

Chapter 26

Theory and Practice of Psychotherapy Integration

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Psychotherapy integration grew out of increasing dissatisfaction with the continuous creation of new schools of therapy, the demands for accountability by payers, and the confusion of the general public about what psychotherapy was (Prochaska and Norcross 2007). The movement promised several advantages: clarity through recognition of common factors and a common language for the many overlapping concepts and strategies; improved outcomes via selection of the most effective concepts and strategies; and a framework within which new ideas could continue to evolve while simultaneously being tempered by continuing contact with other evolving ideas and the core processes that defined psychotherapy. By attempting to conceptualize psychotherapy as a whole, as an entity itself, the integration movement fostered pragmatic findings that did not fit neatly within specific, school-based theoretical orientations. These findings included the predominance of patient variables in determining outcome, the significant role of personal characteristics of the therapist, the key role of the therapeutic alliance, and the value of focusing on outcome rather than theory and technique.

In this chapter we review the history of the movement to integrate the psychotherapies and some of the reasons it is failing to live up to its initial promise. Then, in an effort to develop a more scientific psychotherapy from this integrative perspective, we list several basic principles of psycho-

therapy as a whole that do not fit neatly into specific schools. Finally, we describe an approach to psychotherapy that is built on recognizing similarities while utilizing differences, an approach built on the continuous, evidence-based clarification of core processes that define psychotherapy no matter what the theoretical orientation.

A History of Psychotherapy Integration

Psychotherapy continues to evolve within cultural contexts. Similar to most religions, psychotherapy is syncretic—it incorporates apparently useful ideas from the social, political, and religious sources within which it functions. Although the origins of modern psychotherapy are traced back to the early-twentieth-century work of Sigmund Freud, human societies have for millennia developed a variety of relationships between two people for the purpose of healing. Shamans, witch doctors, diviners, priests, rabbis, ministers, imams, holy men and women, dayanim (in Buddhism), physicians, and others in their own ways have attempted to utilize emotionally charged relationships with help-seekers to encourage emotional and physical healing.

Freud consciously and unconsciously assimilated ideas from his Viennese-European culture to develop psychoanalysis. Without any direct attribution, he is likely to have applied scholarly Jewish principles to his psychoanalytic work. The Talmud, for example, declares that “a dream unexamined is like a letter unopened.” Talmudic interpretations of the five books of Moses (the Pentateuch) may have led Freud to find deeper meanings in the utterances of his patients; the Torah became equivalent to the superficial or explicit meanings and interpretation explored the hidden meanings (Bakan 1958).

Unlike earlier forms of psychotherapy, Freud’s psychoanalysis found widespread and enthusiastic reception in a Western culture ready to begin the process of individual self-exploration. Energized by penetrating insights into human nature as well as intense criticism, psychoanalysis has become a towering intellectual achievement, placing Freud in the company of Karl Marx and Albert Einstein.

After Freud, new forms of psychoanalysis were founded (ego psychology, self psychology, object relations theory), and new schools split off entirely (e.g., Jung’s analytical psychology, Adlerian therapy). Still other schools that were developed by psychoanalytically trained theorists (cognitive therapy, behavior therapy, and emotion-focused therapies) seem quite remote from Freud’s original conceptions. During the last decades of the twentieth century, therapists expanded into systems concepts involving the family, culture, and spirituality, while also yielding to economic pressures to

decrease the number of sessions by developing a variety of brief therapies (Good and Beitman 2006).

Driven also by a data imperative, psychotherapists followed the example of clinical drug trials by pitting their therapies for specific disorders against psychopharmacological treatments as well as against each other. This “horse-race” research yielded equivocal results, with the therapy form favored by the principal investigator usually winning. Meta-analyses done several decades apart repeatedly showed little difference in outcomes among the schools of therapy, yet psychotherapy teachers continued to insist that therapists-in-training must learn the individual “packages” of therapy. These meta-analytic studies have paradoxically diminished emphasis on theory and instead focused researchers on what works (Norcross 2005).

To further demonstrate the questionable nature of treatment packages, Jacobson et al. (1996) deconstructed the basic cognitive-behavioral therapy (CBT) package for depression into three subelements: behavioral activation, focus on automatic thoughts, and focus on underlying schemas. Only experienced CBT therapists were recruited for the study, in which 150 depressed patients were assigned to one of three protocols: behavioral activation exclusively; behavioral activation plus focus on automatic thoughts; or the full therapy with behavioral activation, focus on automatic thoughts, and focus on underlying schema. The results across the three groups were the same, causing much consternation among those who believed in the necessity of the entire package. The study challenged psychotherapists to define treatment-effective techniques and strategies in a more clear fashion. It is likely that as a result of this debate, optimal techniques and strategies will depend on the therapeutic context of patient, therapist, and their alliance rather than some abstract ideas universally applied based on diagnosis.

Furthermore, reliable surveys of psychiatrists and psychologists tend to show a significant percentage espousing either psychoanalysis (among psychiatrists) or cognitive therapy (among psychologists), whereas a higher percentage of professionals in each field report themselves as “integrationists/eclectics” (Prochaska and Norcross 2007). Most teachers and therapists know that the emperor has no clothes; they know that most therapists evolve their approaches to accommodate the needs of their patients despite the persistent image of psychotherapy as an assortment of conflicting schools. More recently, psychoanalysis has been replaced by cognitive therapy as the “leading school” of psychotherapy in the public mind despite the relatively few therapists who have been well trained in it.

In 1984 in Annapolis, Maryland, psychologists Marvin Goldfried and Paul Wachtel convened the first annual meeting of the Society for the Exploration of Psychotherapy Integration. The organization grew out of the frustration that many academics and practitioners were feeling about the

proliferation of conflicting schools. A journal, now called the *Journal of Psychotherapy Integration*, was soon born. Several types of integration were gradually identified:

- Systematic eclecticism
- Theoretical integration
- Assimilative integration
- Common factors (or core processes)

AUTHOR: 1) Note that the previous list is no longer in a table.
2) The fourth item above was “Common factors,” but corresponding text below had “Core processes (or common factors).” Both now read like this item listing—OK?

AUTHOR: Paragraph below: First sentence: Please note rephrasing to “Therapists who advocate systematic eclecticism, . . .” so that noun *eclecticism* could be used. OK?

Therapists who advocate *systematic eclecticism*, exemplified by Lazarus (1981, 1989), rely on “what works” as suggested by research outcome studies, although they must stretch the applicability of research findings to fit the needs of each unique person. Lazarus recommends systematically evaluating patients in seven different categories: Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships, and Drugs (BASIC ID). (“Drugs” actually refers to all things biological, including medications, drugs of abuse, exercise, nutrition, and other physiological inputs.) All research applicable to each of these areas is then applied. For example, if a patient experiences *behavioral* problems such as obsessive-compulsive disorder, the research protocols for obsessive-compulsive disorder are applied. The patient is asked to expose himself to the feared stimulus (e.g., dirt) and then is asked to not wash his hands for as long a time as possible. The sequence is called *exposure and response prevention*. For problems with *affect* or emotion, catharsis (full expression of restrained emotion) coupled with examining and owning one’s feelings might be used. *Sensation* problems might involve muscle tension, which can be addressed with relaxation training, meditation, or physical exercise. Problematic *images* of oneself or failures to *imagine* success might be discovered and replaced. If the patient shows evidence of faulty thinking (*cognition*) patterns, the therapist encourages using

a thought record, a tool used in cognitive therapy to find automatic thoughts and possibly their origins in underlying schemas. If *interpersonal relationship* changes might be helpful, then the therapist might encourage specific ways to alter them. If the person has problems with *drugs* (e.g., alcohol), the therapist recommends several well-studied methods, such as cognitive therapy, Alcoholics Anonymous, and motivational interviewing.

AUTHOR: Previous paragraph: Note rephrasing of last sentence from “alcoholics are offered several well-studied methods.” Do patients choose one?

BASIC ID accommodates to individual patients’ needs. It is systematic and eclectically borrows from many sources. Then why has this rational, research-based approach not taken over the field? There is very little research support for problems with sensation or imagining, although these brain functions are essential to normal functioning. Experimentally validated therapies often do not translate well into the real world outside the tightly controlled research arena. Also, BASIC ID misses some crucial relationship variables. But perhaps most problematic, Arnold Lazarus, the founder, made it too idiosyncratic, too much in his own image, too much like another “school” of psychotherapy with specific protocols and worksheets and prescribed sequences of treatment. Multimodal therapy became a distinctive orientation in 1973 (Wedding and Corsini, p. 330), and that may have limited the influence of this good set of ideas.

AUTHOR: Previous paragraph:

1) Last sentence: Please provide reference for Wedding and Corsini 1973 and/or clarify what is the source of p. 330. There is a reference for Corsini and Wedding 2005—is that the correct source?

2) Last sentence is the first place multimodal therapy is mentioned, and meaning doesn’t seem clear at this point. The date given for multimodal therapy actually precedes the dates given for Lazarus at beginning of section. Please clarify.

Theoretical integration attempts to find overarching principles by which the psychotherapy approaches across the schools can be organized. Prochaska and DiClemente (1984) combined three crucial aspects of psy-

chotherapy that cross schools: readiness to change, processes of change, and levels (or content) of change. Readiness to change can be divided into several stages: not seeing a problem (precontemplation), recognizing a problem (contemplation), getting ready to change (preparation), changing (action), and maintaining the change (maintenance). Clients come into therapy usually recognizing the need to do something (contemplation or preparation), but some have no idea that something needs to be changed (precontemplation). Therapists must adjust their responses to fit clients' stages of change. In couples therapy, for example, one member is likely to be less ready to change than the other and must be assisted along the readiness-to-change continuum to match the partner who is more ready to change. Change can be initiated via a variety of techniques and methods (processes of change), which include raising self-awareness (consciousness raising), education, emotional release (catharsis), facing fears (counterconditioning), choosing, and direct use of the therapeutic relationship.

Prochaska and DiClemente (1984) divided the content of therapy into five levels, from the more superficial to the "deep": 1) symptoms/situational problems, 2) maladaptive cognitions, 3) current maladaptive interpersonal relationships, 4) family/systems problems, and 5) intrapersonal (within the person) problems. Prochaska and DiClemente, like Lazarus (1981, 1989), urged therapists to customize their responses to the patient, rather than attempting to fit the patient into the therapist's theoretical mold. They added the important and obvious notion of readiness to change and, like Lazarus, list the common content and techniques available to therapists.

AUTHOR: Paragraph below: Please note rephrasing in first sentence, again, to present *assimilative integrationists* in noun form. OK?

With *assimilative integration* (Messer 1992), therapists begin with a deep indoctrination into the specific school of therapy that best fits them and then assimilate ideas from different schools into their basic approach. For example, if one begins as a psychoanalytically oriented therapist, one might learn to apply cognitive homework assignments, systems thinking, and behavioral techniques as they seem to fit the needs of patients. All therapists start learning from the base of their own experience. Psychotherapy training, like psychotherapy itself, should be molded to the mind of each trainee.

Common factors, or *core processes*, seek to define what is common to all therapies and build on them (Beitman and Yue 1999a, 1999b, 2004a, 2004b). Psychotherapy has been practiced in varying forms in various cultures throughout human history (Ehrenwald 1976). There exists a single

conceptual thing, an archetype, which is psychotherapy. Each school and each relationship are variations of that archetype, just as each person is a variation in body and mind of the human being. There are many different common *factors*, but there are fewer common *processes*. These processes include establishing and maintaining the therapeutic alliance, activating the patient's observing self, searching for maladaptive patterns, initiating and then maintaining change in those patterns, and saying goodbye. Several studies suggest that significantly more of the variance in psychotherapy outcome is a result of common rather than specific factors (Ahn and Wampold 2001; Lambert 2005; Wampold 2001). From his review of the research literature, Lambert (2005) suggested that the largest outcome variable is neither the therapeutic alliance nor the specific therapeutic techniques, but rather the client (called "extratherapeutic change" in Figure 26-1). Accounting for about 40% of the variance in the outcome of psychotherapy, the key client variables include the following: severity of problem, type of problem, readiness to change, helpful and problematic events during the course of therapy (e.g., person gets a new job or breaks a leg), and degree of support by the social and work networks. Common factors in psychotherapy account for about 30% of outcome, whereas client expectations of success (placebo effects) and specific psychotherapy techniques (schools) each account for about 15% of outcome.

AUTHOR: Previous paragraph: 1) In first sentence, note addition of "a" and "b" to include both Beitman and Yue references dated 1999 and both dated 2004. Or is it possible to simplify the references to one from each year?

2) Note addition of in-text callout for Figure 26-1.

Figure 26-1 is currently at the end of the chapter. It will be positioned about here at a later phase of production.

From this array of four general categories of integration—systematic eclecticism, theoretical integration, assimilative integration, and common factors—an astonishing variety of integrative approaches have been developed. Founded on the principle of parsimony in an attempt to reduce the confusing proliferation of schools, the movement to integrate the psychotherapies seems to foster them. Table 26-1 lists a few of the integrative

schools, with their acronyms and primary authors.

Table 26–1 is currently at the end of the chapter. It will be positioned about here at a later phase of production.

The proliferation of integrative schools seems to contradict the original intention of the movement, which was to simplify the confusing claims. Like good psychotherapists, integrationists are asking themselves more specific questions about the intent and future of the field. These “meta-looks” at the ever-flourishing theories and techniques are yielding fundamental principles by which future developments can be guided (Norcross and Goldfried 2005; Stricker and Gold 2006).

AUTHOR: Norcross and Goldfried 2005 was not in reference list. I added it based on Norcross 2005 reference. OK?

Basic Psychotherapeutic Principles

The external reality that we perceive and know is limited by the range of stimuli our brains can process. For example, our eyes and occipital cortices can register only a narrow band of the light spectrum ranging from infrared to ultraviolet. We cannot register radio waves, although we have at our disposal instruments such as radios to register these waves for us. When we consider complex conceptual processes, we are also limited by the manner in which the brain can organize them. Perhaps we can learn from these limitations and apply the same principles to the social sciences and humanities, as well as psychotherapy.

Evolution seems to have driven the brain to integrate its various components by balancing the two opposing processes of differentiation and linkage. Well-being may grow out of the increasing differentiation of brain parts, with increasing linkages among them (Siegal 2006). Integration of the brain facilitated adaptation to the environment by simultaneously enhancing flexibility, stability, and coherence. A similar phenomenon occurs with psychotherapy patients and most human beings. The analogy can be used to understand the evolving field of psychotherapy. Applied to psychotherapy, the differentiation (i.e., proliferation) of schools seems likely to continue as new ideas are added to old ones and as culture and social pressures create new combinations and new needs. Linkages may seem less at-

tractive to each of these schools as each one differentiates within the conceptual “skull” of psychotherapy. The term *psychotherapy* binds them together. Core processes or common factors help tighten the linkages by reminding therapists that the differentiating concepts share much in common. The continuing differentiation may then shed new light on the core processes that link them, further clarifying and refining them in an ongoing iterative process.

AUTHOR: Previous paragraph, sentence beginning “Applied to psychotherapy”: Note change from “the differentiation-proliferation of schools seems likely to continue.” OK?

Psychotherapy may be leaving its prescientific state as neuroimaging and specialized electroencephalograms of brain function help to define the neurophysiological bases of psychotherapeutic change. As therapists theorize, their theories will be increasingly testable by concrete brain mapping. Such work will challenge therapists to learn that mind and brain are not separate but are different aspects of the same thing (Beitman et al. 2006).

AUTHOR: Previous paragraph: Last sentence has “Such work will challenge us”—is interpretation of “us” as “therapists” correct, or “scientists” or “humankind”?

The scientist of psychotherapy observes psychotherapy from as unbiased and objective a position as possible. The tendency to establish schools limits this necessary objectivity. Several facts generated by decades of research on psychotherapy are generally avoided by those wishing to emphasize their particular theoretical views. These facts, described in more detail next, are summarized in Table 26–2.

Table 26–2 is currently at the end of the chapter. It will be positioned about here at a later phase of production.

1. *People often make profound psychological changes without formal psychotherapy* (Prochaska and Norcross 2007). Individuals use their internal personal resources, family, friends, clergy, bartenders, hairstylists, self-help

groups, and self-help books to improve their mood, change their thinking, and modify maladaptive behaviors. In therapy, they are active participants in the change process, often subconsciously influencing their therapists to provide them with the context and responses to achieve their desired outcomes. Psychotherapy rarely, if ever, is “done to” patients. Instead, the active collaboration with a therapist accelerates the use of available resources within and outside each patient to create change.

2. *Patient variables, rather than theory or technique, most strongly predict outcome.* For example, a 45-year-old, unmarried, unemployed, highly intelligent, very isolated woman was living off the income supplied by her doting 75-year-old parents. They worried what would happen to their daughter when they died. She pleased them by going to psychotherapy. She rambled on and on about the jobs she had had, the excellent grades she had maintained in graduate school, the problems with her house, the discourtesy of clerks in supermarkets, and so on. Her therapist was becoming bored. Although patients are not obligated to entertain their therapists, most therapists like to work on something. When the therapist respectfully and urgently inquired what she would do when her parents died, suggesting that she should face that future, the patient became enraged. “I have come here for *you* to listen to *me*. That’s all. Goodbye.” She never returned. Therapy did not match her expectations.

AUTHOR: Paragraph below: Correct assumption that The National Institute of Mental Health’s Treatment of Depression Collaborative Research Program was intended by NIMH collaborative study of depression?

As this example illustrates, the most important predictor of outcome—the most important variable in the whole formula of psychotherapeutic change—is none other than the patient. What the patient brings to therapy strongly determines what kinds of changes are possible. The more severe the symptoms and the less helpful the social circumstances, the less likely it is that positive gains can be achieved. Think of the cardiac surgeon having to choose between doing a heart transplant on a 56-year-old healthy, athletic man or on a 92-year-old man with emphysema and diabetes. No matter how skilled the surgeon, the first patient is more likely to have a positive outcome. The National Institute of Mental Health’s Treatment of Depression Collaborative Research Program showed that matching the patient’s basic skills to tech-

niques correlated with outcome: Those people with strong interpersonal skills did better in interpersonal therapy, whereas those with strongly cognitive ways of coping did better in cognitive therapy. The implication clearly is to match the method of therapy to the patient's strengths (Imber et al. 1990).

Patients' expectations of psychotherapy play a crucial role in outcome as well. What do they want? How do they expect to behave in therapy? What do they expect from therapists? What outcome do they seek? How much effort are they willing to put into achieving their outcomes?

3. *The therapist is more important to outcome than theory or technique.* The therapist embodies the practice of psychotherapy and therefore plays a more important role in outcome than do techniques, regardless of how closely the techniques follow a manual (Wampold 2001). Although research has yet to determine which therapist variables seem to be most important, it is possible now to look realistically at therapists and recognize what most people intuitively know: some are more skilled and more effective than others.

AUTHOR: Item 4 below: Please note rephrasing in first sentence. OK?

4. *Therapists resemble each other in their practice as they mature, despite having different theoretical beginnings.* There are probably as many integrationists as there are therapists because therapists must amalgamate therapy ideas with their own experiences and apply them to the types of clients they serve. Over the past 60 years, three studies have come to the same conclusion about experienced therapists: more experienced therapists, whatever their professed school of therapy, tend to practice similarly (Bandler and Grinder 1975; Blagys and Hilsenroth 2000, 2002). Studies of new versus experienced therapists in different schools of psychotherapy point out how humans tend to resolve (or live with) the tension between theory and practice. They become more like each other with experience. Presumably, they do this without necessarily knowing which kind of integration they have evolved. They integrate new techniques because they perceive that the techniques work for them and their patients on some level (via true practice-based learning otherwise known as clinical experience).
5. *The strength of the therapeutic relationship is correlated with outcome across schools of psychotherapy.* A remarkably large body of evidence strongly

suggests that the working alliance correlates with outcome (Wampold 2001). What makes the working alliance work? Two people in the room interact with each other to create the relationship. The relationship provides a reflective space within which the patient can safely explore his or her mind. The caring, nonjudgmental therapist imagines the inner landscape of the patient's mind and provides impetus and safety to seek problems and then change. The relationship can be healing by providing corrective emotional experiences of acceptance and understanding perhaps rarely experienced by the patient before. The therapist's warm resonance becomes gradually incorporated into the patient's neuroanatomical circuits. The patient may safely use the therapist as an information coprocessor as procedural memory becomes altered to create new, more effective responses.

AUTHOR: Previous paragraph: Note change from "The caring, nonjudgmental mind of the therapist coimagines the inner landscape of the patient's mind providing impetus and safety to seek problems and then to change" in attempt to clarify what provides the "impetus and safety ..." OK?

2) In last sentence, does "procedural memory" refer to what is happening to both people in the relationship?

6. *Effective therapy is customized to the needs of each patient.* A quiet research voice is beginning to be heard. Process research does not compare therapy packages but rather examines the correlation between the events of psychotherapy and outcome. Whereas "horse race" research applies different organized or manualized therapies to specific diagnoses, just as do drug trials, process research examines the relationship between and among patient characteristics, the strength of the working therapist-patient alliance, and various common therapeutic strategies such as conveying empathic understanding. The conclusion is that psychotherapy works best if it is customized to the needs of the patient (Norcross 2002). Every successful business knows "the customer is always right." It is time for theory to catch up with reality.

AUTHOR: Previous paragraph: 1) Sentence beginning “Whereas ‘horse-race’ research”: Is addition of “therapist-patient” before “alliance” correct?

2) Next-to-last sentence: Norcross 2002 is not in references. Please check date or add reference.

Norcross (2005) suggested a “four-plus” method for tailoring therapist in-session behavior to patient characteristics based on research findings. The first of the four variables involves asking the patient, “What would your ideal therapist do for you?” and “What is the worst thing a therapist could do to you?” The patient then specifies preferences regarding therapist characteristics—warm versus tepid, active versus passive, informal versus formal, and gender or ethnicity. Although it has not been useful to ask individuals with sociopathic personalities or young children about their preferences in a therapist, matching strong preferences improved outcomes by about 10%, and by more than 30% in gay, lesbian and transgender patients (Lambert et al. 2003).

AUTHOR: 1) Last sentence: Outcomes were improved by about 10% in what population?

2) In following paragraphs, note that Norcross was added to tie the list of variables back to him. OK?

The second variable that Norcross recommended utilizes patient feedback to the therapist’s direct questions, asked every three to five sessions, about the patient’s 1) progress and improvement, 2) understanding and approval of the treatment methods being used, and 3) perception of the therapy relationship. The questions can be as simple as “How do you think you are doing?” “How do you think the psychotherapy is going?” and “How am I doing in our relationship to help you?” Lambert (2005) adduced a number of studies that show that therapists are not accurate judges of perceived empathy or of progress in therapy. He found that therapists can reduce patient dropout by over 20% by asking these questions every third to fifth session.

A third variable in Norcross’s method for tailoring the therapy relationship involves asking a few questions to determine the patient’s stage of change. The therapist begins by asking “Do you currently have a problem with something?” If the patient answers yes, the therapist asks,

“When will you change it?” If the patient answers no, the therapist asks, “What leads you to say that?” With these simple questions, the therapist can deduce which stage of change the patient is in: precontemplation, contemplation, preparation, action, or maintenance. The therapist can then tailor therapy to the appropriate stage and avoid large mismatches between stage and therapy, such as urging change on someone in the precontemplation stage (Prochaska and DiClemente 1984; Norcross and Prochaska 2005).

AUTHOR: Previous paragraph: 1) In sentence beginning “With these simple questions”: Note that “preparation” was added as a stage of change. OK?

2) Last sentence: Is added date for “Prochaska and DiClemente correct?

3) Norcross and Prochaska 2005 is not in references. Please add. Thanks!

The fourth variable recommended by Norcross for customizing therapy to the individual patient involves the “reactance” or resistance level of the patient. Patients considered to have a low reactance level are those who are compliant with therapy, accept therapist directions, do homework, seek direction, are submissive to authority and nondefensive, and are open to experience. These patients tend to do better with therapist directiveness and less well with paradoxical instructions. Patients with a high reactance level display an intense need for autonomy, are dominant, resist external influences including therapist interventions, and have a history of social and interpersonal conflict. These patients do better with therapists who do not give instructions, emphasize patient self-change, and can utilize paradoxical interventions (Beutler et al. 2002).

The “plus” variable in Norcross’s (2005) method of tailoring therapy is a patient’s degree of relatedness. This concept is seen in psychoanalytic literature as a patient having one of two interaction styles: 1) an anacletic or emotionally dependent style of interaction or 2) an introjective or self-definitional style. This distinction is described in cognitive literature as sociotropic versus autonomous style.

Psychotherapy performs a social function for which its practitioners are paid. Psychotherapy is a business. But psychotherapists are not in the psychotherapy business—they are in the business of personal change, of which there are many other forms, including diet, exercise,

retreats, and medications. A meta-look at psychotherapy integration and the entire field of psychotherapy includes recognizing that patients want a change and that the goal of psychotherapists is to find the means to help them make a change. Psychotherapists are like the railroad barons of the 1800s who thought they were in the railroad business. They failed to recognize that they were in the transportation business. By neglecting this simple fact, they allowed railroads and their companies to fade from prominence (Miller et al. 2005).

AUTHOR: Last sentence: Please check date for Miller et al.—only 2003 is in references.

7. *Diagnosis limits formulation.* The National Institute of Mental Health provides funding only for manual-based therapies categorized by diagnoses in DSM (e.g., American Psychiatric Association 2000).

Although this approach has led to an increase in knowledge of particular disorders (e.g., depression, borderline personality disorder) it has also obscured the fact that psychological problems develop and manifest in multiple ways, necessitating that treatments be tailored beyond discrete diagnoses. Furthermore, this reification of discrete disorders hinders the recognition of the extent to which various clinical problems share common processes and symptoms that would respond to similar interventions. (Norcross 2005, p. 505)

8. *Psychotherapists help patients create new futures for themselves.* Within the safety and strength of the therapeutic alliance, patients coimagine with their therapists new, more adaptive scenes containing more effective response sets. These changes take place in the patient's brain, likely in procedural memory. These influences have yet to be understood by the interpersonal biology evolving from the therapist-patient relationship (Beitman et al. 2005).
9. *Important areas of research on psychotherapy remain underdeveloped.* Researchers have not developed effective criteria for selecting good therapist candidates or therapeutic action, and have not determined how to teach effective timing of interventions.

Integration Through Core Process Similarities and Useful Differences Among the Schools

A process is a series of events or activities that occur over time. In psychotherapy, core processes should ideally be linked to subgoals or objectives, the accomplishment of which accelerates the achievement of the goals of the relationship. Therapists first strive to establish a strong therapeutic alliance. Then, as the alliance is being formed, therapists help patients activate their self-awareness and their self-observing capacities. Also as the alliance is being established, therapists usually attempt to define maladaptive patterns in terms that suggest how to change them. Therapists then offer ways to help patients change. In this section, we outline these four primary goals and their related stages (for further detail, see Beitman and Yue 2004).

AUTHOR: Last sentence of previous paragraph: Please specify 2004a and/or 2004b.

Engagement

Establishing and then strengthening a therapeutic alliance is generally the initial goal in any psychotherapy. Many subprocesses may, depending on how well they are carried out, contribute to this process:

1. Defining with the patient his or her expectations regarding the outcomes being sought and the role the therapist and the patient will play in seeking those outcomes
2. Accurately tracking the patient's emotional state through the process of psychotherapy,
3. Providing relevant information to the patient
4. Offering effective suggestions to the patient
5. Effectively managing the boundaries of therapy and the therapeutic relationship

Activation of the Self-Observer

Activating and then encouraging the patient's continued self-awareness within a safe, confiding relationship is a second process of psychotherapy. When this process is successfully carried out, patients become less anxious and more able to explore their inner and interpersonal worlds. The increas-

ingly positive therapeutic alliance provides a “reflective space” within which to do such self-exploration. As with any other skill, patients vary in their ability to activate and utilize their observing selves. The increasing utilization of various forms of meditation as part of psychotherapy is aiding this process. Therapists, too, need practice in meditation and other forms of activating self-awareness because exploration of their own inner worlds and their intuitive responses to their patients can play key roles in psychotherapeutic change. There are many names applied to this process in the various schools of psychotherapy: mentalization, mind-sight, mindfulness, insight, recognizing automatic thoughts and schemas, and self-differentiation.

Pattern Search

Defining patterns the patient can change that will lead to a desired goal or subgoal is a third process inherent in psychotherapy. The search for maladaptive patterns relies on a simple formula: examine the unwanted responses (e.g., feelings, thoughts, behaviors); define the events that triggered these responses; and identify the intervening factors that connect the unwanted symptoms to the triggering events (e.g., thoughts, schemas, conflicts, role relationship models). From the specific instances, therapists induce broader patterns that persist over similar situations. Such patterns can be defined at three different levels: personality trait level, psychotherapy school level, and person level.

The *personality trait level* provides a general picture of the client as suggested by the following commonly used labels: submissive, perfectionistic, self-defeating, irresponsible, aggressive, paranoid, borderline, narcissistic, and obsessive. Related general labels include dysfunctional family and maladaptive communication. These terms are used by therapists and the general public in an attempt to categorize, sometimes as a way to blame but rarely as a way to suggest how to change.

At the *school level*, patterns are derived from various theoretical perspectives, each with its own vocabulary. The following are some examples.

Psychodynamic

- Reenactment from past to present
- Unconscious conflicts
- Immature defense mechanisms
- Inadequate mentalization
- Core conflictual relationship themes

Interpersonal

- Role transitions
- Role conflicts
- Unresolved grief
- Interpersonal skill deficits

Behavioral

- Inadequate stimulus control
- Problematic conditioned response
- Problematic modeling
- Neurotic paradox
- Behavioral excesses and deficits

Cognitive

- Dysfunctional automatic thoughts
- Negative cognitive schemas
- Cognitive distortions

Person-Centered

- Conditions of worth and negative self-concept

Existential

- Fear of responsibility and freedom
- Fear of death
- Existential isolation
- Meaninglessness

Emotion-Focused

- Avoidance of emotional awareness
- Conflict splits
- Unfinished business

Family

- Triangulation
- Boundary problems
- Disturbed homeostasis

- Circular causality

AUTHOR: List above: Person-centered therapy has only one example. Possible to add another bulleted item?

Finally, at the *person level*, dysfunctional patterns are defined more concretely in terms that can be observed clinically in daily life. At this level, patterns are defined specifically for individual clients. Consider Iris, for example, who often felt irritated in discussions with others because she felt that they neglected her needs. The therapist discovered that Iris usually assumed that others knew what she needed without having to make herself sufficiently clear. Thus, her person-level pattern could be stated to her as follows: “You incorrectly assume that you have already communicated your wants and needs. You seem to expect others to read your mind.” At the person level, the patient may have a clearer idea about what needs to change.

Change

Psychotherapy does not cure patients; rather, it helps them to change. Cure implies that the problem will never recur—a questionable claim for any helping profession. Therapists help patients decrease symptoms such as anxiety, depression, and substance abuse; increase social functioning at work or school and in relationships; and improve their sense of well-being. Patients “take responsibility for change”; therapists do not change patients. No matter how deeply a therapist may wish to help a patient change, the final decider and implementer is the patient.

AUTHOR: Previous paragraph, sentence beginning “Patients”: Note change from “therapists do not do IT to them” to “therapists do not change patients.” OK?

Therapeutic objectives can be achieved through many different and often overlapping processes, which include but are not limited to the strategies and techniques offered by the schools of psychotherapy. Some of the general change strategies are

- Separating past from present
- Challenging dysfunctional beliefs, behaviors, and emotions

- Generating alternatives
- Deciding what to change
- Exploring the advantages and disadvantages of change
- Suggestions of how and what to change
- Turning stumbling blocks into stepping stones
- Altering future expectations
- Facing fears
- Reframing
- Resolving conflicts
- Practicing in the session
- Working through
- Positive reinforcement
- Role-playing
- Therapist self-disclosure

School-specific approaches can be organized according to their primary orientation: emotion, cognition, behavior, interpersonal, and systems. Although these target areas are listed as if they are separate discrete entities, they actually are mutually influential. Often but not always, if one element changes, another follows suit. Changes in cognition may lead to changes in emotion and behavior. Therapists become part of each patient's interpersonal system and can influence other people in the patient's world through the patient.

The most straightforward way to select a strategy is to decide which ones are most likely to achieve the goal the patient desires and then, of those, which one the client is most likely to accept. Evidence-based strategies must be considered when making such choices, while keeping in mind that most research findings are based on studies of highly selected, diagnostically homogeneous patients recruited through advertising and willing to follow research protocols. Many therapy dilemmas have escaped research scrutiny, leaving therapists without any guidelines for strategy selection. Therapists are left to follow their own experience and training, as well as lessons learned from previous patients. (For further elaboration on this strategies, see Good and Beitman 2006.)

As the therapist and patient glean patterns from a search of the patient's past, current life, or interaction with the therapist, the discoveries inevitably lead to a new view of the patient's future. The therapist and patient may want to develop stories (narratives) to explain and understand what has happened; they may wish to dive deeply into the present to experience the *now*. But each variation on this past-present theme inevitably contains a search for a better future. The size of the human prefrontal cortex hints at the vast importance of the future. Whatever theoretical framework is used, the

therapist is caught up in trying to help the patient develop new ideas, movies, videos of the patient's future. Each time a therapist connects a set of past events with present events, the therapist is implying that this pattern need not be repeated in the future. Each time a therapist comments on a cognitive distortion, the therapist is implying that this reality lens needs adjustment for the future. Psychotherapy is necessarily future oriented. Therapists act as coimaginers of new ways of being, acting, and thinking (Beitman et al. 2005).

AUTHOR: 1) Previous paragraph, first sentence: Note change from "Whether the therapist and patient glean patterns from a search of the patient's past, current life, or interaction with the therapist, they inevitably lead to a new view of the patient's future." OK?

2) Previous paragraph used "we" quite a bit. Did "we" refer to therapists or to the patient-therapist pair or to man in general? Please read paragraph carefully to see if revisions retain your meaning.

Conclusion: Integrating and Evolving

Rather than talking about psychotherapy integration or different schools or core processes, the field of psychotherapy will benefit from collecting its various selves into a cohesive whole made of each of these parts. The psychotherapy organism, like the human organism, aims for coherence—that is, stability with the flexibility that provides adaptability in a changing environment. Respecting the differences as well as the similarities among psychotherapy schools will ensure their evolution through time. Think of a group of circles, each with its own self-proclaimed identity: "I am cognitive therapy," says one. "I am psychodynamic therapy," says another. "I am an integrationist," say a third. "I am my own psychotherapy," says yet another. The circles include a brief therapist, a behavior therapist, an emotion-focused therapist, a family therapist, an Adlerian, a Kleinian, a reality therapist. So many different identities. Some are bigger circles, some smaller, each claiming to be different, special, better. Imagine them on a soft, fuzzy translucent surface that embraces each while permitting each to move on its own. This surface is also alive, vibrating and feeding the circles as they move through time and space. This surface provides the basic energy for the circles. This surface represents the core processes. Imagine the circles reaching tendrils toward each other, connecting with each other and cross-fertilizing each other. The schools influence each other. For example, cog-

nitive therapists pick up the psychoanalytic idea of resistance, and psychodynamic therapists recognize the value of directly addressing cognitions.

Imagine how cultural and technological influences change the functioning of the entire surface and, with those changes, the functioning of each of the circles. Advances in psychopharmacology have dramatically altered the way psychotherapists think about treatment. Where once psychoanalysts claimed that medications would disrupt the therapeutic relationship, now therapists urge patients to seek and maintain useful pills. Therapists must develop ways to adapt psychotherapy to new contexts, new events, new technologies. Just as successfully functioning humans are resilient, so must the field of psychotherapy adapt to new information in a systematic way, minimizing crisis, upheaval, and degradation. Psychotherapy can become one coherent whole, an organization with many components, functioning together in dynamic tension: stable, flexible, and adaptive. It can become an organization resting on a foundation of core processes revealed through experience and research.

Key Points

- Psychotherapy is defined by its core processes, which include engagement, self-awareness activation, pattern search, and change.
- The key outcome variables, in descending order of importance, are the patient (symptom severity and strength of social network,; the therapist (personality, skill, and other unquantifiable factors), and the strength of the working alliance.
- Maladaptive patterns are induced from specific instances to the general.
- Patterns are clinically best presented in terms that fit the patient's current concepts and experiences.
- Change strategies may be selected from the range of interventions in which the therapist has confidence, to be fit with the patient's experience with self-change.
- Psychotherapists may talk about the past and the here and now, but therapy primarily attempts to help patients change the ways in which they conceptualize their futures.

References

- Ahn H, Wampold BE: Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *J Couns Psychol* 48:251–257, 2001

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- Bakan D: Freud and the Jewish Mystical Tradition. New York, Van Nostrand, 1958
- Bandler R, Grinder J: The Structure of Magic, Vol. 1. Palo Alto, CA, Science and Behavior Books, 1975

AUTHOR: Do all four of the following books have the subtitle “A Time-Efficient, Research-Based, and Outcome-Measured Psychotherapy Training Program”?

- Beitman BD, Yue D: Learning Psychotherapy: Trainee’s Manual. New York, WW Norton, 1999
- Beitman BD, Yue D: Learning Psychotherapy: Leader’s Manual. New York, WW Norton, 1999
- Beitman BD, Yue D: Learning Psychotherapy: Trainee’s Manual. New York, WW Norton, 2004

AUTHOR: 1) A Google search indicated that the following reference is a 2nd edition. Is the Trainee’s Manual above also a 2nd edition?

2) Note change to next reference from Leader’s Manual to Seminar Leader’s Manual. OK?

- Beitman BD, Yue D: Learning Psychotherapy: Seminar Leader’s Manual, 2nd Edition. New York, WW Norton, 2004
- Beitman BD, Soth AM, Bumby NA: The future as an integrating force through the schools of psychotherapy, in Handbook of Psychotherapy Integration, 2nd Edition. Edited by Norcross JC, Goldfried MR. New York, Oxford University Press, 2005, pp 65–84
- Beitman BD, Viamontes GI, Soth AM, et al: Toward a neural circuitry of engagement, self-awareness, and pattern search. *Psychiatric Annals* 36:272–282, 2006
- Beutler LE, Harwood TM: Prescriptive Psychotherapy: A Practical Guide to Systemic Treatment Selection. New York, Oxford University Press, 2000
- Beutler LE, Moleiro CM, Talebi H: Resistance, in Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients. Edited by Norcross JC. New York, Oxford University Press, 2002, pp 129–143
- Blagys MD, Hilsenroth MJ: Distinctive features of short-term psychodynamic-interpersonal psychotherapy: a review of the comparative psychotherapy process literature. *Clinical Psychology: Science and Practice* 7:167–188, 2000

- Blagys MD, Hilsenroth MJ: Distinctive activities of cognitive-behavioral therapy: a review of the comparative psychotherapy process literature. *Clin Psychol Rev* 22:671–706, 2002
- Consoli AJ, Chope RC: Contextual integrative psychotherapy, in *A Casebook of Psychotherapy Integration*. Edited by Stricker G, Gold J. Washington, DC, American Psychological Association, 2006, pp 185–199
- Corsini RJ, Wedding D: *Current Psychotherapies*. Itasca, IL, Peacock Press, 2005

AUTHOR: Is previous reference cited in text?

- Ehrenwald J: *The History of Psychotherapy*. New York, Jason Aronson, 1976
- Goldfried MR: *From Cognitive-Behavior Therapy to Psychotherapy Integration: An Evolving View*. New York, Springer, 1995

AUTHOR: Previous reference: Note change from JO Goldfried to MR Goldfried. Correct?

- Good GE, Beitman BD: *Psychotherapy Essentials*. New York, WW Norton, 2006
- Greenberg LS, Watson JC, Lietaer G (eds): *Handbook of Experiential Psychotherapy*. New York, Guilford Press, 1998
- Imber SD, Pilkonis, PA, Sotsky SM, et al: Mode-specific effects among three treatments for depression. *J Consult Clin Psychol* 52:352–359, 1990
- Jacobson NS, Dobson KS, Truax PA, et al: A component analysis of cognitive-behavioral treatment for depression. *J Consult Clin Psychol* 64:295–304, 1996
- Lambert MJ: Psychotherapy outcome research: implications for integrative and eclectic therapists, in *Handbook of Psychotherapy Integration*. Edited by Norcross JC, Goldfried MR. New York, Basic Books, 1992, pp 94–129

AUTHOR: Please cite previous reference in text, or delete the reference.

- Lambert MJ: Enhancing psychotherapy outcome through feedback. *Journal of Clinical Psychology: In Session*, 61:165–174, 2005
- Lambert MJ, Whipple JL, Hawkins EJ, et al: Is it time for clinicians to routinely track patient outcomes? A meta-analysis. *Clinical Psychology: Science and Practice*, 10:288–301, 2003
- Lazarus AA: *The Practice of Multimodal Therapy*. New York, McGraw-Hill, 1981

Lazarus AA: *The Practice of Multimodal Therapy*. Baltimore, MD, Johns Hopkins University Press, 1989

AUTHOR: The two Lazarus references have the same title. Should the second one have "2nd edition"?

- Linehan MM: *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York, Guilford, 1993
- McCullough JP Jr: *Treatment for Chronic Depression: Cognitive Behavioral Analysis System of Psychotherapy*. New York, Guilford, 2000
- Messer SB: A critical examination of belief structures in integrative and eclectic psychotherapy, in *Handbook of Psychotherapy Integration*. Edited by Norcross JC, Goldfried MR. New York, Basic Books, 1992, pp 130–168
- Miller SD, Duncan BL, Hubble MA: Outcome-informed clinical work, in *Handbook of Psychotherapy Integration*. Edited by Norcross JC, Goldfried MR. New York, Basic Books, 2003, pp 84–105
- Norcross JC: A primer on psychotherapy integration, in *Handbook of Psychotherapy Integration, 2nd Edition*. Edited by Norcross JC, Goldfried MR. New York, Oxford University Press, 2005, pp 3–24
- Norcross JC, Goldfried MR: *Handbook of Psychotherapy Integration, 2nd Edition*. New York, Oxford University Press, 2005
- Prochaska JO, DiClemente CC: *The Transtheoretical Approach*. Homewood, IL, Dow Jones–Irwin, 1984
- Prochaska JO, Norcross JC: *Systems of Psychotherapy: A Transtheoretical Analysis, 6th Edition*. Belmont, CA, Thomson Brooks/Cole, 2007

AUTHOR: 1) Is change to 2007 correct for previous book, as in text (and based on Web search)?
2) Please confirm publisher and city for previous book.

- Ryle A, Kerr IB: *Introducing Cognitive Analytic Therapy: Principles and Practice*. Hoboken, NJ, Wiley, 2002
- Shapiro, F: *Eye Movement Desensitization and Reprocessing, 2nd Edition*. New York, Guilford, 2001
- Siegel DJ: An interpersonal neurobiology approach to psychotherapy. *Psychiatric Annals* 36:248–259, 2006
- Stricker G, Gold J: *A Casebook of Psychotherapy Integration*. Washington, DC, American Psychological Association, 2006

- Wachtel PL, Kruk JC, McKinney MK: Cyclical psychodynamics and integrative relational therapy, in *Handbook of Psychotherapy Integration*, 2nd Edition. Edited by Norcross JC, Goldfried MR. New York, Oxford University Press, 2005, pp 172–195
- Wampold BE: *The Great Psychotherapy Debate: Models, Methods, and Findings*. Mahwah, NJ, Erlbaum, 2001
- Zindel V, Segal J, Williams JMG, et al: *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. New York, Guilford, 2001

Suggested Readings

- Beitman BD, Good GE: *Counseling and Psychotherapy Essentials*. New York, WW Norton, 2006
- Beitman BD, Yue DM: *Learning Psychotherapy*, 2nd Edition. New York, WW Norton, 2004
- Norcross JC (ed): *Psychotherapy Relationships That Work*. New York, Oxford University Press, 2002
- Norcross JC, Goldfried MR (eds): *Handbook of Psychotherapy Integration*, 2nd Edition. New York, Oxford University Press, 2005
- Stricker G, Gold J (eds): *A Casebook of Psychotherapy Integration*. Washington, DC, American Psychological Association, 2006
- Wampold BE: *The Great Psychotherapy Debate: Models, Methods, and Findings*. Mahwah, NJ, Erlbaum, 2001

TABLE 26-1. Various integrative psychotherapies

Psychotherapy (acronym)	Primary author(s)
Acceptance and Commitment Therapy (ACT)	Hayes et al.
Cognitive-Affective-Relational-Behavior	Goldfried 1995
Cognitive Analytic Therapy (CAT)	Ryle and Kerr 2002
Cognitive Behavioral Analysis System of Psychotherapy (CBASP)	McCullough 2000
Contextual Integrative Psychotherapy	Consoli and Choqe 2006
Cyclical Psychodynamics and Integrative Relational Psychotherapy	Wachtel et al. 2005
Dialectical Behavior Therapy (DBT)	Linehan 1993
Eye-Movement Desensitization and Reprogramming (EMDR)	Shapiro 2001
Mindfulness-Based Cognitive Therapy (MBCT)	Zindel et al. 2001
Process-Experiential Therapy (PET)	Greenberg et al. 1998
Systematic Treatment Selection and Prescriptive Psychotherapy	Beutler and Harwood 2000
Transtheoretical Approach	Prochaska and DiClemente 1984

AUTHOR: Table 26–1: 1) Note added dates for authors above, as in references.

2) Please add date in table and add reference for Hayes et al.

3) Please check wording for Goldfried's therapy. Should it be "Cognitive-Affective Behavior(al) Therapy"? (I couldn't find "cognitive-affective-relational-behavior" in Google search.)

AUTHOR: Please review title for Table 26–2. We added Basic facts of psychotherapy. Intended?

TABLE 26–2. Basic facts of psychotherapy

People often experience profound psychological changes *without* formal psychotherapy.

Patient variables, rather than the particular theory or technique used, are the strongest predictors of outcome in psychotherapy.

The personal variables of the therapist are far more important predictors of outcome than theory or technique.

Therapists resemble each other in their practice as they mature, despite having different theoretical beginnings.

The strength of the therapeutic relationship is correlated with outcome across schools of psychotherapy.

Effective therapy is customized to the needs of each patient.

Diagnosis limits formulation.

Psychotherapists help patients create new futures for themselves.

Important areas of research on psychotherapy remain underdeveloped (e.g., defining criteria for defining good therapist candidates, determining what makes therapeutic action successful, establishing ways to teach effective timing of interventions).

AUTHOR: Table 26–2: Note change to wording of last item, which read, “Important areas of research on psychotherapy remain underdeveloped, including criteria for defining good therapist candidates, therapeutic action, and how to teach effective timing of interventions.” Did “criteria” apply to timing as well?

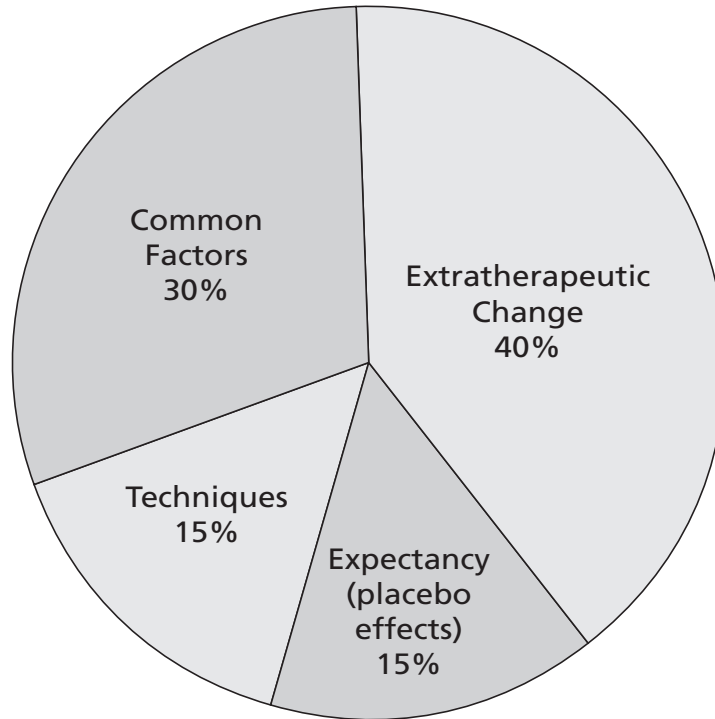


FIGURE 26-1. Variables influencing outcome in psychotherapy.

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AUTHOR: Please verify figure is reprinted from Norcross 2005, as letter granting permission we have on file suggests. Thanks!
