

DEVELOPING A PERSONAL INTEGRATION IN FAMILY THERAPY: PRINCIPLES FOR MODEL CONSTRUCTION AND PRACTICE

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This paper sets forth generic guidelines for the clinician to observe in building and practicing a personal integrative method in family therapy. Principles are articulated around five foci: (a) the need for a personal paradigm, (b) the assimilation of aspects of scholastic approaches, (c) the role of the person of the therapist, (d) the adaptation of the model to specific cases, and (e) the pathways toward the development of a personal integrative model. An informed view of integrative practice is emphasized, in which a theoretical base is created, strategies and techniques are related to this paradigm, and the treatment of specific cases is linked to the general model.

A striking recent development in the field of family therapy has been the vast increase in attention to integrative practice. This interest has been manifested both in considerations of the value of integration (Lebow, 1984; *Journal of Strategic and Systemic Therapies*, 1984) and the development of specific approaches (Feldman, 1982, 1985; Friedman, 1981; Gurman, 1981; Kirschner & Kirschner, 1986; Moultrup, 1981; Pinsof, 1983, 1984).

The term "integrative" connotes the joining of elements of different schools of psychotherapy. In most recent usage, "integrative" has been differentiated from "eclectic" by adding an organizing concept (or concepts) that unifies the disparate pieces of theory and technique utilized in eclecticism (Pinsof, 1984).¹

A wide range of methods may be subsumed under the heading "integrative"; thus, there is great diversity among integrative therapists. The integration may draw from as few as two scholastic approaches or may incorporate concepts from many schools. The theory and technique may be all-inclusive or relatively narrow. The integration may involve approaches that share much in their common base of understanding (e.g., the structural and strategic approaches) or may involve the blending of elements of orientations often thought incompatible (e.g., individual-oriented object relations theory and systems theory). The integration may assume much of one theory as its base (and, thus, constitute more an assimilation of an aspect of another approach than a true integration), or may draw equally from the conceptual base of different approaches. The approaches to be merged may be exclusively methods of treating the entire family or

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exclusively the marital dyad or may include methods that assemble different contexts (e.g., family, dyad, individual). The joining may be primarily at the level of theory or the pragmatics of practice or may equally focus on both. The integration may center on the treatment of one delimited treatment population (e.g., families with eating disorders) or may aim at the broad range of human problems. Within family therapy, most integrative efforts have brought together systemic, psychodynamic, and behavioral concepts, but the content has varied widely across approaches.

In a recent paper, I discussed the strengths and potential difficulties associated with integrative approaches (Lebow, 1984) and concluded that while an integrative perspective has unique advantages, it also is susceptible to a number of problems. Integrative treatments are able to draw from a broad theoretical base and, therefore, are more able to account for the range of human behavior than are scholastic approaches; they allow for greater flexibility in the treatment of any given individual or family and, thus, offer the opportunity for increased acceptability and efficacy of care; they are more readily adapted to diverse client populations; they can be more easily tailored by therapists to match their own personal styles; they offer an armamentarium of powerful interventions and treatment strategies designed to deal with specific problems; they permit greater objectivity in the selection of strategies for change; they are easily augmented and revised in relation to the development of new techniques and research findings; and they offer special advantages in training (Lebow, 1984). However, integrative approaches may suffer from a lack of a theoretical focus, inconsistency in formulation and approach, utopian goal setting that results in interminable treatment, and too much complexity which can have deleterious effects on the therapeutic relationship and lead to a lack of parsimony in intervention strategy. In addition, even exemplary integrative approaches remain more difficult to teach than their simpler counterparts and more difficult to monitor for quality of care (i.e., whether the treatment offered in a specific case is consistent with some standard of good practice). Complexity brings both advantages and problems.

Integrative therapists begin with a number of tools, but must shape these tools in order to avoid the pitfalls that stem from having a complex foundation for theory and practice. It is, therefore, not surprising that those crossing the boundaries of schools of treatment number among the best and worst of psychotherapists, ranging from self-contradictory and incomprehensible to masterful. When offered in a skillful manner, an integrative approach has benefits that far outweigh the costs (Lebow, 1984). The most important question for integrative practice of family treatment is not whether such practice can be beneficial, but how such practice can be optimized and the pitfalls avoided.

Because there has been little, formal attention in the literature or in training programs to the process of how therapists can best integrate concepts and techniques across scholastic boundaries, therapists are largely left to their own devices in this process. Frequently, the process works quite well. The clinician, solidly trained in a particular mode of intervention, becomes interested in another approach or a specific concept or intervention lying outside the domain of present practice. Through reading, workshops and supervision, information about the theory and practice of this method of intervention is gathered. The therapist then experiments clinically with these concepts or interventions, ultimately finding the optimal strategy for incorporating these new ideas into his or her approach, taking what works and leaving behind what does not, then rethinking his or her personal paradigm in terms of the new information acquired. Not only does the clinician emerge with an integration that is effective and fits well with his or her personality, but also the process, itself, adds to therapeutic efficacy in less direct ways by generating energy and a greater sense of personal efficacy.

However, this ideal often is not achieved; the practice of many therapists becomes beset with difficulties because of their failure to arrive at a functional organizing paradigm that complements their personal character. Frequently, new ideas and techniques are added in a manner that promotes confusion and leads to, at least in the short term, less effective practice.

How can we help clinicians with this process of becoming integrative therapists? One helpful aid would be to produce guidelines for this manner of working. It seems obvious that there must be a more effective way to educate integrative practitioners than for each therapist to not only invent his or her own model, but also a system of model development. Our theory and training must help the clinician to build a personal treatment paradigm.

There are two major avenues for developing guidelines for integrative practice. One centers on school building—the generation of replicable methods of treatment that cross the boundaries of the traditional schools; the second centers on helping clinicians order their own process of integration. A number of praiseworthy formal models for integrative practice have been presented (Barton & Alexander, 1981; Epstein & Bishop, 1981; Feldman, 1985; Gurman, 1984; Kirschner & Kirschner, 1986; Kramer, 1980; Pinosof, 1984; Slipp, 1985). Such prescriptive approaches offer the clinician the advantages of a broader range of intervention than within a traditional model, paired with the security of knowing that the relationships among these interventions have already been carefully considered. Adopting such a model provides a method of practice less uniquely tailored to the therapist than when therapists adapt their own models, but also, considerably reduces the dangers inherent in the latter process.

It is not the purpose of this paper to offer yet another integrative approach. The systems that have been developed are sophisticated and well articulated; as such, they provide admirable models for integrative treatment that can be employed either as specific templates for practice or as launching points for the building of a more individualized integrative approach.

Instead, this paper follows the second, and far less often discussed, pathway to integration: the development of principles for how clinicians can organize their own integrative efforts.² This paper is addressed to those who have either begun the process of forming a personal paradigm for treatment decisions or who are contemplating such an effort. It aims to delineate rules for organizing such personal efforts at integration: what therapists need to consider and how therapists can maximize the potential and avoid the pitfalls of integration/eclecticism. My suggestions are presented through a number of working principles, offered not as reified truths but as ideas on which to center discussion. Latent in each principle are inherent questions and exceptions that must be further considered and debated. To the extent possible, I have tried to separate the statement of these principles from my own personal integrative paradigm.

THE NEED FOR A PERSONAL PARADIGM

Principle #1: *An integrative approach must have a clear and internally consistent theoretical underpinning.* Treatments that cross the boundaries of schools are often thought of as atheoretical; however, this represents a basic misunderstanding of the nature of integrative practice (Lebow, 1984; Pinosof, 1984). A theory must be at the base of all treatment; techniques are not employed in a vacuum. The theory may not be fully articulated, may be based in a faulty understanding, and may even be internally inconsistent, but a theory is always involved. As Liddle (1982) has indicated, the psychotherapist cannot not theorize. Information is sorted, punctuated and processed through some template that determines what therapists make of what they see and what they

do in response to this information. Therapists all formulate; they merely differ in the sophistication of their formulations and their ability to articulate these ideas.

Must effective psychotherapists be able to precisely state their formulations? Unfortunately, there are no data that answer this important question.³ Observation suggests it is possible to function effectively as a therapist without being able to fully articulate one's theoretical base. We all know therapists who remain potent despite being unable to name the essence of what they do (and, I should add, therapists who sound as if they should be effective but are not). Powerful therapist characteristics such as the ability to communicate empathy, caring, and hope may even overcome deficits in theory, conception, and technique. However, save for the rare therapist, trying to hoe such a path is dangerous.⁴

Therapists who attempt to integrate theoretical approaches should make a concerted effort to understand and explicate their theories of practice. What is the purpose of therapy? Where and at what level is the locus of change? How does change occur? What aspects of experience are most important? What constitutes normality? What ultimate goals are most important in treatment and what mediating goals are sought to achieve these ends? These are just a few of the questions that each therapist must examine. Such questions assume special importance in integrative practice, since integrative therapists cannot merely defer to a comprehensive philosophy stated by the leaders of their school of practice. The integrative therapist must assemble his or her own vision.

In this process, the opportunities for incorporation of inconsistent and ineffective combinations of techniques and theory grow. To ameliorate this risk, it is especially important for the integrative therapist to complete what Liddle (1982) has referred to as an epistemological check-up (a statement of one's personal paradigm): to articulate what he does and why he does it. The goal here is not to create *the* perfect system; in an activity as complex as psychotherapy it is presumed that there will be inconsistencies and unresolved questions. Exceptions and uncertainties will enter into any sophisticated theoretical stance, the vantage point of the observer will affect the view of what is consistent and helpful, and a bit of inconsistency may even prove useful at times. The goal, instead, is for the therapist to know, as well as possible, the theory behind his or her method of practice, so that the therapist can work from a solid foundation.

Principle #2: *The theoretical formulation should lead to a method of practice consistent with that formulation.* Interventions should be purposeful and parsimonious, designed to a specific end. In the worst examples of eclectic treatment, interventions are delivered without reference to a central conception or to the context of the particular treatment. For an integrative approach to be effective, strategy and technique must be chosen with care.

As with the delineation of theory, the therapist needs to articulate the answers to many specific questions about intervention strategy. What interventions will be attempted with what types of cases in what particular situations? Who will be seen in treatment given different presenting situations? How will interventions vary across presenting problems or types of cases? What will the ordering of interventions be when there are multiple problems assessed across levels; e.g., will a psychodynamic interpretation precede, parallel or follow a structural one? How much will one focus on patient-stated goals and how much on therapist-observed difficulties at levels out of patient awareness? The therapist needs to delineate the nature of the intervention model and relate it to the theoretical stance delineated above.

Principle #3: *No single integrative theory is likely to emerge as the theory of therapy nor will a perfect theory emerge.* In the integrative literature, a vision is sometimes created of an evolving science that one day will yield an ideal integrative model, a general field theory of psychotherapy. Although the concept of integration can, itself, be

a path to better practice, it remains highly unlikely that one accepted theory of treatment will emerge that will encompass the views of all other theories (Liddle, 1982).

At the theoretical level, integrative viewpoints can help us understand the common factors underlying different approaches and at the level of practice, integrative viewpoints can help blend techniques of very different origins. However, the differences across approaches remain major ones. The competing visions of mankind we possess accent different conceptions of the human condition and aim toward diverse goals. Proponents of integrative practice, similarly, can be expected to move in disparate directions. Therefore, rather than looking for the ultimate therapy, we should emphasize each therapist's development of a clinical posture that maximizes that individual's unique strengths.

COMBINING TREATMENT APPROACHES

Principle #4: Scholastic approaches can be disassembled into a set of building blocks of treatment; integrative therapists can create their own combinations of theory, strategy, and technique from these building blocks. Integrative therapists need not accept as an entity all the concepts of the schools from which they borrow, but can select the theoretical precepts and techniques they will employ.

Integrative therapists vary in how and what they integrate. For some, integration means assimilating a few concepts or techniques from another approach into a primary orientation. Others wholly develop their own models from parts of different approaches. The latter path is obviously far more demanding and risky than the former one. The assimilator only needs to examine the impact of the new techniques or precepts on the mother approach (and vice versa); the therapist who builds from raw materials must create an entire theory of treatment. Most choose a path lying between these extremes, anchored to a few core concepts from different approaches.

One of the most important tasks for integrative theory lies in delineating the core theoretical concepts and interventions we possess. Many of the concepts identified as unique within schools of therapy, actually overlap with concepts of the other schools, leaving a manageable list of building blocks of treatment. Such efforts as Orlinsky and Howard's (1986) delineation of generic factors in psychotherapy, Goldfried's (1982) search for common clinical strategies, Gurman's (1978) mediating goals of treatment, Pinsof's (1983) therapist operations, Kantor and Neal's (1985) therapist stances, and Minuchin & Fishman's techniques of family therapy (1981) have begun the process of categorizing these building blocks.

Principle #5: Not all uses of scholastic approaches need be obvious. Integrative therapists can limit their use of the concepts of an approach to the provision of an additional perspective on a strategy derived from another model. Consider a behavior exchange strategy for treating a marital problem. In employing this strategy, the therapist can limit herself to the behavioral theoretical frame within which these techniques originated, or can expand this frame to include the individual dynamics of the patients, the systemic factors in the couple's interaction, and the influence of extended family and the broader social system. Although these insights may not alter the intervention itself, the broader frame alters the view of the intervention and may lead to other interventions that encompass different levels of experience.

In addition to its utility in the treatment of cases, the maintenance of multiple perspectives on change can help ameliorate a major problem in our field, the parochialism maintained by jargon. If therapists can understand that they are discussing concepts that are not mutually exclusive, some of the distance between schools can be bridged (Goldfried, 1982). Of course, there remain real differences between theories and methods of practice that should not be ignored and are not issues of jargon. However,

our jargon and scholasticism stand between our understanding what are real differences and what are merely differences in emphasis.

Principle #6: *Theories, strategies, and techniques may add in synchronous ways to greater power or have negative interactions that reduce overall effectiveness.* Employing more concepts and techniques does not necessarily lead to greater effectiveness. The possibilities of negative interactions between aspects of treatment must be contemplated before adding a new intervention strategy to one's therapeutic armamentarium, and the interaction of the interventions carefully monitored early in the use of the new intervention.

Some strategies and conceptualizations will be more amenable to integration than will others. Like the good chef, the integrative therapist must know how the ingredients are likely to blend together. Action-oriented directive treatments mix readily. Thus, behaviorists add cognitive and gestalt interventions to their armamentariums without presenting a disjointed treatment.⁵ In such models, the therapist's essential position is similar, and the integration merely requires an alteration in content of theory and technique.

More problematic are combinations of intervention strategies that move the therapist to distinct positions. Adding a paradoxical intervention strategy, with its consequent distant therapeutic position (Kantor & Neal, 1985), to a supportive treatment could result in the undoing of the basic support. This is not to suggest that such intervention strategies are necessarily incompatible; pieces of these approaches can be interwoven (as in offering a gentle paradoxical thought in the context of a close position), but the interaction of the components requires considerable attention.

Principle #7: *Problems are manifested simultaneously on a number of levels, e.g., that of the individual intrapsychic structure or character, that of the family structure or system, that of the biochemical or somatic, that of the behavioral, the cognitive, and the affective.* Humans and their problems are, inevitably, bio-psychosocial in nature and change at any level will cause change at other levels. The critical question, therefore, is what is the most efficient and comprehensive path to change, not what will cause change. Any treatment will impact somewhat on any problem (e.g., Montalvo & Haley, 1973, on the impact of child therapy on the family system); only rarely is there one treatment that can be pointed to as *the* intervention of choice.

A layering of problems can be envisioned. At the surface we have the behavior of concern—for example, depression. Beneath this layer of symptomatology lies a multi-determined causal structure, that includes reinforcement patterns, cognitions, ways of handling affect, defenses, the intrapsychic structure of the individual, the biological, interpersonal relations, and the familial and societal nexus within which that individual resides. Further, the various theories do not even delimit distinct domains; reinforcements may be the vehicle for the communication of the interpersonal structure or the determinant of intrapsychic development. We do not have a distinct causal path but, rather, an underbelly of interrelated causal pathways. Pinosof (1983) has labeled this the problem-maintenance structure.

Within this complex causal structure, therapists and theorists choose aspects to accent what they believe essential to the accomplishment of the goals they hold most dear. Their choices are not so much between correct and incorrect viewpoints, but rather, between multiple sets of perspectives that have utility at differing levels.

Principle #8: *In choosing intervention strategies, integrative therapists must be aware of the importance of who is seen as well as what is done.* Often, individual psychotherapists discuss psychotherapy as if individual therapy were the only available modality, and family therapists as if family therapy were the only possible context. Today, a significant percentage of treatments that are offered cut across contexts (e.g., Feldman, 1985; Pinosof, 1984). The integrative therapist need not be involved in the

practice of all these modalities but must, at least, have a schema for the indications and contraindications for different modalities.

The integrative therapist must also be concerned with how treatment in one modality impacts on the other contexts. If a child is seen individually and with his family, what are the effects on the child's honesty in the individual context and the family's willingness to trust the therapist? Further questions revolve around whether the same therapist or different therapists provide treatment across the contexts, and the nature of the working relationship among the therapists when more than one is involved. Each therapist should arrive at a schema for the preferred matching of therapists and contexts under varying conditions.

Principle #9: Each of the formal stages of treatment must be considered; the treatment plan should address each stage. All therapies include an engagement process, some type of case assessment, a contract (formal or informal), a working stage, and termination. Given the wide range of choices in integrative practice, the therapist must be particularly sensitive to accomplishing the requisite goals at each stage.

The alliance must be established; it may be developed in a variety of ways ranging from explicit discussion of the relationship, to direct work on the presenting problem, or explicit efforts to side with family members (Pinsof & Catherall, 1986). Each provider's theory should suggest how the alliance will be forged in various kinds of cases.

Assessment is a particularly vital task in an integrative treatment, since so many choices for action remain available. Assessment may occur in a formal period or be informally done over the course of treatment. Whichever is the case, the therapist must gather the necessary information and sort this information to decide on a treatment strategy. All integrative therapists would do well to formulate a schema for assessment that includes what information is important and how this information will be gathered. Feldman & Pinsof (1982) offer an exemplary assessment schema spanning the behavioral, psychodynamic, and systems levels that focuses on both individual and family functioning and might well serve as a model for others. As with the statement of paradigm, the goal here is not for an obsessive consideration of each case, but rather, for clarification of the categories most important so that the therapist has the data needed to plan an intervention strategy.

Given the broad array of arrangements possible, the creation of a therapy contract (Orlinsky & Howard, 1986) also has amplified meaning in the context of an integrative treatment. Among the issues needing to be addressed are the frequency of sessions, the cost, who is to attend which sessions, the respective roles of patients and therapist, access to information about the treatment, and the manner in which problems will be approached.

The therapist's concept of termination, including when it is appropriate and how it can best occur, also assumes special meaning as an antidote to a potential shortcoming in integrative approaches—the generation of a therapy without end (Watzlawick, Weakland & Fisch, 1974). Given the range of problems human beings have, new goals always can be formulated when old agendas are completed. Does the family decide the appropriate endpoint of treatment? Is termination appropriate at the time of symptom resolution? When is it appropriate to end a therapy that is unsuccessful? Each therapist must know his or her stance with regard to these and related issues.

THE ROLE OF THE THERAPIST

Principle #10: Technique is no substitute for therapeutic skill. Gurman & Kniskern (1978) coined the term "technolatry" to refer to the overreliance on technique in treatment to the exclusion of the therapeutic relationship and other less specific factors in treatment. Given the large number of techniques the integrative therapist has poten-

tially available, there is grave danger of falling prey to this difficulty. Psychotherapy research has consistently shown that the therapeutic relationship is among the most important factors in the efficacy of treatment; this is no less true in family therapy (Pinsof & Catherall, 1986). The therapist must create an environment that is psychotherapeutic, i.e., that can be a vehicle for personal change. The personal qualities of the therapist are vitally important in the pursuit of such an environment.

Therapists must also pay attention to who they are in their choice of techniques and theory (Kramer, 1980; Minuchin & Fishman, 1981). The style and context in which an intervention is delivered, in major part determines how that intervention will be experienced. Among beginning therapists, one often observes a bad fit between the theory/technique and the therapist. Interventions may be delivered in a technically correct way but without the quality of a psychotherapeutic agent. The therapist must be attentive to the fit between his or her personality and the approach chosen.

Training in integrative models should not merely teach technique and theory, but explicitly accent the generation of a therapeutic stance by the therapist. The ability to feel and be hopeful, empathic, assertive, confrontive, and focused are all part of being a therapist. To the extent possible, such skills should be directly taught, supplemented by personal therapy, to help overcome obstacles to attaining a therapeutic position. Each therapist ultimately needs to find a mode (or modes) of operating that is (are) comfortable and blends successfully with the theory, strategies, and techniques utilized.

Principle #11: *The integrative therapist should be attuned to the personal value implicit in theory and practice.* The practice of family therapy is not only the manifestation of scientific principles, it is also a statement of personal values (Aponte, 1985; Lebow, 1981). Beyond the plethora of value-laden choices latent in any treatment (e.g., the selection of the problem on which to focus, the judgment of which behaviors are to be viewed as normal), the breadth of possibility available to the integrative therapist promotes additional concerns.

A typical illustration lies in the choice among different intervention strategies. The range of alternatives available increases the possibility that the type of intervention will be, at least in part, dictated by factors other than the probability of success. The integrative therapist must assess not only the probability that an intervention will have a particular effect, but also, whether this choice among interventions is influenced by personal values. For example, is the development of self-knowledge and/or behavioral competencies a goal with this family or is the aim simply behavior change? What dictates this choice? Does the therapist favor one set of goals and strategies with one group of patients and another set with a second, due to extratherapeutic factors? The impact of values on practice need not be harmful, but the extent and direction of this impact must be known.

Scholastic approaches tend to be accompanied by a set of values that match the mode of practice. Freed of such guidelines, the integrative therapist must be particularly self-aware about the impact of personal values on practice.

Principle #12: *The integrative therapist must also deal with what it means to be an integrative therapist.* The integrative practitioner must adjust to the particular stresses of being an integrative therapist. There are considerable demands in staying current with the latest developments in more than one school of treatment, in the need for self-examination about the present status of one's personal paradigm,⁶ and in the abundance of choices that must constantly be made.

The integrative therapist may also experience identity issues from failing to find a reference group.⁷ In choosing an integrative stance, the safety of a community that agrees about treatment assumptions, is lost. Those who move to integrative positions from a more parochial training experience may be viewed by their original reference

group as wrong-headed, or even disloyal.⁸ Thus, many personal issues may be brought to the fore by attempts at integrative practice.

ADAPTING THE MODEL TO SPECIFIC CASES

Principle #13: *For each case, the therapist must choose among the available explanations and interventions and select a strategy that will maximize the accomplishment of the specific goals of that treatment.* For any particular case, there will be a series of explanations for the behavior in question and a parallel series of potential interventions to alter that particular set of behaviors. The integrative therapist should identify these potential pathways and arrive at a strategy that maximizes the likelihood and efficiency of achieving treatment goals.

An important aspect of this strategy is when, and under what conditions, the method of intervention will be changed (Pinsof, 1983). Obviously, the therapist cannot prepare, a priori, for every potential contingency (indeed, such an approach would likely reduce the sense of immediacy so important in an effective therapy), but a working template is needed. Experienced therapists often establish such a decision tree at a preconscious level; both neophytes and experienced practitioners can benefit from a series of “what if” problems that flush out patterns of decision making.

It is particularly important, within integrative approaches, to relate the specific strategy in each case to the therapist's overall paradigm since the methods of intervention are likely to be more complex and to vary more from case to case than the technique of a scholastic therapist. At the same time, the clinical data from each case offers further opportunity for examination and articulation of the therapist's personal paradigm.

Principle #14: *In choosing a specific intervention strategy, the therapist also must consider such pragmatic factors as its acceptability to the clients and the resources available to serve this particular case.* The concept of acceptability is one that is often ignored in considerations of treatment; a treatment can only be effective if the patients agree to participate and allow the treatment to be delivered (Lebow, 1982). A major factor in treatment failure is early termination from therapy (Garfield, 1978), which often is a by-product of the presentation of methods of intervention unacceptable to the clients.

The resources available must also be considered. Different strategies may be preferable across inpatient, outpatient mental health center, day hospital, and outpatient private practice settings. What may be the best strategy in one setting may simply not be available or applicable in another. Cost considerations also play a role; for example, treatment employing multiple contexts is more practical when multiple sessions can be held during the week than when this cannot be afforded.

Principle #15: *In treating each case, the integrative therapist must balance a coherence of approach and the flexibility to move to additional modes of intervention.* The potential for flexibility numbers among the principal strengths of an integrative approach; however, hazards abound that can undermine this potential for flexibility. Treatment conducted without sufficient planning can readily become disjointed and confusing to patients; that conducted with too formalized a blueprint can degenerate into rigidity and insensitivity. The therapist must find a balance between coherence and flexibility.

BUILDING AN INTEGRATIVE MODEL

Principle #16: *In moving to an integrative approach, the therapist should begin with a delimited range of interventions.* When one observes a skillful integrative therapist, one is impressed with the array of techniques and concepts that can be creatively blended. Within a single hour, the therapist may draw on a behavioral assignment, a cognitive restructuring, a dynamic interpretation, and a structural intervention, in

pursuit of goals on the behavioral, systemic, and psychodynamic levels. Across hours of treatment, the therapist may see different subsystems in addition to the entire family. Such mastery often leads to attempts at immediate mimicry by beginning therapists, and such mimicry is doomed to failure. Learning psychotherapy is an extremely complex activity; in addition to mastering theory and technique, beginning therapists must face their fears about dealing with other people with problems, their anxiety about beginning a new activity, their feelings about their personal ability to be therapeutic, and a nearly endless list of areas of ignorance, from how to begin and end the treatment session to how to determine the suicidal potential of a patient. There simply is too much information to process, for the therapist in training to attempt to model the complexity of the supervisor's intervention strategy and still have the potential to be therapeutic. Not only would the therapist be stressed in a way that would be unproductive, but also, in most training sites, real patients would be the ones who would truly suffer through this leap (Pinsof, 1984), receiving empathy and support one week and a paradoxical intervention the next from a therapist who remains unskilled in any particular intervention strategy.

As I have noted earlier in this paper, there are two common pathways toward the pursuit of an integrative strategy in treatment. The more frequent is being trained well in a base in one theory and set of interventions, and gradually expanding and adapting the base of theory and technique. For example, Wachtel (1977) details his move from a psychoanalytic base to incorporate behavioral and a systemic viewpoint. Following such a route has the strength of providing a secure and nurturant foundation for the trainee in which a simpler method of intervention can be mastered before increased complexity and decision making is introduced. However, this method also has deficits. If intended as a pathway to an integrative approach, such a method is inefficient, and may leave the trainee unable to move beyond the limited range of conceptualization and intervention of the original theory.

The second major pathway lies in the formal presentation of an integrative model. Such models, of necessity, pick and choose from the theories, strategies, and techniques available, exposing the trainee to a delimited range of ideas and interventions presented in a coherent context. Such approaches present greater initial complexity to the trainee and, thus, increase the possibilities for initial confusion, but offer the considerable advantages of orienting the trainee directly to an integrative stance and of providing a structure for practice that manages the complexity, yet that allows for future individual development. While the relative merits of the two modes of learning can be argued, it appears clear that either is preferable to attempts at a premature stretch to the level of the experienced therapist.

Principle #17: *An integrative approach is not a static entity but an evolving method, a system open to new inputs. As such, the specific content of theory and technique can be expected to change over time (Liddle, 1985). The theory and technique must have room for these additional inputs and a solid base around which these data can be assimilated. Ideally, a life-long process is involved, that includes not only professional development but also personal growth. Among the important inputs to professional development are workshops, reading, discussions with colleagues, and the results of research, all of which provide ideas that can become the subject of clinical investigation.*

Principle #18: *Techniques should only be added to the therapeutic armamentarium with care; requisite for experimentation with a technique should be both a technical understanding of the procedures involved and a theoretical understanding of the context within which it was created.* Integrative practice should not derive from the rapid-fire assimilation of many techniques. Instead, careful digestion of each technique under consideration is needed. An insufficient understanding of the use of a technique can make for confusion for both therapist and patient; in the world of clinical service there

is little room for such uncontrolled experimentation. Clinicians have an ethical obligation to their clients to master the cognitive and emotional aspects of a procedure before employing that procedure. For such mastery, the clinician must understand not only the technical aspects of the procedure but also the theoretical context in which it originated.

A number of important questions should be considered in approaching any new technique. Why was this procedure developed? For what patients was it intended? What theoretical goal was it meant to serve? How will the technique fit with the therapist's present mode of working and with the particular family under consideration? What will be the ordering of interventions? Of course, there must be a place for trial and error through which the therapist can gain first-hand knowledge of how this technique works with his or her approach, but in the interest of good clinical service, as much knowledge as possible should be digested before clinical application. Spontaneity is important in psychotherapy, but patients should not be fodder for poorly thought out exploration. One particularly underused source of information is the research concerned with a technique. Is there evidence for its efficacy? If so, how much and under what conditions? The integrative therapist should be an informed consumer of research data (Lebow, 1986).

Principle #19: Programs should more explicitly focus on training in integrative concepts and intervention strategies and should shape a path toward integration. As I noted earlier in this paper, much of the central task for most therapists—the development of a personal theory and treatment paradigm—is left, virtually, entirely to the clinician. Programs seldom offer training in how to build a personal integration, even though the majority of therapists ultimately emerge labeling themselves as eclectic or integrative. Given the propensity of clinicians to explore these pathways, even the most doctrinaire of training programs would do well to more explicitly prepare the clinician for future model building.

A good example of training in an integrative perspective is offered within the clinical training program at the Center for Family Studies/Family Institute of Chicago, which teaches Pinsof's (1983) problem-centered model. At the onset, trainees are provided with an overview of the integrative model and specific presentations concerned with specific modes of intervention. In the context of these presentations, therapists are taught, and practice, specific operations designed to establish specific competencies in methods of intervention. The trainees also receive ongoing group and individual supervision and participate in a variant of live supervision in which both treatment by the trainees is observed and intervention is modeled by the supervisor. Such a comprehensive training program can minimize the problems for the trainee and maximize the learning experience.

Whether or not an integrative model is specifically presented, training programs can learn much from such examples. The concept of integration can be successfully presented to students early in training, providing a framework for future development. Such early exposure to a range of ideas can prove useful, whether or not the clinician is immediately asked to draw upon these ideas. If an open spirit of inquiry can be promoted, intellectual mastery over a range of concepts and competencies achieved, and a set of pathways for development presented, then the clinician will emerge with a solid base from which he or she can develop. Methods may lie dormant for some time, but then be available as the clinician matures.

CONCLUSION: OPENING THE DIALECTICAL PROCESS

I have presented a set of principles that I believe can facilitate the practice of integrative therapy and serve to guide the development of those who are beginning on

the pathway to integration. These principles highlight an informed view of treatment in which the theoretical base for the integration is examined, the strategies and techniques employed are related to this paradigm, and the treatment of specific cases is linked to the broader theory and strategies. Further, I offer a viewpoint that balances attention to the person of the therapist, the patient/therapist relationship, and the content of the treatment. It is a vantage point that assumes there are both general principles of psychotherapy and a constant need to relate these principles to the specific relationship under consideration. It is also a viewpoint that emphasizes the importance of the fit between the therapist and the theory/technique of treatment, and that sees the integrative therapist as capable of actively creating a model of treatment based in the raw material provided by others.

However, I do not mean to propose these principles as reified truths, the last statement on these important issues. Rather, these ideas are offered in the spirit of opening up a path of inquiry—the generation of guidelines to aid therapists in the process of developing personal integrative methods of treatment, that has received little attention despite all the impressive statistics suggesting that most therapists come to regard themselves as integrative/eclectic in orientation.

The task of developing an integrative stance is better represented as the meeting of thesis and antithesis in a dialectical process than as the simple generation of a “best” set of concepts (Liddle, 1984). Many of the ideas expressed in this paper are the result of such a dialectical process. For example, consistency has obvious importance within an integrative approach, but must encounter the importance of spontaneity in such a dialectic. Flat consistency is just as unlikely to be therapeutic as chaotic spontaneity; hopefully, what emerges from the combination of the two is a creative, yet dependable, ordered spontaneity.

Among the other ideas that have clashed in generating this discussion of integration are: (a) The notion of an evolving science of treatment and the impossibility of an ultimate approach to treatment, given that this treatment is offered by human beings about matters relevant to the human condition; (b) the idea that theories are divisible into their component parts and the importance of the overall conception and context to the meaning of those parts; (c) the relative value of the development of schools of integration vs. that of therapists developing their own personal paradigms; (d) the importance of which family members are seen in treatment (i.e., treatment context) vs. the triviality of this decision given a systemic perspective; (e) the concept of treatments continuing to evolve over time and the need for systematic treatments that can be assessed; (f) the notion of the need for a theoretical basis for integration vs. the possibility of an atheoretical technical eclecticism; (g) the importance of care in offering competent clinical service and the need for clinicians to experiment as they develop; (h) the relative merits of being trained well in one mode of intervention vs. being exposed to a broader range of training; and (i) the merit of guidelines to structure personal development and the strictures imposed by such guidelines.

These conflicting ideas are hardly quieted by a single effort at resolution. It is likely the reader will raise issues about some of them. We have barely begun to crack the surface of the multitude of questions that surround the practice of integrative family therapy. The principles in this paper are offered not as an effort toward premature closure, but to open further dialogue about what should be vital concerns—the development of integrative therapists and the generation of guidelines for integrative practice. We need a great deal of further consideration of both the process of integrating and the content of successful integrations. My hope is that this paper will both guide some in the pursuit of their own integrative methods of practice and encourage others to further thought about the nature of guidelines for the integrative therapist.

NOTES

¹However, it should be noted that providers who refer to themselves as “integrative” often remain subject to the same problems as those who call themselves “eclectic”; indeed, as the term “integrative” becomes more popular, many merely switch labels.

²It should be noted that the distinction between the pathways of integrative school development and the development of principles for how clinicians can best form their own integrations, is a somewhat arbitrary one. The best specific integrations are stated in the form of broad principles for making treatment decisions, while some of the principles I have stated here have a fairly specific focus.

³The paucity of data relevant to integrative practice represents a general problem. The relative short history of prominent discussion of integration, coupled with the methodological difficulties inherent in studying more complex modes of intervention (especially when these are likely to be delivered in different ways by different therapists), have contributed to this problem.

⁴The progenitors of many of the schools of family therapy have been precisely such individuals, whose personal communication is so powerful that they would be effective without their theory and technique. Although these personal characteristics of charismatic founders of school surely contribute to the acceptance of their approaches, they also mask the value of the theory and technique, itself. Some charismatic therapists offer prominent methods that appear to have low rates of efficacy when practiced by any one but their creator.

⁵Even here, the interaction must be observed; for example, the stressing of affect and cognition may clash within active, short-term therapies.

⁶It is possible, of course, to be integrative and apply the same integrative strategy across all cases and to maintain the very same integrative strategy across a lifetime; however, these comments will apply to the majority of integrative therapists.

I am indebted to Larry Feldman for highlighting the importance of these considerations.

⁷The inception of such groups as the Society for the Exploration of Psychotherapy Integration and interest groups in integration in the American Family Therapy Association and American Association for Marriage and Family Therapy have begun to mitigate this concern, as integrative therapists establish their own community.

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