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Integration in Psychotherapy: Reasons and Challenges

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Although integration has been formally influencing the field of psychotherapy since the 1930s, its impact gained significant momentum during the 1980s. Practical, theoretical, and scientific reasons help to explain the growing influence of integration in psychotherapy. The field of psychotherapy is characterized by many challenges which integration may change into meaningful opportunities. Nonetheless, many obstacles remain when seeking to advance integration. To appreciate the strength of integration in psychotherapy we describe an integrative, comprehensive approach to service delivery, research, and training. We then discuss the role of integration in the future of psychotherapy.

Keywords: integration in psychotherapy, psychotherapy integration, integrative psychotherapy

Integration has been formally influencing the field of psychotherapy since the 1930s (Goldfried, Glass, & Arnkoff, 2011). Historians of the psychotherapy integration movement single out French's (1933) article on the interrelations between psychoanalysis and Pavlov's experimental work as one the first attempts at building bridges of common understanding and synthesis between the different theoretical orientations in psychotherapy (Goldfried, Pachankis, & Bell, 2005). Subsequently, Rosenzweig's (1936) articulation of the common factors shared by the growing number of psychotherapy approaches at that time has been acknowledged as one of the most seminal works in fostering integration within psychotherapy. Since that time, there have been many important contributions toward the exploration, understanding, and systematization of psychotherapy integration. For example, Dollard and Miller's

(1950) integration of psychoanalytic constructs with those from learning theories and Wachtel's (1977, 1997) integration of psychoanalysis and behavior therapy are among the most prominent.

Initially referred to as eclectic (Norcross, 1986, 1987), psychotherapy integration began anew in the 1980s. It has expanded considerably with the publication of multiple handbooks and casebooks (Norcross & Goldfried, 1992, 2005; Stricker & Gold, 1993, 2006), the circulation of several journals (e.g., the *International Journal of Eclectic Psychotherapy*, later the *Journal of Integrative and Eclectic Psychotherapy*, and the *Journal of Psychotherapy Integration*), and the founding in 1983 of a professional, international society (i.e., the Society for the Exploration of Psychotherapy Integration, www.sepiweb.org).

In principle, the terms *psychotherapy integration* and *integration in psychotherapy* are considered synonymous; they refer to a stance that invites dialogue and exploration as well as a commitment to ongoing developments and processes rather than end-goals in facilitating the evolution of psychotherapy. In practice, psychotherapy integration characterizes an ongoing rapprochement, convergence, and complementarity not only at the conceptual level but also at the clinical and empirical level. It has been regarded as a “leitmotiv” or “zeitgeist” in the field of psychotherapy” (Castonguay, Eubanks, Goldfried, Muran, & Lutz, 2015, p. 365).

Several misunderstandings have surrounded the concept of integration in psychotherapy. A common misunderstanding is equating psychotherapy integration or integration in psychotherapy with integrative or integrated psychotherapy.

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While the former emphasize processes and strivings the latter are specific, particular approaches to psychotherapy. Another common misunderstanding is to confuse integration with unification or to make them synonymous, when actually these are distinct terms with different epistemological assumptions. Integration refers to a state in which different parts can be linked and work together without any loss of meaning on either side, whereas unification involves reaching a state in which both elements are dissolved into something new. Yet, many times a particular approach within unification dominates or prevails, as is the case with the cognitive-behavioral perspective in what is known as the unified protocol (Barlow et al., 2011). Said differently, psychotherapy integration is closer to pluralism (Messer, 2008), where there is not merely an acknowledgment, but a coexistence of differences rather than a melting pot, as would be the case with unification.

Integration is a fundamental concept in not only psychology but in related disciplines such as sociology and anthropology. In these disciplines it refers to the ability of a system to promote actions for overcoming barriers that may arise due to prejudice or cultural differences. The United Nations' Department of Economics and Social Affairs defines social integration as a situation in a community where all members have and may exercise the same rights and where coexistence, collaboration, and cohesion are actively pursued (see www.un.org/esa/socdev/sib/peacedialogue/soc_integration.htm). Those values characterize psychotherapy integration as well.

Strands of Psychotherapy Integration

Another way to appreciate what is meant by psychotherapy integration is through the taxonomy of its different strands. While there have been several attempts to systematize and classify the psychotherapy integration movement, the most accepted taxonomy initially identified three broad strands within integration (Arkowitz, 1989). A fourth strand was added later (Messer, 1992). The first strand in integration is known as common factors and refers to the change processes shared by the human healing arts, including psychotherapy (Frank & Frank, 1991). In addition to Rosenzweig's (1936) article cited above, two representative approaches of this strand are Garfield's (1980) eclectic psychotherapy and, more recently, the writings by Barry Duncan, Scott Miller, Bruce Wampold, and Mark Hubble emphasizing what works in psychotherapy (e.g., Duncan, Miller, Wampold, & Hubble, 2010).

The second strand has been referred to as technical eclecticism and encompasses approaches that emphasize the intentional, empirically, and clinically informed selection of strategies, interventions, and techniques to be utilized with a particular patient above and beyond the theoretical orientation that spawned the therapeutic action. Two representa-

tive approaches of this strand are Lazarus' (2005) multimodal therapy and Beutler's systematic treatment selection (Beutler, Consoli, Lenore, & Sheltzer, 2017).

The third strand in integration is known as theoretical integration and refers to carefully articulated syntheses of two or more theoretical perspectives. Two representative approaches of this strand are Ryle's (2005) cognitive analytic therapy and Wachtel's (2014) cyclical psychodynamics.

The fourth and most recent strand in integration is known as assimilative integration (Messer, 2015) and encompasses psychotherapy approaches that adhere to a specific, traditional theoretical orientation or so-called home theory, such as psychodynamic, yet utilize selectively and occasionally a specific intervention from another orientation, such as systematic desensitization from a behavioral perspective. Representative approaches of this strand are the assimilative psychodynamic psychotherapy of Stricker and Gold (2005), and the cognitive-behavioral assimilative integration of Castonguay, Newman, Borkovec, Holtforth, and Maramba (2005). While there are significant overlaps between the four strands, collectively they highlight the complexities within integration in psychotherapy and its increasing sophistication.

Reasons for Integration

Practical Reasons

There are some important, practical reasons for integration. Integrative psychotherapies have been endorsed by many practitioners in the United States (Norcross, Karpiak, & Santoro, 2005) and abroad such as in Argentina (Muller, 2008), China (Liu et al., 2013; Yin, Huang, & Fu, 2009), Germany, and Switzerland (Caspar, 2008). Endorsements have ranged from as low as 7% in Australia to as high as 42% in Great Britain, with 36% in the United States (Norcross, 2005). An even more striking assessment of the sizable presence of integration among practitioners is the fact that, when given a chance in surveys, practitioners are more likely to endorse multiple orientations from the main cluster of approaches rather than a single, pure-form psychotherapy approach. Multiple orientation endorsements have reached highs of 90% among respondents in the United States and 86% in New Zealand (Norcross, 2005). These multiple endorsements may be understood in the context of the many studies that have explored the development of psychotherapists who presently ascribe to an integrative perspective. One such study identified a process toward integration that involves different phases that are cycled through numerous times in a psychotherapist's professional life (Rihacek & Danelova, 2016). These phases include adherence to and identification with a single theory, destabilization through the encountering of limitations of a

single theory or the growing of epistemological dissatisfactions with a single theory stance, and, finally, consolidation through conceptual organization and increased personal coherence.

Another practical reason for integration of psychotherapy is that many of the so-called pure-form approaches have incorporated, over time, strategies, interventions, and techniques from other pure-form psychotherapies. This phenomenon can be considered a *de facto* integration at a practical and theoretical level. For example, recently a much-explored domain has been the convergence between the psychodynamic and cognitive-behavioral approaches in mentalization therapy and dialectical behavioral therapy, respectively (Swenson & Choi-Kain, 2015). Another example can be found in the treatment of children and adolescents where significant trends toward integration have been identified within cognitive-behavioral therapies (Krueger & Glass, 2013).

Theoretical Reasons

The abundance of different theoretical models within the field of psychotherapy is a source of confusion to professionals and laypeople alike. Indeed, hundreds of approaches have been put forward although most experts agree that they can be reduced to four basic ones: psychodynamic, cognitive-behavioral, existential-humanistic-experiential, and systemic (Fernández-Álvarez, 2001; Längle & Kriz, 2012; Wachtel, 2014). Perhaps more important than counting and then reducing the numbers, and beyond the labels and trademarked approaches (Rosen, & Davison, 2003), is to consider the explanatory hypotheses and functional mechanisms put forth by each of the four main approaches so as to acknowledge their salient contributions to psychotherapy and, ultimately, integration in psychotherapy.

Psychodynamic approaches originally emphasized intrapsychic motivation and the role of past events in present human behavior. Nonetheless, as psychodynamic approaches have evolved, the importance of attachment and relational perspectives in understanding human behavior has become even more prominent. Cognitive-behavioral approaches have traditionally focused on learning and tend to concentrate on the here and now though it is important to observe that in their evolution the role of the past in present day actions occupies a more sizable place. Additionally, constructivist epistemologies have challenged the authoritarian ones that originally characterized some cognitive-behavioral therapies. Existential-humanistic-experiential approaches focus on the construction of meaning in life and the importance of emotions with the hallmarks of these approaches being the pursuit of self-actualization and the facilitation of personal growth. A fourth cluster of approaches, collectively referred to as systemic, focus on the

interactions among individuals, circular causality, and the role of context (Fernández-Álvarez, 2001).

More recently, the advent of a systematic reflection on and an appreciation of the role of context in human behavior brought about multicultural and gender grounded perspectives in psychotherapy, which has resulted in increased concern with social justice, liberatory practices, self-determination, universal design, and respectful relationship with the environment. Similarly, the emphasis of counseling psychology and the multicultural movement on strength-based approaches, including positive psychology, expanded psychotherapy and made it a profession that concerns itself with not only disordered human behavior and interactions but also with the well-being of individuals, couples, families, and communities. Furthermore, psychotherapy as a social science has had to contend with the role of values in its theory and practice as well as the place of spirituality and religion. In short, integration in psychotherapy from a theoretical perspective is the quest for ever-more sophisticated yet systematic articulations of the relationship between motivation, learning, the pursuit of meaning and the role of relational, cultural, and social contexts in human stability and change processes. Said differently, integration in psychotherapy is about increasingly honoring human complexity in the pursuit to address the diversity of patients' needs and to affirm patients' strengths so as to provide pertinent, relevant, and comprehensive services, be those clinical or preventative.

Scientific Reasons

Albeit limited in spite of the popularity of psychotherapy integration, there are growing bodies of research, consensus guidelines, and resolutions that provide some important, scientific reasons for integration. The most prominent sources include the longstanding work on the identification of common factors in healing practices (Frank & Frank, 1991; Wampold, 2001; Wampold & Imel, 2015), the empirical systematization of the principles and mechanisms of change in psychotherapy (Castonguay & Beutler, 2006), the findings from evidence-based as well as practice-based research (Castonguay, Barkham, Lutz, & McAleavey, 2013; Castonguay, Youn, Xiao, Muran, & Barber, 2015), the critical examination of research on psychotherapy integration led by Glass and collaborators (Glass, Arnkoff, & Rodríguez, 1998; Glass, Victor, & Arnkoff, 1993; Schottenbauer, Glass, & Arnkoff, 2005) and by others more recently (Castonguay, Eubanks, et al., 2015), consensus guidelines such as the APA Presidential Task Force on Evidence-Based Practice (2006), and resolutions such as the "Recognition of Psychotherapy Effectiveness" (American Psychological Association, 2013). While the summation of that body of literature is beyond the scope of this article,

some of the findings that provide reasons for integration are highlighted here.

The bulk of the research on psychotherapy integration has been published in the forms of case studies or has focused on process research. Authors have identified many challenges in conducting empirical outcome research on psychotherapy integration and in analyzing the existing literature. For example, there has been a lack of consensus on what is considered an integrative or eclectic psychotherapy and the various modes of integration (see above; Castonguay, Eubanks, et al., 2015; Schottenbauer et al., 2005). Despite these challenges, several empirically based assertions can be made with respect to the scientific reasons for integration.

As scientist-practitioners seek to provide empirically supported treatments to ever more complex patients that are difficult to treat or who are nonresponsive to standard treatments they resort to integrated, comprehensive ones (Norcross, 2005; Schottenbauer et al., 2005). Similarly, following the report of the *APA Presidential Task Force on Evidence-Based Practice* (2006), psychotherapists seeking to provide evidence-based practice are encouraged to integrate the best available research with their clinical expertise in the context of patient characteristics, culture and preferences. In fact, a task force charged with delineating empirically based principles of change in psychotherapy presented its findings based on the role that technical and interpersonal factors as well as clients' and therapists' characteristics played in the treatment of specific disorders such as dysphoric, anxiety, personality, and substance use disorders (Castonguay & Beutler, 2006). The principles of therapeutic change articulated by the task force are not tied to a specific theoretical orientation and can be unique to particular disorders or common across different disorders or beyond given disorders. For example, patients who exhibit high levels of reactance are more likely to benefit from a treatment that is less directive while patients with low levels benefit more from a more directive treatment. Similarly, patients whose coping style can be characterized as internalizing (e.g., blaming themselves and ruminating) tend to benefit from a treatment that facilitates self-exploration and insight while patients with an externalizing style (e.g., blaming others and acting out) benefit from a treatment that is focused on behavioral change and symptom reduction (Castonguay & Beutler, 2006). Such principles are among the strongest arguments in favor of integration.

The role of common factors in healing practices has been amply documented (Frank & Frank, 1991) and thoroughly researched (Wampold, 2001; Wampold & Imel, 2015). Though previously considered pejoratively by some researchers and described as nonspecific variables, common factors are appreciated as crucial in current psychotherapy research, practice, and training. Relational common factors include the working alliance, empathy, and positive regard

(Norcross, 2011; Norcross & Lambert, 2011). Nonetheless, common factors are not limited to relational ones and extend to dimensions such as new perspectives of the self, the increase in positive expectations and hope, and the enhancement of motivation (Castonguay, Eubanks, et al., 2015).

Psychotherapy integration has contributed important, overarching frameworks that have been supported empirically. Among the most noteworthy of such frameworks is the stages of change or transtheoretical model by Prochaska and DiClemente (2005). However, there is still much to be done when it comes to scientific reasons for integration. Specifically, Castonguay and collaborators (Castonguay, Eubanks, et al., 2015) have proposed directions in which research could strengthen integrative practice as well as ways in which the perspective of integrationists could contribute to psychotherapy research in crucial areas: harmful effects, therapist effects, practice-oriented research, and training. Currently, growing efforts are underway to create bridges between practicing clinicians and researchers, which will be of mutual benefit and can contribute to further investigating the influences of integrative approaches to improve the quality of mental health interventions (Fernández-Álvarez, Gómez, & García, 2015).

Challenges and Opportunities for Integration

There are significant challenges within the field of psychotherapy that are also opportunities for the advancement of further integration in psychotherapy. One prominent challenge and unique opportunity is the ongoing debate in the psychotherapy literature on the emphasis given to common factors compared and contrasted with specific interventions and techniques. Referred to alternatively as "culture wars in psychotherapy" (Norcross & Lambert, 2011) or *The Great Psychotherapy Debate* (Wampold, 2001; Wampold & Imel, 2015), supporters of each side have emphasized different variables with respect to therapeutic procedures and the training of psychotherapists. For example, supporters of the common factors approach emphasize the importance of the therapeutic relationship and the processes involved in therapy sessions. On the other hand, those who defend the importance of specific interventions stress the benefits that patients derive from the correct application of particular procedures or techniques. The history and current status of psychotherapy integration offer a meaningful framework to appreciate the differences and unique contributions of both perspectives without demeriting either.

Another important challenge and opportunity for psychotherapy integration is the historical and ongoing debate on the philosophy and epistemology that ought to drive psychotherapy as a science. A recent version of this debate juxtaposes two practical approaches and two ways of doing science, one applied and prescriptive, based on techniques,

and the other focused on therapeutic dialogue and the analysis of processes (Carere-Comes, 2015). According to Carere-Comes, in the first approach the psychotherapist is mainly a technician who applies the best results of empirical research to benefit patients, while in the second approach psychotherapists and patients cocreate a space in which the process unfolds in a unique manner for each particular dyad. Moreover, Carere-Comes argues that there is a strong, reciprocal delegitimization between the two approaches and their advocates. According to Luyten (2015), these two perspectives are not distinct but rather part of a broader attitude that characterizes scientific enterprises. This duality can be overcome through psychotherapy integration, based on a close collaboration between clinical practice and research. It is important to note that the two positions have recently drawn closer together (Hofmann & Barlow, 2014; Laska, Gurman, & Wampold, 2014), and this is likely to move the field of psychotherapy toward greater integration.

Another challenge, similar to the previous one, separates psychotherapists who promote focused treatments to eliminate or alleviate symptomatic distress from those who defend psychotherapy as a process with more global objectives that are linked to improving general well-being. This difference is strongly connected to different diagnostic conceptions. On the one hand, members of the first group base their patients' diagnoses on classification systems such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Treatment programs and their corresponding manuals are designed to address specific disorders described in those systems (Echeburúa, Salaberría, Corral, & Polo-López, 2010). On the other hand, psychotherapists who belong to the second group seek a more complete understanding of the individual and prefer diagnostic criteria that go beyond these categories. They take into account a set of interdependent variables to develop more idiographic (i.e., personalized) approaches, as in the case of systematic treatment selection (Beutler, Consoli, & Lane, 2005). Furthermore, the psychopathological framework in which psychotherapists operate greatly influences treatment plans and therapeutic interventions, making it particularly important for such framework to be comprehensive and inclusive.

Recent advances in psychotherapy integration have put forth taxonomies that are more clinically relevant and pertinent than those such as the *DSM*. Among the more useful clinical heuristics, the idea of "symptoms, problems, and conflicts" figures prominently (Beutler & Clarkin, 1990; Fernández-Álvarez, 2008, 2015). These dimensions refer to the way in which people may articulate the help they are seeking in psychotherapy and are strongly related to patients' treatment expectations. Symptoms refer to a form of disorder that compromises behavior, and cognitive or emotional functions in a specific activity such as anxiety reactions. Problems refer to interpersonal situations in which there are significant communication difficulties such as

couple's issues and family crises. Conflicts refer to difficulties in decision-making in vital circumstances such as when experiencing ambivalence or opposing feelings at a critical life-juncture (e.g., to emigrate or not in search of better living circumstances). These three dimensions are not mutually exclusive and the person seeking help may have a particular focus on one or more of them. Nonetheless, psychotherapists consider all three dimensions simultaneously when assessing patients, as the following case illustrates.

A new patient sought consultation due to a marked fear of flying (a symptom) exposed by her job's requirement to travel abroad frequently. During intake, and while exploring her fear of flying the patient stated "actually, my problem is obesity" and began talking about the impact that obesity has in her relationship not only with her husband (problem) but also with her view of self and self-esteem (conflict), all within a hostile societal context that discriminates against obese people as opposed to one that affirms healthy habits. The patient seeks help in overcoming her fear of flying yet the fear is grounded in self-esteem issues, which contribute to her feeling unable to cope with a perceived risk. The main reason for her low self-esteem is that she has gained weight over the past five years. The patient attributes her overeating to problems in the relationship with her husband. She believes her husband has lost interest in her. Her main conflict is between wishing to lose weight and finding satisfaction in eating. She currently describes herself as a person who lacks the will power to stop overeating, dislikes her body, and feels physically judged by the people in her social context. She is finding it increasingly difficult to cope with her life circumstances and is now seeking help.

Obstacles to Integration

Beyond the challenges and opportunities for integration detailed earlier in this article, there are still many significant obstacles for the advancement of integration. Paris (2015) notes a persistent tendency for psychotherapists and researchers to create new models, generally packaged in a three-letter acronym. These models defend a particular domain within psychotherapy and do so for reasons closer to marketing than science. Another obstacle is the theoretical dogmatism or ideological zeal with which some psychotherapists and researchers defend the alleged purity of a particular model, rejecting any attempt to link it to notions outside their own specific, trademarked models while clinging firmly to the idea that different theoretical approaches are irreconcilable (see Paris, 2015; Wachtel, 1977, 2014).

Yet another obstacle to integration can be found in psychotherapy's own history. Psychotherapy began as a medical specialty, and for years it was thought of as a "medical psychology" and/or as a branch of psychiatry. Even though medicine has not provided the knowledge structure for

clinical practice for many years, it continues to influence practices, applications, and even research standards through an overemphasis on randomized control-group trials (RCTs; see below). Physicians, not only psychiatrists, still dabble in psychotherapy and are allowed to practice it in most countries (Fernández-Álvarez, 1999).

There are two additional obstacles that are closely related to the one immediately above. One is that the vast majority of manuals that have been used thus far in RCTs represent pure-form psychotherapy approaches. The other is the marked discrepancy between the different criteria and methods for assessing psychotherapy processes and results. There is an ongoing debate about what counts as therapeutic evidence and how to obtain this data (Ogles, 2013). Medicine has exerted a strong influence and evidence has been equated with efficacy studies based mainly on RCTs. Efficacy studies have a high level of internal validity, which is strengthened by well-conducted meta-analytic studies. These studies have helped to create methods and techniques that can be used with protocols and guidelines for systematic treatment. However, overreliance on efficacy studies has led to the downgrading of effectiveness studies which present evidence obtained in natural settings and which can provide externally validated clinical evidence needed to assess the generalizability of interventions (Messer, 2004). The tension between these two alternative approaches has not yet been resolved (Nathan, 2007). In addition, journals and agencies that grant funding for research tend to insist on quantitative studies, for which RCTs are a “gold standard” (Hershenberg & Goldfried, 2015). However, for many researchers, psychotherapy is not exclusively amenable to quantitative methods, and therefore they advocate for the use of qualitative and mixed methods as well (for a review, see Rennie & Frommer, 2015).

To overcome some of these obstacles, Barlow (2004) proposed dividing the vast territory of psychotherapy into at least two fields, one reserved for psychological treatments and another that would include traditional forms of psychotherapy. The first group included manualized practices aimed at promoting changes in targeted objectives, in line with practices recognized by health systems. In the second group, which he also considered valuable, he included interventions to treat problems with interpersonal relationships, adjustment, and personal growth. The proposal is coherent, especially as it recognizes that both procedures should follow the general principles of evidence and, therefore, their difference does not depend fundamentally on the theory on which they are based or on the techniques used, but instead on the problems with which they deal. However, for this very reason we believe it is necessary not to further divide the field but to integrate it and seek ways to link these and other alternatives so that they can cross-fertilize one another.

An Example of Psychotherapy Integration

The first rendition of Fernández-Álvarez's (1992) integrative approach to psychotherapy was published in 1992 and it has been elaborated further in subsequent publications (e.g., Fernández-Álvarez, 2008, 2015). While a thorough discussion of the approach is beyond the purpose of this article, a few aspects of it are highlighted here to illustrate the strength of an integrative, inclusive approach that is research-based and clinically informed. The fundamental purpose of this integrative therapeutic approach is to articulate the different levels of human organization (i.e., bio-psycho-social), together with mental functional and dysfunctional dimensions and corresponding therapeutic interventions; this articulation involves the use of nomothetic principles from psychotherapy research and practice (such as those derived from evidence-based practices and practice-based evidence) and the idiographic tailoring of treatment.

Fernández-Álvarez's integrative approach falls within the definition of psychotherapy integration offered earlier in the article to the extent that it emphasizes processes and strivings in an open-ended fashion. The present synthesis can be described as an integrative psychotherapy that draws from the original strands of the psychotherapy integration movement: common factors, theoretical integration, and technical eclecticism. This integrative approach is based on three, interrelated perspectives. These are (a) a bio-psycho-social definition of clinical phenomena and resilience which support a comprehensive way to address the origin of human dysfunctions and strengths, including how to operate with a menu that takes into account the combination of pharmacological, psychological, and sociocommunity interventions; (b) a systematic, intentional selection from all available strategies, interventions, and techniques that have proven effective; and (c) the fostering of a flexible yet intentional attitude among psychotherapists to work within broad and adaptable criteria while formulating the treatment design and implementing the corresponding procedures.

This integrative approach seeks to bring together the conceptual contributions of the four traditional models of psychotherapy. In brief, from the psychodynamic model the approach honors the importance of drives in human functioning, the basic motivational tendency to action, and the role of the early stages of human development in thoughts, behavior, emotions, and views of self. From the cognitive-behavioral model the approach incorporates an appreciation of the ways actions are performed and reinforced while systematizing the different forms of information processing with an emphasis on the present. The approach borrows from the existential-humanistic-experiential model the conceptual tools to consider the person as a whole, with emphases on internal consistency in meaning-making and the role of the future. To the extent that human behavior does

not occur in isolation and each individual develops in micro-, meso-, and macrosocial contexts (Bronfenbrenner, 1979) the approach makes use of the contributions of the systemic model and its focus on the influence of interactive systems.

Fernández-Álvarez's integrative approach to psychotherapy seeks to articulate the strengths of the different, traditional models in psychotherapy into a comprehensive, evolving approach that emphasizes human cognitive function and its developmental nature. With respect to human cognitive function, individuals are perceived as information processors whom, unlike binary computer systems, deal with complex webs of meaning making. With respect to the evolving nature of human cognitive function, the approach emphasizes the progressive need for ever more sophisticated meaning construction that characterizes the sequence of developmental stages.

Clinical practice within this integrative approach involves a multidimensional patient assessment that takes place at two levels. One of the levels involves identifying operational functions such as attention, memory, reasoning, and emotional regulation related to difficulties in information processing. The other level seeks to determine the depth of personal meaning construction implicated in the clinical situation. For example, while dysfunctional constructions associated with an earlier developmental stage (e.g., severe difficulties in self-organization) are likely to require long-term therapy, those associated with later developmental stages (e.g., specific phobias of a recent onset) are more likely to be amenable to short-term treatment. Furthermore, the approach involves assessing other dimensions such as level of distress, impairment, nature of the disorder in terms of severity, chronicity and complexity, together with patients' attribution of the presenting problem (e.g., internal or external, stable or unstable, controllable or uncontrollable), motivation for change, expectancies, reactance level, and available resources, including social support. The process and outcome of this comprehensive assessment guides the treatment recommendations that include a preferred modality such as individual, couple, family, or group therapy, as well as the frequency and length of sessions. The initial agreement for the treatment plan includes providing diagnosis and prognosis (i.e., recovery expectancy; degree of possible improvement; treatment length; activities during the treatment process, including homework assignments; costs, in terms of time, efforts, and expenses). Indications may involve psychotherapy or combined treatments that include other interventions such as drug therapy, milieu therapy, nutrition consultation, and the like.

This integrative approach relies on the use of multiple resources, suitable to the complexity of each clinical situation. Interventions are targeted at different levels of the individual's mind organization according to a basic principle of promoting gradual changes to achieve expected goals.

In highly complex clinical situations such as personality disorders, the therapeutic approach gradually progresses toward the core of the dysfunction, which is often related to personal identity (Fernández-Álvarez & Fraga Míguez, 2010). Therefore treatments using this approach can range from minimal interventions to long-term management, from simple procedures and the limited involvement of resources to very complex ones, including the use of an inter and multi disciplinary team.

Collaborative research studies as well as education, training, and supervised clinical experience have shaped this integrative approach over time. With respect to research, the integrative approach has been tested with a range of clinical populations from children with enuresis (García, 2006) to patients with obsessive-compulsive disorder. In the latter, an ongoing research program has involved the comparison of individual and group therapy, process and outcome, and post treatment follow-up methods (Belloch et al., 2011; Cabedo et al., 2010). This research has also involved qualitative investigations exploring the variables influencing change (Castañeiras, Fraga Míguez, Fernández-Álvarez, & Belloch, 2009; Castañeiras, Fraga Míguez, García, Fernández-Álvarez, & Belloch, 2009) and single cases studies exploring processes and outcomes of obsessive-compulsive disorder treatments (Behobi Baudou, García, & Fernández-Álvarez, 2013). These studies have supported common factors as an important contributor to change, beyond the application of standard cognitive psychotherapy procedures.

In addition to psychotherapy process and outcome research, education and training are at the center of the feedback loops that have facilitated the evolution of the integrative approach as practiced at Aiglé (Fernández-Álvarez, 2008, 2015). The education and training program based on Fernández-Álvarez's integrative approach is a 2-year long, graduate-level program conducted jointly with public and private universities in Argentina and in agreement with international universities and institutions. Trainees admitted to the program are practicing mental health professionals who have earned a *licenciatura* (a 5-year degree earned after high school) in clinical psychology or a medical degree with a specialization in psychiatry. Congruent with the integrative approach, the formal education of the program relies on the three pillars of psychotherapy theory: theory of mind, psychopathological model, and principles of change. The training component involves the acquisition of four main competencies which are central throughout the therapeutic process albeit in different manners: clinical interviewing including building the therapeutic alliance, designing treatment plans, applying therapeutic techniques, and assessing process and outcome. These competencies are presented to trainees in tiers starting with the intake process, followed by short-term and then long-term therapeutic processes, interactional processes and finally,

complex therapeutic processes which involve collaborating with inter and multidisciplinary teams to address severe difficulties such as eating disorders, substance-related and addictive disorders, bipolar disorders, and psychotic disorders.

The training process is centered on the therapists and their personal styles, which are assessed through a self-descriptive questionnaire (García & Fernández-Álvarez, 2007; Fernández-Álvarez, García, Lo Bianco, & Corbella Santomá, 2003). The training program has been evaluated regularly in terms of the competencies acquired and the quality of the didactic resources. The outcomes of these evaluations have been used to update the program and the approach (Fernández-Álvarez, Kirszman, & Vega, 2015). The training program started in 1999 and, during its first 15 years, over 1,000 psychotherapists completed the training. The graduates were from every single one of the 23 provinces of Argentina as well as from nine other countries (Bolivia, Ecuador, Guatemala, Mexico, Paraguay, Peru, Spain, Uruguay, and Venezuela).

The Role of Integration in Psychotherapy's Future

Psychology and psychotherapy have made great strides toward being recognized as disciplines that are part of the health care delivery system and that work together to not only treat but to prevent disorders, as well as to promote wellness and healthy living in the population (American Psychological Association, 2014; Prince et al., 2007). The training of current and future psychotherapists requires the proper grounding in integrative, holistic, evolving psychological perspectives that view patients as cultural beings immersed in multiple contexts facing significant challenges and as human beings who bring unique strengths to deal with the intricacies of contemporary living.

In their everyday work, psychotherapists engage in integrative assessment of patient concerns that extend along a continuum of severity, chronicity and especially, complexity (American Psychological Association, 2013). Many patients present with disorders that are quite severe and have highly recurrent clinical symptoms that seriously affect their quality of life specifically and in general. Personality dysfunctions are a case in point, given the serious effect they have on everyday life because they occur throughout much of the life span, have high prevalence rates, and the empirical studies of therapeutic efficacy show that, despite some progress, there are still many weaknesses (Bateman, Gunderson, & Mulder, 2015; Tyrer, Reed, & Crawford, 2015). For this reason, it is important to place personality at the center of integrative diagnostic explorations and treatment plans (Krueger, 2013).

Disturbances are typically anchored in personality; therefore understanding the influence of the patient's personality

provides a comprehensive view of the problem. In fact, there is evidence that the success of treatment for anxiety and depression varies according to the degree of dysfunctionality in the patient's personality (see, e.g., Powers & Westen, 2009). This does not mean that different conditions are expressions of a personality dysfunction, but it does mean that personality is involved and should be considered in any clinical diagnosis as part of an integrated assessment. These considerations of personality are congruent with the current emphasis on moderators (and mediators) in psychotherapy research (Kazdin, 2007); these together could serve to advance integration further.

The type of integrated assessment and its concomitant integrated clinical approach requires a model of psychopathology and a nosographic classification system that are not limited to nomothetic aspects but that can seriously take into account the idiographic aspects of mental activity (Barlow, Bullis, Comer, & Ametaj, 2013). Criticisms of the *DSM* are mentioned earlier in this article. Moreover, the ambitious Research Domain Criteria project does not seem as promising for psychotherapy (Hershenberg & Goldfried, 2015). Despite its dimensional approach, which is in line with the nature of mental processes, it still emphasizes an individualistic framework of normality and pathology, which excludes, in effect, the role of interactional, contextual, and broader cultural variables. These variables are of prime importance in understanding the reasons and circumstances that have brought about suffering in a particular person who asks for help and will prove crucial during treatment in terms of patient's perceived treatment relevance and adherence. While each traditional theoretical model has emphasized some aspect of this complexity and different therapeutic approaches have aimed to promote change, they have done so accentuating distinct levels of a reality that is ultimately wide-ranging and multifaceted. Many attempts at theoretical integration have sought precisely to provide a model that can operate on multiple levels, which is adjusted to the specific nature of each concern, and allows for changes in design and intervention levels according to an individual patient's response.

These attempts at integrative theorizing are supported by everyday clinical evidence. For example, maintenance factors play a decisive role in dysfunctional cycles sustaining emotional disorders. Different cognitive-behavioral approaches propose distinct therapeutic strategies that have proven successful, starting with behavioral activation. However, often an affective relationship may be the maintenance agent of the emotional disturbances. In that case, it may be appropriate to address this factor from a systemic perspective and employ appropriate techniques to deactivate it. Something similar occurs in the care of children with behavioral problems who are involved in a family dynamic that reinforces their emotional disturbance. Another example is the case of people who have exacerbated experiential

avoidance behaviors, common in mood disorders. In addition to cognitive-behavioral techniques to correct this avoidance behavior, it may be useful to work with the difficulties in the patient's search for meaning in life. In fact, the articulated integration between a cognitive-behavioral approach and the principles of humanistic psychotherapy is well established (Hayes, 2012). In their everyday work, psychotherapists have been challenging the notion that the various theoretical models of psychotherapy are irreconcilable and, in doing so, they have been advancing greater integration while delivering it daily.

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