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Stop Exploring! Start Defining the Principles of Psychotherapy Integration: Call for a Consensus Conference

Bernard D. Beitman[1,2]

Since its inception, the Society for the Exploration of Psychotherapy Integration (SEPI) has attempted to include members of all schools in an open dialogue. The time has come for SEPI to stop exploring and to start defining the principles of psychotherapy integration. This paper proposes several principles of psychotherapy integration covering (1) influences outside the schools, (2) psychotherapy structures, (3) standard data-gathering techniques, (4) commonly used causal patterns, (5) principles of change, (6) psychotherapy values, and (6) the limitations of psychotherapy. I call for a consensus conference on psychotherapy integration to further develop these principles.

KEY WORDS: psychotherapy integration; psychotherapy principles; systems thinking.

INTRODUCTION

Psychotherapy integration is recognized as useful by a majority of practicing clinicians (Norcross & Goldfried, 1992; Stricker & Gold, 1993) and a large number of students of psychotherapy. The reason has become obvious: none of the schools of psychotherapy has sufficient explanatory, technical, or conceptual power to help all patients despite implicit claims to the contrary. The Society for the Exploration of psychotherapy Integration has fostered acceptance of the integrative concept. However, with in-

[1]Department of Psychiatry and Neurology, University of Missouri—Columbia School of Medicine, Columbia, Missouri.
[2]Correspondence should be directed to Bernard D. Beitman, Department of Psychiatry and Neurology, University of Missouri—Columbia School of Medicine, Three Hospital Drive, Columbia, Missouri 65201.

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creasing economic and ideological pressures, the time has come to stop exploring and to start defining what is currently meant by psychotherapy integration and how this entity is to develop into the future (Beitman, Beutler, Goldfried, Glass, Stricker, & Norcross, 1993). This paper is intended to sharpen the process of defining psychotherapy integration for several constituencies: students, patients, teachers, practitioners, third-party insurers, and politicians. I also hope to stimulate debate over the basic principles of psychotherapy integration—a debate that should lead to a consensus conference from which a clear articulation of basic principles will emerge.

Attempts at psychotherapy integration resemble the efforts of the blind wise people, each of whom were examining a part of the elephant from a unique perspective. Feeling a leg one said, "I think this is a tree." Feeling the tail, one said," I think this is a rope." Feeling the side, one said, "I think this is a blanket." Feeling the tusks, one said, "I think this is a smooth tree branch." And feeling the trunk, another said, "I believe this is a large hose." Each of the major schools of psychotherapy may be represented by one of the blind wise people; each one possesses only part of the truth.

This elephant must also eat and drink, is driven by storms, is influenced by other animals, and is moved about by a variety of other external and internal forces. The schools of psychotherapy have tended to avoid attention to external influences, preferring to concentrate on the therapeutic hour and its implications for theory and practice. No longer can these external influences be so easily ignored. Brain, culture, the patient's readiness to change, and therapeutic innovations form shifting contexts to which psychotherapy and therapists must and do respond. These forces have shaped, do shape, and will continue to shape psychotherapy.

The elephant can be described in simple, clear language. One desirable aspect of any description of psychotherapy involves its clarity. Students can no longer afford arduous, often unsatisfactory trips through survey courses and textbooks describing historical and theoretical notions that have little practical use. Psychotherapists can no longer afford to allow third-party payers, politicians, and patients to misunderstand psychotherapy. There may have been a good reason to develop complicated theories in the past, that had to do with helping psychotherapists appear wiser than the uninformed. Theory has tended to obfuscate what actually transpires during the therapeutic hour, which usually has to do with feelings, thoughts, behaviors, and relationships; these content areas are now addressed by the general public during television talk shows, during soap operas, and in their daily lives.

Psychotherapy must now be described in terminology comprehensible to its various constituents.

Several integrative principles reach beyond the specific content of the psychotherapy schools because each school touts its unique concepts and techniques rather than general psychotherapy principles. The following section of this paper concerns influences external to the study of psychotherapy: brain vs. culture, the patient's predisposition to change, reactance, and the necessity for the flexible incorporation of innovations into psychotherapy. The next section after that addresses the basic structures necessary for psychotherapy-assisted change: the self–observer alliance, the therapeutic contract, and the stages of psychotherapy. The third section concerns the tools with which to gather information. The subsequent section contains a list of causal explanations that suggest how to change. I have chosen these principles for their apparent (to me) efficacy and generalizability. The section following that concerns the general principles of psychotherapeutic change, including the multiple possible change foci, the patient's responsibility for change, building on the patient's strengths, fear of change, and the fact that change reverberates throughout the psychotherapeutic target system. The penultimate section outlines psychotherapy values; the final section addresses the limitations of psychotherapy.

Some believe the scientific method rather than the opinions of therapists provides the primary means by which to know the principles of psychotherapy integration. I reply to this belief by suggesting that psychotherapy research should be considered another perspective from which to build consensus rather than the final arbiter. Its major limitation lies in the necessity to lag behind clinical innovations until they are sufficiently utilized by practicing clinicians to justify controlled analysis either through comparative studies or process analysis (Rice & Greenberg, 1984). Very few innovations, however desirable, are tested as they are being touted. Perhaps more basic psychological science research will more forcefully lead to innovation from such arenas as cognitive neuroscience and social influence. Psychotherapy research itself suffers from several other restrictions. One involves the problem of defining valid and reliable outcome measures. A second restriction relates to the determination of the most desirable perspective from which to measure change (e.g., patient, therapist, or outside observer), although many are searching for solutions to these dilemmas. In this paper, research findings will be used to support some basic principles. Other key principles have not yet been adequately addressed empirically.

This paper has a definite purpose: to call for a consensually developed definition of psychotherapy. The accomplishment of this objective requires a journey through a wide range of political constituencies. Consensus of whom? Teachers, practitioners, researchers, the Center for Mental Health

Services, third-party payers, or patients? I believe the initiative must come from those who study and write about psychotherapy as a living conceptual entity, and have developed succinct phrases to capture its essence. These people should be gathered together in a consensus conference to outline a strategy for defining the elements of psychotherapy, the languages for various constituents, and the politics of gathering a broader consensus. The product could be presented to various constituencies for refinement and clarification. The value of this effort lies in our finally defining what we do as psychotherapists, finally taking the long-standing mystery out of psychotherapy. The drama will no longer lie with the method, but more with the compassion, grandeur, and pettiness of the human mind and human relationships. We can also take pride in our mastery of this complex artful science by letting people know what we do.

IMPORTANT INFLUENCES EXTERNAL TO SCHOOLS OF PSYCHOTHERAPY

Psychotherapy integration implies the bringing together of the schools of psychotherapy into an organic whole. This implication ignores the very real contextual elements that directly influence the practice of psychotherapy. The elements include the brain, culture, self-change, patient's reactance levels, and the integrative requirement for flexible responses to innovation.

Brain

For many decades psychiatry had been "brainless." For a longer period of time, psychotherapy has been "brainless." When Freud abandoned his project for a scientific psychiatry, he also abandoned the limits that brain structure could place on his theorizing. Although he warned against too much theorizing, it was almost an addiction of his (Gay, 1988). Subsequent therapists have generated a myriad of theoretical notions. Future theories should be constrained by current and potential knowledge of brain function. Nature seems to be relatively conservative; evolution seems to build upon already developed structures and functions. The synaptic responses of the sea slug to various patterns of stimulation may be a prototype for learning by the human brain (Kandel & Schwartz, 1982). Patterns of brain structure and function can provide models for mind function.

Take "self-observation" as a possible example of brain-constrained theorizing. Self-observation, the ability to be aware of one's own thoughts and feelings, is a higher cortical function that appears to depend upon the prefrontal cortex (Prigatano & Schachter, 1991). What, for example, happens in the brain when a patient is asked to report feelings? One hypothesis suggests that when the subject decides to comply with the request a projection or pathway is opened up between the prefrontal cortex and the cingulate gyrus. The cingulate gyrus sits astride the limbic system, which is the seat of emotion. The cingulate gyrus, a primitive cortical structure, could contain "emotional thought," which then could be transmitted to the prefrontal cortex, then to Broca's speech area, and finally through the aid of the motor strip, expressed through speech. This simple concept provides a model by which future hypotheses about psychotherapeutic functions could be conceptualized. These hypotheses might increase psychotherapy efficiency by more precisely targeting the brain structures that support psychotherapy and the brain dysfunctions that are ultimately the targets of psychotherapeutic efforts rather than reliance on complex theories like psychoanalysis on the one hand or cognitive thought-based theories on the other. Targets for psychotherapeutic efforts could be clearly defined for patients as well as therapists.

Consider another example to illustrate the possibility that brain-based models might augment psychotherapeutic conceptualizing in the service of more efficient treatment. Some evidence suggests that obsessive-compulsive disorder may be associated with a reverberating feedback loop involving the prefrontal cortex and the caudate nucleus of the basal ganglia. Behavior therapy and clomipramine both dampen this putative feed loop (Baxter *et al.*, 1992). Does it help patients and therapists to visualize the functional neuroanatomic target of their efforts?

The human need for interpersonal relationships also appears to be biologically driven. Supportive relationships seem to insulate against disease (House, Landis, & Umberson, 1988). Our needs for love, respect, and understanding appear to be biologically based, the brain pathways of which may be becoming better defined (Kissin, 1986). The psychotherapeutic relationship utilizes brain-based processes of the participants to help patients (and therapists) improve opportunities for benefits from interpersonal relationships.

A word of caution regarding an equivalence between mind and brain. The question of the existence of a Higher Power limits the discourse to psychological realms. The dividing line between the spiritual and psychological becomes an interesting problem for brain reductionists. Where resides the soul?

Culture

For centuries theorists have had trouble distinguishing between the influences of nature and nurture, or in current terminology, brain and culture. For example, how much of our sex role behavior is culturally determined and how much of it is genetically influenced? Are phobias phylogenetically instilled or are they developmentally formed? (Ohman, 1986). Questions like these will be answered by explicating varying combinations of these two major influences. Monkey brains and, by extrapolation, human brains possess specific brain cells that begin to fire only when the visual system is presented at a right angle. Still others fire only when displayed an acute angle; still others, an obtuse angle. Still others fire only when presented a hand. Another group reacts only to a face (Kissin, 1986). These facts suggest that a good deal of "software" programming comes with the human biocomputer. What are the limits of this programming? What kind of faces are each of us born to respond to?

What is culture? How can it be defined? Schein (1990) suggests the following definition:

> Culture can now be defined as (a) a pattern of basic assumptions, (b) invented, discovered, or developed by a given group, (c) as it learns to cope with its problems of external adaption and internal integration, (d) that has worked well enough to be considered valid and therefore (e) is to be taught to new members as the (f) correct way to perceive, think and feel in relation to those problems.

Culture organizes individual reactions to self and others. It influences the way we think about ourselves as sexual beings, the way we construe friendships, our understanding of a Higher Power, the nature in which families are to be organized and the ways we love. Culture determines what we value and what will be perceived as reinforcers (Favazza & Oman, 1978).

Psychotherapy is influenced by cultural values of both patients and therapists, and in turn, reciprocally influences their cultures. Therapists and patients construe their realities at the intersections of powerful group influences including family of origin, work or school organizational cultures, current family and social circles, popular culture, and religion. Through modeling, direct experience, and teaching by others in these contexts we socially learn normative views of self and other. Because of the strong influence of both biological and cultural imperatives, psychotherapy cannot be "value free" despite claims to the contrary. Religious values, particularly the universally embraced ideals of peace, love, harmony, moderation of greed, mutual respect, tolerance, and acknowledgment of forces greater than individual power deserve to be recognized as culturally influenced ideals for psychotherapists and their patients. Cultural values and biological

programming weave powerful determinants of desirable individual behavior that exert more influence than psychotherapy.

Self-Change

Much evidence suggests that people with psychological and behavioral problems change without benefit of psychotherapy (Prochaska, DiClemente, & Norcross, 1992). They appear to use a variety of change techniques that are also common to many psychotherapies (Prochaska & DiClemente, 1984). Rather than being seen as a specific agent of change, psychotherapy might be more accurately construed as a facilitator or accelerator of the self-change potential available to each patient, each couple, and each family seeking assistance. Research evidence suggests that patient readiness to change provides a powerful predictor of outcome in a variety of helping situations, including the behavioral treatment of smokers and the pharmacotherapy of panic disorder (Beitman & Prochaska, 1993). These findings suggest that therapists should learn to capitalize more effectively upon patients' predisposition to change, and also to confront their reluctance to change. Role induction interviews (Frank, Hoehn-Saric, Imber, Liberman, & Stone, 1978) and "reluctant changer" groups are likely to enhance psychotherapeutic efficiency and effectiveness.

Reactance

Psychotherapists usually attempt to influence their patients to change beliefs, take risks, and try new behaviors. Psychotherapists, therefore, persuade (Frank, 1973), despite efforts at denying this fundamental reality. "Reactance" describes a person's tendency to respond against an external influence effort (Brehm & Brehm, 1981). People vary in their reactance (trait) and also vary in the degree of reactance in differing circumstances (state). Reactance tends to increase when individuals perceive that their range of choices is being limited by others. Therapists' efforts to persuade can be perceived as attempts to limit the range of choices and may therefore increase reactance levels. This pretreatment variable can be measured and could be used to help define degrees to which patients can be directly persuaded (Beutler, 1983). The more highly reactant patients will need to be treated in a manner that permits them to feel greater self-control over the decision-making process. They will need to be presented with more options, encouraged to consider new alternatives, and left alone to decide at their own speed. Low-reactant patients will respond more favorably to direct encouragement and suggestions.

Flexible Responses to Innovation

Psychotherapists must remain open to potential changes in the conceptual context of psychotherapy. Practitioners and writers about psychotherapy will continue to develop refinements and offer new breakthroughs in psychotherapeutic conceptualization and technique. The major problem with the notion of "school" is its relative inflexibility in response to new ideas in psychotherapy. Schools have responded to varying degrees to psychotherapy innovation, but the value of schools has been to preserve good ideas. At this point in psychotherapy's history, these good ideas within schools have been preserved well enough. Now we must develop more flexible conceptualizations that foster rapid integration of useful, new ideas. School-bound practitioners will contribute to the general knowledge of all psychotherapists by refinements within their own models. Innovation also proceeds by therapist intuition and experiment. We need to develop meta-concepts (concepts about concepts) by which to help individual practitioners identify and integrate their own discoveries. (E.g., how do we decide if a new idea is useful and how do we rapidly integrate it into our practice?)

Culture changes, and these changes affect both the theory and practice of psychotherapy. For example, reimbursement questions have frightened many therapists. Psychotherapists are now being implicitly asked to define their complicated activities in terms comprehensible to politicians, third-party payers, and the general public. Like major social upheavals such as war and recession, these political and economic changes influence the manner and purpose of psychotherapeutic activities.

How is psychotherapy integration handling the emergence of managed care? Visions of the future suggest that systems of service delivery—not independent practitioners operating as *individuals*—will dominate practice (Kiesler & Morton, 1988). How can the principles of psychotherapy integration assist managed care networks to make providers (therapists) more efficient and consumers (patients) more responsible for their own mental health? How do the principles of psychotherapy integration apply to the changing system in which the traditional psychotherapy dyads continue to exist? Do various systems change by similar principles?

Current and future understanding of psychotherapy should include conscious and deliberate integration of the manner in which sociocultural shifts influence psychotherapeutic practice. As suggested by a Chinese proverb: When a tiger enters the temple, include him in the ceremony.

PSYCHOTHERAPY STRUCTURES

There is a pressing need for the identification of "structures" that will provide students and practitioners with grounding and direction. The concepts developed should provide a maximum amount of practical information and should require a minimal amount of description. The following three terms are candidates for inclusion as psychotherapy structures: self–observer alliance, therapeutic contract, and stages of psychotherapy. These conceptual structures define psychotherapy the way baseball is defined by bats, balls, bases, innings, and rules, or the way academic tenure tracks are defined by papers, grants, teaching, time limits, and the approval of colleagues and superiors.

The Self–Observer Alliance

The importance of the therapeutic alliance has been well recognized and well studied. Research findings suggest that the patient's sense of its strength is a crucial variable (Weinberger, 1993). However, its essential practical element, the self–observer alliance, the patient's willingness to self-report to the therapist, has escaped research scrutiny. The self–observer alliance metaphorically resembles the physician's ophthalmoscope. Unlike the ophthalmoscope, patients play an active role in creating and maintaining the instrument. It allows the practitioner to peer into the mind/brain of the patient. Without an adequate self–observer alliance through which the patient reports thoughts and feelings to the therapist, therapy will proceed with difficulty. Three elements of the therapeutic relationship seem to play important roles in the development and maintenance of the self–observer alliance: (1) the professional relationship (the patient's confidence in the therapist's competence), (2) the real relationship (the mutual caring and liking that usually develops between people working together toward a common goal), and (3) the transference relationship (the patient's distortions of the person of the therapist; (Greenson, 1967).

The Therapeutic Contract

Ground rules are an essential part of any professional interaction and are implicit in most of them. Psychotherapy, at least for the therapist, requires explication of these sometimes complicated ground rules. For some patients they are simple and easily understood. For others, especially those who have what we call borderline personality disorders, the therapeutic contract plays an essential role in understanding and "containing" the

therapeutic field by defining its borderlines (Koerner & Linehan, 1992; Langs, 1973).

Stages of Psychotherapy

As a subset of problem-solving relationships, the psychotherapeutic relationship follows stages that parallel those found in decision making. These stages may be defined by their objectives and have been classified as engagement, pattern search, change, and termination (Beitman, 1987). Stage theory requires explication of the complicated elements of this basic model. Questions for such a theory include the following: Does engagement begin before people actually see each other? Can't one search for patterns and change and then solidify engagement? Isn't there great fluidity between pattern search and change? And doesn't termination begin when change begins?

SOME GENERALLY USEFUL TECHNIQUES FOR GATHERING INFORMATION

This section contains the commonly used methods for gathering information about patients in addition to listening. They are summarized in Table I. The reason for including these mundane details in this discussion rests on the need to embrace the very basic elements of any overarching conceptualizing on the daily, repeated techniques and tactics of most psychotherapists.

Standardized Instruments

Questionnaires measuring a host of parameters provide potential problem definitions and measures for change. Researchers are striving to answer the ever-insistent call to take into account the uniqueness of the

Table I. Techniques for Gathering Information

Standardized instruments
Collateral information
Empathic understanding
Stimulus-Organism-Response diaries
Resistance/noncompliance
Countertransference/interpersonal pulls
In-the-office enactment
Visualization

individual and the category of the problem. Computers offer time- and labor-saving potential to evaluate patients and their problems.

Collateral Informants

In addition to records from previous professionals, relatives and friends can be helpful in defining problems to be changed.

Empathic Understanding

In addition to its well-recognized role in establishing the therapeutic relationship, empathic understanding provides some of the raw data for developing concepts of psychological dysfunction. For the "tuned-in" therapist with the active collaboration of the patient, empathic understanding works like a PET scanner of the psyche by outlining activated emotions and cognitive structures. Once integrated into a set of conceptual maps for psychological dysfunction, empathic understanding provides targets for change and a means to monitor it.

Stimulus–Organism–Response Diaries

Data gathering begins with recording a target behavior, emotion, or thought that is defined as maladaptive. Therapists and patients then seek the stimulus situations in which this target for change emerges. Simultaneously they examine the thoughts and beliefs that link the stimulus to the response. The triple column technique (Beck, Rush, Shaw, & Emory, 1979) provides an efficient means to organize this information.

Resistance/Noncompliance

The path of psychotherapeutic change commonly leads through rough territory where progress can be hindered or stopped. This predictable event may be explained in several different ways: (1) the manner in which patients refuse to follow expectations of the therapist may reflect specific patterns of dysfunction, (2) the therapist may be proposing ineffective strategies, and (3) each participant may be contributing to a transference–countertransference deadlock. Each of these perspectives may offer vital information about key patterns (Wachtel, 1982).

Countertransference/Interpersonal Pulls

The problem of countertransference is often discussed but rarely fully addressed. Countertransference reactions have several major components, including what follows: (1) neurotic countertransference, which refers to the therapist's own difficulties as triggered by the appearance, behavior, or emotions of the patient (Freud, 1963); (2) concurrent countertransference, in which the therapist unwittingly experiences the inner turmoil of the patient; and (3) complementary transference, in which the patient induces certain behavioral, emotional, or cognitive responses in the therapist (Racker, 1968). This third component has been referred to as interpersonal "pull" (Kiesler, 1988), and it provides valuable information about the effects patients have on others.

In-the-Office Enactment

By the way individuals react to the therapist and the ways family members react to each other, therapists are offered in vivo demonstrations of maladaptive patterns that are likely to play roles in outside-the-office dysfunction. Therapists may encourage enactment through role playing, including the empty chair technique (Perls, 1969). The manner in which individuals omit information from their reports (e.g., the patient who reports hurt and not anger) and distort their reports (e.g., by taking the entire responsibility) reveals underlying dysfunctional patterns (Bandler & Grinder, 1975).

Visualization

Often patients are the only potential reporters present at a psychologically significant event. They may be asked to "run a video" of an event and report it to the therapist as it unfolds. They also may be asked to allow their minds to run future tapes of likely consequences of specific relationships or tapes of desirable futures.

At this, the halfway point of the paper, I pause to summarize where we have been and where we are going. This paper proposes an outline for a definition of psychotherapy. In it, we have traversed its contexts, identified its conceptual structures, and outlined its basic information-gathering methods. In so doing, we are proceeding, like persons presenting for help, along the stages of psychotherapy. Next we confront the most intellectually challenging aspect of psychotherapy—our causal models of dysfunction and change. Following this most controversial arena are the vital principles by which change takes place. We end with the difficult questions concerning

the imposition of therapist values and questions about the future—in this case, should we develop a consensus conference and how should it be organized?

CAUSAL EXPLANATIONS THAT SUGGEST HOW TO CHANGE

Human beings seem predisposed to seek out causes for their psychological problems, presumably because knowing these causes could lead to solutions for the problems. They select from a variety of templates to be placed over details of the situation in order to define a pattern by which to understand the difficulty (Kelly, 1955). For many centuries religious leaders have explained personal and group problems by suggesting that affected individuals and groups have strayed from the Divine Path and that prevention of future problems requires stricter adherence to religious prescriptions. Recently, psychological explanations have proliferated.

Unfortunately, many psychological explanations do not offer clear and direct means by which problems can be solved. Terms like "Oedipal conflict," "codependent," and "identity crisis" have been popular for several reasons, but aside from the implication to simply say "no" to the role suggested by these titles (e.g., stop being a codependent), these explanations do not readily offer change scripts. (Change scripts are problem-solving sequences by which distressed individuals may move from an undesired state to a more desirable one.) On the other hand, psychotherapists have generated a list of causal explanations that, with varying levels of clarity, do suggest what to do to change. The identification and explication of these generic patterns should be a top priority for psychotherapy integration.

One problem in identifying such patterns arises from two definitions of the term "change." The term is both a noun and a verb: a desired end state and the means by which to get to the desired end state. Change is both the objective and the means by which to get there. To further complicate these definitions, a desired end state may be one in which the means to additional change may be more accessible. For example, a desired end state may be relief of anxiety. Another desired end state may be the acquisition of coping behavior that reduces the likelihood of anxiety recurrence.

An ideal causal template organizes the data of experience in ways which offer a script for change. The script for change ideally includes a definition of what is maintaining the problem along with the suggestion that altering the forces maintaining the problem will help resolve it. This ideal template would also provide a coping tool by which future problems may be avoided or minimized. The following concepts approximate this

Table II. Causal Explanations that Suggest How to Change

Phobic stimuli lead to avoidance that creates distress.
Thoughts determine behavior and emotion.
Interpersonal schemas can interfere with interpersonal functioning.
Symptoms represent once-adaptive behavior carried forward into the present.
Boundary problems cause psychological distress.
Conflicts cause psychological distress.
Reinforcers control behavior.
Systemic dynamics control individual and group behavior.
Abnormal brain biochemistry causes mental illness.
Human development creates psychological instability.
Personal futures can cause problems in the present.

ideal to varying degrees. This listing cries out for integration. (See Table II.)

Phobic Stimuli Lead to Avoidance that Creates Distress

Many psychological problems seem to involve irrational fears. Phobic stimuli may take a variety of intrapsychic and interpersonal forms besides the commonly noted external objects: Patients may fear their own emotions (e.g., anger) or specific memories (e.g., the loss of a loved one or traumatic events). They may fear rejection by others or separation from loved ones. Paranoid people are afraid to trust, borderline patients often fear engulfment by others, and some narcissistic people fear their own helplessness and dependency. These irrational fears lead to avoidance behavior that fosters psychological symptoms. For example, fear of one's own anger can lead to panic attacks. Avoidance of traumatic memories can lead to unresolved grief reactions and post-traumatic stress disorders. Fear of criticism engenders the symptoms of social phobia.

Exposure is an effective treatment form suggested by this causal paradigm (Wolpe, 1973). Encouraging patients to face the fear in order to relieve the symptoms becomes the therapeutic work. The tactics to successful treatment center around clear definition of the phobic stimulus and careful programming of a sequence for exposure suited to each patients' predisposition.

From the success of this corrective emotional experience, some patients will develop a new coping strategy by learning to define additional phobic stimuli and finding ways to reduce life-interfering avoidance by direct exposure to the fears as a new coping strategy.

Thoughts Determine Behavior and Emotion

The thoughts produced by misconceptions of reality lead to behavioral and emotional as well as cognitive problems (Kelly, 1955; Raimy, 1975). Human beings are guided by discrete sets of guiding principles from which situation-specific self-instructions are derived (Beck *et al.*, 1979; Ellis, 1962; Meichenbaum, 1977).

These faulty general operating principles may be edited in a variety of ways. Patients may be encouraged to define experiments in real life that test the underlying beliefs as hypotheses about reality rather than fixed certainties (Beck *et al.*, 1979). Therapists may also argue for rationality and logic (Ellis, 1962). A complementary approach suggests that the editing begin not with the bedrock construct or general operating principle, but with the "automatic thoughts" or "self-talk" generated from them. The final common pathway for change directly involves what patients say to themselves about themselves, about the immediate situation, and the future. Learning better self-directions and kinder self-reinforcement will likely lead to modified behavior and altered misconceptions (Meichenbaum, 1977).

Ideally, patients will learn how to modify constructs and self-talk discovered to be faulty with the methods used to reduce the presenting symptoms. Experimental hypothesis testing of questionable beliefs and direct editing of self-talk provide useful maintenance and generalization coping techniques.

Interpersonal Schemas Can Interfere with Interpersonal Functioning

Among the crucial cognitive maps are interpersonal schemas: the manner in which the self is represented in relationship to others (Horwitz, 1988). Interpersonal schemas contain "scripts" that direct how specific role relationships, as represented in the schemas, will be played out.

Distortions and deletions of these schemas provide the targets for psychotherapeutic change (Bandler & Grinder, 1975).

Symptoms Represent Once-Adaptive Behavior Carried Forward Into the Present

Many children successfully adapt to the strange circumstances of their upbringing with patterns of feeling, behavior, and/or attitudes that persist into later life where they become obsolete. In becoming obsolete, the patterns may become dysfunctional and lead to symptoms of distress. The patterns may originate in the seemingly universal desire to please an adult

care giver and in the related universal desire to maintain physical and psychological integrity. Some patterns seem to be passed from generation to generation (Bowen, 1978).

This form of explanation presents the opportunity to develop a reasonable, acceptable cause for the development of a currently maladaptive pattern (e.g., "I did it because I wanted to be loved by my father," and/or "I did it to survive in my very dangerous childhood circumstance"). Such explanations also present the opportunity to renounce the pattern: "I need no longer think, feel, and behave in this way because the past is not the present." With renuciation, comes the opportunity to generate and to select from a new set of options.

Boundary Problems Cause Psychological Distress

Psychological boundaries that are too flexible, or too rigid or drawn in the wrong psychological spaces, can foster distress. Boundary problems appear in several arenas: Cross-generational alliances, disengaged or enmeshed families (Minuchin & Fishman, 1981), boundary violations of the therapeutic contract (Langs, 1973), boundary experiences of human existence (Yalom, 1980), and self–other boundary difficulties in narcissistic and borderline patients. People who become repetitively involved with married lovers or psychotherapists who seek romantic relationships with their patients are also experiencing boundary problems.

Boundary problems can be resolved by several means, including softening of rigid ones, tightening overly flexible ones, and redrawing (for example, by strengthening a parent bond while loosening a child–parent one).

Conflicts Cause Psychological Distress

Conflicts may appear in most areas of psychological space. They arise between internal representations of the self, between internal representations of self and other, in thoughts vs. emotions, interpersonal relationships (parent/child, lovers, spouses, co-workers), and in approach/avoidance situations.

Resolution of conflict requires that the polarities be desensitized to the communications from each side in order to discover common ground so that clarified disagreements become open for compromise (Heitler, 1990; Perls, 1969). Models for narcissistic patients utilizing grandiose vs. depreciated self (Kohut, 1968) and for borderline patients (Kernberg, 1975) using splitting are based upon the assumption that resolution of these conflicting polarities will be beneficial. Similar concepts may be applied to persons seeking "ultimate rescuers" by acting as "supplicants" who may

recognize the pattern being played out intrapsychiacally as well as interpersonally (Yalom, 1980).

Reinforcers Control Behavior

Human behavior is controlled by its consequences. Maladaptive responses recur because they are being reinforced by salient operants.

New behaviors, thoughts, and emotional states may be initiated voluntarily, by coercion or accidentally. If the new behavior is reinforced by diminution of a noxious consequence or by an increase in a desirable consequence, then the change is likely to be maintained. Finding and supplying the innumerable potential reinforcers of desirable change presents a continuing therapeutic and personal challenge.

Systemic Dynamics Control Individual and Group Behavior

Individuals, couples, and families function at the intersection of multiple systems that influence behavior, thought, and feelings (Guttman, 1991). Individuals are usually a part of a couple and/or family system that struggles to maintain homeostasis in the context of shifting biological, developmental, work, and cultural forces. Family and other units are controlled by often unspoken rules, dysfunctional alliances (Minuchin & Fishman, 1981), and invisible loyalties (Boszormenyl-Nagi, & Spark, 1978).

Therapists must carefully choose intervention points in complex couple, family, and other unit dynamics to help adjust homeostasis to more desirable end states of individuals within the system and/or the entire system.

Abnormal Brain Biochemistry Causes Mental Illness

Much research has shown that brain dysfunction is associated with mental illness and that many forms of mental illness are genetically transmitted. Manic-depressive illness, depression, panic disorder and agoraphobia, schizophrenia, and obsessive-compulsive disorder are among the disorders with likely biochemical and genetic characteristics.

These Axis I DSM-IV disorders also suggest certain pharmacological treatments that research evidence supports to be reasonably effective. Medications may also have subtle psychological effects. For example, some of my patients report that psychoactive medications for depression, bulimia, and panic attacks help them to distance themselves from disturbing thoughts, thereby increasing their accessibility to new alternatives. Effective

medications may also help patients to learn. The key question is whether or not psychotherapists can help patients maintain the medication-induced neuronal circuitry after the external molecules are discontinued.[3]

The biological basis of mental illness also requires therapists to note that chemicals external to the brain may aggravate dysfunctional brain biochemistry. Caffeine, for example, worsens anxiety, and alcohol worsens depression. One of the easiest treatments available to psychotherapists is the suggestion to eliminate harmful chemicals.

Human Development Creates Psychological Instability

Individuals, couples, and families move through biological and cultural contexts in which patients struggle to maintain homeostasis. The birth of a first child invariably alters parental relationships, while the premature death of a child often devastates marital relationships. An unattached 40-year-old continuing to live with a parent suggests developmental arrest. Unsuccessful negotiation of steps in the individual, couple, or family life cycle are likely to engender distress. Drug abuse or major disease processes can interfere with normal development, leaving the affected individual at an arrested developmental stage.

Psychotherapeutic approaches to developmental difficulties include assistance in traversing a developmental step or accommodation to the failure in being able to do so.

Personal Futures Can Cause Problems in the Present

The views that people hold of themselves in the future can impair decision making and lead to maladaptive responses in the present (Melges, 1982). This concept is implied in many of the foregoing causal templates, but requires further explication. Interpersonal scripts, for example, that predict abandonment prevent interpersonal bonding. "What if?" catastrophic thinking generates irrational fears and avoidance. Hopelessness correlates with suicide. Craving leads to addictions. The pain of grief springs from the loss of an expected future relationship. Severe trauma seems to diminish the sense of trust in the world and others (Horwitz, 1988). Self-efficacy

[3]To illustrate, Ms. A. is obsessed with food. She is disturbed by her inability to put these thoughts to rest. Ms. A must eat and must feel guilty. Prozac (fluoxetine) helped Ms. A gain distance from her food obsessions. She changed the situational stimuli for eating and seemed to learn how to hold onto her nonobsessional state with directed self-talk. She stopped the medication due to its expense after six months. One year later she was a little more plagued by her food obsessions.

(the prediction of future effectiveness) strongly correlates with successful behavior (Bandura, 1977).

Among the strategies for beneficially altering views of the future are (1) positive reframing or "turning stumbling blocks into stepping stones" by which events that seem to indicate negative consequences are construed to have plausible positive outcomes, and (2) paradoxically "giving up that which is intensely desired in order to get it." For example, a person intensely desiring to be liked, accepts loneliness and rejection, thereby increasing the likelihood of acceptance.

This list of causal templates indicates the wide variety of organizing concepts available to the modern psychotherapist. Occasionally, one patient will be suitably helped with one concept. However, it is more probable that two or more templates may be required. The choice is influenced by several factors, including the therapist's training and comfort level, and the level of acceptance by patient, couple, or family. Another challenge for psychotherapy integration is to define principles by which causal templates may be "mixed and matched" for various individuals, couples, and families. Ideally, change models should be fashioned into the conceptual framework of each patient couple or family to develop the most efficient and effective approach to change. Unfortunately, therapist preference sometimes overrides this ideal.

Finally, the notion of psychological cause may be an illusion. We will have great difficulty proving whether any of these notions truly causes psychological distress. As psychotherapists we may allow ourselves to suspend efforts at such proof instead being satisfied with our need to use such ideas to promote change in its two meanings: the process of change and the desired end state of change.

GENERAL PRINCIPLES OF CHANGE

These principles have been chosen, with the aid of research findings, for their apparent usefulness and generalizability. See Table III for a summary.

Principle 1: Identify Potential Elements for Change

The arena for psychotherapeutic interventions includes the following elements: thoughts, behavior, images, emotions, schemas, neurobiology, interpersonal relationships, and system dynamics. The availability of multiple intervention points contributes to the tendency for different approaches to

Table III. General Principles of Change

1. Identify potential elements for change.
2. Hold the patient responsible for change.
3. Build on patient's strengths.
4. Address the fear of change.
5. Utilize the fact that patients are part of dynamic systems that reequilibrate to alterations in their components.
6. Encourage new action.
7. Help to gain new learning.

have similar outcomes (Rosenzweig, 1936; Smith, Glass, & Miller, 1980).[4] Sometimes several available intervention points must be worked on simultaneously to move a cumbersome system in the desired direction. The therapist can become part of patients' systems and therefore may be another intervention point.

Therapists help patients to identify and select from the available intervention points. Choosing requires risk taking since choice usually demands action (Yalom, 1980). Therapists generally strive to identify alternatives that are relatively easy to change and that are likely to produce significant change.

Principle 2: Hold the Patient Responsible for Change

Responsibility for psychotherapeutic change lies within the person or set of persons seeking help. Neuroscientists are confirming the often-stated belief of prominent psychotherapists including Freud, Jung, Rogers, May, and Erickson that a vast untapped potential for creative adaptation lies within each human brain (Gazzaniga, 1992). Therapists do not make changes directly; they influence patients' construction of the future and their decisions regarding these constructs. Circumstances may inhibit change but therapists must assume patients will be responsible or else terminate the relationship; therapists cannot do it for them. Therapists help patients learn the limits of their responsibility (some patients minimize, others exaggerate) by helping them find specific means within their abilities,

[4]Similar outcomes of diverse approaches have implied to some that all therapies are operated by similar mechanisms. However, similar outcomes may also have been achieved through different technical approaches just as antidepressants and benzodiazepines may be equally effective in panic disorder by utilizing different biochemical means.

utilizing their strengths, to act in ways that are likely to promote desired change.

Principle 3: Build on Patient's Strengths

The emphasis on diagnosis in psychiatry and by third-party payers has tended to obscure the search for patient strengths as building blocks for change. Therapists must organize their interventions around enduring abilities and fortuitous events (Haley, 1973). Instances of deviation from the expected dysfunction must be exploited. Why, for example, did a couple not argue when on similar occasions they did? What prevented the usually depressed person from once again becoming depressed?

Principle 4: Address the Fear of Change

Because change involves loss of the familiar (and sometimes, therefore, grief) and also demands new learning to adapt to new circumstances, people often balk at change opportunities despite rational comprehension of their value. Crises that disengage patients from old, familiar patterns seem to reduce the pain of their loss and accelerate the motivation for new learning.

Principle 5: Utilize the Fact that Patients are Part of Dynamic Systems that Reequilibrate in Response to Alterations in Their Components

Change in affect can reciprocally change behavior. Change in behavior can reciprocally change another person. Change in another person can reciprocally alter one's interpersonal schemas and so on (Guttman, 1991; von Bertalanffy, 1968). The effectiveness of an intervention might be judged by the degree to which it reverberates positively throughout the psychotherapeutic target system. A small change at the right place can initiate a spiral of events that shifts the system to a more desirable equilibrium (Haley, 1973; O'Hanlon, 1987).

Principle 6: Encourage New Action

Therapists help patients activate change processes in their daily lives. Patients should be encouraged to carry out behavioral, cognitive, interper-

sonal, and other assignments during the approximately 100 waking hours per week spent outside of the therapist's office.

Principle 7: Encourage New Learning

Patients learn by a variety of means including therapist explanation, reading, out-of-the-office experiments, and reported observations by significant others. New learning serves to provide alternative views that can lead to new behavior. Action and insight reciprocally augment each other (Wachtel & Wachtel, 1986). The end product of much new learning involves the modifying of misunderstandings of the self (Raimy, 1975). The result of these modifications can often be more adaptive ways of talking to oneself (Meichenbaum, 1977) and new, more adaptive actions.

Methods by which to gather data and principles of change have now been stated. No matter how clearly these principles are articulated, no matter to what degree they are agreed upon, a more difficult problem remains: What to do when. Relying largely on experience, training, and intuition, therapists generate lists of alternative interventions at specific choice points and then rapidly estimate the efficacy of each. Psychotherapy integration will need to proceed to principles by which such lists and such efficacy estimates can be generated at choice points. We have the tools; what are the rules? This crucial question can be answered only by including the differential value structures of individual therapists as well as their varying technical understanding and abilities.

PSYCHOTHERAPY VALUES

Psychotherapists hold certain values. Values can be processes by means of which certain valued end states can be reached and the end states themselves. Which means to which ends do psychotherapists hold in common? In what ways do psychotherapist values differ?

This paper has implicitly reviewed psychotherapeutic values. These include beliefs like "each individual is responsible for change" and "warm, empathic regard fosters strong relationships" and the utility of coping strategies like self-observation, exposure to fears, and resolution of conflict. Psychotherapists also value outcomes like increased functioning at work and in loving relationships.

None of these beliefs and coping strategies can be established as always valuable, yet they seem to be important in the psychotherapy culture.

Psychotherapists also differ in what they want for and from their patients. Some believe in using psychotherapy to enact social change; others believe psychotherapy should instill a greater appreciation of religious and spiritual values. Some therapists work with patients to learn more about themselves ("the only way to be in therapy without having to be the patient is to be a therapist") and also to improve their psychotherapeutic skills. Regrettably, some use the opportunity to help others to enhance themselves through sexual exploitation or financial and other self-centered persuits.

How do psychotherapists mesh their values with the values of their patients, families, and payers? There is a pressing need to define and describe therapists' value systems.

THE LIMITS OF PSYCHOTHERAPY

Any legitimate, rational analysis of the purpose of psychotherapy would identify problem solving as a key component. Yet each reader of this paper recognizes that some psychotherapeutic relationships have meandered down many blind pathways and dead ends without termination, without stated objectives. These relationships may represent the "purchase of friendship" (Schofield, 1964) or attempts to solve problems that exceed the powers of psychotherapy. Which borderline patients can psychotherapists help? If so, how much? When can ongoing psychotherapy be legitimately used to prevent relapse? (e.g., Frank, *et al.*, 1990). When are patients and therapists meeting because they like each other and do not want to separate? What are the limits to the limits imposed on psychotherapists by managed care? (Hubble, 1992).

The definition of limitations is a key to defining psychotherapy. Epistemologically, we know an entity by what it is not as well as by what it is.

TOWARD A CONSENSUS CONFERENCE

This attempt to define the principles of psychotherapy integration is limited by the personal and professional experiences of the author. On my own, I cannot define a generally accepted psychotherapy integration. I hope to have developed a preliminary scaffolding upon which debate can take place while proposed planks and beams are also challenged and replaced.

Principles of psychotherapy integration must include mechanisms by which this body of knowledge can be molded to the needs of the individual therapist for specific patients at specific times. These principles should be

flexible in at least three ways: for the therapist, for the patients, and for the innovations of the time. Perhaps "triflexibility" should be added as a principle of psychotherapy integration (Beitman, 1992).

If a consensus conference is to be developed, several pertinent questions will need to be addressed: who (will participate), where and when (will the meeting take place), how (will it be managed), and what (will be discussed)? More difficult questions will concern how to accommodate the multiple opinions of the participants in an operational manner. The process by which the accommodations successfully take place in this setting will likely add to our knowledge of psychotherapeutic flexibility. If so, the conference should designate process observers who can help to articulate the principles of flexible accommodation hopefully demonstrated by successful negotiation.

CONCLUSION

This paper has reviewed the principles of psychotherapy integration with the intention to stimulate consensus development among leaders and practitioners. The time has come to stop exploring psychotherapy integration. Now we must finally state what it is we are doing.

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