The Integrative Revolution in Couple and Family Therapy

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A quiet revolution has resulted in significant movement toward integrative practice in couple and family therapy. This article examines the present status of integrative methods, highlighting the factors that have led to their broad acceptance, issues surrounding the definition of integration and the nomenclature used, the content of recent approaches, and specific conceptual developments and directions.

We have entered the era of integration in couple and family therapy. Any cursory observation of recent writing or clinical practice suggests how completely the trend toward integration has transformed our work. Not only has a considerable literature concerned with integration emerged (Grunebaum, 1988; Lebow 1984, 1987a,b; Liddle, 1984; Moulthrop, 1981, 1986), and numerous integrative models have been developed and widely disseminated (Feldman, 1985, 1990; Gurman, 1981; L'Abate, 1986; Pinsof, 1995), but, emblematic of a paradigm shift, the move to integration has become so much a part of the fabric of our work that it largely goes unrecognized.

There are many signs of this emerging paradigm. Methods often cross the boundaries of what earlier were distinct schools of couple and family therapy. Methods of "behavioral" therapists now often include strains of strategic (Barton & Alexander, 1981) and even experiential treatments (Jacobson, 1992). "Structural" therapists draw on multigenerational explorations of family of origin (Breunlin, Schwartz, & Mac Kune-Karrer, 1993; Melito, 1988). Work with "object relations" frequently involves the teaching of communication skills and pragmatic help in solving problems. Articles and presentations refer again and again to a merging of concepts across diverse orientations (Grunebaum, 1988; Watts-Jones, 1992). We have entered an era during which the pure form practice of schools of family therapy has become a rarity. Although professional identities continue to form within training programs grounded in schools of treatment, and to be maintained despite the idiosyncratic pathways of professional development, actual methods of practice continue to broaden.

Although integrative models in family therapy have existed for several decades (see Sager, 1976),1 the extent of their acceptance is unprecedented. Even those who were initially cool to integrative concepts now often speak of their personal evolution to a broader base of practice (Jacobson, 1992; Liddle, Dakof, & Diamond, 1991). Even as new therapies continue to emerge that emphasize a narrow range of conceptualization and intervention, the impact of these therapies often is greatest when concepts and interventions are integrated with more traditional methods. The time line between the development of an approach and its integration with other methods has become very short.

Even the broadest disjunction, that between "individual" and "family" therapy, is regularly negotiated. Increasingly, interventions and theoretical precepts derived from individual therapy (for example, cognitive-behavioral, psychodynamic, self-psychology) are used in conjunction with systemic perspectives (Barton & Alexander, 1981; Pinsof, 1995), and individual, couple, and family sessions are mixed freely in treatments (Feldman, 1985; Wachtel & Wachtel, 1986). Recent articles by many of those who adhered to structural and strategic stances have pointed to the "rediscovery" of the individual (who actually was there all the time, living in other models). This markedly contrasts with the writing of the first generation of family therapists, who criticized such flexibility as evidence that the therapist was insufficiently systemic (for example, Minuchin, 1974; Whitaker & Keith, 1981).

Another sign of the change that has occurred is the extent to which discussion now centers on generic aspects of treatment. Concepts like therapeutic alliance (Pinsof & Catherall, 1986), loss (McGoldrick & Walsh, 1983), life cycle (Carter & McGoldrick, 1988), cohesion ( Olson, 1986), isomorphism (Liddle, 1984); macro-system (Imber-Black, 1988), and differentiation (Bowen, 1978); interventions such as enactment (Minuchin & Fishman, 1984), ritual (Imber-Black & Roberts, 1992), and genogram (McGoldrick & Gerson, 1985); and tactics for dealing with such processes as engagement (Minuchin & Fishman, 1981), resistance (Anderson & Stewart, 1983), and termination (Lebow, 1995) are used by a wide range of family therapists, transcending the approach in which they were first used. We have also seen the development of a common language that transcends approach (Simon, Steirlin, & Wynne, 1985), and the beginnings of catalogs of interventions that transcend orientation (Figley & Nelson, 1989; Minuchin & Fishman, 1981).

We have also seen the emergence of several thoughtfully constructed integrative therapies (Barton & Alexander, 1981; Minuchin & Fishman, 1981; Jacobson, 1992; Liddle, 1984; Moulthrop, 1981, 1986); and tactics for dealing with such processes as engagement (Minuchin & Fishman, 1981), resistance (Anderson & Stewart, 1983), and termination (Lebow, 1995) are used by a wide range of family therapists, transcending the approach in which they were first used. We have also seen the development of a common language that transcends approach (Simon, Steirlin, & Wynne, 1985), and the beginnings of catalogs of interventions that transcend orientation (Figley & Nelson, 1989; Minuchin & Fishman, 1981).
that have acquired considerable numbers of followers, and have helped popularize integrative practice. However, a telling aspect of the integrative movement is that no one integrative therapy has emerged as predominant, nor has there even appeared a serious contender for this distinction. Instead, the generic aspects of the act of integrating have taken precedence.

Like the Fall of the Berlin Wall, the emergence of the integrative paradigm probably was inevitable, but few anticipated its arriving so quickly. Our therapies have moved from a radical accent on differences, both between family therapies and between individual and family therapy (see, for example, Minuchin, 1974; Haley, 1963), to a focus on similarity and amalgamation. This article overviews the state of integrative couple and family therapy, highlighting a few of the most significant issues in this work.²

ROOTS OF INTEGRATION

The paradigm shift toward integration has evolved from many sources. Among the most prominent are the following:

1. The imposing logic behind the integrative perspective (Lebow, 1984): Integration offers a broad view of the change process that can account for a wide range of behavior. Integrative approaches permit a great range of choices in treatment and therefore great flexibility, and the potential for a high level of treatment acceptability among clients and treatment efficacy. An integrative stance also encourages the development of an armamentarium of interventions valuable in the treatment of specific difficulties. Further, integrative methods are easily tailored to match the stylistic strengths of the individual therapist and are readily augmented as methods evolve and therapists develop.

2. The zeitgeist of our time: The trend toward integration parallels the movement away from the modernist belief in the endless possibility of a single model, toward postmodern understandings of the limits of any single perspective.

3. The acceptance of family therapy within the broader mental health field: Acceptance has promoted contact with other approaches and reduced the need to heighten differences from other models. Better communication between family therapists and the outside world has promoted reciprocal influence.

4. The umbrella of systems theory: A systemic viewpoint invites examination of what lies within and outside the system, opening up a world of multiple inputs and possible actions. Being truly systemic ultimately meant confronting the importance of individuals that lie within the system.

5. The strong ideological commitment to a diversity of ideas within the community of family therapists: Journals like Family Process, The Family Therapy Networker, and Journal of Marital and Family Therapy, as well as organizations like the American Association for Marriage and Family Therapy (AAMFT) and the American Family Therapy Academy (AFTA), have promoted discourse that transcends scholastic boundaries.

6. The pragmatics of clinical practice: Practicing family therapists have always remained highly pragmatic. Most come to family therapy after training in some individual therapy model. Most have varied practices that naturally invoke multiple methods of intervention.³ Changes in patterns of mental healthcare service delivery and financing, with the advent of managed care, have augmented the need for providers to be able to offer interventions that best fit with a broad range of the patient systems. Most family therapists today themselves are at mid-life, a point where clinicians have the experience and skills to integrate, and a time in life when personal developments tend to move toward less idealization of specific methods and ideas (Anderson, 1992; Moulthrop, 1986).

8. The emergence of research: Research has demonstrated the lack of superiority of any one method of treatment and the importance of generic dimensions of treatment (for example, therapeutic alliance). It also has provided support for a diverse range of treatments for specific conditions (Lebow & Gurman, 1995).

9. The historical association between family therapy and the treatment of the most difficult disorders: In treating such problems as eating disorder, chemical dependency, schizophrenia, and depression, the considerable base of knowledge developed in the individual treatment of these disorders could not be ignored, nor could the need for family therapists to collaborate with others in multidisciplinary settings. Much of the most impressive work integrating family and individual therapy has resulted from specifically focusing on the goal of building the most efficacious treatment for targeted problems (for example, spousal abuse and adolescent substance abuse). Such a narrow focus naturally invites merging intervention strategies.

DEFINITION AND CLASSIFICATION

Defining Integration

"Integration" refers both to the process of bridging the concepts and interventions of schools of therapy, and to the product that results from this activity (Goldfreid & Padawer, 1978; Lebow, 1984, 1987b; Wachtel, 1977). The major issues
that surround usage are about the necessary and sufficient conditions for an approach to be termed "integration." For some, any melding of approaches is sufficient, while for others, only specific combinations of ingredients that meet particular criteria will suffice.

The domain of "integration" should not be limited in a way that is overly restrictive. Integration appropriately includes all combinations of approaches that are not inherently contradictory, be it object relations and systems theory, or structural and strategic approaches, or the pairing of primal scream and the invariant prescription. Methods may be drawn from various family therapies or may even cross the boundaries of family and individual therapy models, or family therapy models and other models of intervention (for example, macro-systemic, group).

However, several further conditions must be met beyond the presence of two treatment approaches. First, integration implies a melding not only at levels of strategy and intervention, but also some effort to construct a theory that transcends the approaches included. Second, the term is best reserved for methods that cross some clear boundary of treatment philosophy. Bringing one distinct intervention into an approach in which that concept is not employed (for example, genograms into strategic therapy) is more appropriately labeled "assimilation" (Lebow, 1987b). The blending of approaches that are very similar (two methods of object relations family therapy or two methods of conceptualizing narratives) also should not suffice for the label to be applied. Third, integration within couple and family therapy should presume the inclusion of some variant of systems theory, an essential ingredient to any couple or family therapy. Fourth, given that systems theory is essential to family therapy, an integrative therapy should include more than the combination of systems theory and one other approach. For example, approaches that combine psychodynamic principles and systems theory are more appropriately labeled as "psychoanalytic family therapy" rather than as "integrative."4

In most usage, integration includes the melding of approaches that cross a method of directive task-centered intervention (for example, behavioral or structural interventions) and some notion of an internal psychodynamic process. Although we need to recognize this common use of the term "integration," such a usage is overly restrictive. Some of our best integrations combine different elements that lie outside this narrow band. See, for example, Sheinberg's (1992) combinations of feminism and social constructivism.

Classifying Integrations

Since most family therapists practice some form of integration, calling a treatment 'integrative' adds little to what we know about it. What does matter and what differentiates therapists is how they integrate: what the ingredients are and how they are blended. There is enormous variation in what is blended and how the mix is implemented. We need a nomenclature that describes integrative practice.

What elements of theory, strategy, and interventions are included? What is the framework for understanding and enabling change? Our naming should provide a description that communicates the content of the treatment offered, a shorthand by which informed consumers, or at least referral sources, can identify the methods practiced (Lebow, 1987b).

The easiest and most informative system of labeling would be to join—hyphenate—the names of the approaches included in a model in order of their prominence within the approach. Thus, a therapy might be structural-strategic, strategic-structural, or Bowenian-feminist. For more sophisticated audiences (say, other therapists or third-party payers), a second, more complete delineation of the approach could be derived through providing a profile of the core therapy methods, like the generic list of concepts and interventions developed by Figley and Nelson (1989). Either of these ways of describing treatments would communicate much more information than the typical, broad brand-names used to label most integrative family therapies.

Integration and Eclecticism

Both "integration" and "eclecticism" involve the application of theoretical concepts and interventions that cross scholastic boundaries. In common usage, these terms often have been employed interchangeably, with treatments labeled "eclectic" in the 1960s and 1970s often having been more chicly relabeled as "integrative" in the 1980s and 1990s.

Nonetheless, a conceptual difference emerges between these terms in more sophisticated usage. "Eclectic" is identified with a pragmatic, case-based approach in which the ingredients of different approaches are employed without concern for theory. In contrast, "integration" presumes a more extensive melding of approaches into a meta-level theory that struggles with and works through the juxtaposition of the meanings of different concepts or intervention strategies entailed. A trend toward "integration" rather than "eclecticism" appears evident, but we cannot assume a particular model primarily is "integrative" or "eclectic" based on which of these words is chosen to describe it.

CONTENT OF INTEGRATIVE MODELS

Theory, Strategy, Intervention
Integrative models merge the raw material of scholastic approaches. This merger occurs at three distinct levels: theory, strategy, and intervention. Because there are numerous therapies to merge, and several levels along which to merge them, integrative models vary enormously in content.

At the conceptual level, integrative approaches build a meta-theory, an understanding of the essential elements of human functioning and the change process. At the level of therapeutic strategy, the emphasis is on developing maximally effective tactics consistent with the theoretical emphasis. At the level of intervention, the therapist assembles and uses specific techniques to execute the strategy.

At the level of theory, the integrative process includes both reconciling the differences in focus and in methods within particular areas of emphasis among the constituent models. The theoretical foundation for an integration should include a description of each of the specific concepts involved and a consideration of how these ideas fit together. Often, this process involves more of a dialectic between concepts than a simple addition of ideas. The assumptions behind the constituent theories need to be understood, disassembled, compared, and reworked into a new fabric. Many efforts at integration come up short in this regard, settling for merely listing concepts included or just the models chosen, and failing to struggle with the differences implied.

Talking about an integration of object relations and structural approaches has meaning only when we describe which parts of these complex theories are in the field of attention, how the included ideas work with one another, and how the presence of each idea affects the others. In this example, there clearly are assumptions of structural family therapy (that only structure matters and internal process is unimportant) that clash with aspects of object relations (that internal processes are at base in all interaction), which leaves a substantial task for theoretical integration (Rosenbaum & Dyckman, 1995). The strength of the theoretical integration depends on the effort to probe and uncover such basic assumptions, make informed choices about which aspects of the constituent approaches are selected, and develop a framework that joins the concepts in a way that has internal consistency: that is, to accept the importance of internal process and of family structure, and then show how they interact.

There are numerous questions about theory that must be answered in the context of any integrative therapy. What specific ideas from each approach are being integrated? Which concepts within the constituent models are left out and why? How are the central aspects of the change process in each model brought together? Does a dominant central theme emerge? How well do the assumptions that are included fit together? Are mutually incompatible aspects included? What values derived from each model are emphasized?

Models also involve the crossing of interventions at the level of operations (Goldfried & Padawer, 1978), that is, what the therapist does. Operations can be further divided between strategy—the overall plan—and interventions—the specific therapist behaviors that implement the strategy. Thus, a behavioral and psychodynamic integration might involve a strategy of first employing behavioral assignments, and moving to psychodynamic interventions only after a trial of behavioral interventions fails to produce change (see Pinsof, 1995). The interventions would consist of the specific behavioral tasks (for example, modeling, sensate focus) and psychodynamic procedures (for example, interpretation) employed.

Several key questions form at the level of strategy. What are the core set of tactics to be employed? Why have these been chosen in relation to theory and pragmatic factors? How consistent are the strategies with the emphasis of the theoretical integration? What kinds of changes are required in one set of tactics in relation to the inclusion of another? How does the presence of one set of interventions within a strategy affect the impact of another? How does the therapist choose among possible alternative strategies within the model? What should be the order of interventions? When should one approach be abandoned and another invoked? How much are strategies affected by various factors in a case or characteristics of the therapist?

Moving to the level of interventions, similar questions arise. What interventions have been chosen and why? How does the addition of interventions that are not typically joined together alter the impact of each? (For example, what is the impact of adding interpretation to a structural intervention traditionally offered without explanation?) How do clients perceive these combinations? Is there coherence in the coupling? How does the choice of interventions fit with the intended strategy and theory?

The three levels of integration have circular influence on one another: changes on one level affect other levels. In the most fully developed models, the levels of theory, strategy, and intervention remain recursively linked and consistent with one another.

**Choices about Content**

Integrative approaches vary enormously in content along numerous dimensions. Any concept, strategy, or intervention that has been applied in psychotherapy is potentially grist for the mill. Fortunately, while there are many choices, the considerable overlap between psychotherapies leaves a finite number of core, underlying building blocks within the domains of theory, strategy, and intervention from which to create an integration. This section discusses a few of these
building blocks.

One core consideration is field of vision: delineated as what part of the system is in the center of attention at the level of theory, and who participates in the treatment at what point at the levels of strategy and intervention. Integrative treatments can center on the macro-system, the family, the couple, or the individual. Some integrative approaches work exclusively within one level of the system. Most move between these system levels (Feldman, 1990; Liddle et al., 1991). Here, as elsewhere, the central issues extend well beyond simply stating the value of "both-and" inclusiveness. The important questions lie in defining the relative priorities assigned to each level of emphasis, when to include whom, and how to deal with the complexities that emanate from the mix created, for example, how to deal with secrets when holding sessions with both the family and individuals within it.

Another central thread is the relative importance assigned to the classic dimensions of individual and collective experience: biology, behavior, affect, cognition, and systemic function. Most therapies are primarily organized around an emphasis on one of these dimensions, and in many integrations a clear emphasis remains. For example, Greenberg and Johnson (1988) move affect into central focus, while Jacobson (1992) accents behavior. Other integrative treatments balance their emphasis across these dimensions (Pinsof, 1995).

Another core thread is concerned with the place of the therapist. Models of therapist roles range from a detached emitter of instructions, to teacher, to intimate companion. Many decisions (for example, the role of therapist disclosure) flow directly from the role the therapist is to fill. All decisions in therapy are affected by it.

Each treatment also emphasizes a core set of values. Not only does this involve specific value choices (for example, attitudes about gender), but also, as Messer (1986) has emphasized, a basic vision of the human condition. Messer suggests that some approaches are comedic, highlighting optimism and the creation of happy endings with hard work (behavioral), while others are tragic or ironic in world view (object relations; psychodynamic). Among family therapies, some suggest life as comedy (behavioral and solution-focused), while others see the tragic (psychodynamic; contextual).

Different core threads within treatment powerfully affect one another. As an example, narrative and cognitive-behavioral family therapies share a cognitive emphasis; each is about change brought about through the process of thinking. However, narrative therapies also include a humanistic thread that emphasizes the power of opening discourse and the value of the therapist as collaborator (with roots in the work of Carl Rogers), while cognitive-behavioral therapy incorporates an emphasis on learning in which the therapist as teacher corrects faulty thinking (with roots in the behaviorism of Skinner). Whether a cognitive therapy includes the Rogerian assumption of an underlying healthy core process to be brought out, or the Skinnerian assumption of bad learning to be corrected, this radically transforms how cognition is treated and the role of the therapist in the treatment. In a similar vein, homeostatic and epigenetic assumptions about systems are both systemic but have quite different implications for the task of the therapist (Hoffman, 1981).

From such core choices flow innumerable decisions about what to focus on and do in treatment. A list of important choices includes such varied concerns as the roles assigned to insight, personal history, family history, present focus, problem focus, solution focus, skill building, transference and countertransference, experiencing, emotional arousal, homework, differentiation, contracting, therapist structuring, discourse, as well as innumerable others. There are a range of positions about each of these entities that therapists can assume. The most successful integrations clearly articulate the choices available and how these relate to the superordinate theory.

**Prescriptive vs. Therapist-Centered Models**

Some integrative approaches accent each therapist's building of a personal method, while others offer highly prescriptive delineations of therapeutic ingredients and a specific map for when to do what. Moulthrop's work (1981, 1986), describing the therapist's personal odyssey, and my own (Lebow, 1987a), suggesting guidelines for each therapist's model development, offer examples of conceptions focused on the therapist as agent of integration. Jacobson's (1992) couple therapy and Liddle et al.'s (1991) treatment for adolescent drug abusers and their families offer examples of highly specific, prescribed routes to intervention, which can be specified in treatment manuals. Other models, such as Pinsof's (1983) problem-centered therapy or Gurman's (1981) integrative marital therapy, bridge this chasm through prescribing ingredients, but allowing varying levels of room for improvisation, especially for more advanced practitioners.

A natural tension arises between integrative models that accent prescription and those that are therapist-centered. The former stress the need for replicable methods of practice; the latter accent the unique qualities of each therapist. Both kinds of models serve important purposes. For some, a well-organized set of directives as to how to practice is most helpful, while others will want to build their own models. Often, the former type of model is most helpful early in the career of a therapist when rules for action are widely sought, while the latter type is more helpful later when improvisation becomes the norm.

We are also reaching the point of maximum benefit from the articulation of general prescriptive models for integrative practice. Although it remains useful to hear from expert clinicians about how they practice so that others can learn from
their experience, having many broad, competing models of integrative practice only serves to confuse the landscape, and
segments the movement toward integration into a number of competing camps, each with a small following. As Liddle
(1995) has suggested, scholastic difference is readily transposed to competition over the best integration, leaving the basic
dynamic of conflicting models unchanged. Further, the excitement of integration begins to be lost in the numbing
succession of models.

I therefore offer the following radical proposal. Let us declare a hiatus from efforts that essentially name theories invoked
and ingredients assembled, that is, the exposition of "my integration" and "how I practice." We learn more from
explorations that wrestle in greater depth with some specific piece of the integrative puzzle.

Prominent Approaches

We can point to a number of valuable, well-articulated and widely disseminated global models that can guide practice.
Most common are efforts that combine behavioral notions of learning with a systemic understanding of the family process,
and the individual psychodynamics that are brought to bear in these patterns (Feldman, 1985, 1990; Gurman, 1981;
Kirschner & Kirschner, 1986; M.P. Nichols, 1987; W.C. Nichols, 1995; Pinsof, 1983, 1995; Sander, 1979; Wachtel,
1992, 1995; Wachtel & Wachtel, 1986). Pinsof's (1983) "Problem-Centered Therapy" offers a highly refined version of
this type of model, in which self psychology is the internal system. Gurman (1981) has developed an innovative
combination of object relations, behavioral, and systemic procedures for working with couples. Feldman (1990) adds an
integration of similar ingredients envisioned as linked in a multilevel, circular process.

However, as noted above, integration does not necessarily include this set of ingredients, and many efforts have taken
other directions. For example, Seaburn, Landau-Stanton, & Horwitz (1995) mix what they term here and now (primarily
structural, strategic, and behavioral tasks), transgenerational (primarily Bowen and experiential work), and ecosystemic
behavioral, and Greenberg and Johnson (1988) experiential and systemic. There also have been numerous efforts to
combine structural and strategic approaches (Liddle, 1984).

Much of the recent, creative edge in integration has been concerned with the development of specific treatments for
specific populations. Goldner et al. (1990) have merged feminist, narrative, systemic, and psychodynamic concepts in the
treatment of abuse within couples. Liddle et al. (1991), and Piercy and Frankel (1989) have brought structural, systems,
and behavioral principles together along with a developmental perspective in the treatment of adolescent chemical
dependency. Similarly, Kaplan (1974) has brought an integrative approach to sex therapy; Rolland (1994), Wright and
Leahy (1994), and Wood (1994) to families with a physically ill member; Wachtel (1995) to families with young children;
Steinglass (1992) to alcoholism; Alexander and Parsons (1982), and Henggeler, Melton, and Smith (1992) to adolescent
acting out; Addis and Jacobson (1991) to adult depression; Markman (1979) to pre-marital couples; Trepner and Barrett
(1989) to sexual abuse; and Harkaway (1987) to eating disorder. Others have looked at integration through the lens of
treatments centered on clients from specific cultures (Aporte, 1985; Boyd-Franklin, 1989; Hardy, 1994). Each of these
methods provides a hearty integration that includes theory, methods of intervention, and particular values that guide
treatment.

Probably the most widely practiced integrative models are the psychoeducational approaches used in the treatment of
severe mental illness. These models share a common belief in the importance of biology, instruction about what is known
about particular disorders and their ramifications for the family, crisis management, and teaching families about responses
that best enable change. Psychoeducation first appeared as treatment for families of schizophrenics, combining didactic
presentation about schizophrenia with medication and a range of family and individually focused interventions (primarily
A central goal was the reduction of expressed emotion in families, causing these treatments to aim for a minimum of
negative affective expression. Similar approaches that combine medication, an individual focus on the person with the
specific DSM diagnosis, and efforts to enable the family's ability to respond in the most constructive way to the problem
behavior, have also been developed for a range of other problems (see Moltz, 1993, and Miklowitz and Goldstein, 1990, on
manic-depression).5

Paradoxically, the primary liabilities as well as the strengths of models created to deal with specific problems lies in their
delimited scope. The danger exists that we may be left with numerous distinct yet overlapping treatments for different
problems, blocking our understanding of the factors that transcend disorders and of common pathways toward change. This
difficulty is especially problematic, given recent findings that indicate high rates of co-morbidity of problems such as
depression and marital difficulty, and of multiple problems within families. The antidotes to this emerging difficulty lie in
maintaining dialogue between those promoting these delimited models of change and those promoting broader models, and
in work that integrates these integrations. The dialectic between the global and the specific can help us distinguish what is
special to a problem area from that which represents a more global process. This dialogue also can help avoid the
frequently encountered drift from a model carefully crafted in a special context toward a global model with limited utility
outside the problem area for which it was created.

**When To Do What**

It remains much easier to create a generic model of what to do than to state the order in which to proceed with these activities. Because of this, many integrative approaches never suggest the order in which aspects of the approach are to be pursued. Within those approaches that do suggest sequences, there are two essential kinds of models: linear and oscillating. Some models feature linear sequences in which certain strategies invariably proceed others. A good example is Pinsof's (1983) problem-centered therapy, in which “direct” interventions such as behavioral task assignment and structural enactment proceed those that emphasize affective experience, which, in turn, precede investigation of the individual psychodynamic level. In problem-centered therapy, parsimony is emphasized: additional levels of intervention are included only when treatment is blocked from achieving its goals through the use of simpler, more directive measures; and additional problems are included only with the explicit agreement of the parties. Liddle (1984) has noted that many structural/strategic therapists also assume a clear, unidirectional pathway, first structural then strategic, again using the latter only after the former fails. Psychoeducational models also use preordained sequences but differ in completing the sequence of interventions, regardless of response along the way.

Other approaches oscillate back and forth between levels of experience and interventions over the course of the treatment. For example, Feldman (1990), in his "multi-dimensional family therapy," moves between interventions on the behavioral, systems, and psychodynamic levels. Oscillating models may move to the most expedient problem resolution, but most often emphasize a thorough working through of the sources of difficulty. As yet we have no evidence comparing the efficacy of sequential and oscillating models.

Closely related is the question of how long to use a particular intervention before moving to an alternative, given a lack of positive response to that intervention. What constitutes a fair trial of a given strategy? The answer clearly varies across difficulties and clients. It is important that each intervention offered have sufficient treatment integrity so that it is clear that that procedure has been delivered. Generally, this means several sessions devoted to a strategy; although there may be grounds for quickly moving away from a set of methods if client acceptability of the treatment is sufficiently low. The frame of the treatment also matters. In time-limited work, there may be an imperative to move on after only a few sessions devoted to a strategy, whereas in longer-term work, some methods may be employed (for example, interpretation) to which the response is expected to be slow.

**EFFECTIVE INTEGRATIVE THERAPIES**

**What Makes Integration Successful?**

What constitutes a robust integration? Does success lie in having the highest degree of consistency and theoretical integrity, in the strongest empirical support for its hands-on clinical implementation, in having the broadest applicability across the widest range of situations, or in having the largest number of followers? Looking at the most impressive integrative work, it is clear that there is no single answer to each of these questions. Creative minds have followed a multitude of pathways. What these efforts share lies in providing more than yet another model of therapy, that is, in exploring an area of interest in sufficient depth so as to offer something special.

This creativity is best conveyed through a few examples. Some exemplary efforts emphasize theory. A prime example is Liddle's (1984) explication of the juncture between structural and strategic approaches, which digs down into the assumptions latent within these models, describes the differences in basic understanding of the change process (direct and continuous in structural therapy, and paradoxical and discontinuous in strategic therapy), and then proposes a number of solutions to bridge this gap.

Goldner et al.’s (1990) merging of feminist, systemic, psychodynamic and narrative approaches in their work with spousal abuse also probes deeply at the level of theory, but adds a rigorous examination of the implications of the theory for clinical cases. Goldner et al. explicate and deconstruct the ideas within the constituent approaches (for example, the contrast of feminist ideas about violence and systemic ideas about circular causality), and then use their cases as a laboratory for testing the applicability of the theory, and for honing and assessing the effectiveness of the clinical approach. Uncovering the strong attachment of the women in these couples to their husbands, Goldner et al. altered some of their initial concepts to fit their experience with their clients. Goldner et al. also clearly articulate the values that guide them in shaping their therapy model. The shaping is clear, but not without regard for the clinical data. The resultant model is far more than the sum of its parts.

Liddle et al.’s (1991) multidimensional family therapy for adolescent substance abuse also begins with relevant theory, derived from the diverse realms of structural family therapy, adolescent development, and substance abuse. Again, the ideas are rigorously explored and integrated. But what emerges as most striking in this effort is the adaptation of strategies of
intervention in relation to the realities that emerge in work with families in which there are adolescent substance abusers; even who is seen at what juncture in treatment is adjusted in relation to what is learned. New treatment strategies are introduced and others altered to increase effectiveness and acceptability, with the theory then being revised in relation to what has been discovered.

Grunebaum (1978, 1981) begins with a probing analysis of systemic, behavioral, and psychodynamic couple therapies that emphasizes goals of treatment. In this examination, Grunebaum divides goals into ultimate goals (the endpoints sought) and mediating goals (intermediate ends to be achieved in the process of moving toward the ultimate goals), compiles a generic list of goals, and then considers the importance of each goal within each approach. Building from this conceptual framework, Grunebaum creates an integrative couple therapy that clearly delineates goals and the interventions aimed at accomplishing these goals. Grunebaum also highlights how changes at various levels mutually evolve and reinforce one another: for example, improved systemic functioning, the development of more accurate interpersonal perception and self-experiencing within individuals, and learning behavioral relationship skills. Grunebaum pays equal attention to generic aspects of psychotherapy, such as the therapeutic alliance, and specific intervention strategies, such as communication training.

Psychoeducational approaches exemplify the central role research can play in model development and validation. The substantial bodies of research documenting the risk associated with expressed emotion in the families of schizophrenics, and the skill deficits and the biological vulnerabilities in the afflicted individuals, serve as the launching points for developing treatments that seek to reduce these vulnerabilities through increasing individual competence, reducing expressed emotion, promoting circular processes of coping and support, and providing medication. The theory of change that results stems directly from the relevant research. Additional research has also validated the beneficial effects of psychoeducational intervention across multiple sites and problems.

There are several common threads that characterize the best integrative therapies. Each model is quite specific in spelling out what is included and how, moving well beyond the vague notion that more is better. Each builds from core assumptions that are clearly stated, and each transmutes the constituent methods rather than simply adding ingredients, digging down to a level that pushes our understanding of how the included elements relate to and affect one another. Although the best integrative therapies are rich in concepts and interventions, each also features some relatively simple focus around which treatment is shaped. Each suggests specific methods for conceptualizing and intervening, yet each also underscores the importance of core, generic factors in effective psychotherapy, such as the creation of hope and the building of the therapeutic alliance. In each of the best integrations, theory has a critical role in developing and organizing treatment, but theory is adapted as the treatment is clinically tested, and discordant results lead to changes in approach, resulting in a co-evolution of theory and methods of practice. The best integrative therapies develop treatment strategies that have high probabilities of success in treating the difficulties in focus, but also allow the clinician considerable flexibility. They are sufficiently simple to be teachable and to offer clear guidelines for practice, while also permitting improvisation, particularly in the hands of more experienced therapists.

I do not mean to suggest here that the only road to effective intervention that blends approaches lies in such probing in depth and testing. One does not have to deconstruct in the manner of Goldner et al. (1990) or research an approach to the extent of the developers of psychoeducation in order to conduct effective therapy. Some very thoughtful approaches limit themselves to presenting the constituent models as what amount to parallel, alternative explanatory narratives (like object relations, behavioral, structural) that are never quite reconciled, but which provide a useful range of practical conceptual understandings and intervention options for the therapist. Therapists following such approaches are often quite effective. Even the most atheoretical, eclectic mix can prove efficacious in the hands of a skillful clinician. However, rigorous theoretical and pragmatic investigation ultimately produces a more consistent method of practice that is more easily explained, taught, and defended, and that should prove, on the whole, more effective.

**Self-examination by the Therapist**

Not all integrative practice lies at the level of explicit model development. Much of the clinical decision making in integrative practice lies outside the conscious awareness of the practitioner, emanating from a level of clinical "intuition" at a preconscious level (Kramer, 1980). Integrative practice is greatly enhanced by bringing the principles behind practice into consciousness. Grunebaum (1988) has offered an instructive example of a clinician working to understand the implicit theories, strategies, and interventions operating in the context of a specific case. Grunebaum deconstructs his own integrative method, moving from his plan, to observations about his own behavior, and to the theories and precepts that guide him but initially were out of conscious awareness. He then considers the repercussions of these interventions both within the specific treatment and his broader model of practice.

Beginning at the other end of the spectrum, from theory down, Liddle (1982) has emphasized the value of what he terms an "epistemological declaration," a statement from each practitioner of underlying principles of practice that can serve as a template for the consideration of the treatment of each case. Whether beginning at the case level as does Grunebaum, or
theory level as does Liddle, such self-examination can help integrative therapists better understand what they do and become more consistent and effective.

Toward an All-encompassing Model?

Integrative concepts can help us move to more efficacious and acceptable treatments. Integration can increase the range of choices available and allow for better tailoring of treatment to specific cases. However, we would do well to move away from grandiose goals and model construction. Some have imagined the creation of an all-encompassing model, a super-model, that would include the broadest range of concepts and suggest the appropriate treatment in every instance. However, the construction of such a super-model would be highly problematic. Such a model would in its super-model, that would include the broadest range of concepts and suggest the appropriate treatment in every instance.

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REFERENCES

treatments became reified as schools, the original integrative nature of these efforts became obscured. The methods they taught and emphasized in their writing were more narrowly focused, and with the passage of time, as their diverse sources in their clinical practice and model building (Ackerman, 1958; Bowen, 1978; Whitaker & Keith, 1981). However, integration is not new to family therapy. The pioneers of family therapy freely assimilated concepts and interventions from various disciplines, including psychoanalysis, behavior therapy, and social constructionism (Mikesell, D.D. Lusterman, & S.H. McDaniel (eds.), 1995).


Wood, B. L., Beyond the "psychosomatic family": A biobehavioral model of pediatric illness, Family Process, 32, 261-278.


Integration is not new to family therapy. The pioneers of family therapy freely assimilated concepts and interventions from diverse sources in their clinical practice and model building (Ackerman, 1958; Bowen, 1978; Whitaker & Keith, 1981). However, the methods they taught and emphasized in their writing were more narrowly focused, and with the passage of time, as their treatments became reified as schools, the original integrative nature of these efforts became obscured.
Due to limitations of space, this article neither seeks to be comprehensive in describing all the issues confronting integrative practice, nor all of the useful integrative models. In particular, I omit such important concerns as the role of gender and culture, the person of the therapist, and contribution of clients in this work, and other important topics such as the interface with those outside family therapy, and the implications for training. The discussion also emphasizes work in North America.

A recent survey of marriage and family therapists found that 49% of their cases were primarily individuals seen in "individual" therapy (Doherty & Simmons, 1996).

Because almost all family therapies blend a range of concepts found in other models, virtually all family therapy could be labeled "integrative." I offer this suggestion simply to differentiate "integrative" treatments from the clearly identifiable traditional schools of family therapy.

Psychoeducation also suggests the importance of biology and medication within mental health treatment. Our concept of integrative therapy needs to include these modes of intervention.

Although feminists have provided among the richest integrative frameworks, feminist work has seldom been labeled as integrative. One consequence of overlooking these prominent examples has been that integrative therapy has remained too closely identified with male model building.