).

More formal ideas on synthesizing the psychotherapies appeared in the literature as early as the 1930s (Goldfried, Pachankis, & Bell, 2005). For example, Thomas French (1933) stood before the 1932 meeting of the American Psychiatric Association and drew parallels between certain concepts of Freud and of Pavlov. In 1936, Sol Rosenzweig published an article that highlighted commonalities among various systems of psycho-therapy. These and other early attempts at integration, however, were largely serendipi-tous, theory driven, and empirically untested.

If not conspiratorially ignored altogether, these precursors to integration appeared only as a latent theme in a field organized around discrete theoretical orientations. Al-though 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.

Beginnings

Systematic integration was probably inaugurated in the modern era by Frederick Thorne (1957, 1967), who is credited with being the grandfather of eclecticism in psychother-apy. Persuasively arguing that any skilled professional should come prepared with more than one tool, Thorne emphasized the need for clinicians to fill their toolboxes with methods drawn from many different theoretical orientations. He likened contemporary psychotherapy to a plumber who would use only a screwdriver in his work. Like such a plumber, inveterate psychotherapists applied the same treatment to all people, regard-less of individual differences, and expected the patient to adapt to the therapist rather than vice versa.

Thorne's admonitions went largely ignored, as did a book published more than a decade later by Goldstein and Stein (1976) that first identified the *Prescriptive Psycho-therapies* of its title. This book, far ahead of its time, outlined treatments for different people based on the nature of their problems and on aspects of their living situations.

Since the late 1960s, Arnold Lazarus (1967, 1989) has emerged as the most promi-nent spokesperson for eclecticism. His influential *multimodal therapy* inspired a genera-tion of mental health professionals to think and behave more broadly. He was joined by the two of us and others soon thereafter (e.g., Beutler, 1983; Frances, Clarkin, & Perry, 1984; Norcross, 1986, 1987).

Simultaneously, efforts were under way to advance common factors. In his clas-sic *Persuasion and Healing*, Jerome Frank (1973) posited that all psychotherapeutic methods are elaborations and variations of age-old procedures of psychological heal-ing. Frank argued that therapeutic change is predominantly a function of four factors common to all therapies: an emotionally charged, confiding relationship; a healing set-ting; a rationale or conceptual scheme; and a therapeutic ritual. Nonetheless, the fea-tures that distinguish psychotherapies from each other receive special emphasis in the

pluralistic, competitive American society. Little glory has traditionally been accorded to common factors.

In 1980, Sol Garfield introduced an eclectic psychotherapy predicated on common factors, and Marvin Goldfried published an influential article in the *American Psychologist* calling for the delineation of therapeutic change principles. Goldfried (1980), a leader of the integration movement, argued,

> To the extent that clinicians of varying orientations are able to arrive at a common set of strategies, 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. (p. 996)

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

In the late 1970s and the 1980s, several attempts at theoretical integration were introduced. Paul Wachtel authored the classic *Psychoanalysis and Behavior Therapy: Toward an Integration,* which attempted to bridge the chasm between the two systems. His integrative book began, ironically, in an effort to write an article portraying behavior therapy as "foolish, superficial, and possibly even immoral" (Wachtel, 1977, p. xv). But in preparing his article, he was forced for the first time to look closely at what behavior therapy was and to think carefully about the issues. When he observed some of the leading behavior therapists of the day, he was astonished to discover that the particular version of psychodynamic therapy toward which he had been gravitating dovetailed considerably with what a number of behavior therapists were doing. Wachtel's experience should remind us that separate and isolated theoretical schools perpetuate caricatures of other schools, thereby foreclosing basic changes in viewpoint and preventing expansion in practice.

The transtheoretical (across theories) approach of James Prochaska and Carlo DiClemente was also introduced in the late 1970s with the publication of one of the first integrative textbooks, *Systems of Psychotherapy: A Transtheoretical Analysis* (Prochaska, 1979). This book reviewed different theoretical orientations from the standpoint of common change principles and of the stages of change. The transtheoretical approach in general, and the stages of change in particular, are the most extensively researched integrative therapies (Schottenbauer, Glass, & Arnkoff, 2005).

Only within the past 30 years, then, has psychotherapy integration developed into a clearly delineated area of interest. The temporal course of interest in psychotherapy integration, as indexed by both the number of publications and the development of organizations and journals (Goldfried et al., 2005), reveals occasional stirrings before 1970, a growing interest during the 1970s, and rapidly accelerating interest from 1980 to the present. To put it differently, integrative psychotherapy has a long past but a short history as a systematic movement.

Current Status

Between one-quarter and one-half of contemporary clinicians disavow an affiliation with a particular school of psychotherapy, preferring instead the label of *eclectic* or *integrative*. Some variant of integration is routinely the modal orientation of responding psychotherapists. A review of 25 studies performed in the United States between 1953 and 1990 (Jensen, Bergin, & Greaves, 1990) reported a range from 19% to 68%. A more recent review of a dozen studies published during the past decade (Norcross, 2005) found that integration was still the most common orientation in the United States but that cognitive therapy was rapidly challenging it and might soon become the modal theory. That same review also determined that integration receives robust but lower endorsement outside

of the United States and Western Europe. Thus, integration is typically the modal orientation in the United States, but not in other countries around the world.

The prevalence of integration can be ascertained directly by assessing endorsement of the integrative orientation (as above) or gleaned indirectly by determining endorsement of multiple orientations. For example, in a study of Great Britain counselors, 87% did *not* take a pure-form approach to psychotherapy (Hollanders & McLeod, 1999). In a study of clinical psychologists in the United States, for another example, fully 90% embraced several orientations (Norcross, Karpiak, & Santoro, 2005). Very few therapists adhere exclusively to a single therapeutic tradition.

The establishment of several international organizations both reflects and reinforces the popularity of integrative psychotherapies. Two interdisciplinary societies, the Society for the Exploration of Psychotherapy Integration (SEPI) and the Society of Psychotherapy Research (SPR), hold annual conferences devoted to the pluralistic practice and ecumenical research of psychotherapy. Both societies also publish international scientific journals: SEPI's *Journal of Psychotherapy Integration* and SPR's *Psychotherapy Research*.

Psychotherapy integration, then, has taken earliest and strongest root in the United States. Nonetheless, it is steadily spreading throughout the world and is becoming an international movement. Both SPR and SEPI now have multiple international chapters and regularly hold their annual meetings outside the United States.

In past years, psychotherapists were typically trained in a single theoretical orientation. The ideological singularity of this training did not always result in clinical competence, but it did reduce clinical complexity and theoretical confusion (Schultz-Ross, 1995). In recent years, psychotherapists have come to recognize that single orientations are theoretically incomplete and clinically inadequate for the variety of patients, contexts, and problems they confront in practice. They are receiving training in several theoretical orientations—or at least are exposed to multiple theories, as evidenced in this book.

The evolution of psychotherapy training has moved the field further toward integration, but this may have been a mixed blessing. On the one hand, 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 under different treatments, formats, and relationships. On the other hand, integrative training increases the pressure for students to obtain clinical competence in multiple methods and formats and, in addition, challenges the faculty to create a coordinated training enterprise (Norcross & Halgin, 2005).

Recent studies indicate that training directors are committed to psychotherapy integration but disagree on the best route toward it. Approximately 80 to 90% of directors of psychology programs and internship programs agree that knowing one therapy system is not sufficient; instead, training in a variety of models is needed. However, their views on the optimal integrative training process differ. About one-third believe that students should be trained first to be proficient in one therapeutic system; about half believe that students should be trained to be at *least* minimally competent in a variety of systems; and the remainder believe that students should be trained in a specific integrative system from the outset (Lampropoulos & Dixon, 2007).

Multimedia procedures may increase the effectiveness of training in integrative psychotherapies. A pilot study using a virtual patient (Beutler & Harwood, 2004) reported case-by-case success in training clinicians to recognize cues suggesting which treatment is likely to be most effective for the patient. A computerized treatment selection procedure has been developed (Harwood & Williams, 2003) to help clinicians plan treatment.

More recently, we launched a user-friendly Web site (www.innerlife.com) that clients can access for free in order to help them select the optimal psychotherapy for them. Taking Systematic Treatment (ST) requires approximately 15 minutes and takes

the person through a series of item-branching questions. At completion, ST renders a report addressing six critical treatment issues tailored to the person:

- Potential Areas of Concern
- Treatments to Consider
- Treatments to Avoid
- Compatible Therapist Styles
- Picking a Psychotherapist
- Self-Help Resources

The ensuing treatment recommendations in this system are governed by 30 years of research on identifying evidence-based principles that point to optimal relations among patient characteristics (including diagnosis), treatment methods, and the therapeutic relationship.

Integrative training 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. The hope is that educators will develop and deliver integrative products that are less parochial, 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 a manner that is consistent with the pluralism and openness of integration itself. The intention of integrative training is not necessarily to produce card-carrying, flag-waving "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 liberating in content but certainly not in process. Instead, the goal is to educate therapists to think (and, perhaps, to behave) integratively—openly, flexibly, synthetically, but critically—in their clinical pursuits (Norcross & Halgin, 2005).

Integrative therapies respond to the mounting demands for short-term and evidence-based treatments in mental health. With 90% of all patients in the United States covered by some variant of managed care, short-term therapy has become the de facto treatment imperative. Integration, particularly in the form of technical eclecticism, responds to the pragmatic injunction of "whatever therapy works better—and quicker—for this patient with this problem."

The international juggernaut of evidence-based practice (EBP) lends increased urgency to the task of using the best of research and experience to tailor psychological treatment to the client (Norcross, Beutler, & Levant, 2006). Data-based clinical decision making will become the norm. Evidence-based practice has sped the breakdown of traditional schools and the escalation of informed pluralism (Norcross, Hogan, & Koocher, 2008). The particular decision rules for what qualifies as evidence remain controversial, but EBP reflects a pragmatic commitment to "what works for whom." The clear emphasis is on what works, not on what theory applies. Integrative therapies stand ready to meet this challenge.

PERSONALITY

Theory of Personality

Beginning with Freud, most psychotherapy systems have consisted primarily of theories of personality and psychopathology (*what* to change). This is not true of most integrative therapies, which instead emphasize the process of change (*how* to change).

The integration is directly focused on the selection of therapy methods and relationships as opposed to theoretical constructs of how people and psychopathology develop. Although a latent theory necessarily underpins any treatment, integrative therapy is relatively personality-less and immediately change-full.

Our integrative conceptualization makes no specific assumptions about how personality and psychopathology occur. Such a determination is relatively unimportant if one knows what therapy methods and relationships are likely to evoke a positive response in a specific patient. Effective treatment can be applied from a wide number of theories or from no theoretical framework at all.

To the limited extent that they exist, integrative theories of personality are predictably broad and inclusive. They embrace life-span approaches of developmental psychology. They reflect that humans are, whether functional or dysfunctional, the products of a complex interplay of our genetic endowment, learning history, sociocultural context, and physical environment.

Variety of Concepts

To say that integrative therapies do not rely on a theory of personality is not to say that they pay no heed to personality characteristics. Indeed they do. As detailed in the next section, the patient's personality is a key determinant in integrative therapy, as are the therapist's personality and their mutual match. However, personality characteristics are not separated out into a broader theory of human development and motivation. Like all other patient characteristics in integrative therapy, personality traits are incorporated to the extent that the research evidence has consistently demonstrated that identifying them contributes to effective treatment.

Our data-based therapy eschews the view that one needs to know how a problem developed in order to solve it. Instead, we assert that when one encounters particular behavior patterns or environmental characteristics, it is more important to know what treatment is likely to promote change.

In the next section, we will describe several personality characteristics that the research indicates are useful in helping the clinician improve the efficacy of psychotherapy. To anticipate ourselves, we will present here an example of how personality concepts differ between conventional psychotherapies and integrative therapies.

A patient's coping style is a vital personality characteristic to consider when deciding to conduct insight-oriented or symptom-change methods. Coping style is an enduring quality defined by what one does when confronted with new experience or stress. A person may engage in a cluster of behaviors that disrupt social relationships, such as impulsivity, blaming, and rebellion, on the one hand, or in a cluster of behaviors that increase personal distress, such as self-blame, withdrawal, and emotional constriction, on the other. These clusters are relatively enduring, they cut across situations, and they distinguish among people. Thus, they are personality characteristics. But integrative therapy makes little effort to understand why they occur and makes few efforts to say how they are related to other key qualities of treatment selection, such as the amount of social support and the stage of change. Although there may be correlations among these dimensions, the intercorrelations assume far less importance than knowing how they impact psychotherapy and improve its success.

Our integrative approach is principally concerned with tailoring psychotherapy to the patient's personality, not with developing a theory about that personality. We are committed to the remediation of psychopathology, not preoccupied with its explanation. Let us now move on to the practice of integrative psychotherapy.

PSYCHOTHERAPY

Theory of Psychotherapy

In contrast to the absence of a cohesive theory of personality and psychopathology, integrative psychotherapy strongly values clinical assessment that guides effective treatment. Such assessment is conducted early in psychotherapy to select treatment methods and therapy relationships that are most likely to be effective, throughout therapy to monitor the patient's response and to make mid-course adjustments as needed, and toward the end of psychotherapy to evaluate the outcomes of the entire enterprise. Thus, assessment is continuous, collaborative, and invaluable.

In this section, we begin with an extensive discussion of clinical assessment that fuels and guides treatment selection. This account then segues naturally into the process of psychotherapy, just as it does in actual practice.

Clinical Assessment

Clinical assessment of the patient in integrative therapy is relatively traditional, with one major exception. The assessment interview(s) entail collecting information on presenting problems, relevant histories, and treatment expectations and goals, as well as building a working alliance. As psychologists, we also typically use formal psychological testing as a means of securing additional data and identifying Axis I and Axis II disorders. We recommend both symptomatic rating forms (e.g., Beck Depression Inventory II, Symptom Checklist-90R) and broader measures of pathology and personality (e.g., Minnesota Multiphasic Personality Inventory-II, Millon Clinical Multiaxial Inventory-III).

The one way in which assessment for integrative therapy departs from the usual and traditional is that we collect, from the outset, information on multiple patient dimensions that will guide treatment selection. In fact, the computer-based assessments for both clinicians and clients described earlier enhance the development of treatment plans within the integrative tradition (Beutler & Groth-Marnat, 2003; Harwood & Williams, 2003).

In order to apply treatment-focused assessment, integrative therapy is faced with the central challenge of identifying those patient dimensions and corresponding treatment qualities that will improve our treatment decisions. There are tens of thousands of potential permutations and combinations of patient, therapist, treatment, and setting variables that could contribute. We rely primarily on the available empirical research to identify a limited number of patient dimensions that influence therapy success, and we use focused assessments to target those dimensions that are most predictive of differential treatment response.

This assessment tactic is not without several problems. The main problem has always been the sheer number of potentially valuable patient characteristics that have been researched. Even if all were effective predictors of change, there are far too many of them for clinicians to organize and use consistently. Moreover, researchers may disagree about which characteristics of patients and therapies are the most important. Both of these problems must be overcome before it is possible to balance and weigh their contributions in a predictive algorithm.

Fortunately, our programmatic research over the years (see Beutler, Clarkin, & Bongar, 2000) addressed these problems by sequencing three strategies to identify the most potent patient contributors to change and the treatment qualities with which they interact. First, we reviewed an extensive body of research in order to identify what characteristics had been found that contributed to treatment success. Second, these characteristics were reduced in number by a process of iterative discussions and review of research studies. Third, we undertook a cross-validation study on nearly 300 depressed patients. A sophisticated statistical analysis (structural equation modeling)

led to further reductions in the numbers of patient and treatment qualities to the most efficient few. Algorithms were developed to predict change, and these were then used to help clinicians plan treatment.

Five Patient Characteristics

In this chapter, we present a sampling of five patient characteristics commonly used by integrative psychotherapists. These patient characteristics guide us in identifying a beneficial fit between patient and treatment. Of course, integrative therapists are not confined to these five considerations in making treatment decisions, but they do illustrate the process of clinical assessment and treatment matching in integrative psychotherapies.

Diagnosis. We organize our treatment planning in part around the disorders as described in DSM-IV. Although diagnosis alone is not sufficient, there are practical reasons why diagnosis is necessary. First, insurance companies demand a diagnosis, and utilization review is done in reference to diagnosis. Second, treatment research is usually organized around the task of determining what is helpful to specific diagnostic groups, and the major symptoms comprising a diagnosis make a suitable way of evaluating the effectiveness of treatment. In order to profit from this research, one must know the patient's diagnosis. Third, specialized and manualized treatments have been developed for many disorders.

At the same time, there are many reasons why diagnosis alone is insufficient for treatment planning. Diagnoses are pathology oriented and neglect a patient's strengths. The criteria established for disorders are multiple, change continually, and select different groups of patients. Axis I patients may also suffer from comorbid Axis I disorders, in addition to one or more Axis II disorders. Few treatments exert effects that are restricted or specific to a particular diagnostic group. It is for these reasons that one must formulate treatment plans for individuals, not for isolated disorders.

We focus on Axis I and Axis II disorders for treatment planning. However, the combination of all five axes—a large array of possibilities—must be considered in treatment planning for the individual. In the multiaxial DSM-IV, the diagnosis is not limited to Axis I (symptoms) and Axis II (personality disorders) considerations but includes environmental stress (Axis IV) and overall functioning (Axis V). This is why it should be no surprise that patients sharing the same Axis I disorder could and should receive quite different treatments. The Axis V or GAF rating may be of particular importance in treatment planning, serving as a simple index of the patient's level of functional impairment.

Stages of Change. The stages represent a person's readiness to change, defined as a period of time as well as a set of tasks needed for movement to the next stage. The stages are behavior and time specific, not enduring personality traits. *Precontemplation* is the stage at which there is no intention to change behavior in the foreseeable future. Most individuals in this stage are unaware or underaware of their problems; however, their families, friends, and employers are often well aware that the precontemplators have problems. When precontemplators present for psychotherapy, they often do so because of pressure or coercion from others. Resistance to recognizing or modifying a problem is the hallmark of precontemplation.

Contemplation is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action. People can remain stuck in the contemplation stage for years. Contemplators struggle with their positive evaluations of their dysfunctional behavior and the amount of effort, energy, and loss it will cost to overcome it. Serious consideration of problem resolution is the central element of contemplation.

Preparation is a stage that combines intention and behavioral criteria. Individuals in this stage intend to take action in the near future and have unsuccessfully taken action in the past year. Individuals who are prepared for action report small behavioral changes, such as drinking less or contacting health-care professionals. Although they have reduced their problem, they have not yet reached a threshold for effective action, such as abstinence from alcohol abuse. They are intending, however, to take such action in the very near future.

Action is the stage in which individuals modify their behavior, experiences, and/or environment in order to overcome their problems. Action involves the most overt behavioral changes and requires considerable commitment of time and energy. Behavioral changes in the action stage tend to be most visible and externally recognized. Modification of the target behavior to an acceptable level and concerted efforts to change are the hallmarks of action.

Maintenance is the stage in which people work to prevent relapse and consolidate the gains attained during action. For addictive behaviors, this stage extends from 6 months to an indeterminate period past the initial action. For some behaviors, maintenance can be considered to last a lifetime. Being able to remain free of the problem and to consistently engage in a new, incompatible behavior for more than 6 months are the criteria for maintenance.

A patient's stage of change suggests the use of certain treatment methods and relationships. Table 14.1 illustrates where leading systems of therapy are probably most effective in the stages of change. Methods and strategies associated with psychoanalytic and insight-oriented psychotherapies are most useful during the earlier precontemplation and contemplation stages. Existential, cognitive, and interpersonal therapies are particularly well suited to the preparation and action stages. Behavioral methods and exposure therapies are most useful during action and maintenance. Each therapy system has a place, a differential place, in the big picture of behavior change.

The therapist's relational stance is also matched to the patient's stage of change. The research and clinical consensus on the therapist's stance at different stages can be characterized as follows (Prochaska & Norcross, 2002). With precontemplators, often the therapist's stance is like that of a nurturing parent joining with the resistant youngster who is both drawn to and repelled by the prospect of becoming more independent.

TABLE 14.1   Integration of Psychotherapy Systems within the Stages of Change

Stages of Change				
Precontemplation	**Contemplation**	**Preparation**	**Action**	**Maintenance**
Motivational interviewing				
Strategic family therapy				
Psychoanalytic therapy				
	Analytical therapy			
	Adlerian therapy			
		Existential therapy		
		Rational emotive behavior therapy (REBT)		
		Cognitive therapy		
		Interpersonal therapy (IPT)		
		Gestalt therapy		
			Behavior therapy	
			Structural family therapy	
			EMDR and exposure	

With contemplators, the therapist's role is akin to that of a Socratic teacher who encourages clients to develop their own insights and ideas about their condition. With clients who are preparing for action, the therapist is like an experienced coach who has been through many crucial matches and can provide a fine game plan or can review the person's own action plan. With clients who are progressing into maintenance, the integrative psychotherapist becomes more of a consultant who is available to provide expert advice and support when action is not progressing as smoothly as expected.

Coping Style.   The client's coping style consists of his or her habitual behavior when confronting new or problematic situations. Patients tend to adopt a style of coping that places them somewhere between two extreme but relatively stable types. They are identified by which of the prototypical end points they most resemble when confronted with a problem and the need to make change. Simply, they tend either toward *externalizing* coping (impulsive, stimulation-seeking, extroverted) and *internalizing* coping (self-critical, inhibited, introverted).

Coping style is a marker for whether the psychotherapy should ideally focus on symptomatic reduction or broader thematic objectives. Symptom-focused and skill-building therapies are more effective among externalizing patients. Acting-out children and impulsive adults, for example, are usually best served by reducing their problems via skill development methods. By contrast, a shift from a skill building or symptom focus to the use of insight and awareness-enhancing therapies is typically most effective among internalizing patients. Methods here vary from therapist to therapist but may well include interpretations of the parent–child linkage, analysis of transference and resistance, review of recurrent themes, and exercises to enhance awareness of feelings. Nonetheless, research suggests that moving from a symptomatic to an insight focus is most supportive of change among these patients (Beutler, Clarkin, & Bongar, 2000).

Reactance Level.   Patient reactance is a variation of behaviors that are often described as "resistance." A reactant patient is easily provoked by and responds oppositionally to external demands. The propensity to engage in a reactant pattern is a reliable marker for the amount of therapist directiveness to be employed. High reactance indicates the need for nondirective, self-directed, or paradoxical techniques. Conversely, low reactance indicates the patient's accessibility to a wider range of directive techniques, including therapist control. In other words, the use of nondirective and self-directed interventions improves effectiveness with highly resistant patients. By contrast, directive and structured techniques, such as cognitive restructuring, advice, and behavior contracting, improve effectiveness with less resistant patients.

Patient Preferences.   When ethically and clinically appropriate, we accommodate a client's preferences in psychotherapy. These preferences may be heavily influenced by the client's sociodemographics—gender, ethnicity, culture, and sexual orientation, for example—as well as by their attachment styles and previous experiences in psychotherapy. These preferences may be related to the person of the therapist (age, gender, religion, ethnicity/race), to the therapeutic relationship (how warm or tepid, how active or passive, and so on), to therapy methods (preference for or against homework, dream analysis, two-chair dialogues), or to treatment formats (refusing group therapy or medication).

We work diligently in the beginning sessions to identify our patients' strong preferences and subsequently to accommodate these preferences when feasible. Controlled research (Swift & Callahan, 2009) and clinical experience demonstrate that attending to what the patient desires decreases misunderstandings, facilitates the alliance, and establishes collaboration—all relationship qualities connected to therapy success (Norcross,

2002). It would be naïve to assume that patients always know what they want and what is best for them. But if clinicians had more respect for the notion that their clients often sense how they can best be served, fewer relational mismatches might occur (Lazarus, 1993).

Summary.   The five client characteristics listed above serve as reliable markers to systematically tailor treatment to the individual patient, problem, and context. Although this list is likely to change as research progresses, these variables have evolved from extensive reviews and meta-analyses of treatment research. These client characteristics, including but not limited to diagnosis, can be applied independently of a specific theoretical orientation. All of this is to say that psychotherapy has progressed to the point where clinically relevant and readily assessable patient characteristics can suggest specific treatments and thereby enhance the effectiveness of our clinical work.

Process of Psychotherapy

The integrative imperative to match or tailor psychotherapy to the patient can be (and has been) misconstrued as an authority-figure therapist prescribing a specific form of psychotherapy for a passive client. The clinical reality is precisely the opposite. Our goal is for an empathic therapist to work toward an optimal relationship that both enhances collaboration and secures the patient's sense of safety and commitment. The nature of such an optimal relationship is determined both by patient preferences and by therapist's knowledge of how the client's personality determines his or her behavior. If a client frequently resists, for example, then the therapist considers whether she is pushing something that the client finds incompatible (preferences), or the client is not ready to make changes (stage of change), or is uncomfortable with a directive style (reactance). Integrative psychotherapy leads by following the client (Norcross, 2010).

Change takes place through interrelated processes: the nature of the patient–therapist relationship, the treatments that are used, and the way the patient avoids relapse. A comprehensive treatment involves defining the setting in which treatment will be applied, the format of its delivery, its intensity, the role of pharmacotherapy (medications), and the particular therapeutic strategies and techniques.

Therapeutic Relationship

All psychotherapy occurs within the sensitive and curative context of the human relationship. Empirically speaking, therapy success can best be predicted by the properties of the patient and of the therapy relationship (see Norcross, 2002, for reviews); only 10 to 15% of outcome is generally accounted for by any particular treatment technique.

It is a colossal misunderstanding to view treatment selection as a disembodied, technique-oriented process. Integrative psychotherapies attempt to customize not only therapy techniques but also relationship stances to individual clients. One way to conceptualize the matter, paralleling the notion of "treatments of choice" in terms of techniques, is how clinicians determine "therapeutic relationships of choice" in terms of interpersonal stances (Norcross & Beutler, 1997).

In creating and cultivating the therapy relationship, we rely heavily on clinical experience and empirical research on what works. Reviews of hundreds of studies indicate that the therapeutic alliance, empathy, goal consensus, and collaboration are demonstrably effective (Norcross, 2002). Collecting feedback from the client about his/her progress and satisfaction throughout the course of psychotherapy also demonstrably improves success (Lambert, 2005). Therapists' positive regard, congruence, feedback, moderate self-disclosure, and management of their countertransference are probably

effective (Norcross, 2002). Conducting the best of evidence-based treatment all comes to naught unless the client feels connected and participates willingly.

Early on, then, we strive to develop a working alliance and to demonstrate empathy for the client's experiences and concerns. We proceed collaboratively in establishing treatment goals, in securing the patient's preferences, in allaying the initially expected distrust and fear, and in presenting ourselves as caring and supportive. Of course, the therapy relationship must also be matched or tailored to the individual patient.

Treatment Planning

Treatment planning invariably involves the interrelated decisions about setting, format, intensity, pharmacotherapy, and strategies and techniques. The important point here is that each client will respond best to a different configuration or mix of components. We cannot and should not assume that the treatment will automatically be outpatient individual therapy on a weekly basis. Below we consider each of these decisions, devoting more time to the strategies and methods.

Treatment Setting. The setting is where the treatment occurs—a psychotherapist's office, a psychiatric hospital, a halfway house, an outpatient clinic, a secondary school, a medical ward, and so on. The choice of setting depends primarily on the relative need for restricting and supporting the patient, given the severity of psychopathology and the support in the patient's environment.

Each treatment decision is related to the other treatment decisions, as well as to certain patient characteristics (to be considered shortly). The optimal setting, for example, is partially determined by symptomatic impairment and partially reflects reactance level. Those clients who are most impaired and resistant have the greatest need for a restrictive environment. Outpatient treatment is always preferred over a restrictive setting; indeed, preference is nearly always for the least restrictive setting.

Treatment Format. The format indicates who directly participates in the treatment. It is the interpersonal context within which the therapy is conducted. The typical treatment formats—individual, group, couples, and family—are characterized by a set of treatment parameters, all determined largely by the number and identities of the participants. (See the Treatment section in this chapter for additional remarks on treatment formats.)

Treatment Intensity. The intensity of psychotherapy is the product of the *duration* of the treatment episode, the *length* of a session, and the *frequency* of contact. It may also involve the use of multiple formats, such as both group and individual therapy or both pharmacotherapy and psychotherapy.

Intensity should be gauged as a function of problem complexity and severity, also taking into account the patient's resources. For example, a patient with a multiplicity of treatment goals, severe functional impairment, few social supports, and a personality disorder is likely to require substantially longer, more intense, and more varied treatment than a patient with a simpler problem. Brief treatments are obviously not for everyone; many patients will need long-term treatment or lifetime care.

Pharmacotherapy. Decades of clinical research and experience have demonstrated that psychotropic medications are particularly indicated for more severe and chronic disorders. If pharmacotherapy is indicated, the question becomes how it should be prescribed: Which medication in which dosage and for how long?

Unlike some systems of psychotherapy, integrative psychotherapies are well suited to the integration of pharmacotherapy and psychotherapy. This position, of course, is consistent with the pluralism underlying treatment selection.

At the same time, we would offer a cautionary note here. Tightening insurance reimbursements and restrictions on mental health care are unduly favoring pharmacotherapy at the expense of psychotherapy. This situation is clinically and empirically appalling to us because research indicates that, in fact, there is frequently no stronger medicine than psychotherapy (e.g., Antonuccio, 1995; DeRubeis, Hollon, et al., 2005). The preponderance of scientific evidence shows that psychotherapy is generally as effective as medications in treating most nonpsychotic disorders, especially when patient-rated measures and long-term follow-ups are considered. This is not to devalue the salutary impact of pharmacotherapy; rather, it is to underscore the reliable potency of psychotherapy. In addition, we believe that combined treatments should be carefully coordinated and should entail psychoeducation for patients and their support system. Medication alone is not an integrative treatment.

Strategies and Techniques.   When clinicians first meet clients, they are tempted to focus immediately and intensely on particular therapy strategies and techniques. However, as we have noted, treatment selection always involves a cascading series of interrelated decisions. A truly integrated treatment will recursively consider these other decisions before jumping to therapy strategies.

The selection of techniques and strategies is the most controversial component of integrative therapies. Proponents of disparate theoretical orientations endorse decidedly different views of what appear to be the same techniques. Moreover, any given technique can be used in different ways. Thus, rather than focusing on specific techniques per se, we prefer prescribing change principles. These principles can be implemented in a number of ways and with diverse techniques. By mixing and matching procedures from different therapy systems, we tailor the treatment to the particular patient.

Humans, including psychotherapists, cannot process more than four or five matching dimensions at once (Halford, Baker, McCredden, & Bain, 2005). As illustrated above, we principally consider five patient characteristics (diagnosis, stage of change, coping style, reactance level, and patient preferences) that have a proven empirical track record as prescriptive guidelines.

Relapse Prevention.   Tailoring psychotherapy to the individual patient, as we have described, enhances the effectiveness of psychotherapy. But even when psychotherapy is effective, relapse is the rule rather than the exception in many behavioral disorders, particularly the addictive, mood, and psychotic disorders. Thus, teaching relapse prevention to clients toward the end of psychotherapy is strongly advisable in practically all cases.

Relapse prevention helps clients identify "high risks" for regression, makes plans for avoiding such situations, and builds maintenance skills (Marlatt & Donovan, 2007). The patient and therapist examine the environment in which the patient lives, works, and recreates and then pinpoint those locations, people, and situational demands that have characteristically provoked dysfunction This analysis is coupled with teaching the patient to identify cues that signal when he or she is beginning to experience the depression, anxiety, or even euphoria that has typically preceded problem onset. These cues are linked to alternative behaviors that involve help seeking, self-control practice, and avoidance of overwhelming situational stress. Finally, in most circumstances, we try to overcome obstacles that may prevent the patient from seeking help from us or from other mental health professionals once again.

Maintenance sessions are indicated when the problem is complex, when the patient suffers from high functional impairment, and when a personality disorder is present. Maintenance work may also be indicated when the course of treatment is erratic and when symptom resolution is not consistently obtained within a period of 6 months. These features are particularly strong indicators of the tendency to relapse, and maintenance sessions can address emerging problems before they are recognized by the patient.

Mechanisms of Psychotherapy

Integrative psychotherapies do not presume single or universal change mechanisms. The mechanism of action may be very different for different individuals, even though they all may manifest similar symptoms. To an individual who is defensive, the mechanism may be the benevolent, corrective modeling of trust and collaboration offered by an empathic therapist, but for an individual who is trusting and self-reflective, the mechanism of action may be insight and reconceptualization. Similarly, the change mechanism for helping a fearful and anxious patient may be exposure to feared events and supportive reassurance. The point is that there are multiple pathways of change.

Table 14.2 presents nine mechanisms of action or, as we would prefer to call them, change processes. These processes have received the most empirical support to date in our research. The change processes most often used by psychotherapists are consciousness raising and the helping relationship. Virtually all therapies endorse the expansion of consciousness and the therapeutic relationship as potent mechanisms of action or change processes. The least frequently used processes are environmental control and

TABLE 14.2 **Nine Change Processes and Representative Therapy Methods**

Change Process	Definition: Representative Methods
Consciousness raising	Increasing awareness about self and problem: observations; reflections; confrontations; interpretations; bibliotherapy
Self-reevaluation	Assessing how one feels and thinks about oneself with respect to a problem: value clarification; imagery; corrective emotional experience
Emotional arousal	Experiencing and expressing feelings about one's problems: expressive exercises; psychodrama; grieving losses; role playing
Social liberation	Increasing alternatives in society: advocating for rights of oppressed; empowering; policy interventions
Self-liberation	Choosing and committing to act or belief in ability to change: decision-making therapy; logotherapy techniques; commitment-enhancing techniques
Counterconditioning	Substituting incompatible healthy alternatives for problem behaviors: relaxation; desensitization; assertion; cognitive restructuring
Environmental control	Re-engineering environmental stimuli that elicit problem behaviors: adding positive reminders; restructuring the environment; avoiding high-risk cues; fading
Contingency management	Rewarding oneself or being rewarded by others for making changes: contingency contracts; overt and covert reinforcement; self-reward
Helping relationships	Being understood, validated, and supported by a significant other: empathy, collaboration, positive regard, feedback, self-disclosure

Source: Adapted from Prochaska, Norcross, & DiClemente, 1995.

social liberation; the former is seen by some therapists as unduly emphasizing the power of the environment, the latter as improperly bordering on political advocacy.

Integrative therapists experience no hesitation in employing any or all of these change processes; we have no ideological axe to grind. Like therapists from single-school systems, integrative therapists rely heavily on consciousness raising and the therapeutic relationship. But unlike many therapists from single-school approaches, integrative therapists have at their disposal the full range of these change processes, ready to choose among them depending on the specific situation. Some cases call for building skills and implementing environmental control; addicts, in particular, need to learn to avoid people, places, and things that trigger their substance abuse. Other cases call for social liberation; oppressed and minority clients, in particular, profit from a therapist's modeling political advocacy and encouraging liberation strategies.

Moreover, these change processes are differentially effective at different stages of change. In general terms, change processes traditionally associated with the experiential and psychoanalytic persuasions are most useful during the earlier precontemplation and contemplation stages. Change processes traditionally associated with the existential, cognitive, and behavioral traditions, by contrast, are most useful during action and maintenance.

This pattern serves as an important guide. Once a patient's stage of change is evident, the integrative psychotherapist knows which change processes to apply in order to help that patient progress to the next stage of change. Rather than apply the change processes in a haphazard or trial-and-error manner, therapists can begin to use them in a much more systematic and effective way. It is not enough simply to declare that multiple change processes operate in psychotherapy; we must know how they can be selected and sequenced in ways that accelerate psychotherapy and improve its outcome.

We have observed two frequent mismatches in this respect. First, some therapists rely primarily on change processes most indicated for the contemplation stage, such as consciousness raising and self-reevaluation, when clients are moving into the action stage. They try to modify behavior by helping clients become more aware. This is a common criticism of psychoanalysis: Insight alone does not necessarily bring about behavior change. Second, other therapists rely primarily on change processes most indicated for the action stage, such as contingency management, environmental control, and counterconditioning, when clients are still in the precontemplation or contemplation stage. They try to modify behavior by pushing clients into action without the requisite awareness and commitment. This is a common criticism of radical behaviorism: Overt action without insight is likely to lead only to temporary change.

APPLICATIONS

Who Can We Help?

By virtue of its flexibility, integrative psychotherapy is applicable to practically all patient populations and clinical disorders. Children, adolescents, adults, and older adults; diagnosable disorders and growth experiences; private pay or managed care. Avoiding one-size-fits-all treatment and tailoring therapy to the unique individual make it adaptable to a wide range of problems. In fact, we cannot envision a client or a disorder for whom integrative psychotherapy would be contraindicated.

Integrative psychotherapy is particularly indicated for (1) complex patients and presentations, such as clients with multiple diagnoses and comorbid disorders; (2) disorders that have not historically responded favorably to conventional, pure-form psychotherapies, such as personality disorders, eating disorders, PTSD, and chronic mental illness; (3) disorders in which the controlled treatment outcome research is

scant; and (4) clients for whom pure-form therapies have failed or have been only partially successful.

The research indicates that patients who are functionally impaired respond best to a comprehensive and integrated treatment. Specifically, more impaired or disabled patients call for more treatment, lengthier treatment, psychoactive medication, multiple therapy formats (individual, couples, group), and explicit efforts to strengthen their social support networks (Beutler, Harwood, Alimohamed, & Malik, 2002). Schizophrenia, borderline personality disorder, and multiple addictions are cases in point; to put it simply, complex problems require complex treatments.

No therapy or therapist is immune to failure. It is at such times that experienced clinicians often wonder whether therapy methods from orientations other than their own might more appropriately have been included in the treatment or whether another orientation's strength in dealing with the particular problems might complement the therapist's own orientational weakness. Integrative therapies assume that each orientation has its particular domain of expertise and that these domains can be linked to maximize their effectiveness (Pinsof, 1995).

When integrative therapy fails, it may be a result of a failure to follow the guiding integrative principles, a lack of skill in implementing a particular treatment, or a poor fit between the particular patient and the particular therapist. Each of these alternatives should be considered when a patient is not accomplishing his or her goals at a rate expected among similar patients.

One clear strength of mixing and matching therapy methods is the ability to address clients' multiple goals. Most clients desire both insight and action; they seek awareness into themselves and their problems, as well as reduction of their distressing symptoms. The integrative therapist can focus on one or both broad goals, depending on the client's preferences. Similarly, integrative psychotherapists can simultaneously tackle improvement in several domains of a client's life: symptoms, cognitions, emotions, relationships, and intrapsychic conflicts. Change in one domain or on a single level nearly always generates synergistic change in another.

Treatment

The term *integration* refers typically to the synthesis of diverse systems of psychotherapy, but it also has a host of other meanings. One is the combination of therapy formats—individual, couples, family, and group. Another is the combination of medication and psychotherapy, also known as combined treatment. In both cases, a strong majority of clinicians (more than 80%) consider these to be part of the meaning of integration (Norcross & Napolitano, 1986).

In practice, integrative psychotherapies are committed to the synthesis of practically all effective, ethical change methods. These include integrating self-help and psychotherapy, integrating Western and Eastern perspectives, integrating social advocacy with psychotherapy, integrating spirituality into psychotherapy, and so on. All are compatible with a comprehensive treatment, but we have restricted ourselves in this chapter to the traditional meaning of integration as the blending of diverse theoretical orientations.

We are impressed by the effectiveness of group, couples, and family therapy. Therapy conducted in these formats is generally as effective as individual therapy, but patients and therapists usually prefer the individual format. Even so, a multiperson format is indicated if social support systems are low and if one or more of the major problems involves a specific other person.

Integrative psychotherapy embraces both long-term and short-term treatments. The length of therapy should be determined not by the therapist's preference or theoretical orientation but by the patient's needs. Virtually every form of brief therapy advertises itself, in comparison to its original long version, as active in nature, collaborative in

relationship, and integrative in orientation (Hoyt, 1995). Brief therapy and integrative therapy share a pragmatic and flexible outlook that is contrary to the ideological one that characterized the earlier school domination in the field.

Evidence

The empirical evidence on integrative treatments has grown considerably in recent years, and controlled research has been undertaken on several specific integrative therapies, including our own.

The outcome research supporting integrative psychotherapies comes in several guises. First and most generally, the entire body of psychotherapy research has provided the foundation for the key principles on which integrative treatment rests. This is the basis from which we have systematized the process of treatment selection. A genuine advantage of being integrative is the vast amount of research attesting to the efficacy of psychotherapy and pointing to its differential effectiveness with certain types of disorders and patients. Integration tries to incorporate state-of-the-art research findings into its open framework, in contrast to becoming yet another "system" of psychotherapy.

A second source of research evidence is that conducted on specific integrative treatments. A review of integrative therapies (Schottenbauer, Glass, & Arnkoff, 2005) determined substantial empirical support (defined as four or more randomized controlled studies) for

- Acceptance and commitment therapy
- Cognitive analytic therapy
- Dialectical behavior therapy
- Emotionally focused couple therapy
- Eye movement desensitization and reprocessing (EMDR)
- Mindfulness-based cognitive therapy
- Systematic treatment selection (STS)
- Transtheoretical psychotherapy (stages of change)

Integrative therapists can use these treatments for a particular patient—say, dialectical behavior therapy for a patient suffering from borderline personality disorder. Or integrative therapists can use parts of these treatments for many patients—say, teaching mindfulness or employing EMDR whenever indicated. These treatments and their elements are optimally employed with patients and in situations for which research has found evidence of effectiveness. We hasten to add that the incorporation of these treatments and their parts should occur within a systematic process and an integrative perspective. That is, be integrative, not syncretic.

Another dozen self-identified integrative therapies have garnered some empirical support, defined as between one and four randomized controlled studies. These include behavioral family systems therapy; integrative cognitive therapy; process–experiential therapy; and Lazarus's multimodal therapy.

A third source of research evidence for integrative psychotherapies is the identification of guiding principles on which a clinician of any theoretical orientation can map treatment. Systematic treatment selection (STS), as listed above, does not advocate for specific methods but, instead, proposes the use of research-informed principles. A joint task force of the Society of Clinical Psychology (APA Division 12) and the North American Society for Psychotherapy Research (Castonguay & Beutler, 2006) undertook comprehensive reviews of treatment research on mood, anxiety, personality, and substance abuse disorders. Their mission was to extract, from the more than 5,000 studies reviewed, a set of principles that could be used to guide clinicians in treatment planning.

Research on participant, relationship, and treatment variables was undertaken and separately analyzed. The principles ultimately extracted from that literature included the patient characteristics considered in this chapter.

A fourth and specific source of research evidence supporting our particular integrative psychotherapy is the ongoing programmatic research on treatment selection according to client characteristics, including the stages of change. Below we summarize the reviews of research evidence underpinning our approach presented in this chapter in terms of patient characteristics.

Stages of Change

The amount of progress clients make following treatment tends to be a function of their pretreatment stage of change. This has been found to be true for patients suffering from depression, panic, eating disorders, cigarette smoking, brain injury, and cardiac conditions, to name just a few. The strong stage effect applies immediately following intervention, as well as 12 and 18 months afterward (Prochaska, DiClemente, Velicer, & Rossi, 1993). In one representative study of 570 smokers, the amount of success was directly related to the stage they were in before treatment (Prochaska & DiClemente, 1983). Of the precontemplators, only 3% took action by 6 months; of the contemplators, 20% took action; and of those in preparation, 41% attempted to quit by 6 months. These data demonstrate that treatment designed to help people progress just one stage in a month can double the chances of their taking action in the near future.

One of the most powerful findings to emerge from our research is that particular processes of change are more effective during particular stages of change. Twenty-five years of research in behavioral medicine and psychotherapy converge in showing that different processes of change are differentially effective in certain stages of change. A meta-analysis (Rosen, 2000) of 47 cross-sectional studies examining the relationships among the stages and the processes of change showed large effect sizes ($d = .70$ and $.80$) across the stages.

Controlled research on the transtheoretical model indicates that tailoring treatments to the client's stage of change significantly improves outcome across disorders. This stage matching has been demonstrated in large trials for stress management, smoking cessation, bullying violence, and health behaviors (see Prochaska & Norcross, 2010, for review).

In sum, hundreds of studies have demonstrated the effectiveness of tailoring treatment to the client's stage of change. Longitudinal studies affirm the relevance of these constructs for predicting premature termination and treatment outcome. Comparative outcome studies attest to the value of stage-matched treatments and relationships. Population-based studies support the importance of developing interventions that match the needs of individuals at all stages of change (see Prochaska, Norcross, & DiClemente, 1995).

Coping Style

In the research, attention has been devoted primarily to the externalizing (impulsive, stimulation-seeking, extroverted) and internalizing coping styles (self-critical, inhibited, introverted). Approximately 80% of the more than 20 studies investigating this dimension have demonstrated differential effects of the type of treatment as a function of patient coping style. Effect sizes associated with a "good fit" between patient coping style and the therapist's methods has been found to range from .61 to 1.40 (Beutler, in press). Specifically, interpersonal and insight-oriented therapies are more effective among internalizing patients, whereas symptom-focused and skill-building therapies are more effective among externalizing patients (Beutler, in press; Beutler, Harwood, Alimohamed, & Malik, 2002).

Reactance Level

Research confirms what one would expect: that high patient reactance is consistently associated with poorer therapy outcomes (in 82% of more than 25 studies). But matching therapist directiveness to client reactance improves therapy outcome (80% of studies; Beutler et al., 2002). Specifically, clients presenting with high resistance benefited more from self-control methods, minimal therapist directiveness, and paradoxical interventions. By contrast, clients with low resistance benefited more from therapist directiveness and explicit guidance. The strength of this finding has been expressed as an effect size (d) averaging .83 (Beutler, in press).

These client markers provide prescriptive as well as proscriptive guidance on the treatments of choice. In reactance, the prescriptive implication is to match the therapist's amount of directiveness to the patient's reactance, and the proscriptive implication is to avoid meeting high client reactance with high therapist direction. In stages of change, action-oriented therapies are quite effective with individuals who are in the preparation or action stage. However, these same therapies tend to be less effective and even detrimental with individuals in the precontemplation and contemplation stages.

Preferences

Client preferences and goals are frequently direct indicators of the best therapeutic method and relationship for that person. Decades of empirical evidence attest to the benefit of seriously considering, and at least beginning with, the relational preferences and treatment goals of the client (Arnkoff, Glass, & Shapiro, 2002). A meta-analysis of 26 studies, involving 2,300 clients, compared the treatment outcomes of clients matched to their preferred treatment to those clients not matched to a preferred treatment. The findings indicated a small, positive effect (d = .15) in favor of clients matched to preferences. But, more importantly, clients who were matched to their preference were only about half as likely to drop out of psychotherapy—a powerful effect indeed (Swift & Callahan, 2009).

Diagnosis

Of the patient characteristics considered here, diagnosis is the one with the least evidence of differential treatment effects. Although we cannot match with certainty, some marriages of disorder and treatment are probably better than others. For example, moderate depressions seem to be most responsive to cognitive therapy, interpersonal therapy, and pharmacotherapy. Behavior therapy and parent training seem to be the treatments of choice for most externalizing child conduct disorders. Some form of exposure seems best for obsessive–compulsive disorders and posttraumatic stress disorder. Conjoint treatments seem best suited for sibling rivalry and couples distress. At the same time, we would reiterate that excessive reliance on diagnosis alone to select a treatment is empirically questionable and clinically suspect.

Psychotherapy in a Multicultural World

The integrative maxim of "different strokes for different folks" converges naturally with multiculturalism. And by culture, we do not refer solely to race, but more broadly to the wonderful diversity of humanity: age and generational influences, disability status, religion, ethnicity, social status, sexual orientation, indigenous heritage, national origin, gender, and so on (Hays, 1996).

Single-school therapies, particularly those born of a dominant "father" and rooted in a culture-bound theory of personality, tend to subtly maintain White, androcentric

(male-centered), Western-European, heterosexual norms. Many of the single-school "universal" principles are now rightfully perceived as examples of clinical myopia or cultural imperialism. Integrative therapies, by contrast, rely on neither a particular founder nor a theory of personality. Our sole "universal" principle is that people and cultures differ and should be treated as such. Evidence-based pluralism reigns as integration infuses diversity and flexibility into psychotherapy. No wonder that virtually every feminist, multicultural, and cultural–responsive theory describes itself as eclectic or integrative in practice.

Integrative psychotherapies have been applied cross-culturally and internationally with equal success. As offered to clients, integrative psychotherapies manifest as culturally sensitive or culturally adapted—modified to improve utilization, retention, and outcome. Psychotherapy can be adapted in many ways, such as incorporating the cultural values of the client into therapy, collaborating with indigenous healers, and matching clients with therapists of the same culture who speak, literally, the same language.

As in all practical matters in integrative psychotherapy, incorporating culture should be informed by the cumulative research. A meta-analysis of 76 studies (Griner & Smith, 2006) tells us, inter alia, that adapting therapy to the client's culture exerts a medium, positive effect ($d = .45$), that therapy targeted to a specific cultural group is more effective than that provided to clients from a variety of cultural backgrounds, and that therapy conducted in clients' native language (if other than English) is twice as effective as when it is conducted in English. Moreover, avoid translators in sessions whenever possible as their use is associated with weak alliances, more misdiagnoses (usually more severe than necessary), and higher dropout rates (Paniagua, 2005).

The upshot is for psychotherapists of all persuasions to mutually explore the singular needs and unique cultures of clients from the inception of psychotherapy. One effective practice, especially for historically marginalized populations, is to acquaint beginning clients with the respective roles of patient and therapist. Many patients hold divergent expectations about the process of psychotherapy and may be uncomfortable with mental health treatment. Pretherapy orientation is designed to clarify these expectations and to collaboratively define a more comfortable role for the client.

Another effective practice entails augmenting an individualistic position with a collectivistic orientation to clinical work. The optimal treatment format and therapist team, for example, may well depend on the culture of the particular client. In some cultures, clients will automatically enlist the support of friends, family members, neighbors, clergy, and perhaps traditional healers as part of their treatment and perhaps in their sessions. The culture-sensitive relationship, for another example, may well demand more than ordinary therapist empathy; it may require cultural empathy (Pederson, Crethar, & Carlson, 2008). As defined in the Western culture, empathy takes on an individualistic interpretation of human desire and distress. "I understand your personal feelings." Cultural empathy takes on a more inclusive orientation by placing cultural responsiveness at the center. It is a learned ability to accurately understand the client's self-experience from another culture and then to express that understanding back to the client. "I understand your personal feelings *and* your cultural context."

We enthusiastically embrace multiculturalism in psychotherapy. It's called integration, diversity within unity. Integrative therapy posits that the context for every individual—African, Asian, Latino, or Anglo; straight, gay, bisexual, or trans; Muslim, Christian, Jew, or atheist—is unique. And each psychotherapy needs to be individually constructed to match the needs of a particular person. In some cases, this involves helping individuals become free from social oppression. In other cases, it means helping them become free from mental obsessions. In yet other cases, it involves treatment of biological depression (Prochaska & Norcross, 2010).

CASE EXAMPLE

Ms. A is a 72-year-old European-American widow who was referred for psychotherapy by her son, a practicing psychiatrist in her neighborhood. She sought treatment for anxiety and agoraphobia.

History and Background

Ms. A was raised in Boston as the daughter of a modestly wealthy family. She was the only child of middle-aged and quite rigid parents. She related a poor relationship with her family and especially experienced difficulties with her mother, whom she described as "bossy and unreasonable."

Ms. A related that her first experience of panic when going out of the house occurred when she was 12. At the time, she was staying with a girlfriend while her mother shopped. As they were playing with dolls, Ms. A suddenly experienced a full-blown panic attack. She was overcome with a fear of dying, experienced heart palpitations, and felt short of breath to the point of fearing suffocation. Ms. A ran into the street and tried to yell for help, but she couldn't communicate, and no one heard her or offered assistance. She gradually calmed herself through self-control and forced breath control. She experienced periodic but relatively mild and spontaneous panic attacks through the next 2 years.

At about the age of 16, Ms. A began suffering from panic attacks more frequently and more severely. This resulted in her sleeping with her parents for several months and in her increasingly confining herself to known places and locations. She denied knowing what precipitated the increase in her panic attacks, but they occurred with the development of a relationship with a young man. He pursued her, but she found him unattractive and had no interest in a long-term relationship. He was insistent, and as a result, Ms. A began to see him socially; however, they had a tumultuous relationship punctuated by many separations and reunions. She finally succumbed to his insistence on marriage when she was 17, partially in response to the persuasion of her mother. The couple subsequently moved to Rhode Island to live close to his family.

Throughout the courtship and early years of marriage, the patient endured periodic panic attacks and periods of agoraphobia. Ms. A's symptoms increased and necessitated their moving back to Boston to be close to her family, where she could get the care that she felt she needed. She contemplated divorce and, indeed, separated and moved back with her parents, only to discover that she was pregnant. Ms. A reunited with her husband briefly after the baby's birth, but the panic symptoms became so extreme that she called and begged her mother to allow her to return home, claiming the situation to be a matter of life or death. She subsequently filed for divorce, but her husband fought the marital dissolution and successfully prevailed on the court to disallow the divorce.

Ms. A blamed her parents for her marital difficulties, and when she was unable to obtain a divorce, she left home, leaving the baby in the care of her mother, whom she despised. The patient successfully escaped the pursuit of her husband and her parents for several years. During that time, she experimented with lesbian relationships and came to think of herself as a lesbian. Concomitantly, her symptoms of panic and agoraphobia abated, and she recalled having no panic attacks for a period of about 3 years. The attacks began again, however, shortly after her parents, who had hired a private investigator to find her, reinitiated contact with her through an attorney. She was forced to negotiate an arrangement for the care of her daughter because her parents were getting too old to take care of the girl.

As plans for the future progressed, Ms. A was forced to meet with her estranged husband. For some time before and following these visits, the patient's panic episodes

escalated. Through some counseling with the attorney, the patient acceded to her husband's demand that they reconcile and take the child and move away from her parents to "start over." They moved to Oregon.

The patient's effort to reestablish her marriage was successful for only a short period of time. In Oregon, she first sought medical treatment for panic and was briefly hospitalized. She was discharged with medication but stopped taking it after a couple of months. She reported no long-term benefit from the hospitalization. After discharge from the hospital, Ms. A initiated several lesbian affairs, which finally provoked her husband to leave. He subsequently returned to his family on the East Coast and left her to raise the child on her own. He successfully filed for divorce. She struggled to find work and to support her daughter, yet despite this turmoil, the intensity of her panic and agoraphobia abated once again. Nonetheless, she worried about the effect of her lesbian relationships on her daughter.

Soon, Ms. A met a wealthy man who fell in love with her in spite of her "secret" lesbian lifestyle. He proposed marriage to her and vowed to support her and her daughter, to adopt the daughter, and even to tolerate her lovers, on the condition that she would attempt to have children with him. Her daughter and any children that they produced would then be his heirs. After much thought, Ms. A agreed. The marriage lasted 25 years and produced two more children, a boy and a girl. Her husband died of cancer shortly after her youngest daughter graduated from high school. Following her husband's death, she began to live openly as a lesbian, and she has remained unmarried for the past 16 years.

About 10 years ago, Ms. A met a woman with whom she fell in love. They have maintained an ongoing, supportive relationship. It is notable that during this time, even dating back to the end of her second marriage, Ms. A experienced only occasional mild anxiety and no panic. She continues to fear the prospect of panic—"the fear of fear"—and describes a general "distaste" for travel, as well as what she calls a "tendency to put off" going out for fear of becoming anxious. She also describes "being uncomfortable" when she is away from home, but she has not had any clinical symptoms of panic or phobia for more than a decade and a half. Even the most dominant and disturbing feeling that has plagued her through most of her life, the sense of being smothered and unable to breathe, disappeared. However, Ms. A does feel despondent and lethargic, has difficulty staying asleep, and has suffered other troubling symptoms of dysphoria and avoidance.

One event was particularly troubling. Approximately 5 years ago, while Ms. A and her lover were on vacation in another country, she awoke disoriented after having sex. She characterized this state as "disassociation" and "amnesia." She was unable to recall where she was, why she was there, and who her lover or her parents were. These symptoms passed within hours, but they recurred several more times, all immediately after having an intense sexual encounter. It was at this time that Ms. A sought psychotherapy for the first time. She saw a psychiatrist who found no medical reason for her dissociative experience and diagnosed it as a "transitory histrionic conversion." The psychiatrist followed Ms. A for about a year and prescribed antidepressants. This work was somewhat helpful, and as a result, Ms. A and her lover decided to cease further sexual contact for fear of triggering another "dissociation" attack. She terminated psychotherapy shortly after that time but has continued to get a variety of tranquilizers from her family physician because she has felt the need for them since that time. Ms. A and her female partner continue to maintain a loving platonic relationship.

Clinical Assessment and Formulation

The integrative therapist took the preceding history, developed a positive alliance with Ms. A, and secured consensus on her treatment goals in the first session. The patient was asked to complete several self-report instruments to evaluate her mental status

and to identify those characteristics important in treatment planning. These instruments included the Stages of Change Questionnaire, the MMPI-2, the STS Self-Report Form, the Symptom Checklist 90R (SCL 90-R), and the Beck Depression Inventory-2 (BDI-2).

The results revealed Ms. A to be at the contemplation stage—aware of her problems but uncertain, conflicted, and anxious about how to solve them. She was worried and ruminative, with fears about her continuing ability to take care of herself and with guilt over her past mistakes. Ms. A was especially concerned that she might have harmed her children through ambivalence and neglect. She was, in addition, remorseful over not being able to provide the sexual gratification that her partner desired. These results suggested that the patient would be receptive to exploring her motivations and plans and to seeking understanding about the options that faced her in resolving her concerns.

Diagnostically, Ms. A had suffered from relatively severe panic in the past, but at the time she sought treatment it was considered to be largely in remission. Her agoraphobia, also severe in the past, was only mild to moderate. Like many anxious and agoraphobic patients, Ms. A was suffering from moderate concurrent depression.

Her STS-SR and the MMPI-2 results both suggested relatively mild impairment of daily activities, cognitive focus, and emotional control. Ms. A was able to carry on basic life tasks, to maintain intimate and social relationships, and to provide for her care and comfort. She denied any suicidal ideation and intention. Although driving and traveling caused her some discomfort, she did both on a regular basis. The fear of fear seemed to be more disabling than her actual symptoms. The patient did not warrant an Axis II diagnosis.

The chronicity of Ms. A's problem suggested a guarded prognosis, but she possessed many intellectual strengths and insights that would improve her prognosis. With a mild level of current impairment, a nonintensive treatment was considered sufficient. We agreed on weekly sessions of individual psychotherapy, entailing neither medication nor more frequent sessions.

After some discussion of her "dissociative" experiences, the clinician talked to the patient's family physician, who could not explain the symptoms. The clinician contacted a neurologist and found that a similar, relatively obscure condition had been observed, primarily among older males, to occur following strong exertion, including sexual activity. This condition, known as sudden transient amnesia, had rarely been noted among women, and even among men it was typically experienced only once or twice. It was not thought to be a continuing condition and was probably occasioned by exertion, hyperventilation, and the pattern of entering deep or delta sleep very shortly after the exertion.

Ms. A favored a predominantly internalizing style of coping (versus an externalizing style). Although she had some externalizing qualities, her test scores and interpersonal patterns indicated that her contemplative and ruminative style of functioning were dominant. These results were consistent with her contemplation stage of change and generally favored the use of insight-oriented and awareness-increasing methods.

At the same time, insight-based work should be preceded by efforts to reduce symptoms. This was especially a valued determination, given the patient's concerns with panic and her history of angry, panic-driven behaviors. Thus, we combined both action and insight with Ms. A. We began by using desensitization and exposure to address her fear of panic and her fear of fear. This was followed by stress management methods derived from cognitive analyses of stress. It was necessary to ensure that her panic and fear behaviors were under control before proceeding to insight-based themes.

We examined Ms. A's theme of wishes and avoidance in our insight work. We inspected her persistent phobic response when she was pushed into heterosexual

relationships and hypothesized that such relationships may have induced guilt and fear that exacerbated and maintained panic. We hypothesized that the first panic attack may have occurred during sexual play with her playmate at age 12. Based on the strength of this interplay of heterosexual pressure and panic, we explored ways in which Ms. A had been smothered and pressured into these relationships by her parents. Both Ms. A and the therapist believed that the key to insight was understanding her marriages and feel-ings of being pressured sexually.

The patient's reactance level was assessed by her interpersonal history and her test results on the MMPI-2 and STS-SR. Ms. A's family history was characterized by conflict, mistrust, and forced control. It was associated with her response of moderate to severe rebelliousness. This pattern continued through at least her first marriage but dropped significantly in later relationships. The test results, on the other hand, suggested that at present, Ms. A was reasonably responsive and nonresistant to therapist directiveness. She was willing to take direction and exhibited compliance with structure, as well as the ability to work collaboratively with the therapist. Accordingly, we opted to employ moderate levels of therapist guidance and direction to accomplish both her behavioral action goals and her insight goals.

In the early stages of treatment, therefore, the integrative therapist guided Ms. A into exposure situations and suggested direct contact with feared and avoided activi-ties (e.g., driving, leaving home). Later in treatment, the therapist used interpretations and suggestions about areas of emotional avoidance and thematic patterns in childhood related to the development of panic and agoraphobia. In particular, we focused on the patient's symptoms of "suffocating" within a restricted environment and her subsequent symptom reduction during times when she was less restricted and scrutinized.

In terms of treatment goals, Ms. A expressed a preference for both symptom relief and psychological insight. After a life of fear and avoidance, she sought and was pre-pared for a therapy that exposed her to her anxiety symptoms associated with driving and traveling and then gradually confronted her thematic conflicts of relationship demands.

In terms of the therapeutic relationship, Ms. A was comfortable with the prospect of a male, heterosexual therapist, declining when asked whether she might be more com-fortable with a female therapist. She sought an active collaborator in her growth who would provide direction for her, would be a sounding board, and who would help her discover the origins of her anxiety. Ms. A was eager to engage in homework assignments to facilitate her progress, and although she balked when these assignments required her to drive, she always complied with the therapist's recommendations. On one occasion, she drove 50 miles in a heavy rainstorm to come to psychotherapy, surpassing any accomplishment she thought she would ever achieve.

Treatment Course

The first goal of any psychotherapy is the creation of an empathic, trusting relationship between patient and therapist. Two sessions were spent exploring the patient's feelings and trying to uncover her ambivalence and fear associated with self-expression. We explored feelings of guilt about her children and fears of aging.

The next four sessions were devoted to in vivo work on Ms. A's avoidance patterns. Since her symptoms of panic and agoraphobia were not obvious in the initial evalua-tion, we tried to produce some of those symptoms through rapid breathing, exposure training, and homework assignments. As we contacted areas of anxiety and fear, we in-troduced breathing control and cognitive restructuring to help her cope and to provide reassurance. For example, we walked around the neighborhood, spent time doing im-agery to evoke arousal, and discussed matters about which she thought she might have anxiety. Interestingly, only momentary and mild anxiety was provoked. Relatively soon

(within the first eight sessions), we began exploring her relationships with parents and children that were associated with her guilt and fear.

Ms. A identified her fears of having become like her mother, an authoritarian tyrant. She explained that she blamed herself for having injured her oldest daughter by her demands and abandonment, and she expressed guilt for having "made" her oldest son gay by not being a good role model. With encouragement and supportive advice, Ms. A spoke to these children and was surprised to discover that they were accepting and acknowledging of her difficulties. They also reassured her that they did not feel pressured or smothered by her—the metaphorical symptoms that she loathed as an agoraphobic.

Ms. A's guilt led to discussions of her belief in God. She had been raised in a reformed Jewish family, but her first husband was an orthodox Jew. She found religion troubling and had, she said, largely left her belief in God behind, except in her sense of being punished for neglecting her children. In that domain, try as she might, she still found herself praying to God for forgiveness whenever she thought about her children. To address these concerns, the patient kept a log of her religious thoughts and then used bibliotherapy materials to help her evaluate these thoughts. Specifically, she selected a cognitive therapy self-help book to work on her anxiety and depression. She kept track of thoughts and tried ways of changing those that were most hurtful to her. She kept notes about her progress, and we discussed these at each session.

In these sessions we also discussed Ms. A's negative reaction to having sex with her partner. One session was held with the two of them together, largely because Ms. A's difficulty had never been experienced outside this relationship. We explored their relationship and discussed their sexual desires. Discovering that Ms. A's symptoms of acute amnesia had been described in the medical literature as sudden transient amnesia gave her some relief, but she was still reluctant to go through the experience again. The patient's partner remained devoted and supportive of her decisions, whether or not they could ever restore sexual contact. On one occasion they initiated a sexual encounter, but it was suspended when the patient began having anticipatory fears. They agreed not to try sexual relations again. Although this was not an entirely satisfactory conclusion, the therapist chose to honor the couple's informed decision to seek their own resolution over time.

Outcome and Follow-up

Over the course of 12 sessions, Ms. A impressively reduced her anxiety, minimized her avoidance of driving and traveling, and decreased her concurrent depression. The SCL-90R and BDI-2 were repeated at the end of treatment. Both her anxiety and her depression had dropped substantially (the BDI from 24 to 14 and the SCL-90R from 75T to 54T). Symptomatically, she was better than ever. Ms. A courageously approached and apologized to her grown children for her potentially neglectful actions and negotiated a more satisfying relationship with her partner. Interpersonally, she mourned her losses and was moving forward. Despite all of these positive outcomes, as with most cases in psychotherapy, not all of her goals were realized. Her anticipatory fear of sexual relations led her not to attempt sex again.

Ms. A called the psychotherapist approximately one year after she had ended treatment "just to check in." She indicated that she had made several trips to the East Coast during the year and had experienced only one mild episode of panic. Nonetheless, she was thinking of returning to therapy for a few sessions to work on some "family issues." An appointment was made, but Ms. A called and cancelled, indicating that she would call again if she couldn't resolve the problem herself. An inadvertent contact with the patient's family some months later suggested that she was doing very well and had experienced no further difficulties.

Case Commentary

We have deliberately chosen to illustrate our integrative treatment with a patient that psychotherapy has historically neglected: elderly and lesbian. Although we live in an in increasingly multicultural world, much of psychotherapy is still developed for and researched on the young and heterosexual. Let Ms. A remind us all of the clinical and research imperative to extend psychotherapy to the marginalized and oppressed in society.

The integrative therapist can share some credit for the salubrious outcome in this case, but Ms. A deserves the lion's share. She intentionally exposed herself to anxiety-provoking situations and topics. She was a bright, brave, and hard-working client who progressed from the contemplation stage to the action stage and ultimately to the maintenance stage.

Where the integrative therapist was probably most effective was in systematically tailoring the therapeutic relationship and treatment methods specifically to Ms. A. The treatment proceeded stepwise in accordance with the empirical research, the patient's preferences, and her other nondiagnostic characteristics. The therapist combined several treatment goals (action and insight), therapy methods (those traditionally associated with behavioral, cognitive, psychodynamic, experiential, and systemic approaches), healing resources (psychotherapy, self-help, and spirituality), and treatment formats (individual, couples, and family) in a seamless and responsive manner.

Would a psychotherapist endorsing a single, brand-name therapy have achieved such impressive and comprehensive changes in the same number of sessions as the integrative therapist? We immodestly think not.

SUMMARY

Integrative psychotherapies are intellectually vibrant, clinically popular, and demonstrably effective. Integration converges with the evidence-based movement in emphasizing that different problems require different solutions and that these solutions increasingly can be selected on the basis of outcome research. Integrative therapies offer the evidence, flexibility, and responsiveness to meet the multifarious needs of individual patients and their unique contexts. For these reasons, integration will assuredly be a therapeutic mainstay of the 21st century.

Integration can take several different paths—theoretical integration, technical eclecticism, common factors, and assimilative integration—but it consistently searches for new ways of conceptualizing and conducting psychotherapy that go beyond the confines of single schools. Integration encourages practitioners and researchers to examine what other therapies have to offer, particularly when confronted with difficult cases and therapeutic failures. Rival therapy systems are increasingly viewed not as adversaries, but as welcome partners (Landsman, 1974); not as contradictory, but as complementary.

Integration is a meta-psychotherapy. It does not offer a model of psychopathology or a theory of personality, nor does it limit the mechanisms through which psychotherapy works. Instead, integration embraces the therapeutic value of many systems of psychotherapy and can be superimposed on whichever psychopathology model or therapy system a clinician endorses.

This chapter outlined our integrative therapy and its process of systematic treatment selection. This process applies empirical knowledge from multiple theoretical orientations on both diagnostic and nondiagnostic patient characteristics to the optimal choice of technical and relational methods. Such a therapy posits that many treatment methods and interpersonal stances have a valuable place in the repertoire of the contemporary psychotherapist. Their particular and differential place can be determined through outcome research, seasoned experience, and positioning the individual client at the center of the clinical enterprise. In the future, psychotherapy will be defined not by its brand names but by its effectiveness and applicability.

ANNOTATED BIBLIOGRAPHY AND WEB RESOURCES

Beutler, L. F., & Groth-Marnat, G. (Eds.). (2003). *Integrated assessment of adult personality* (2nd ed.). New York: Guilford Press.
Identifies psychological assessment procedures and tests to evaluate the dimensions that predict psychotherapy outcome. Based on systematic treatment selection, this book reveals the relationships among patient variables and treatment effects and describes the computerized systems for helping the clinician develop treatment plans.

Beutler, L. E., & Harwood, T. M. (2000). *Prescriptive psychotherapy: A practical guide to systematic treatment selection.* New York: Oxford University Press.
Translates the principles of systematic treatment selection into a treatment manual, which has been used in two randomized controlled trials of integrative psychotherapy. Includes methods of assessment, rating therapist compliance with the principles, and assessment of progress and outcome.

Castonguay, L. G., & Beutler, L. E. (Eds.). (2006). *Principles of therapeutic change that work.* New York: Oxford University Press.
Reports the results of a Society of Clinical Psychology (APA Division 12) and North American Society for Psychotherapy Task Force that identified research-informed principles that account for therapeutic change.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work.* New York: Oxford University Press.
Compiles the empirical research on what works in the therapy relationship in two ways: effective elements of therapy relationships (what works in general) and effective methods of tailoring or customizing therapy to the individual patient (what works for particular patients).

Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.). New York: Oxford University Press.

A state-of-the-art, comprehensive description of psychotherapy integration and its clinical practices by the leading proponents. Along with integrative therapies, the book addresses the concepts, history, training, research, and future of psychotherapy integration.

Prochaska, J. O., & Norcross, J. C. (2010). *Systems of psychotherapy: A transtheoretical analysis* (7th ed.). Pacific Grove, CA: Cengage-Brooks/Cole.
A systematic and balanced survey of 15 systems of psychotherapy from an integrative perspective. The comparative analysis demonstrates how much psychotherapy systems agree on the processes producing change while disagreeing on the content that needs to be changed.

Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1995). *Changing for good.* New York: Avon.
The best and most accessible summary of the stages and the processes of change. Written in a self-help format for educated laypersons and professionals.

Society for the Exploration of Psychotherapy Integration: www.sepiweb.com/
The homepage of SEPI, the foremost integration organization, provides information on membership, conferences, the *Journal of Psychotherapy Integration,* and training opportunities.

Inner Life: Systematic Treatment: www.innerlife.com/
Online assessment and treatment matching based on the 30 years of research on systematic treatment. Generates an individualized yet comprehensive report to treatment plans.

Transtheoretical Model: www.uri.edu/research/cprc/
The homepage of the transtheoretical model features publications, measures, and research studies on the stages of change.

CASE READINGS AND VIDEOTAPES

Beutler, L. E. (2008). *Evidence-based treatment.* DVD. Washington, DC: American Psychological Association.
Dr. Beutler demonstrates his research-directed systematic treatment. He uses a presession assessment to tailor his approach to working with a young man suffering with depression who wants to be able to enjoy life again.

Beutler, L. E., Consoli, A. J., & Lane, G. (2005). Systematic treatment selection and prescriptive psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 121–143). New York: Oxford University Press.
This chapter summarizes research and practice of systematic treatment selection and of prescriptive therapy. A case study illustrates the use of principles rather than models to guide treatment.

Beutler, L. E., Harwood, T. M., Bertoni, M., & Thomann, J. (2006). Systematic treatment selection and prescriptive

therapy. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration.* Washington, DC: American Psychological Association. [Revised and reprinted in D. Wedding & R. J. Corsini (Eds.), (2011). *Case studies in psychotherapy.* Belmont, CA: Brooks/Cole.]
This chapter describes the systematic treatment selection model for planning and integrating treatment.

Norcross, J. C. (2005). *Prescriptive eclectic psychotherapy.* DVD. Washington, DC: American Psychological Association.
Dr. Norcross demonstrates his adaptable, client-focused approach that tailors the therapy on the basis of the client's unique needs and situation. In this session, he works with a 33-year-old man whose substance use and marital infidelity have resulted in problems with his relationships and career.

Norcross, J. C. (Ed.). (1987). *Casebook of eclectic psychotherapy.* New York: Brunner/Mazel.

This edited volume presents 13 cases that concretely illustrate the practice of eclectic and integrative psychotherapy. Each case presents extensive transcripts, therapist remarks, and written patient impressions, followed by two invited commentaries on the case.

Norcross, J. C., Beutler, L. E., & Caldwell, R. (2002). Integrative conceptualization and treatment of depression. In M. A. Reinecke & M. R. Davison (Eds.), *Comparative treatments of depression.* New York: Springer.

This book reviews the major treatments for clinical depression; our chapter presents the integrative perspective and applies it to the case of Ms. Nancy T., who suffers from unipolar depression and a mixed personality disorder.

Norcross, J. C., & Caldwell, N. A. (2000). Prescriptive eclectic approach with Ms. Katrina. *Cognitive and Behavioral Practice, 7,* 514–519.

This article illustrates prescriptive eclecticism with Ms. Katrina, a complex and challenging woman, by demonstrating the process of customizing psychological treatments and therapeutic relationships to her specific needs as defined by diagnostic and nondiagnostic considerations.

Stricker, G., & Gold, J. (Eds.). (2006). *Casebook of psychotherapy integration.* Washington, DC: American Psychological Association.

Prominent practitioners describe their respective integrative psychotherapies and then demonstrate them in brief cases.