**The Integrative Movement**
The "Integrative Movement" in clinical psychology has in actuality been moving forward in three separate but overlapping camps. One, Technical Eclecticism (Lazarus, 1989; Lazarus, 1967; Lazarus, 1992), states that there are probably techniques that are more (or most) effective for certain symptoms or disorders. A second, Common Factor theory (Garfield, 1980; Arkowitz, 1992; Beitman, 1989; Beitman, 1992), adheres to the belief that there are likely common factors across different approaches, and that those common factors are what actually make psychotherapy effective. The third, Theoretical Integration ([Pinsof, 1983; Feldman & Pinsof, 1982; Prochaska & DiClemente, 1992a; Prochaska & DiClemente, 1992b; Prochaska, Norcross & DiClemente, 1994], attempts to combine the best aspects of different theories into a single, coherent approach by blending on a theoretical level. While there are strong proponents of each camp who clearly believe their model to be superior to the others, I believe that an integration of these models is possible.

**Brief Review of the Literature:**

*Technical Eclecticism/Multimodal Therapy:*
The least theoretical of the three approaches, Technical Eclecticism should not be construed as either atheoretical or antitheoretical. Technical eclectics seek to improve the ability of therapists to select the best treatment for the person and the problem. This search is guided primarily by data on what has worked best for others in the past with similar problems and characteristics. Eclecticism focuses on predicting for whom the interventions will work (the foundation is actuarial rather than theoretical). The *Multimodal Therapy* of Lazarus (Lazarus, 1989; Lazarus, 1967; Lazarus, 1992) is generally considered to be the standard in this approach.

*Multimodal Therapy*
This approach, founded by Lazarus in 1967, was inspired by his dissatisfaction with behavior therapy and its limitations. With it, Lazarus assesses and then treats problems in seven different areas, Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal Relationships, and Drugs/Biological Functioning.

This BASIC ID Model is designed to determine the different areas in which the patient is experiencing difficulties, and then treat the appropriate problems. Technical Eclectics such as Arnold Lazarus state, as Lazarus (1992a) did, “I subscribe mainly to a social and cognitive learning theory (Bandura, 1989) because its tenets are open to verification or disproof (p. 232).” However, when a client presents with a complex of problems, this approach does not have a model that guides where to start and how then to proceed. In addition, this approach requires a lengthy evaluation before treatment begins that may or may not enhance the effectiveness of treatment. Also, Lazarus himself has written on the importance of certain interpersonal characteristics of the therapist and their impact on therapy (Lazarus, 1989a). However, even though he recognizes the impact of the relationship between therapist and client, it is not adequately addressed in his model.

*Theoretical Integration:*
Those who advocate integration on a theoretical level combine different therapies in the hope that the resulting approach will be more effective than the constituent parts. Contrasted with Technical Eclecticism, the goal is to integrate not just the techniques employed by each approach, but also the theories involved. The history of such work dates back many decades (French, 1933; Dollard & Miller, 1950). In this form of integration, more than an effective
blend of techniques is sought. Truly, Theoretical Integration seeks to create a theory that is more than the sum of its parts, and that brings together the best of different approaches. The goal of this endeavor is to move the field forward in both practice and research.

As an example, William Pinsof's (1983) work stresses the need for different treatment modalities and theoretical approaches depending on the needs of the client. He advocates that therapists start with the approach that is most likely to produce rapid change (if it is successful), i.e., behavioral family therapy. This allows the client(s) to make problem-focused changes in a meaningful context. If this approach does not work, the therapist can change modalities (generally to couple and then individual) or approaches (generally to cognitive/affective and then to historical) or both. The rationale for this is that the ability to make further progress in treatment will be realized by doing so. After this problem is addressed successfully, treatment moves back toward behavioral family therapy. There are many possibilities in this treatment, including that the client(s) may decide not to change the presenting complaint, or that the therapist may decide to go against convention in the process of therapy if her/his clinical judgment guides her/him in this direction.

![Diagram of treatment modalities](image)

This approach makes rational sense and has some empirical support. However, why some people are able to complete behavioral family therapy successfully and others are not is not explained within the model. Why some are able to do individual cognitive work and then move on and others need a historical-couples approach before making progress is not clear in this model.
Another important transtheoretical model is the Stages of Change model developed by Prochaska & DiClemente (1992a; 1992b; Prochaska, Norcross & DiClemente, 1994). This model, instead of focusing on particular techniques or theoretical approaches, attends to the stages individuals go through in the process of attaining their therapeutic goals. They describe this process as occurring in six stages.

*Precontemplation:* People at this stage typically deny having a problem. They tend to come to therapy because of pressures from others. Generally, they don’t want to change anything about themselves, just the people around them. They are often demoralized, feeling that they face problems which cannot be solved.

*Contemplation:* People who are at this stage recognize that they have a problem and begin to think seriously about solving it. They have indefinite plans to take action in the next several months. However, contemplators may be far from taking a commitment to action. They may know what they want to change and even how to go about doing so, but may not be ready to follow through just yet.

*Preparation:* These people plan to take action within the next month and are making the final adjustments before they begin to change their behavior. Although they are committed to taking action, however, they have not necessarily resolved their ambivalence. They may have made a small number of behavioral changes, but need to convince themselves that changing is genuinely in their own best interests.

*Action:* This is the stage in which people make the most overt, observable changes to modify their own behaviors. People in this stage make the changes they have been contemplating and preparing for.

*Maintenance:* People in this stage work to consolidate the gains they have made during the previous stages. Relapse prevention is a primary task during this stage. It is a step that, while often given short shrift by many therapists, is likely critical in solidifying the changes made during the action stage.

*Termination:* For people who have reached this stage, the former problem no longer presents any temptation or threat. With no further effort, the changes made in the previous stages are maintained without threat of relapse.

(Prochaska, Norcross, & DiClemente, 1994)

The Stages of Change model may describe well the process of change that many people go through. However, it does not address well the issue of the relationship that exists between the therapist and client, how that relationship helps some clients, and hinders others. It seems to describe a person’s relationship with his/her problems and the change process decontextualized from a therapeutic relationship.

**Common Factors:** Those who support a common factors approach advocate determining the ingredients different therapies share, and then, separating the wheat from the chaff, creating a therapy that focuses on those commonalities that seem to make a difference in the change process. This approach carries with it the assumption that these shared factors are more important in
accounting for therapy outcome than those aspects that differentiate them. The factors commonly cited as being relevant or efficacious include: the therapeutic relationship, the structure that therapy provides, and an investment in the change process. Beitman (1992) relies on both these commonalities and the differences afforded by different approaches to bring about therapeutic change. He has described his approach as consisting of eight Guiding Principles. They are summarized as follows:

**Triflexibility of Integration:** 1) integrate the multiple schools of psychotherapy; 2) combine this integration with the personal and psychotherapeutic concepts of each individual therapist; 3) employ this combination with the concepts, self definitions, and world views of the patients currently in front of the therapist.

**Similarities and Differences Among the Schools:** Integration requires therapists simultaneously to see differences and similarities. Integration should define fundamental similarities and incorporate useful differences among the schools.

**Cause and Personal Future:** Theories developed by schools of psychotherapy are designed to offer causal explanations for psychological difficulty. However, any change that occurs will happen in the present or future, rather than in the past. Human beings can be considered to be drawn by their future conceptions, rather than created by their past (although future conceptions are formed by past experiences). When the future view is reconstructed by new alternatives, change can be attributed to these new constructions. Since the future is moldable and the past is “passed,” the future offers the clearest avenue for causal explanations that lead to change.

**Symptom Relief Versus Core Schematic Change:** Patients and therapists may differ on the value placed on symptom relief versus change in the underlying schema. Many patients may feel that symptom remission is enough, while many therapists may feel a change in the core schema is necessary for lasting change. Each patient-therapist dyad must decide how much emphasis to put on each of these.

**The 70-percent Rule of Technical Efficacy:** No concept or technique is always useful or correct. Many interventions work approximately 70 percent of the time. In addition, even after a successful treatment, many patients continue to have difficulties. To expect any psychotherapy technique to be more frequently effective is to expect too much.

**Keep It Simple:** Simple flexible models are more easily communicated and adapted to the mind sets of patients. In this context, “simple” refers to the difficult explication of basic psychotherapeutic principles that may be applied in various combinations to individuals, patients, couples, or families.

**Self-observation Is Crucial to Change:** By recording one’s own thoughts, emotions, and behaviors, one can report personal experiences as targets for pattern analysis and change. Through these reports, therapists can direct patients to optimal fulcrums for change.

**Exposure is the Key to Most Change:** Although first emphasized in behavior therapy, exposure is central to both intrapersonal and interpersonal change. Exposure seems to
mean “controlled exposure to reality” so that new information helps correct old distorted schemas.

*Stages in Psychotherapy:* The change process is divided into 1) giving up the old pattern; 2) beginning a new pattern; 3) maintaining the new pattern.

(pp.204-5)

Beitman goes on to elaborate the aspects of different approaches, including Humanistic, Existential, Behavioral, Cognitive, Psychodynamic, Interpersonal, Marital Systems, and Family Systems, that are useful concepts in psychotherapy. He advocates that these concepts be used by integrative therapists.