Psychotherapy integration: Thoretical, research and clinical developments

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ABSTRACT *Psychotherapy integration in its many guises represents a revolutionary departure from decades of parochial and antagonistic schoolism in mental health services. In this article I offer a primer on psychotherapy integration and trace ten of its postmodern developments. These theoretical, research and clinical directions entail recognizing integration as a therapeutic mainstay, delineating the various pathways to integration, defining the parameters of integration, repudiating syncretism, appreciating the contributions of pure-form therapies, pursuing evidence-based treatments of choice for select disorders and particular clients, embracing relationships of choice as well as treatments of choice, developing explicitly integrative training processes and programs, facilitating the ongoing shift toward more clinically relevant psychotherapy research and promoting integration as an international movement.*

Key words: Psychotherapy integration, Postmodern developments.

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

As the field of psychotherapy has matured, integration or eclecticism has emerged as a developing climate of opinion. Since the early 1990s we have witnessed both a general decline in ideological struggle and the movement towards rapprochement. Psychotherapists now acknowledge the inadequacies of any one theoretical system and the potential value of others. What is distinctive of the present era is tolerance for and assimilation of formulations that were once viewed as deviant.

Psychotherapy integration has crystallized into a formal movement, or, more dramatically, a «revolution» (Lebow, 1997) and a «metamorphosis» in mental health (London, 1988). Although various labels are applied to t his movement –eclecticism, integration, rapprochement–, the goals are similar indeed. Psychotherapy integration is characterized by dissatisfaction with single-school approaches and a concomitant desire to look across school

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boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency and applicability of psychotherapy.

Any number of indicators attest to the maturity of psychotherapy integration. Eclecticism, or the more favored term *integration,* is the modal theoretical orientation of English speaking psychotherapists. Leading psychotherapy textbooks routinely identify their theoretical persuasion as eclectic, and an integrative or eclectic chapter is regularly included in compendia of treatment approaches. The publication of books that synthesize various therapeutic concepts and methods continues unabated, now numbering in the hundreds. Handbooks on psychotherapy integration have been published in at least six countries. Reflecting and engendering the movement have been the establishment of interdisciplinary organizations devoted to integration, notably the Society for the Exploration of Psychotherapy Integration (SEPI), and of international publications, including SEPI's *Journal of Psychotherapy Integration.*

In this article I offer a primer on psychotherapy integration and trace ten of its theoretical, research and clinical directions. These post-modern developments are based on my editorial, clinical and research experiences over the past 20 years in such ventures as coediting two editions of the *Handbook of Psychotherapy Integration,* chairing the SEPI Education Committee, conducting original research in this area, serving as associate editor for the *Journal of Psychotherapy Integration* and practicing a particular form of eclectic therapy. Despite my considerable clinical experience and frequent international presentations, I hasten to add that my vision is limited by the contextual particularity as a clinical psychologist in the United States.

1. Recognizing integration as a therapeutic mainstay

Approximately one quarter to one half of contemporary American clinicians disavow an affiliation with a particular school of therapy, preferring instead the label of «eclectic» or «integrative». Some variant of eclecticism or integration is routinely the modal orientation of responding psychotherapists. Reviewing 25 studies performed in the USA between 1953 and 1990, Jensen, Bergin and Greaves (1990) reported a range from 19% to 68%, the latter figure being their own finding. It is difficult to explain these variations in percentages, but differences in the organizations sampled and in the methodology used to assess theoretical orientations account for some of the variability (see Poznanski & McLennan, 1995; Arnkoff, 1995).

More recent studies confirm and extend these results. A review of a dozen studies published during the past decade (Norcross, 2005) found that eclecticism/integration continued as the most common orientation in the United States, but that the cognitive/cognitive-behavioral orientation is rapidly challenging eclecticism/integration for the modal theory. Cognitive therapy lags only two to four percentage points behind eclecticism/integration or actually supercedes it in several studies. The review also determined that eclecticism/integration receives robust but lower endorsement outside of the United States and Western Europe. Eclecticism/integration is typically the modal orientation in the USA, but not in other countries around the world.

The prevalence of integration can be ascertained directly by psychotherapist endorsement of a discrete integrative or eclectic orientation. It can also be gleaned indirectly by psychotherapist endorsement of multiple orientations. For example, in a study of Great Britain counselors 85%-87% did not take a pure form approach to psychotherapy (Hollanders &

McLeod, 1999). In our recent study of clinical psychologists in the United States, for another example, fully 90% of psychologists embraced several orientations (Norcross, Karpiak, & Santoro, 2004). In a study of New Zealand psychologists, for a final example, 86% indicated that they used multiple theoretical orientations in the practice of psychotherapy (Kazantzis & Deane, 1998). Indeed, very few therapists adhere tenaciously to a single therapeutic tradition.

The results of the massive collaborative study of the Society of Psychotherapy Research (SPR) bear this out dramatically (Orlinsky et al., 1999). Nearly 3,000 psychotherapists from 20 countries answered the question «How much is your current therapeutic practice guided by each of the following theoretical frameworks?». Responses were made to six orientations on a 0 to 5 scale. Twelve percent of the psychotherapists were uncommitted in that they rated no orientations as 4 or 5; 46% were focally committed to a single orientation (rating of 4 or 5); 26% were jointly committed; and 15% were broadly committed, operationally defined as three or more orientations rated 4 or 5. The commitment toward integration is even clearer when one considers that 54% were not wed to a single orientation. As the authors conclude (Orlinsky et al., 1999, p. 140), «While there is a substantial group whose theoretical orientations are relatively pure, they are a minority in the present data base».

This integrative fervor will apparently persist well into the 2000s: A recent panel of psychotherapy experts portended its escalating popularity, at least in the United States (Norcross, Hedges, & Prochaska, 2002). A panel of 62 psychotherapy experts using Delphi methodology predicted psychotherapy trends in the next decade. The experts rated the extent to which a variety of theoretical orientations will be employed over the next decade. As presented in Table 1, cognitive-behavior therapy, culture sensitive/multicultural, cognitive (Beck), interpersonal therapy, technical eclecticism and theoretical integration were expected to increase the most. By contrast, classical psychoanalysis, implosive therapy, transactional analysis and Adlerian therapy were expected to decrease. These expert composite ratings portend «what's hot» and «what's not». Integration and eclecticism are expected to be in the former category.

2. Delineating the various pathways to integration

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

Technical eclecticism seeks to improve our ability to select the best treatment for the person and the problem. This search is guided primarily by data on what has worked best for others in the past with similar problems and similar characteristics. Eclecticism focuses on predicting for whom interventions will work: the foundation is actuarial rather than theoretical. The multimodal therapy of Lazarus (1989, 1997, 2005) and the systematic treatment selection (STS) of Beutler (Beutler & Clarkin, 1990: Beutler & Consoli, 2005) are exemplars of technical eclecticism.

Proponents of technical eclecticism use procedures drawn from different sources without necessarily subscribing to the theories that spawned them, whereas the theoretical integrationist draws from diverse systems which

Table 1
Composite predictions for theoretical orientations of the future

Theoretical orientation	*M*	*SD*	*Rank*
Cognitive-behavioral therapy	5.67	.99	1
Culture-sensitive/multicultural	5.40	.98	2
Cognitive therapy (Beckian)	5.07	1.18	3
Interpersonal therapy (IPT)	5.05	1.11	4
Technical eclecticism	4.89	1.20	5
Theoretical integration	4.89	1.07	6
Behavior therapy	4.81	1.09	7
Systems/family systems therapy	4.80	.96	8
Exposure therapies	4.70	1.34	9
Solution-focused therapy	4.70	.99	10
Motivational interviewing	4.47	1.35	11
Feminist therapy	3.92	1.27	12
Rational-emotive behavior therapy	3.83	1.24	13
Narrative therapy	3.83	1.15	14
Psychodynamic therapy	3.80	1.19	15
Male-sensitive therapy	3.58	1.36	16
Experiential therapy	3.58	1.12	17
Trans-theoretical therapy	3.56	1.46	18
Client/person-centered therapy	3.20	1.24	19
Eye movement desensitization and reprocessing (EMDR)	3.18	1.43	20
Humanistic therapy	3.03	1.03	21
Reality therapy	2.95	1.06	22
Existential therapy	2.85	1.09	23
Gestalt therapy	2.78	.88	24
Jungian	2.33	.95	25
Adlerian	2.25	.89	26
Transactional analysis	2.13	.77	27
Implosive therapy	1.91	.94	28
Psychoanalysis (classical)	1.16	1.07	29

Note: 1 = great decrease, 4 = remain the same, 7 = great increase.
Adapted from Norcross, J. C., Hedges, M., & Prochaska, J. O. (2002). The face of 2010: A Delphi poll on the future of psychotherapy. *Professional Psychology: Research and Practice, 33, 316-322.*

may be epistemologically or ontologically incompatible. For technical eclectics, no necessary connection exists between metabeliefs and techniques. «To attempt a theoretical rapprochement is as futile as trying to picture the edge of the universe. But to read through the vast amount of literature on psychotherapy *in search of techniques* can be clinically enriching and therapeutically rewarding» (Lazarus, 1967, p. 416).

In *theoretical integration* two or more therapies are integrated in the hope that the

result will be better than the constituent therapies alone. As the name implies, there is an emphasis on integrating the underlying *theories* of psychotherapy («theory smushing») along with the integration of therapy techniques from each («technique melding»). Proposals to integrate psychoanalytic and behavioral theories illustrate this direction, most notably the cyclical psychodynamics of Wachtel (1977, 1987), as do efforts to blend cognitive and psychoanalytic therapies, notably Ryle's (1990, 2005) cognitive-analytic therapy. Grander schemes have been advanced to meld most of the major systems of psychotherapy – for example, the transtheoretical approach of Prochaska and DiClemente (1984, 2005).

Theoretical integration involves a commitment to a conceptual or theoretical creation beyond a technical blend of methods. The goal is to create a conceptual framework that synthesizes the best elements of two or more approaches to therapy. Integration aspires to more than a simple combination; it seeks an emergent theory that is more than the sum of its parts and that leads to new directions for practice and research.

The preponderance of professional contention resides in the distinction between theoretical integration and technical eclecticism. How do they differ? Which is the more fruitful strategy for knowledge acquisition and clinical practice? An NIMH workshop on integration (Wolfe & Goldfried, 1988) and several studies (e.g., Norcross & Napolitano, 1986; Norcross & Prochaska, 1988; Norcross, Karpiak, & Lister, 2004) have clarified these questions. Table 2 summarizes the consensual distinctions between integration and eclecticism.

The primary distinction is that between empirical pragmatism and theoretical flexibility. Integration refers to a commitment to a conceptual or theoretical creation beyond eclecticism's pragmatic blending of procedures. Or, to take a culinary metaphor (cited in Norcross & Napolitano, 1986, p. 253), «The eclectic selects among several dishes to constitute a meal, the integrationist creates new dishes by combining different ingredients». A corollary to this distinction, rooted in the theoretical integration's earlier stage of development, is that current practice is largely eclectic; theory integration represents a promissory note for the future. In the words of Wachtel (1991, p. 44): «The habits and boundaries associated with the various schools are hard to eclipse, and for most of us integration remains more a goal than a daily reality. Eclecticism in practice and integration in aspiration is an accurate description of what

Table 2
Consensual distinctions between eclecticism and integration

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

most of us in the integrative movement do much of the time».

The *common factors* approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on those commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy success than the unique factors that differentiate among them. The common factors most frequently proposed are the development of a therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviors, and clients' positive expectancies (Grencavage & Norcross, 1990; Tracey et al., 2003). The work of Beitman (1987, 2005), Frank (1973; Frank & Frank, 1993), Garfield (1980, 1992) and Miller, Duncan and Hubble (2005; Hubble, Duncan, & Miller, 1999) have been among the most important contributions to this approach.

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

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). In doing so, assimilative integration combines the advantages of a single, coherent theoretical system with the flexibility of a broader range of technical interventions from multiple systems. A behavior therapist, for example, might use the Gestalt two-chair dialogue in an otherwise behavioral course of treatment. In addition to Messer's (1992, 2001) original explication of it, exemplars of assimilative integration are Stricker and Gold's and assimilative psychodynamic therapy (1996, 2005), Castonguay and associates' (2004, 2005) cognitive-behavioral assimilative therapy and Safran's (1998; Safran & Segal, 1990) interpersonal and cognitive assimilative therapies.

To its proponents, assimilative integration is a realistic way station to a sophisticated integration; to its detractors, it is more of a waste station of people unwilling to commit to a full evidence-based eclecticism. Both camps agree that assimilation is a tentative step toward full integration: Most therapists have been –and continue to be– trained in a single approach, and most therapists gradually incorporate parts and methods of other approaches once they discover the limitations of their original approach. Therapists do not discard original ideas and practices, but rework them, augment them and cast them all in new form. They gradually, inevitably, integrate new methods into their home theory.

Of course, these 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 therapy, theoretical integration would be impossible. Assimilative integrationists and technical eclectics both believe that synthesis should occur at the level of practice, as opposed to theory, by incorporating therapeutic procedures from multiple schools. And even the most ardent proponent of common factors cannot practice «non specifically» or «commonly»; specific techniques must be applied.

3. Defining the parameters of integration

By common decree, technical eclecticism, common factors, theoretical integration and assimilative integration are all assuredly part of the integration movement. However, where are

the lines to be drawn, if drawn at all, concerning the boundaries of psychotherapy integration?

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

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

4. Repudiating syncretism

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

But much of the opposition to psychotherapy integration should be properly redirected to *syncretism* – uncritical and unsystematic combinations. This haphazard «eclecticism» is primarily an outgrowth of pet techniques and inadequate training, an arbitrary, if not capricious, blend of methods by default (Norcross, 1990). They have been called grab-bag feckless eclectics (Smith, 1999). Eysenck (1970, p. 145) characterized this indiscriminate smorgasbord as a «mish-mash of theories, a hugger-mugger of procedures, a gallimaufry of therapies», having no proper rationale or empirical verification. This muddle of idiosyncratic and ineffable clinical creations is the antithesis of effective and efficient psychotherapy.

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

5. Appreciating the contributions of pure-form therapies

Conspicuously absent from most of the literature on psychotherapy integration has been acknowledgement of the conventional, «pure-

form» (or brand name) therapy systems, such as psychoanalytic, behavioral, experiential and systems. Although it may not be immediately apparent, pure-form therapies are part and parcel of the integration movement. In fact, integration could not occur without the constituent elements provided by the respective therapies - their theoretical systems and clinical methods.

In a narrow sense, pure-form or single-theory therapies do not contribute to the integration movement, because they have not generated paradigms for synthesizing various interventions and conceptualizations. But, in broader and more important ways, they add to 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.

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

An appreciation of this historical process can temper the judgmental flavor frequently expressed toward those who may be antagonistic toward psychotherapy integration. These antagonistic characterizations -«rigid», «inveterate», «narrow», for instance- are likely to result in a win-lose, zero-sum encounter in which the integrative «good guys» seek victory over the separatistic «bad guys». Such an attitude will do little to promote a welcoming attitude toward integration on the part of the «opposition» and even less to build on the documented successes of pure-form therapies. The objective of the integration movement, as I have repeatedly emphasized, is to improve the effectiveness of psychotherapy. To obtain this end, the valuable contributions of pure-form therapies must be collegially acknowledged and their respective strengths collaboratively enlisted.

6. Pursuing evidence-based «treatments of choice» for select disorders and particular clients

Almost every psychotherapist subscribes to the belief that psychological treatment should be tailored to the individual patient - different strokes for different folks. A cardinal value of psychotherapy integration in general, and technical eclecticism in particular, is that different patients will be best served by different psychotherapies. Over the past two decades research has demonstrated the differential effectiveness of a few psychotherapies for (a) select behavioral disorders and (b) particular patient characteristics beyond diagnosis.

Psychotherapy research has demonstrated the differential effectiveness of a few therapies with select disorders. Despite the power of common factors across the therapies, treatments of choice or prescriptive treatments have been documented for select disorders; cognitive therapy and interpersonal therapy for depression, exposure therapies for post-traumatic stress disorder, conjoint therapy for marital discord, cognitive-behavioral disorder for panic disorder and childhood aggression, to name some prominent examples.

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

differences across the schools.

While there will be a continued movement toward the development of specific treatments for specific diagnoses, psychotherapy research also demonstrates that psychotherapy should be tailored to the patient's non diagnostic characteristics. As is frequently said in health psychology, it is more important to know the person with the disorder than to know the person's disorder. Put differently, diagnosis alone is limited as a basis for selecting psychotherapy of choice.

A task force of the APA Division of Psychotherapy (Norcross, 2002) recently published its findings on the effective elements of the therapy relationship and effective methods of tailoring therapy to the individual patient on the basis of his/her (non diagnostic) characteristics. In other words, we sought to answer the dual pressing questions of «What works in general in the therapy relationship?» and «What works best for particular patients?». The evidence-based conclusions are summarized, in abbreviated form, in Table 3.

The task force concluded that tailoring treatment to specific patient needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment. The task force identified two patient behaviors or qualities that are demonstrably effective as a means of tailoring therapy (resistance level and functional impairment) and another five as promising and probably effective as a means of customizing treatment.

For example, research confirms that high patient resistance is consistently associated with poorer therapy outcomes (in 82% of studies). But matching therapist directiveness to client level of resistance improves therapy outcome (80% of studies). 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 clinical implication is to match the therapist's level of directiveness to the patient's level of resistance.

The prescriptive mandate is to create a unique psychotherapy for each patient –considering diagnosis, treatment goals, resistance level and other cross-diagnostic characteristics– that resonates to the patient and that has been supported by the empirical evidence. We can now selectively prescribe different treatments, or combination of treatments, for some clients and some disorders on the basis of the research.

7. Embracing «relationships of choice» as well as «treatments of choice»

At the same time, psychotherapy is at root an interpersonal experience. Psychotherapy will never be so technical as to overshadow the power of a given therapist's ability to form a therapeutic relationship. Moreover, the predictors and contributors to these human influences are not beyond the scope of psychological science (Lazarus, Beutler, & Norcross, 1992). It is regrettable that the historical emphasis of eclecticism/integration on synthesis of techniques has led to a relative neglect of the therapy relationship. This lacuna is all the more serious in that the therapeutic relationship accounts for as much of psychotherapy success as the particular treatment method. Quantitative reviews and meta-analyses of psychotherapy outcome literature consistently reveal that specific techniques account for only 5% to 12% of the outcome variance (e.g., Wampold, 2001), and much of that is attributable to the investigator's therapy allegiance (Luborsky *et al.*, 1999).

Suppose we asked a neutral scientific panel from outside the field to review the corpus of psychotherapy research to determine what is the most powerful phenomenon we should be studying, practicing and teaching. Henry (1998, p. 128) concludes that the panel would find the

Table 3
Conclusions of the APA division of psychotherapy task force on empirically supported therapy relationships

◆ The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment.

◆ Practice and treatment guidelines should explicitly address therapist behaviors and qualities that promote a facilitative therapy relationship.

◆ Efforts to promulgate practice guidelines or evidence-based lists of effective psychotherapy without including the therapy relationship are seriously incomplete and potentially misleading on both clinical and empirical grounds.

◆ The therapy relationship acts in concert with discrete interventions, patient characteristics and clinician qualities in determining treatment effectiveness. A comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and their optimal combinations.

◆ Adapting or tailoring the therapy relationship to specific patient needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment.

◆ The following list embodies the task force conclusions regarding the empirical evidence on **General Elements of the Therapy Relationship** primarily provided by the psychotherapist.

Demonstrably effective
Therapeutic alliance
Cohesion in group therapy
Empathy
Goal consensus and collaboration
Promising and probably effective
Positive regard
Congruence/genuineness
Feedback
Repair of alliance ruptures
Self-disclosure
Management of counter-transference
Quality of relational interpretations

◆ The following list embodies the task force conclusions regarding the empirical evidence on **Customizing the Therapy Relationship to Individual Patients** on the basis of patient behaviors or qualities.

Demonstrably effective as a means of customizing therapy
Resistance
Functional impairment
Promising and probably effective as a means of customizing therapy
Coping style
Stages of change
Anaclitic/sociotropic and introjective/autonomous styles
Expectations
Assimilation of problematic experiences

◆ Current research on the following patient characteristics is insufficient for a clear judgment to be made on whether customizing the therapy relationship to these characteristics improves treatment

outcomes.

Attachment style
Gender
Ethnicity
Religion and spirituality
Preferences
Personality disorders

◆ The preceding conclusions do not by themselves constitute a set of practice standards, but represent current scientific knowledge to be understood and applied in the context of all the clinical data available in each case.

Adapted from Norcross (2002).

answer obvious and *empirically validated.* As a general trend across studies, the largest chunk of outcome variance not attributable to pre-existing patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and therapist, regardless of technique or school of therapy. This is the main thrust of three decades of empirical research.

All of this is to say that the scope of integration will be enlarged to include the prescriptive use of the therapeutic relationship. One way to conceptualize the issue, paralleling the notion of «treatment of choice» in terms of techniques, is how clinicians determine the «relationship of choice» in terms of their interpersonal stances for individual clients.

To take one evidence-based example, people progress through a series of stages of change –pre-contemplation, contemplation, preparation, action and maintenance– in both psychotherapy and self-change. A meta-analysis of 47 studies found effect sizes of .70 and .80 for the use of different change processes in the stages; specifically, cognitive-affective processes are used most frequently by clients in the pre-contemplation and contemplation stages, whereas behavioral processes most frequently by those in the action and maintenance stages. The therapist's optimal stance also varies depending on the patient's stage of change: a nurturing parent with patients in the pre-contemplation stage; a Socratic teacher with patients in the contemplation stage; an experienced coach with patients in the action stage; and a consultant during the maintenance stage. The immediate clinical implications are to assess the patient's stage of change, match the therapeutic relationship and the treatment method to that stage and systematically adjust tactics as the patient moves through the stages (Prochaska & Norcross, 2002).

Such an integrative and evidence-based psychotherapy –one that systematically adapts both treatments and relationships to the individual client– addresses the critical mandate of psychotherapy practice and research. Which treatment (and relationship) works best for which patient with a particular disorder (Paul, 1967)?

8. Developing explicitly integrative training processes and programs

Once upon a time psychotherapists were trained exclusively in a single theoretical orientation and in the individual therapy tradition. The ideological singularity of training did not always result in clinical competence, but did reduce clinical complexity and theoretical confusion (Schultz-Ross, 1995). But over time psychotherapists began to recognize that their

orientations were theoretically incomplete and clinically inadequate for the variety of patients, contexts and problems they confronted in practice. They began receiving training in several theoretical orientations –or, at least, exposed to multiple theories– and in diverse therapy formats – individual, couples, family and group.

The gradual evolution of psychotherapy training toward integration has 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 from different treatments, formats and relationships. On the other hand, integrative training exponentially increases the student press to obtain clinical competence in multiple theories, methods and formats, and, in addition, challenges the faculty to create a coordinated training enterprise. Not only must the conventional difficulties in producing competent clinicians be resolved, but an integrative program must also assist its students in acquiring mastery of multiple treatments and then in adjusting their therapeutic approach to fit the needs of the specific client (Norcross & Halgin, 2005).

Psychotherapy trainers are immediately confronted with a critical decision with respect to their training objectives. The major choice is whether the program's objective will be to train students to competence in a single psychotherapy system and subsequent referral of some clients to more indicated treatments or whether its avowed mission will be for students to accommodate most of these patients themselves by virtue of the students' competence in multimethod, multi-theory psychotherapy. The former choice is favored by briefer training programs and smaller faculty; the latter seems to be preferred by longer and larger training programs with more resources.

Recent data indicate that program and internship directors in the United States are committed to psychotherapy integration but disagree on the routes toward it. Approximately 80%-90% of directors of counseling psychology programs and internship programs agree that knowing one therapeutic model is not sufficient for the treatment of a variety of problems and populations; instead, training in a variety of models is needed. However, their views of the optimal integrative training process differ: about one third believe that students should be trained first to be proficient in one therapeutic model; about half believe that students should be trained minimally competent in a variety of models; and the remainder believe that students should be trained in a specific integrative or eclectic model from the outset (Lampropoulos & Dixon, in press).

As formidable as the challenge is, the future of psychotherapy integration rests heavily on instruction and dissemination. SEPI's Education Committee has disseminated information on integrative training programs and commissioned special sections on training for publication. Training programs have established formal mechanisms for insuring competence in multiple clinical procedures and relationship stances. This is an ambitious and arduous task to be sure, but the future of integration depends on sophisticated training of the next generation of psychotherapists.

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. The more fervent hope is that psychotherapy integration will be disseminated in training processes consistent with the openness of integration itself. The intention of integrative training is not necessarily to produce card-carrying, flag-waving «eclectic» or «integrative» psychotherapists. This scenario would simply

replace enforced conversion to a single orientation with enforced conversion to an integrative orientation, a change that may be more pluralistic and liberating in content, but certainly not in process. Instead, our goal is to educate therapists to think and, perhaps, to behave integratively –openly, synthetically, but critically– in their clinical pursuits.

9. Facilitating the ongoing shift to more clinically relevant psychotherapy research

Psychotherapy integration is, at heart, a systematic quest for synthesizing what works in diverse systems of psychotherapy. This pragmatic focus is facilitating a shift to more utilitarian research that can directly inform clinical practice. Research must adhere to clinical realities and answer urgent clinical questions to be meaningful.

Eubanks-Carter, Burckell and Goldfried (2005) recently analyzed the responses of 22 integrative/eclectic psychotherapists to the question of «What research directions should the field take in order to improve psychotherapy integration?» (see Norcross & Goldfried, in press, for individual responses). The contributors converged on two principal points: First, most stressed the need to demonstrate empirically the effectiveness of integrative therapies rather than assuming that they work simply because they are labeled «integrative». Little research is available to indicate how a clinician should integrate, including what should be integrated or the order in which elements should be integrated.

Second, the contributors expressed the need for increased collaboration between researchers and clinicians. Researchers complain that clinicians do not attend to research findings, and clinicians, in turn, complain that research is conducted in a vacuum and does not apply to their clients and circumstances. Bridging this gap between research and practice may well produce integrative treatments that are rooted both in clinical reality and empirical validation.

Multiple steps can be taken to repair the clinician-research rupture and to make research more useful to practicing clinicians. The contributors specifically suggested:

- Researchers should address questions that have relevance to clinical practice (the imperative «so what» questions).
- Researchers and practitioners should collaborate through the creation of practice-research networks.
- The use of more complex research designs to capture interactions among client, therapist, and relationship variables.
- The marriage of process research with outcome research in order to understand how change occurs rather than focusing exclusively on what has changed.
- Research with patients typically encountered in practice, such as those with comorbid diagnoses and Axis II disorders.
- Studies on clients who do not benefit from pure-form therapies to provide avenues for the development of integrative treatments.
- Movement beyond measures of therapist adherence to measures of therapeutic skill.
- Formation of theoretically diverse research groups to develop more innovative questions.
- Research on in-session processes, such as clinical decision-making, to identify the in-session markers effective therapists use in their decisions.

As might be expected, the integrative contributors were urging more pluralistic research designs, more realistic patient samples, more convergence between clinical reality and empirical research, and more pragmatic use and dissemination of the empirical literature.

10. Promoting integration as an international movement

Psychotherapy integration has taken strongest root in the United States. As an unfortunate

side effect, in a narrow and egocentric world view, many thought that it was largely an American enterprise. International developments were only dimly known; psychotherapy integration had adopted an isolationist stance (Gold, 1990). This is an embarrassing confession when one writes for an international audience or stands before world congresses, but it is nonetheless an accurate observation.

Beginning in the early 1990s, we were repeatedly admonished for our «Americacentric» view and began to change accordingly. The postmodern corrective is to recognize and promote integration as an international movement. SEPI (www.cyberpsych.org/sepi), for one prominent example, now has about a dozen international chapters and holds its annual meeting outside the United States every other year.

Concluding comments

Psychotherapy integration is a vibrant, maturing and international movement that has made encouraging contributions to the field. Integrative perspectives have been catalytic in the search for new ways of conceptualizing and conducting psychotherapy that go beyond the confines of single-schools. They have encouraged practitioners and researchers to examine what other therapies have to offer, particularly when confronted with difficult cases and therapeutic failures. Rival systems are increasingly viewed not as an adversary, but as a welcome diversity (Landsman, 1974); not as contradictory, but as complementary. Whether considered a paradigm shift or merely a theme that cuts across theoretical orientations, psychotherapy integration will most certainly be a therapeutic mainstay of the 21st century.

The success of the integration movement, however, raises two critical questions for its future in a postmodern era. The first question: Will there be competition and proliferation of various schools of integrative therapy, just as there has been intense competition among «pure-form» schools? Partisanship and competition among developing integrative models would simply be repeating the same historical mistakes of psychotherapy. Integrative therapies could, ironically, become the rigid and institutionalized perspectives that psychotherapy integration attempted to counter in the first place. Whether or not integration can successfully navigate between the perils of haphazard syncretism, on the one side, and the dangers of ideological institutionalization, on the other, will largely determine its continuing contribution.

The second question for the future of psychotherapy integration concerns its teleos, its overarching goals. An old Middle Eastern proverb reminds us: «He who plants dates does not live to eat dates». We need to be careful to plant dates rather than pumpkins; we need to adopt the long perspective. While psychotherapy integration will continue to grow in the short run, we must appreciate that its greater legacy lies in the future. This legacy, for me, entails the promotion of trans-theoretical inquiry, informed pluralism and enhanced client outcomes. As with the clinical enterprise itself, the seeds we sow now may produce enticing flowers quickly, but may not bear the sustaining fruit for years to come. I hope we all work diligently enough, and live long enough, to partake of that fruit together.

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