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METHOD PAPER

Research on psychotherapy integration: Building on the past, looking to the future

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Abstract

Integration has become an important and influential movement within psychotherapy practice, reflected by the fact that many treatment providers now identify as integrative. However, integration has not had as great an influence on psychotherapy research. The goal of this paper is to highlight the growing body of research on psychotherapy integration, and to identify future directions for research that may strengthen the integration movement as well as the field of psychotherapy as a whole. We first summarize the past 25 years of research on integration, with a focus on four approaches to integration: theoretical integration, technical eclectic, common factors, and assimilative integration. Next, we identify directions of research within these four areas that could strengthen and support integrative practice. We then propose ways in which the perspective of integrationists could contribute to psychotherapy research in the critical areas of harmful effects, therapist effects, practice-oriented research, and training. We end this paper by suggesting that a greater collaboration between integrationists and psychotherapy researchers will help to create a unified landscape of knowledge and action that will benefit all participants and advance the field.

Keywords: psychotherapy integration; psychotherapy research; theoretical orientation; training

Integration, as a theme or movement in psychotherapy, is old but vibrant. We have seen, over the last 100 years, a rich conceptual and clinical literature delineating points of convergence and complementarity between different therapeutic approaches, as well as describing how they can be combined or integrated with the goal of providing more comprehensive views of psychopathology and more effective practice (Goldfried, Pachankis, & Bell, 2005). Psychotherapy integration could now justifiably be referred to a “leitmotiv” or “zeitgeist” in the field of psychotherapy (see Castonguay & Goldfried, 1994). Reflecting this influential status in the literature, a large number of mental health providers across many countries define themselves as integrative or eclectic (e.g., Caspar, 2008; Kazantzis & Deane, 1998;

Muller, 2008; Norcross, Karpiak, & Santoro, 2005; Yin, Huang, & Fu, 2009). In contrast with some of the “pure” forms of therapy, however, empirical efforts within the psychotherapy integration movement have lagged behind conceptual and clinical contributions. Perhaps reflecting the divide between science and practice, there is a vast discrepancy between the influence that an integrative perspective appears to have in day-to-day clinical work and the impact it has on academic research. Nevertheless, we believe that research that has been done under the umbrella of psychotherapy integration can provide helpful clinical guidelines. We also believe that an integrative perspective is likely to be relevant in investigating some of the most complex and intriguing questions facing the field.

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As part of a special series devoted to the 25th anniversary of *Psychotherapy Research*, the first goal of this paper is to briefly describe empirical investigations that have been conducted over the last quarter century on issues related to psychotherapy integration. Not intended to be comprehensive (and undoubtedly reflecting the cognitive-behavioral leanings of many of the authors of this paper), our synopsis will highlight how some of the findings suggest new understandings of the therapeutic process, as well as innovative ways to expand and/or improve the clinical repertoire—whether it is across orientations or within particular approaches. Our second goal is to delineate lines of research that could provide further support to integrative practice and, reciprocally, to identify research directions that could benefit from the integration movement. We also hope to show that paving this two-way street may foster greater collaboration between researchers and clinicians.

A Synopsis of the Past 25 Years of Research in Psychotherapy Integration

Broadly defined, psychotherapy integration refers to a movement of conceptual and clinical rapprochement “which is not only an effort to integrate diverse models and techniques but also an attempt to better understand and improve psychotherapy by considering the perspective of different approaches” (Castonguay & Goldfried, 1994, p. 160). Arguably, the most prominent contributions in psychotherapy integration can be parceled into four major trends (see Norcross, 2005): theoretical integration, technical eclectic, common factors, and assimilative integration. Theoretical integration involves the integration of the theories and techniques of two or more psychotherapies into a new conceptualization of change or treatment approach. Technical eclectic, by contrast, entails the use of techniques from different approaches without attempting to create a new conceptual model that integrates the diverse theories that underlie them. The common factors approach focuses on the components and principles that are shared across orientations and highlights the therapeutic impact of these common elements over aspects of treatments that are purportedly unique. Finally, assimilative integration, in contrast to the other three forms of integration, involves remaining anchored in a primary theoretical orientation while thoughtfully integrating techniques and principles from other orientations. Below, we describe these trends further and highlight a few prominent examples of research programs conducted within each of these frameworks.

Theoretical Integration

A large number of models have been developed with the goal of either integrating or transcending constructs originally associated with divergent orientations. Unfortunately, relatively few of them have generated substantial research. Among the exceptions are two theoretical models about the process of change. The earliest of these is the trans-theoretical model, which portrays the development of psychotherapy across five stages of change (pre-contemplation, contemplation, preparation, action, and maintenance), each of them characterized by processes of change (e.g., awareness raising, contingency management) that are likely to be optimized by interventions of diverse schools of therapy (Prochaska, 1979; Prochaska & DiClemente, 1984, 2005). A substantial amount of research has been conducted based on this approach, especially on health behaviors and the treatment of substance abuse. Findings suggest, for example, that the client’s pretreatment stage of change reliably predicts psychotherapy outcome (Norcross, Krebs, & Prochaska, 2011). Stiles’ assimilative model also defines the process of therapeutic change along several phases that progress from the warding off to the assimilation of internal voices that represent the client’s problematic experiences. Stiles and colleagues have built a body of studies that provide promising preliminary empirical support for this model (see Stiles, 2011).

In addition to these two theoretical approaches, newer integrative models have begun to garner empirical support. Guided by dynamic or chaos theories of change, Adele Hayes has developed a model for the treatment of depression that involves a series of interventions (associated with diverse orientations) aimed at fostering three phases of change: stabilization of the client’s life functioning, destabilization of the client’s emotional and cognitive experience, and re-stabilization of the client’s view of self and behavior. Built in part on intriguing process findings (such as the link between emotional processing and exploration of the past and outcome in cognitive therapy [CT]), both the process and the outcome of this integrative treatment have begun to receive empirical support (Grosse Holtforth et al., 2011; Hayes, Beevers, Feldman, Laurenceau, & Perlman, 2005; Hayes, Feldman, & Goldfried, 2007). Tying together constructs of psychodynamic theory (attachment), CT (schema), and basic (social psychology) literatures, Constantino and Westra (2012) have offered an expectancy-based model to explain a specific mechanism or process of change, i.e., corrective experiences in therapy. Their approach also involves a sequence of distinct phases that are fostered by a variety of interventions, such as the validation of

interpersonal expectations early in treatment, the provision of challenging (corrective) feedback mid-treatment, and confirmation late in therapy of revised expectations of self and others. Evidence supporting this model includes the finding that in cognitive-behavioral therapy (CBT), early confirmation by the therapist of the client's view of self is related to the alliance (Constantino, Arnow, Blasey, & Agras, 2005).

Interestingly, a number of similarities can be found across these models, such as a focus on a period of acceptance or stabilization, followed by challenge or action, and finally solidification. In addition, all of these theories offer guidelines that could help clinicians adjust their interventions based on the specific needs of clients and/or phases of intervention. Because the interventions are not restricted to one orientation, these models can also help therapists to expand their repertoire of techniques to meet specific treatment goals or objectives.

It should be noted that broad theoretical models of personality, psychopathology, and psychotherapy have been developed by some of the pillars of the integration movement, such as Paul Wachtel (1977) and Barry Wolfe (2005). To a large extent, however, these models have not yet been the direct source of systematic research programs, with the noteworthy exception of the work of Klaus Grawe (see Caspar & Grosse Holtforth, 2010). Grawe proposed a conceptual framework aimed at explaining human functioning from a complex interaction of motivation, cognition, and learning factors. Based on constructs derived from several theoretical traditions (including basic sciences such as psychopathology, cognitive and developmental psychology), this model emphasizes the determining role of needs, approach and avoidance motives, core schemas, and past experiences. Interventions are aimed at realizing four therapeutic factors: clarification, problem activation, resource activation, and mastery. Corrective experiences, both emotional and cognitive, play an important role in the process of change. This model has served as the basis of a large number of studies conducted by Grawe and colleagues, most notably Franz Caspar (2007), related to assessment, case formulation, process, and outcome. Some of the findings, for example, have shown that the fostering of different types of corrective experiences are linked to improvement in different phases of therapy (Grosse Holtforth, Grawe, & Castonguay, 2006). Furthermore, a randomized controlled trial (RCT) has found that an integrative CBT protocol guided by Grawe's consistency theory (*General Psychotherapy*; Grawe, 2004) led to better outcome than traditional CBT for highly symptomatic clients (Grosse Holtforth et al., 2011). Like the integrative

research described above, this study points to the benefit of expanding our clinical focus and adjusting treatment interventions to meet the needs of particular clients.

Technical Eclecticism

One could argue that the earliest publications about integration were mostly by and for academicians, such as French's (1933) attempt to draw parallels between Freud and Pavlov, Rosenzweig's (1936) description of common factors, and Dollard and Miller's (1950) seminal translation of psychodynamic concepts within learning principles. One might also argue that the first books and papers about integration that were of direct clinical relevance were about eclecticism—describing when and how to use specific approaches, or a combination of approaches, for a particular client. Interestingly, this prescriptive and individualized philosophy has been a point of convergence for clinicians and researchers for a long time. In the late sixties, Gordon Paul (1967) made a recommendation for future research that became a mantra for many psychotherapy researchers: identifying what treatment is the most effective for a particular client in a specific situation. A few years later, one of the earliest and most influential surveys of clinical practice revealed that a majority of therapists identified as eclectic (Garfield & Kurtz, 1976). The pragmatic use and combination of theoretically different techniques is still prominent in today's clinical practice (Norcross, 2005). Formal eclectic systems have also been proposed; however, many of them have not generated substantial and sustained empirical research, including some of the most visible ones (e.g., Lazarus, 2005). A noteworthy exception is the work of Larry Beutler and colleagues.

Based on a review of both client characteristics and processes of change underlying different forms of psychotherapy, Beutler (1979) set up a research program to test specific propositions about treatment matching. Beutler's systematic treatment selection approach has led to two prescriptive principles that have been recognized as empirically supported (Norcross, 2011). The first is based on the client's level of reactance, or resistance toward efforts from others to control him or her. Research indicates that clients with high levels of reactance will benefit more from treatment when therapists are less directive, whereas clients with low levels of reactance will show further improvement with therapists at the higher end of the directiveness spectrum. The second prescriptive principle is based on the client's coping style. Specifically, evidence suggests that clients who cope with stressful events by blaming themselves and

ruminating (or internalizing) will be more responsive to treatments that foster self-exploration. By contrast, interventions directly aimed at behavioral change and symptom reduction appear to be more effective for clients who tend to blame others and act out (or externalize) in the face of difficult events.

By focusing on client characteristics that are not tied to a particular disorder, these principles offer therapeutic guidelines that have broad implications in terms of client populations. Furthermore, these principles are not restricted to specific types of treatment and can therefore be relevant to clinicians of different orientations. Perhaps more importantly, these principles do not impose drastic changes on the practice of most clinicians. For example, directive cognitive therapists do not have to abandon their preferred set of cognitive-behavioral interventions when working with highly reactant or internalizing clients. Rather, these empirically based principles simply suggest that cognitive therapists can adapt the way they use their preferred procedures to be more attuned to their clients' individual characteristics (see Castonguay, 2000; Goldfried & Castonguay, 1992).

Common Factors

While eclecticism may have been the first integrative theme to directly guide clinicians, the delineation of common factors—constructs and components of therapy that cut across different theoretical orientations—may have been the earliest and most consistent topic to generate researchers' interest in the integration movement. Such interest was stimulated by many factors, including reports that therapists of diverse allegiances did not restrict themselves to the interventions prescribed by their respective approaches, and many behaved in ways that were more similar than dissimilar (e.g., Fiedler, 1950; Klein, Dittman, Parloff, & Gill, 1969); the bold hypothesis that some relationship variables might not only be necessary but sufficient for therapeutic change to occur (Rogers, 1957); early findings suggesting that the outcome of theoretically divergent approaches might be more equivalent than discrepant (e.g., Frank, 1961); and the suggestion that many of the “unique” interventions of particular orientations are idiosyncratic manifestations of more general strategies or principles of change, such as the increase of positive expectations, establishment of a therapeutic relationship, provision of a new view of self, facilitation of corrective experiences, and the continued testing of change with day-to-day reality (Goldfried, 1980; Goldfried & Padawer, 1982).

For a long time, many researchers (especially those associated with the behavioral tradition) referred to

common factors as “non-specific” variables. As such, they were defined as factors that are auxiliaries to theoretically driven techniques and whose nature and impact are not yet understood (see Castonguay, 1993). Today, common factors have not only been recognized as legitimate therapeutic processes, they are by far the variables that have received the most empirical attention in psychotherapy process research. The work of Bruce Wampold (e.g., Laska, Gurman, & Wampold, 2014; Wampold & Imel, 2015) deserves special mention for both highlighting and building research support for the role of common factors in explaining therapeutic change across orientations.

One common factor that has received considerable attention in the research literature is the working alliance. In a recent review, Horvath, Del Re, Flückiger, and Symonds (2011) identified more than 200 research reports on the working alliance alone (and only for individual therapy with adults). The correlation between the alliance and outcome is robust across different types of therapy, including CBT, and remains so even when moderators such as study design and researcher allegiance are included in the analysis (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012). Clearly, the nature of the alliance can be defined and measured. Moreover, its link with outcome and other crucial aspects of therapy challenges the perception of it as a mere “auxiliary” or noninstrumental factor. However, it must be noted that there is controversy about whether the alliance is an important causal factor in producing change (e.g., DeRubeis, Brotman, & Gibbons, 2005). Concerns have been raised that claims in favor of common factors like the alliance have been overstated, and evidence in favor of specific factors should not be overlooked (e.g., Asnaani & Foa, 2014). Additional research using rigorous methodologies, including both RCTs (see Crits-Christoph, Chambless, & Markell, 2014) and qualitative studies (e.g., Nilsson, Svensson, Sandell, & Clinton, 2007), is needed to clarify the relative importance of common versus unique factors.

As reflected in the work of two recent Task Forces (Castonguay & Beutler, 2006a; Norcross 2002, 2011) several other relationship variables that cut across theoretical orientations have received empirical support, such as empathy and positive regard. It should also be noted, however, that common factors are not restricted to relationship variables (Castonguay, 1993, 2006; Grenavage & Norcross, 1990; Lambert, 2013) and that a number of non-relational factors have also been the focus of research, such as therapist focus of interventions (Goldfried, Raue, & Castonguay, 1998), exposure (see Weinberger & Rasco, 2007), as well as procedures that foster the

client's acquisition of a new perspective of self (Castonguay & Hill, 2007) and that facilitate corrective experiences (Castonguay & Hill, 2012). A substantial number of learning (e.g., feedback) and action (e.g., modeling) factors have also been identified by Lambert (2013) as treatment commonalities. Along with supportive (mostly relationship) variables, these factors are presented as one explanation for the lack of marked differences between various forms of therapy. According to Lambert, most of the variables and constructs he identified "have been operationally defined and then correlated with outcome in research studies of therapy" (p. 199).

It should also be noted that a number of common factors might be best defined as "faux unique" variables: variables that have been traditionally associated with one form of therapy but that may serve a beneficial role in other orientations. For example, although the deepening of emotional experience and the exploration of the past have been found to be less frequent in CBT than in psychodynamic therapy, both processes have been linked to improvement in CBT (Castonguay, 2011). Faux unique factors, however, are not only relevant to the practice of CBT. As found in a recent investigation, the use of CBT interventions was associated with an increase in insight, suggesting that such interventions might facilitate treatment goals emphasized in psychodynamic therapy (McAleavey & Castonguay, 2014). Also supporting the same idea are much older findings suggesting the impact of operant conditioning on the practice of Rogerian therapy (Truax, 1966).

While common factors have clearly sparked the interest of researchers, they can also have meaningful clinical relevance. For example, research on common factors can and should serve as evidence-based guidelines for the training of graduate students, irrespective of the theoretical orientation of the training program (Beck et al., 2014; Boswell & Castonguay, 2007). Furthermore, such research provides clinicians of all experience levels with a list of interventions that they can use in establishing clinical rapport, facilitating client engagement in prescribed interventions, as well as identifying and resolving alliance ruptures or difficulties during treatment. An excellent example of the clinical application of common factors research is Swift and Greenberg's (2015) investigation of premature termination in psychotherapy. The authors delineate evidence-based strategies to reduce dropout that draw on common factors such as strengthening hope and enhancing motivation.

While several common factors, such as the alliance and empathy, should be viewed as basic (albeit not simple to enact and optimize) tools for all forms of psychotherapy, several faux unique variables can

help clinicians to expand their repertoire of interventions. And like the principles related to the client's reactance level and coping style, the integration of faux unique variables does not necessarily require drastic changes on the part of practicing therapists. CBT therapists do not have to cease their attempts to impart coping skills because they have begun to pay more systematic attention to developmental issues, and psychodynamic therapists do not have to deny the importance of insight just because they are looking to other theoretical orientations for tools to foster it.

Assimilative Integration

Although the psychotherapy integration movement has been influential, we also believe that the four primary traditions of psychotherapy—CBT, humanistic/experiential, psychodynamic, and systemic—will survive and continue to grow. One might say that this prediction is simply reflecting an epistemological destiny, as these four paradigms can be viewed as a contemporary manifestation of longstanding ways of accumulating and using knowledge, either by relying on observation and logical thinking, by focusing on phenomenological experience, by interpreting or constructing the reality with which humans are confronted, or by appreciating the complex relational systems that guide human development across the lifespan. We would also argue that one way for these four major approaches to grow is to assimilate, in a cohesive way, concepts and techniques of other orientation. This assimilative trend of integration is the youngest of the four trends of integration, but it is one that could, in our opinion, be of strong appeal to researchers and clinicians alike.¹

For researchers whose theoretically driven research programs are associated with one of the major orientations, an assimilative perspective offers a window for bold and innovative expansions. Rather than engaging in a frequently illusory attempt to reinvent the wheel, assimilative integrationists can devote their creativity and insightfulness to refining a solid tradition of thinking and practice. It is difficult to imagine a better way to accumulate knowledge and thus advance science. Similarly, for clinicians, an assimilative approach allows for an expansion of clinical repertoire without shaking the foundations of their most typical ways of practicing. As emphasized elsewhere (Castonguay, 2011, 2013), it may well be that one fruitful way to improve the effectiveness of psychotherapy is to build upon our conceptual, empirical, and clinical foundations while opening ourselves to potential contributions of researchers and practitioners working in other communities of knowledge seekers.

A number of research programs can be identified under the theme of assimilative integration. Two of them are directly related to Jeremy Safran's expansion of the CT concept of schema (Safran, 1990a, 1990b; Safran & Segal, 1990). By emphasizing the interpersonal, developmental, motivational, emotional, and conflictual aspects of this concept that have traditionally received less attention in CBT than in other orientations (see Blagys & Hillsenroth, 2000; Jones & Pulos, 1993), Safran has provided a conceptual basis to widen the scope of the cognitive interventions. Among the interventions described by Safran to change core schema and maladaptive patterns of functioning are the exploration of affective experience; the exploration of past and current interpersonal relationships with significant others; the exploration of the therapeutic relationship; and the resolution of alliance ruptures, which in turn provide corrective emotional experiences.

The first of these research programs building on Safran's work has been developed by Safran in collaboration with Chris Muran at the Mount Sinai-Beth Israel Psychotherapy Research Program (see Muran, 2002). Through a series of small-scale studies (e.g., Safran & Muran, 1996), Safran and Muran developed a stage process model of the rupture resolution process. They also developed a short-term psychotherapy approach informed by this research, referred to as brief relational therapy (BRT; Safran & Muran, 2000). The emphasis in BRT is on helping patients develop greater awareness, often through the use of metacommunication in which the therapist draws attention to the interpersonal patterns that are emerging in the patient-therapist interaction. In a RCT comparing BRT with CBT and a short-term dynamic treatment in a sample of patients with Cluster C personality disorders (Muran, Safran, Samstag, & Winston, 2005), BRT was as effective as the other two treatments on standard outcome measures and was more successful at retaining patients in therapy. Currently, Muran, Safran and colleagues are conducting a study (incorporating a multiple baseline design) in which therapists are first trained in CBT and then introduced at different time intervals to an alliance-focused training that draws on the same principles as BRT. Preliminary findings show a significant shift in patient-therapist interactions that suggests a positive effect of the training (Muran, Safran, Eubanks-Carter, Gorman, & Winston, 2014; Safran et al., 2014).

The second program building on Safran and Muran's work has emerged from efforts conducted at (or related to) Penn State University. The first segment of this program has focused on assessing whether the impact of CT for depression can be increased by adding Safran and Muran's metacommunication tools

to repair alliance problems. At this point in time, two preliminary studies have been conducted, with the first showing this assimilative approach to CT to be superior to a waiting list condition (Castonguay et al., 2004), and the second finding integrative CT to have higher pre-posttreatment effect sizes, as well as higher levels of alliance and empathy than CT (Constantino et al., 2008). Interestingly, Constantino, Klein, Smith-Hansen, and Greenberg (2009) have also provided preliminary evidence for a similar form of assimilative therapy for depression, one that adds to the CT protocol interventions derived from different orientations to increase client expectations about treatment.

The second segment of the Penn State research program has relied more broadly on Safran and Muran's contributions with the goal of improving the outcome of CBT for generalized anxiety disorder (GAD). Safran's assimilative model was adapted to address dimensions of functioning not systematically focused on in CBT, but yet at the core of GAD psychopathology (Newman, Castonguay, Borkovec, & Molnar, 2004)—interpersonal and emotional issues. While a preliminary study of this integrative treatment found pre-posttreatment effect sizes higher than those of previous CT studies for GAD (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008), a subsequent randomized trial fail to find a difference between these two treatments (Newman et al., 2011). Interestingly, however, analyses based on the second study found a client and treatment interaction, suggesting that clients with dismissive attachment benefited more from the integrative therapy than traditional CBT (Newman, Castonguay, Fisher, & Borkovec, 2008). This finding suggests that the addition of specific humanistic, psychodynamic, and interpersonal interventions allows a CBT assimilative protocol to be more attuned to the needs and deficits of particular GAD clients.

Several well-known CBT-based approaches have also integrated contributions traditionally emphasized in other orientations to treat patients with challenging interpersonal problems. The cognitive-behavioral analysis system of psychotherapy (CBASP; McCullough, 2000) integrates interpersonal and psychodynamic components into CBT for patients with chronic depression in order to help them improve their current relationships and heal from painful past experiences with significant others. CBASP has garnered empirical support (Klein et al., 2004; Schatzberg et al., 2005). In Linehan's (1993) dialectic behavior therapy (DBT), developed for patients with borderline personality disorder, the use of CBT interventions is guided by a dialectical principle of balance between the therapist's challenge and acceptance of the client. Within this approach,

the enactment of Rogerian attitudes and interventions, as well as the use of the relationship (including metacommunication skills to address alliance ruptures) are viewed as therapeutic tools to provide corrective experiences to address the severe and chronic invalidation many clients have experienced. Also focusing on personality disorders, and guided by an integrative philosophy very similar to Safran's, Young has developed a therapy "that significantly expands on traditional cognitive-behavioral treatments and concepts." In the words of Young and his colleagues, schema therapy "blends elements from cognitive-behavioral, attachment, Gestalt, object relations, constructivist, and psychoanalytic schools into a rich, unifying conceptual and treatment model" (Young, Klosko, & Weishaar, 2003, p. 1). Although characterized by different levels of research support (strong for DBT and modest for schema therapy) both treatments have been endorsed as empirically supported by the American Psychological Association (Division 12; <http://www.psychologicaltreatments.org/>). Finally, cognitive analytic therapy (CAT; Ryle, Leighton, & Pollock, 1997) integrates cognitive theory with aspects of object relations theory and has demonstrated good outcomes in RCTs with samples of patients with borderline personality disorder (Chanen et al., 2008, 2009).

Not all assimilative approaches have been based on an expansion of CBT. Stricker and Gold (2003), for example, have argued that clients of psychodynamic therapists could benefit from the systematic use of CBT interventions, including homework. Interestingly, learning principles or mechanisms underlying the prescription of homework in CBT, such as exposure and the acquisition of social skills, have also been retained and emphasized by integrative oriented psychodynamic therapists (e.g., McCullough et al., 2003; Wachtel, 1977). For example, drawing on a treatment approach that yielded clinically significant improvement in a small sample of patients with comorbid depressive disorders and borderline pathology, Hilsenroth and colleagues (Hilsenroth & Slavin, 2008) proposed an assimilative psychodynamic approach that integrates more active CBT interventions such as homework assignments, as well as experiential strategies such as exploring patients' affective experience by focusing on their bodily sensations. A recent study has also provided preliminary evidence that the systematic integration of homework in psychodynamic therapy for depression is not only feasible, but shows potential to improve its efficacy (Nelson & Castonguay, 2012).

As a whole, the diverse lines of research related to an assimilative approach to integration suggest that clinicians attached to a particular orientation (and especially, at this point in time, to CBT), have access

to a number of avenues to expand the basis of their case formulations and increase their clinical repertoire, without having to abandon their theoretical foundations or drastically change their clinical practice. Interestingly, however, findings related to the treatment of GAD also suggest that the addition of new interventions might be beneficial only to some types of clients. Since we know that a substantial number of clients are likely to benefit from empirically supported treatments, the question for researchers and clinicians alike, is to identify who should receive a "pure" form of therapy and who should be prescribed a treatment that integrates interventions from different orientations. Additional challenges raised by this form of integration include: What techniques should be added to a specific treatment in order address the needs of a particular client? How much additional training should clinicians get before attempting to implement interventions foreign to their preferred orientation? And even when competently trained in theoretically varied types of techniques, how and when can clinicians systematically and cohesively use therapeutic procedures out of their original context?

Specific Populations and Modalities

Most of the research programs described in the four major trends of psychotherapy integration focus on individual therapy for adults. However, there is also a small but growing body of research on integrative treatments for other populations and modalities. A few integrative treatments for children and adolescents have been developed and tested (see Krueger & Glass, 2013, for a review). Integrative treatment for older adults is another promising area for psychotherapy integration. Using a Delphi poll of expert clinicians, Cloosterman, Laan, and van Alphen (2013) have identified characteristics of integrative treatment for depression in older adults that could guide future research with this population.

With respect to other modalities, we should note the contributions of the family and systems therapies to psychotherapy integration. Jay Lebow, an important voice for integration in family therapy, has observed that integration is consistent with the systemic perspective, which "invites examination of what lies within and outside the system, opening up a world of multiple inputs and possible actions" (Lebow, 1997, p. 2). Several integrative couples and family treatments have garnered empirical support. For example, both emotionally focused therapy for Couples, which integrates an experiential approach with principles derived from attachment theory (e.g., Johnson, Hunsley, Greenberg, & Schindler, 1999), and integrative behavioral couples therapy, an integration of behavior therapy and acceptance-based principles (e.g., Christensen, Atkins,

Baucom, & Yi, 2010) have demonstrated strong findings. Multisystemic therapy (MST; Henggeler, Schoenwald, Boruin, Rowland, & Cunningham, 2009), which integrates family and systems approaches with CBT, has been empirically validated for the treatment of severe behavior problems in adolescents (see Henggeler, 2011), and has also been adapted for health problems in adolescents with chronic medical conditions (e.g., Naar-King et al., 2014).

An Agenda for the Next 25 Years of Research on Integration: Setting up a Two-way Street toward the Future of Psychotherapy

A number of clinically relevant findings have emerged from and contributed to the psychotherapy integration movement. However, unless more research is conducted by integrationist-minded researchers and clinicians, the integrative perspective will lose the opportunity to play a prominent role in organized mental health policy and even in academic training. Considering the complexity of psychopathology and psychotherapy, it is probable that few clinicians will ever restrict their practice to one form of therapy. Therefore, the risk of the integration movement is not that it will disappear, but that it will not be systematically and prominently featured in mainstream practice and training guidelines. As a case in point, while common factors have been recognized as important elements of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006) and training (Beck et al., 2014), few integrationist treatments have received sufficient research to be recognized as empirically supported. This is important as we know that empirically supported treatments (ESTs) have received strong emphasis in policy-making in the USA and abroad (see Holmqvist, Philips, & Barkham, 2015; Holt et al., 2014). As we mentioned above, the contrast between what is emphasized by national policies and many faculty members, and how integration is influencing day-to-day practice, is both reflecting and contributing to the clinician-research divide.

Sadly, the relative paucity of research cannot be attributed to a lack of encouragement or guidance. Anticipating that integration would be a major focus of future empirical research and funding, National Institute of Mental Health sponsored a Task Force that brought together a large number of influential researchers to delineate recommendations for future research (Wolfe & Goldfried, 1988). More than 25 years later, unfortunately, one is forced to admit that these recommendations have not had a substantial influence on research agendas (and on the priorities of grant reviewers). The wind may be shifting,

however, not only because the pressure to carve out a place in evidence-based practice may bring integrationists against a wall, but because the main professional organization that has been at the helm of the integrative movement (the Society for the Exploration of Psychotherapy Integration, SEPI) has recently adopted a new goal: building stronger links between science and practice (Goldfried, 2013).

In the second section of this paper, we would like to suggest research directions that might help the integration movement to gain more scientific credibility and a stronger voice in training and practice guidelines. We would also like to suggest how an integrationist perspective might be relevant to questions that are central to current research in psychotherapy. To paraphrase a famous quote, it is not only important to ask ourselves what research can do to help integration survive and grow, but also what integration can do to help psychotherapy research become more valid and relevant to clinical practice.

What Type of Research Can Best Help Psychotherapy Integration?

In our opinion, the answer to this question is quite simple: What is most urgently needed is research on each of the four current themes of the integration movement! Although we would more than welcome the demarcation of new avenues of psychotherapy integration for future research, we also think that current integrative practice and models provide a rich source of ideas and challenges. We will suggest here just a few examples of the wealth of research that can and should be conducted to solidify and expand the scientific foundations of integration. (Other recommendations have been offered elsewhere, and many of them are still pertinent despite being a decade or more old, e.g., Arnkoff, Victor, & Glass, 1993; Castonguay, 1993; Castonguay, Newman, Borkovec, Grosse Holtforth, & Maramba, 2005; Eubanks-Carter, Burckell, & Goldfried, 2005; Glass, Victor, & Arnkoff, 1993; Schottenbauer, Glass, & Arnkoff, 2005; Wolfe & Goldfried, 1988).

Theoretical Integration. With regard to theoretical integration, we would first recommend empirical investigations of treatment protocols that can be derived from some of the broad models of psychopathology and psychotherapy that have served for many years as “figure de proulx” of the integration movement. For example, we see no reason for leaders of this movement (and their students or colleagues) not to test whether cyclical psychodynamic (Wachtel, 1977) and self-experiencing (Wolfe, 2005), approaches can meet the criteria that are specified to

sanction new EST. Interpersonal reconstructive therapy (Benjamin, 2003), a therapy for nonresponders that is based on principles derived from a rich body of research using the structural analysis of social behavior (Benjamin, 1974) is another promising avenue for empirical validation through clinical trials. As alluded to elsewhere (Castonguay, 2011), perhaps the timing is right for both SEPI and the society for psychotherapy research (SPR) to have their members build on their shared and complementary expertise in order to expand upon the repertoire of treatment available to evidence-oriented clinicians. We also believe that the empirical validation of integrative models built on basic research (social and developmental psychology, dynamic sciences; e.g., Constantino & Westra, 2012; Hayes et al., 2005) should, for epistemological reasons alone, offer approaches that many EST proponents—especially cognitive-behavior therapists—may not be able to refuse. (If you practice CBT, and truly believe in the method of knowledge acquisition that your orientation is based on, you *have* to consider treatment guidelines that are built on science, irrespective of whether or not the scientific data are consistent with your current theoretical model.)

Technical Eclecticism. We believe that future research on moderators of change, within and between treatments, is likely to build a stronger case for a prescriptive or eclectic perspective in mental health practice and training. For example, a recent study showed the moderating impact of early attachment figures on the relationship between alliance and outcome in a CBT-based residential treatment for juvenile drug abusers (Zack et al., in press). By providing evidence that the establishment of a strong alliance is especially important for clients with insecure attachment, this study suggests the relevance of two psychodynamically based empirical traditions (attachment and alliance) on the implementation of CBT. The study does not imply that CBT should be drastically changed. Rather, it suggests that the effectiveness of the CBT protocol might be improved by implementing techniques in ways that are more attuned to the individualized needs of clients—needs that may not have been traditionally emphasized in this orientation. Researchers could also increase the clinical relevance and scientific foundations of an eclectic perspective by expanding the list of empirically based matching principles (e.g., coping style, reactance level). Using Beutler's (Beutler, Harwood, Kimpara, Verdrame, & Blau, 2011; Beutler, Harwood, Michelson, Song, & Holman, 2011) work as a model, it might be particularly fruitful to examine dimensions of functioning that have received support

from basic and/or applied research. A potential candidate would be the assessment of defense mechanisms, which have been studied across a number of scientific domains including psychopathology, psychotherapy, social psychology, and neurology (e.g., Anderson et al., 2004; Baumeister, Dale, & Sommer, 1998; Drapeau et al., 2011; Hentschel, Smith, Draguns, & Ehlers, 2004; Perry et al., 1998). Interestingly, they have also received respect from one of the most unexpected figures in psychology: B.F. Skinner (Overseid, 2007).

Common Factors. As we mentioned above, of all the themes of integration, common factors have received the most empirical attention and support. As such, we think that the future should not only lead to an increase in terms of frequency of studies but also in terms of sophistication. We need to go further than showing that common factors are statistically related to outcome, and investigate whether they are (i) predictive of change when important variables are controlled for (such as early treatment gains) and (ii) meaningful enough to be defined as mediators or causal mechanisms of change. As argued by Borkovec and Castonguay (1998), the ultimate pursuit of science is to establish cause and effect relationships, and there is no doubt that common factors can be investigated via research methodologies (additive, dismantling, or parametric research designs) that are optimal to test causality (e.g., Constantino et al., 2008; Newman et al., 2011).

Also reflecting the timing for more sophisticated research, we think that investigations should be conducted to clarify, empirically and conceptually, the relationships between different common factors (such as empathy and alliance), between common factors and unique variables (such as the interaction between particular techniques and client preferences), and the complex interaction between technique, relationship and client characteristics (see Castonguay & Beutler, 2006b). Interestingly, Lundh (2014) has recently offered a conceptual model that could guide future research on common factors, while recognizing the complexity of therapeutic change. Rooted in the original work of Goldfried (1980), this model assumes that common methodological principles exist, that these principles can operate via diverse techniques, and that these principles and techniques can be combined with various levels of skills. Based on these assumptions, Lundh has suggested that "an important task for psychotherapy research would be to identify as many such basic principles as possible, and explore their various specific manifestations, and how they can be combined as efficiently as possible in various contexts" (p. 136). The increased level of

sophistication needed for research on already established common factors should not, of course, preclude the investigation of variables that are likely to cut across different orientations but have never been tested as such. In particular, we believe that the delineation and study of “faux unique” variables would be particularly fruitful, process- and outcome-wise. It would help us expand the list of variables that should be part of the practice and training of all therapists by relying on the expertise developed by fellows working in different communities of knowledge seekers (see Castonguay, 2011, 2013).

Assimilative Integration. As also recommended above, collaborating to build and investigate more assimilative treatments would be another strategy to further improve the field. Rather than focusing on pitting one treatment against another, we should encourage and fund efforts to bring together scholars of diverse allegiances with the aim of refining already established treatments. We would argue that such research might also set the optimal conditions for the actualization of the integration movement itself. Investigators could indeed contribute to and benefit from different facets of integration by conducting studies that would (i) test, via an additive design, the effectiveness of an assimilative protocol with a traditional treatment that it is aimed to expand; (ii) investigate common and unique mediators of change across the two treatments compared; and (iii) examine moderators that could inform who is more likely to respond to a traditional treatment and who might benefit from an expanded version of this approach. Needless to say, the contribution of such research programs to the integration movement would be further increased if investigators were to rely on well-known integrative theories to build their assimilative approaches, and if they were to investigate them across a number of clinical populations (e.g., children, adolescents, and older adults) and treatment modalities (e.g., groups, couples, and families).

How Can Integration Help Psychotherapy Research?

In this section, we consider how integration might contribute to the future of research by providing a unique perspective on issues that are at the core of current empirical questions and methods. The open-minded, exploratory spirit of the integration movement has always embraced not only the integration of various theoretical orientations, but also various methods: process and outcome research, quantitative and qualitative research, and theory-building case studies as well as RCTs. The mind-sets and methodologies of integrative researchers and theorists

make them ideally suited to be at the forefront of several areas of research that are critical for the advancement of psychotherapy.

Harmful Effects. Perhaps the most important conceptual, clinical, and empirical question currently facing psychotherapy is identifying the factors that can lead to, prevent, or repair negative effects. We have clear evidence that psychotherapy works (Lambert, 2013). Since the mid-sixties, the field has also been put on notice that a nonnegligible number of our clients will not only fail to respond to our treatment, but will actually deteriorate during therapy (Bergin, 1966). A resurgence of studies and reviews (e.g., Lilienfeld, 2007) are now warning that every therapist should have a sign in his/her office (obviously hidden from his/her clients) stating: “First, do no harm”! Research indicates that between 5 and 10% of clients will be worse off at the end of treatment than they were when they began, and that clinicians not only tend to underestimate the rate of deterioration in their caseload, but are also not good at predicting which clients will deteriorate (Lambert, 2010). As deterioration seems to take place in different forms of therapy (Lambert, 2013), the integration movement could provide a fruitful forum to delineate and investigate potential causes of and remedies for harmful effects. Put differently, by fostering dialogs and studies about what may be going wrong in several treatments and what can be learned from each orientation about solving therapeutic impasses, the integration movement could find itself at the center of an important crossing point for the future understanding of psychotherapy.

As a field, we are fortunate that research has been able to identify treatments that are potentially harmful (Lilienfeld, 2007). Complementing this knowledge about orientation-specific variables, research also points to a number of therapist (e.g., recollections of negative perceptions of parents during childhood), client (e.g., perfectionism), technical (e.g., rigid adherence to prescribed interventions) and relational (e.g., hostile messages of control and separation) variables that have been associated with negative effects (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). However, much more research is needed, and researchers interested in clarifying what harms clients are likely to find guidance in various conceptual and clinical territories covered by the integration movement. For example, integrationist scholars and psychotherapy researchers could join to identify and test factors that are related to unskillful and inappropriate use of various interventions, relational and technical processes that are toxic within and across orientations, as well as inadequate matching of client and treatment.

Therapist Effects. Therapist variables related to deterioration represent one aspect of a larger, understudied phenomenon in psychotherapy: the therapist effect. Research indicates that some therapists are less effective than others, but also that some clinicians are significantly more effective than others (see Baldwin & Imel, 2013). There is also evidence suggesting that therapist effects are greater than the effect of the type of treatment (Wampold & Imel, 2015). As noted by Lambert (2013), “[a] logical extension of research on therapist outcome is to encourage research focused on the ‘empirically supported therapist’ rather than on empirically supported treatments” (p. 198). Yet, Lambert also encouraged the field to adopt a nuanced approach toward the complexity of therapeutic change by stating that:

[a]lthough the individual therapist can play a surprisingly large role in treatment outcome even when treatment is being offered within the stipulations of manual-guided therapy, recognition of the important place held by a therapy should in no way be construed as suggesting that technical proficiency has no unique contribution to make. (p. 206)

A similar view has been voiced by one of the founders of SEPI, Paul Wachtel, who argued that:

it is important not to pit the therapist and therapy against each other as separate “portions of the variance” in a way that implies that the more variance is due to the therapist, the less to the therapy. In an important sense, the therapy *is* the therapist and the therapist *is* the therapy. That is, what matters is not the “brand” of therapy but the therapeutic approach *as administered or practiced by a particular therapist*. Different therapists will be a psychodynamic therapist or a cognitive behavioral therapist (or any other) in a different way. (Paul Wachtel, personal communication, March 5, 2013)

One might argue that this converging view emerging from two of the most influential leaders in psychotherapy research and psychotherapy integration is quite timely. As noted elsewhere, the therapist effect might represent the most urgent and important paradox in the field (Castonguay, 2011). We know that some therapists are more (or less) effective than others, but we have a lot to learn about how this happens! As provocatively raised by Laska et al. (2014):

Why is it that therapist differences have been acknowledged for over 40 years, yet as a field we are not much further in understanding the role of therapist variables than when Kiesler first acknowledged the “uniformity assumption” almost half a century ago? If we continue to disregard the importance of the therapist, a full one half of the clinical dyad, we

drastically limit our ability to reduce the burden of mental illness (p. 476)

However, studying therapist effects is not an easy task. For example, the impact of therapist skill on outcome may vary for patients with different responses patterns, as highlighted by DeRubeis and colleagues in a recent study using data simulations (DeRubeis, Gelfand, German, Fournier, & Forand, 2014). Considering both the importance and complexity of therapist effects, it might be fruitful for psychotherapy researchers of different orientations and/or integrationist scholars to generate and examine ideas about therapist characteristics, clinical competencies that facilitate change events and correct hindering ones, and actions that inhibit change or exacerbate impasses, as well as client and treatment characteristics that moderate both the positive and negative impact of the therapist.

Practice-oriented Research. Both harmful effects and therapist effects are central pieces of a new paradigm of research, which has been referred to as practice-oriented research (POR, Castonguay, Barkham, Lutz, & McLeavey, 2013). In contrast with traditional “evidence-based research” (EBR), POR is characterized by the use of measures that are part of clinical routine, the active participation of clinicians in diverse aspects of research (including the selection of the topic to investigate, the design of the study protocol, and the dissemination of the findings), and the use of data collected to inform clinical practice as it is being conducted. The ultimate short-term goal of POR is to foster studies that are directly addressing the day-to-day concerns of clinicians (rather than the theoretical interests of academic researchers), that are feasible (and thus do not require drastic change of clinical practice), and that are immediately actionable. More than being meaningful, the aim is to create conditions for “clinically syntonetic” studies, namely research that is a natural part in clinical intervention. In essence, these are studies involving tasks for which it is impossible for clinicians to know whether they are collecting empirical data or conducting a clinical task, as they are doing both at the same time (see Castonguay, Nelson, et al., 2010). In the long term, one of the goals of POR is to contribute to a more robust knowledge base about psychotherapy by complementing EBR (Barkham & Margison, 2007; Barkham, Stiles, Lambert, & Mellor-Clark, 2010). Rather than being antagonists, POR and EBR can be viewed as complementary methods with unique strengths and limitations (in terms of internal and external validity, for example) that could broaden our

knowledge, as well as increase confidence in our understanding of psychotherapy.

Also in the long term, POR is aimed at correcting an unfortunate state of blindness or inattentiveness in our field. As noted by Kazdin (2008):

[W]e have taken as a given that research contributes to the knowledge base and that clinical practice is the application of that base. This is an exceedingly unfortunate way of conceptualizing the contributions of each domain because it fosters and maintains the research–practice gap. Clinical work can contribute directly to the scientific knowledge base.

He further lamented that “[W] e are letting the knowledge from practice drip through the holes of a colander” (p. 155). Being based, at least in part, on their concerns, expertise, knowledge, and day-to-day experience, POR not only allows for clinicians to contribute to the accumulation of knowledge but also to have a voice in setting an agenda for current and future research (Zarin, Pincus, West, & McIntyre, 1997). Because clinical practice is populated by therapists of different orientations (and blends of orientations), such a research agenda will by definition reflect and contribute to the advancement of psychotherapy integration. A case in point is a Practice Research Network study that was designed and implemented in private practice because clinicians wanted to know what their clients felt had been helpful or hindering during each session of therapy. For both clients and therapists (who represented a diversity of approaches including cognitive-behavioral, humanistic, and psychodynamic), the most frequent type of helpful events reported were those that facilitated an increase in self-awareness. Interestingly, for both therapists and clients, the therapeutic relationship was the most frequent focus of both the helpful and hindering events (Castonguay, Boswell, et al., 2010). This is an example of how research, practice, and psychotherapy integration can converge and be mutually beneficial.

While a variety of POR studies have been conducted (see Castonguay et al., 2013, for a review), compared to EBR this type of investigation is only at a burgeoning stage. Much more needs to be done to slow down the colander effect. With the hope of generating more interest in POR, as well as learning from the experience of a several researchers and clinicians who have been involved in its development, a special issue of *Psychotherapy Research* has been devoted to collaborative endeavors (Castonguay & Muran, 2015). Across a variety of naturalistic settings (e.g., private practice, residential treatment, community center, training clinics), authors from different parts of the world have described some of their studies, lessons learned (in terms of obstacles faced

and strategies to solve them), and recommendations about what kinds of POR are particularly needed and ways to conduct them.

Training. By definition all licensed psychotherapists, irrespective of their professional backgrounds, need to receive formal and approved training. Ironically, however, there is a paucity of research on this crucial issue (see Hill & Knox, 2013). How are we to maximize the effectiveness of therapy when we do not know what are effective and ineffective ways of training current and future therapists? In fact, the sharp contrast between the relative lack of research and the need for empirical guidance regarding training is one of the factors that led SPR to create a special interest group on the training and development of therapists (Orlinsky, Strauss, Hill, Carlsson, & Castonguay, 2012). There are at least three reasons to suggest that the work of integrative scholars should guide or be included in the research priorities on psychotherapy training. First, an integrative perspective has clearly infiltrated many training programs, at least in North America. As noted by Norcross and Halgin (2005), “[A]lthough the particular objectives and sequences will invariably differ across training programs, recent research demonstrates that the vast majority of training programs profess a pro-integration position” (p. 454). Second, as we mentioned above, aspects of integration (such as common factors and client variables to be considered for prescriptive treatment matching) have been included in recommendations to guide training programs (Beck et al., 2014). Finally, and most obviously, irrespective of how pluralistic training programs actually are, many individuals who have emerged from them identify themselves as integrative. To be relevant, research on training should reflect how a large number of therapists are trained, as well as how they will most likely define themselves as experienced professionals. A number of questions have already been voiced to guide such a pertinent research agenda, including: Should graduate students be trained from the beginning as integrative therapists, or should they first master competencies in some orientations before they learn how to integrate them? Can or should integration be achieved within the framework of one theoretical orientation? (Castonguay, 2005; Eubanks-Carter et al., 2005). In addition, several competencies of integrative therapists, as well as core elements, seminars and systematic models of integrative training have been proposed and could be the focus of future investigation (Boswell & Castonguay, 2007; Boswell, Nelson, Nordberg, McAleavey, & Castonguay, 2010; Castonguay, 2000, 2006; Lecomte, Castonguay, Cyr, & Sabourin, 1993).

We also anticipate that postgraduate integrative training programs or workshops might be in strong demand in the not-too-distant future and, therefore, would benefit from gathering empirical support. Our observations at professional meetings and discussions with other trainers (in graduate schools and clinical internship sites) have made us concerned that a substantial portion of the current generation of graduate students are being trained in technically as opposed to principle-driven applications of ESTs. As the lack of a relationship between technical adherence and outcome suggests (Webb, DeRubeis, & Barber, 2010), this “by the manual” approach might not be an optimal way to prepare trainees to face the complexity of clinical reality, and may lead many of them to seek additional training. Postgraduate programs offering training on principles of change and other common factors, matching treatment processes and client characteristics, and/or cohesive assimilation of theoretically diverse interventions within current practice may end up being attractive options to both increase and improve the clinical repertoire of many evidence-based graduated therapists.

Furthermore, we predict that a recent shift in clinical training will take a stronger hold in the near future: Outcome monitoring (Lambert, 2010; Lutz, Böhnke, & Köck, 2011; Lutz et al., 2013). Whereas traditional clinical training programs have focused predominantly on techniques and/or relational aspects of therapy, this new development comes with a stronger attention giving to individual client change (as measured by psychometric information) and with the provision of “on-time” feedback during the course of the treatment process—especially when patients do not make progress (Lambert, 2010). This new development requires the addition of new courses in clinical programs, in order for students to keep abreast of the already substantial empirical literature of “patient-focused” research (see Castonguay et al., 2013, for a recent review), as well as to learn how to integrate this information into their practice. Needless to say, this opens up new possibilities and challenges for training. On the one hand, it offers an exciting opportunity to reduce the scientist–practitioner gap by allowing a seamless integration of science and practice at the earliest stage of therapists’ careers (see Castonguay, 2011). It may also dilute the atmosphere of competition between treatment approaches by encouraging students to focus less on abstract conceptual models and more on the actual outcome of real clients. On the other hand, the implementation of outcome monitoring and feedback systems calls for research on the impact that it may have on students and their clients, especially in terms of what might work best

for clients who have difficulty benefiting from therapy (Castonguay et al., 2013; Lutz et al., 2013).

Conclusion

In this paper, we have described some of the psychotherapy integration research that has been conducted over the last 25 years. Although we have pointed out how such empirical investigations can be the source of helpful clinical guidelines, we have also argued that the contrast between the influence that integration has on clinicians as opposed to researchers is yet another example of the gap between science and practice. We have also offered recommendations about what kinds of research could strengthen the impact of integration, and how integration can provide helpful contributions to the investigation of crucial research questions. We strongly believe that the future of both psychotherapy integration and psychotherapy research are, using a statistical term, nested: the progress of one will depend on and benefit from the advancement of the other. In addition to being mutually beneficial, we have also attempted to demonstrate that a collaboration between integrationist scholars and psychotherapy researchers can foster a greater rapprochement between science and practice.

In closing, we would like to go one step further and suggest that under the correct circumstances, such collaboration could help the field move beyond its efforts of building bridges between research and practice. As argued elsewhere (Castonguay et al., 2013), rather than conceiving of the scientist–practitioner philosophy as a link between two groups of individuals standing on opposite banks of a river, it might be more fruitful to create new, unified landscapes of knowledge where clinicians and therapists are working together on clinically actionable and scientifically rigorous studies. If these studies become part of the research culture, it will then be the responsibility of researchers, clinicians, academicians, administrators, and policy-makers to implement their findings within actual training and provision of care. Closing the loop between the generation and implementation of knowledge might be a necessary condition for the survival and growth of a unified—and integrated—landscape of research and practice.

Note

¹ Although the assimilative integration appears to have been formally recognized in the early 1990s by Messer (1992), it should be mentioned that scholars have pointed out complementarities between theoretical orientations for many years, and used them as anchor points for developing integrative treatments (e.g., Birk & Brinkley-Birk, 1974). Incidentally, in the

early 1980s, the first author of this paper invited influential scholars and clinicians of major approaches to describe how their own approach could contribute to the effectiveness of other orientations and, reciprocally, how their preferred orientations might benefit from concepts and interventions developed in other schools of therapy (these presentations, as well as others that took place in Montreal, were published in French, Lecomte and Castonguay (1987)). Witnessing some of the recent debates about what should be viewed as ESTs and whether ESTs should be the only forms of therapy taught and practiced, it might be a- propos to try to recreate such open and conciliatory dialog 30 years later.

References

- Anderson, M. C., Ochsnew, K. N., Kuhl, B., Cooper, J., Robertson, E., Gabrieli, S. W., ... Gabrieli, J. D. (2004). Neural systems underlying the suppression of unwanted memories. *Science*, *303*, 232–235. doi:10.1126/science.1089504
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285. doi:10.1037/0003-006X.61.4.271
- Arnkoff, D. B., Victor, B. J., & Glass, C. R. (1993). Empirical research on factors in psychotherapeutic change. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration* (pp. 27–42). New York, NY: Plenum Press.
- Asnaani, A., & Foa, E. B. (2014). Expanding the lens of evidence-based practice in psychotherapy to include a common factors perspective: Comment on Laska, Gurman, and Wampold. *Psychotherapy*, *51*, 487–490. doi:10.1037/a0036891
- Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258–297). Hoboken, NJ: John Wiley & Sons.
- Barkham, M., & Margison, F. (2007). Practice-based evidence as a complement to evidence-based practice: From dichotomy to chiasmus. In C. Freeman & M. Power (Eds.), *Handbook of evidence-based psychotherapies: A guide for research and practice* (pp. 443–476). Chichester: John Wiley & Sons.
- Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge base for the psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (pp. 21–61). Chichester: Wiley-Blackwell.
- Baumeister, R. F., Dale, K., & Sommer, K. L. (1998). Freudian defense mechanisms and empirical findings in modern social psychology: Reaction formation, projection, displacement, undoing, isolation, sublimation, and denial. *Journal of Personality*, *66*, 1081–1124. doi:10.1111/1467-6494.00043
- Beck, J. G., Castonguay, L. G., Chronis-Tuscano, A., Klonsky, E. D., McGinn, L. K., & Youngstrom, E. A. (2014). Principles for training in evidence-based psychology: Recommendations for the graduate curricula in clinical psychology. *Clinical Psychology: Science and Practice*, *21*, 410–424. doi:10.1111/cpsp.12079
- Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review*, *81*, 392–425. doi:10.1037/h0037024
- Benjamin, L. S. (2003). *Interpersonal reconstructive therapy: Promoting change in nonresponders*. New York, NY: Guilford Press.
- Bergin, A. E. (1966). Some implications of psychotherapy research for therapeutic practice. *Journal of Abnormal Psychology*, *71*, 235–246. doi:10.1037/h0023577
- Beutler, L. E. (1979). Toward specific psychological therapies for specific conditions. *Journal of Consulting and Clinical Psychology*, *47*, 882–897. doi:10.1037/0022-006X.47.5.882
- Beutler, L. E., Harwood, T. M., Kimpara, S., Verdirame, D., & Blau, K. (2011). Coping style. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 336–353). New York, NY: Oxford University Press.
- Beutler, L. E., Harwood, T. M., Michelson, A., Song, X., & Holman, J. (2011). Resistance/reactance level. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 261–278). New York, NY: Oxford University Press.
- Birk, L., & Brinkley-Birk, A. W. (1974). Psychoanalysis and behavior therapy. *The American Journal of Psychiatry*, *131*, 499–510.
- Blagys, M. D., & Hilsenroth, M. J. (2000). Distinctive feature of short-term psychodynamic-interpersonal psychotherapy: A review of the comparative psychotherapy process literature. *Clinical Psychology: Science and Practice*, *7*, 167–188. doi:10.1093/clipsy/7.2.167
- Borkovec, T. D., & Castonguay, L. G. (1998). What is the scientific meaning of empirically supported therapy? *Journal of Consulting and Clinical Psychology*, *66*, 136–142. doi:10.1037/0022-006X.66.1.136
- Boswell, J. F., & Castonguay, L. G. (2007). Psychotherapy training: Suggestions for core ingredients and future research. *Psychotherapy*, *44*, 378–383. doi:10.1037/0033-3204.44.4.378
- Boswell, J. F., Nelson, D. L., Nordberg, S. S., McAleavey, A. A., & Castonguay, L. G. (2010). Competency in integrative psychotherapy: Perspectives on training and supervision. *Psychotherapy*, *47*, 3–11. doi:10.1037/a0018848
- Caspar, F. (2007). Plan analysis. In T. Eells (Ed.), *Handbook of psychotherapeutic case formulations* (2nd ed., pp. 251–289). New York, NY: Guilford Press.
- Caspar, F. (2008). The current status of psychotherapy integration in Germany and Switzerland. *Journal of Psychotherapy Integration*, *18*, 7–78. doi:10.1037/1053-0479.18.1.74
- Caspar, F., & Grosse Holtforth, M. (2010). Klaus Grawe: On a constant quest for a truly integrative and research-based psychotherapy. In L. G. Castonguay, J. C. Muran, L. Angus, J. A. Hayes, N. Ladany, & T. Anderson (Eds.), *Bringing psychotherapy research to life: Understanding change through the work of leading clinical researchers. Legacies from the society for psychotherapy research* (pp. 113–123). Washington, DC: APA Books.
- Castonguay, L. G. (1993). “Common factors” and “nonspecific variables”: Clarification of the two concepts and recommendations for research. *Journal of Psychotherapy Integration*, *3*, 267–286.
- Castonguay, L. G. (2000). A common factors approach to psychotherapy training. *Journal of Psychotherapy Integration*, *10*, 263–282. doi:10.1023/A.1009496929012
- Castonguay, L. G. (2005). Training issues in psychotherapy integration: A commentary. *Journal of Psychotherapy Integration*, *15*, 384–391. doi:10.1037/1053-0479.15.4.384
- Castonguay, L. G. (2006). Personal pathways in psychotherapy integration. *Journal of Psychotherapy Integration*, *16*, 36–58. doi:10.1037/1053-0479.16.1.36
- Castonguay, L. G. (2011). Psychotherapy, psychopathology, research and practice: Pathways of connections and integration. *Psychotherapy Research*, *21*, 125–140. doi:10.1080/10503307.2011.563250
- Castonguay, L. G. (2013). Psychotherapy outcome: An issue worth re-visiting 50 years later. *Psychotherapy*, *50*, 52–67. doi:10.1037/a0030898
- Castonguay, L. G., Barkham, M., Lutz, W., & McAleavey, A. A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 85–133). Hoboken, NJ: John Wiley & Sons.
- Castonguay, L. G., & Beutler, L. E. (Eds.). (2006a). *Principles of therapeutic change that work*. New York, NY: Oxford University Press.
- Castonguay, L. G., & Beutler, L. E. (2006b). Common and unique principles of therapeutic change: What do we know and

- what do we need to know? In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 253–369). New York, NY: Oxford University Press.
- Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training implications of harmful effects of psychological treatments. *American Psychologist*, *65*, 34–49. doi:10.1037/a0017330
- Castonguay, L. G., Boswell, J. F., Zack, S., Baker, S., Boutselis, M., Chiswick, N., ... Grosse Holtforth, M. (2010). Helpful and hindering events in psychotherapy: A practice research network study. *Psychotherapy: Theory, Research, Practice, and Training*, *47*, 327–344.
- Castonguay, L. G., & Goldfried, M. R. (1994). Psychotherapy integration: An idea whose time has come. *Applied & Preventative Psychology*, *3*, 159–172. doi:10.1016/S0962-1849(05)80068-X
- Castonguay, L. G., & Hill, C. E. (Eds.). (2007). *Insight in psychotherapy*. Washington, DC: American Psychological Association.
- Castonguay, L. G., & Hill, C. E. (Eds.). (2012). *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches*. Washington, DC: American Psychological Association.
- Castonguay, L. G., & Muran, J. C. (2015). Fostering collaboration between researchers and clinicians through building practice-oriented research: An introduction. *Psychotherapy Research*, *25*, 1–5.
- Castonguay, L. G., Nelson, D. L., Boutselis, M. A., Chiswick, N. R., Damer, D. D., Hemmelstein, N. A., ... Borkovec, T. D. (2010). Psychotherapists, researchers, or both? A qualitative analysis of psychotherapists' experiences in a practice research network. *Psychotherapy*, *47*, 345–354. doi:10.1037/a0021165
- Castonguay, L. G., Newman, M. G., Borkovec, T. D., Grosse Holtforth, M., & Maramba, G. G. (2005). Cognitive-behavioral assimilative integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 241–260). New York, NY: Oxford University Press.
- Castonguay, L. G., Schut, A. J., Aikens, D. E., Constantino, M. J., Laurenceau, J.-P., Bologh, L., & Burns, D. D. (2004). Integrative cognitive therapy for depression: A preliminary investigation. *Journal of Psychotherapy Integration*, *14*, 4–20. doi:10.1037/1053-0479.14.1.4
- Chanen, A. M., Jackson, H. J., McCutcheon, L. K., Jovev, M., Dudgeon, P., Yuen, H. P., ... McGorry, P. D. (2008). Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: Randomised controlled trial. *The British Journal of Psychiatry*, *193*, 477–484. doi:10.1192/bjp.bp.107.048934
- Chanen, A. M., Jackson, H. J., McCutcheon, L. K., Jovev, M., Dudgeon, P., Yuen, H. P., ... McGorry, P. D. (2009). Early intervention for adolescents with borderline personality disorder: Quasi-experimental comparison with treatment as usual. *Australian and New Zealand Journal of Psychiatry*, *43*, 397–408. doi:10.1080/00048670902817711
- Christensen, A., Atkins, D. C., Baucom, B., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology*, *78*, 225–235. doi:10.1037/a0018132
- Cloosterman, N. H. M., Laan, A. J., & van Alphen, B. P. J. (2013). Characteristics of psychotherapeutic integration for depression in older adults: A Delphi study. *Clinical Gerontologist: The Journal of Aging and Mental Health*, *36*, 395–410. doi:10.1080/07317115.2013.816815
- Constantino, M. J., Arnow, B. A., Blasey, C., & Agras, W. S. (2005). The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. *Journal of Consulting and Clinical Psychology*, *73*, 203–211. doi:10.1037/0022-006X.73.2.203
- Constantino, M. J., Klein, R., Smith-Hansen, L., & Greenberg, R. P. (2009, October). *Augmenting cognitive therapy for depression with an Expectancy Enhancement module: Preliminary efficacy*. Paper presented at the meeting of the Canadian Chapter of the Society for Psychotherapy Research, Montreal, Canada.
- Constantino, M. J., Marnell, M. E., Haile, A. J., Kanther-Sista, S. N., Wolman, K., Zappert, L., & Arnow, B. A. (2008). Integrative cognitive therapy for depression: A randomized pilot comparison. *Psychotherapy*, *45*, 122–134. doi:10.1037/0033-3204.45.2.122
- Constantino, M. J., & Westra, H. A. (2012). An expectancy-based approach to facilitating corrective experiences in psychotherapy. In L. G. Castonguay & C. E. Hill (Eds.), *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches* (pp. 121–139). Washington, DC: American Psychological Association.
- Crits-Christoph, P., Chambless, D. L., & Markell, H. M. (2014). Moving evidence-based practice forward successfully: Commentary on Laska, Gurman, and Wampold. *Psychotherapy*, *51*, 491–495. doi:10.1037/a0036508
- DeRubeis, R. J., Brotman, M. A., & Gibbons, M. B. (2005). A conceptual and methodological analysis of the nonspecific argument. *Clinical Psychology: Science and Practice*, *12*, 174–183. doi:10.1093/clipsy.bpi022
- DeRubeis, R. J., Gelfand, L. A., Gorman, R. E., Fournier, J. C., & Forand, N. R. (2014). Understanding processes of change: How some patients reveal more than others—and some groups of therapists less—about what matters in psychotherapy. *Psychotherapy Research*, *24*, 419–428. doi:10.1080/10503307.2013.838654
- Dollard, J., & Miller, N. E. (1950). *Personality and psychotherapy: An analysis in terms of learning, thinking, and culture*. New York, NY: McGraw-Hill.
- Drapeau, M., de Roten, Y., Blake, E., Beretta, V., Strack, M., Körner, A., & Despland, J.-N. (2011). Defensive flexibility and its relation to symptom severity, depression, and anxiety. *Journal of Nervous and Mental Disease*, *199*, 38–41. doi:10.1097/NMD.0b013e3182043b4e
- Eubanks-Carter, C., Burckell, L. A., & Goldfried, M. R. (2005). Future directions in psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 503–521). New York, NY: Oxford University Press.
- Fiedler, F. E. (1950). A comparison of therapeutic relationships in psychoanalytic, nondirective, and Adlerian therapy. *Journal of Consulting Psychology*, *14*, 436–445. doi:10.1037/h0054624
- Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology*, *59*(1), 10–17. doi:10.1037/a0025749
- Frank, J. D. (1961). *Persuasion and healing: A comparative study of psychotherapy*. Oxford: Johns Hopkins University Press.
- French, T. M. (1933). Interrelations between psychoanalysis and the experimental work of Pavlov. *American Journal of Psychiatry*, *89*, 1165–1203. doi:10.1176/ajp.89.6.1165
- Garfield, S. L., & Kurtz, R. (1976). Clinical psychologists in the 1970s. *American Psychologist*, *31*, 1–9. doi:10.1037/0003-066X.31.1.1
- Glass, C. R., Victor, B. J., & Arnkoff, D. B. (1993). Empirical research on integrative and eclectic psychotherapies. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration* (pp. 9–25). New York, NY: Plenum Press.
- Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist*, *35*, 991–999. doi:10.1037/0003-066X.35.11.991

- Goldfried, M. R. (2013). What should we expect from psychotherapy? *Clinical Psychology Review*, 33, 862–869. doi:10.1016/j.cpr.2013.05.003
- Goldfried, M. R., & Castonguay, L. G. (1992). The future of psychotherapy integration. *Psychotherapy*, 29, 4–10. doi:10.1037/0033-3204.29.1.4
- Goldfried, M. R., Pachankis, J. E., & Bell, A. C. (2005). A history of psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 24–60). New York, NY: Oxford University Press.
- Goldfried, M. R., & Padawer, W. (1982). Current status and future directions in psychotherapy. In M. R. Goldfried (Ed.), *Converging themes in psychotherapy* (pp. 3–49). New York, NY: Springer.
- Goldfried, M. R., Raue, P. J., & Castonguay, L. G. (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology*, 66, 803–810. doi:10.1037/0022-006X.66.5.803
- Grawe, K. (2004). *Psychological therapy*. Seattle, WA: Hogrefe.
- Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, 21, 372–378. doi:10.1037/0735-7028.21.5.372
- Grosse Holtforth, M., Grawe, K., & Castonguay, L. G. (2006). Predicting a reduction of avoidance motivation in psychotherapy: Toward the delineation of differential processes of change operating at different phases in treatment. *Psychotherapy Research*, 16, 626–630. doi:10.1080/10503300600608215
- Grosse Holtforth, M., Wilm, K., Beyermann, S., Rhode, A., Trost, S., & Steyer, R. (2011). Differential change in integrative psychotherapy: A re-analysis of a change-factor based RCT in a naturalistic setting. *Psychotherapy Research*, 21, 631–643. doi:10.1080/10503307.2011.602749
- Hayes, A. M., Beevers, C. G., Feldman, G. C., Laurenceau, J.-P., & Perlman, C. (2005). Avoidance and processing as predictors of symptom change and positive growth in an integrative therapy for depression. *International Journal of Behavioral Medicine*, 12(2), 111–122. doi:10.1207/s15327558ijbm1202_9
- Hayes, A. M., Feldman, G. C., & Goldfried, M. R. (2007). The change and growth experiences scale: A measure of insight and emotional processing. In L. G. Castonguay & C. Hill (Eds.), *Insight in psychotherapy* (pp. 231–253). Washington, DC: American Psychological Association. doi:10.1037/11532-011
- Henggeler, S. W. (2011). Efficacy studies to large-scale transport: The development and validation of multisystemic therapy programs. *Annual Review of Clinical Psychology*, 7, 351–381. doi:10.1146/annurev-clinpsy-032210-104615
- Henggeler, S. W., Schoenwald, S. K., Boruin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic therapy for antisocial behavior in children and adolescents* (2nd ed.). New York, NY: Guilford Press.
- Hentschel, U., Smith, G., Draguns, J. G., & Ehlers, W. (Eds.). (2004). *Defense mechanisms: Theoretical, research, and clinical perspectives*. Oxford: Elsevier Science.
- Hill, C. E., & Knox, S. (2013). Training and supervision in psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 775–811). Hoboken, NJ: John Wiley & Sons.
- Hilsenroth, M. J., & Slavin, J. M. (2008). Integrative dynamic treatment for comorbid depression and borderline conditions. *Journal of Psychotherapy Integration*, 18, 377–409. doi:10.1037/a0014317
- Holmqvist, R., Philips, B., & Barkham, M. (2015). Developing practice-based evidence: Benefits, challenges, and tensions. *Psychotherapy Research*, 25, 20–31.
- Holt, H., Beutler, L. E., Castonguay, L. G., Silberschatz, G., Forrester, B., Sealey Temkin, R., ... Miller, T. W. (2014). A critical examination of the movement toward evidence-based mental health treatments in the U.S. department of veterans affairs. *The Clinical Psychologist*, 66(4), 8–14.
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 25–69). New York, NY: Oxford University Press.
- Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Psychology: Science and Practice*, 6, 67–79. doi:10.1093/clipsy/6.1.67
- Jones, E. E., & Pulos, S. M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology*, 61, 306–316. doi:10.1037/0022-006X.61.2.306
- Kazantzis, N., & Deane, F. P. (1998). Theoretical orientations of New Zealand psychologists: An international comparison. *Journal of Psychotherapy Integration*, 8, 97–113. doi:10.1023/A:1023236406807
- Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist*, 63, 146–159. doi:10.1037/0003-066X.63.3.146
- Klein, M. H., Dittman, A. T., Parloff, M. B., & Gill, M. M. (1969). Behavior therapy: Observations and reflections. *Journal of Consulting and Clinical Psychology*, 33, 259–266. doi:10.1037/h0027595
- Klein, D. N., Santiago, N. J., Vivian, D., Blalock, J. A., Kocsis, J. H., Markowitz, J. C., ... Keller, M. B. (2004). Cognitive-behavioral analysis system of psychotherapy as a maintenance treatment for chronic depression. *Journal of Consulting and Clinical Psychology*, 72, 681–688. doi:10.1037/0022-006X.72.4.681
- Krueger, S. J., & Glass, C. R. (2013). Integrative psychotherapy for children and adolescents: A practice-oriented literature review. *Journal of Psychotherapy Integration*, 23, 331–344. doi:10.1037/a0034949
- Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: American Psychological Association.
- Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advance. *Psychotherapy*, 50, 42–51. doi:10.1037/a0030682
- Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy*, 51, 467–481. doi:10.1037/a0034332
- Lazarus, A. A. (2005). Multimodal therapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 105–120). New York, NY: Oxford University Press.
- Lebow, J. (1997). The integrative revolution in couple and family therapy. *Family Process*, 36, 1–17. doi:10.1111/j.1545-5300.1997.00001.x
- Lecomte, C., & Castonguay, L. G. (Eds.). (1987). *Rapprochement et integration en psychotherapie: Psychanalyse, behaviorisme et humanisme* [Rapprochement and integration in psychotherapy: Psychoanalysis, behaviorism, and humanism]. Chicoutimi, QC: Gaetan Morin.
- Lecomte, C., Castonguay, L. G., Cyr, M., & Sabourin, S. (1993). Supervision and instruction in doctoral psychotherapy integration. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration* (pp. 483–498). New York: Plenum.

- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2, 53–70. doi:10.1111/j.1745-6916.2007.00029.x
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.
- Lundh, L.-G. (2014). The search for common factors in psychotherapy: Two theoretical models with different empirical implications. *Psychology and Behavioral Sciences*, 3, 131–150. doi:10.11648/j.pbs.20140305.11
- Lutz, W., Böhnke, J. R., & Köck, K. (2011). Evaluation and feedback of recovery and non-response in psychotherapy. *Community Mental Health*, 47, 311–317.
- Lutz, W., Ehrlich, T., Rubel, J., Hallwachs, N., Röttger, M. A., Jorasz, C., ... Tschitsaz-Stucki, A. (2013). The ups and downs of psychotherapy: Sudden gains and sudden losses identified with session reports. *Psychotherapy Research*, 23, 114–124. doi:10.1080/10503307.2012.693837
- McAleavey, A. A., & Castonguay, L. G. (2014). Insight as a common and specific impact of psychotherapy: Therapist-reported exploratory, directive, and common factor interventions. *Psychotherapy*, 51, 283–294. doi:10.1037/a0032410
- McCullough, J. P., Jr. (2000). *Treatment for chronic depression: Cognitive behavioral analysis system of psychotherapy (CBASP)*. New York, NY: Guilford Press.
- McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Lanza-Hurley, C. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy*. New York, NY: Guilford Press.
- Messer, S. B. (1992). A critical examination of belief structures in integrative and eclectic psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 130–165). New York, NY: Basic Books.
- Muller, F. J. (2008). Psychotherapy in Argentina: Theoretical orientation and clinical practice. *Journal of Psychotherapy Integration*, 18, 410–420. doi:10.1037/a0014318
- Muran, J. C. (2002). A relational approach to understanding change: Plurality and contextualism in a psychotherapy research program. *Psychotherapy Research*, 12, 113–138. doi:10.1093/ptr/12.2.113
- Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy*, 42, 532–545. doi:10.1037/0033-3204.42.4.532
- Muran, J. C., Safran, J. D., Eubanks-Carter, C., Gorman, B. S., & Winston, A. (2014, June). *Exploring changes in interpersonal process, intermediate and ultimate outcome in a within-subject experimental study of an alliance-focused training*. Paper presented at the annual meeting of the Society for Psychotherapy Research, Copenhagen, Denmark.
- Naar-King, S., Ellis, D., King, P. S., Lam, P., Cunningham, P., Secord, E., ... Templin, T. (2014). Multisystemic therapy for high-risk African American adolescents with asthma: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 82, 536–545. doi:10.1037/a0036092
- Nelson, D. L., & Castonguay, L. G. (2012, June). *The systematic use of homework in psychodynamic – Interpersonal psychotherapy for depression*. Paper presented at the annual meeting of the Society for Psychotherapy Research, Virginia Beach, VA.
- Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., Boswell, J. F., Szkodny, L. E., & Nordberg, S. S. (2011). A randomized controlled trial of cognitive-behavioral therapy for generalized anxiety disorder with integrated techniques from emotion-focused and interpersonal therapies. *Journal of Consulting and Clinical Psychology*, 79, 171–181. doi:10.1037/a0022489
- Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., & Nordberg, S. S. (2008). An open trial of integrative therapy for generalized anxiety disorder. *Psychotherapy*, 45, 135–147. doi:10.1037/0033-3204.45.2.135
- Newman, M. G., Castonguay, L. G., Borkovec, T. D., & Molnar, C. (2004). Integrative psychotherapy. In R. G. Heimberg, C. L. Turk, & D. S. Mennin (Eds.), *Generalized anxiety disorder: Advances in research and practice* (pp. 320–350). New York, NY: Guilford Press.
- Newman, M. G., Castonguay, L. G., Fisher, A. J., & Borkovec, T. D. (2008, November). *The addition of interpersonal and emotional processing techniques to the treatment of generalized anxiety disorder*. Paper presented at the Annual meeting of the Association for the Behavior and Cognitive Therapy, Orlando.
- Nilsson, T., Svensson, M., Sandell, R., & Clinton, D. (2007). Patients' experiences of change in cognitive-behavioral therapy and psychodynamic therapy: A qualitative comparative study. *Psychotherapy*, 17, 553–566. doi:10.1080/10503300601139988
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York, NY: Oxford University Press.
- Norcross, J. C. (2005). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 3–23). New York, NY: Oxford University Press.
- Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York, NY: Oxford University Press.
- Norcross, J. C., & Halgin, R. P. (2005). Training in psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 439–458). New York, NY: Oxford University Press.
- Norcross, J. C., Karpiak, C. P., & Santoro, S. O. (2005). Clinical psychologists across the years: The division of clinical psychology from 1960 to 2003. *Journal of Clinical Psychology*, 61, 1467–1483. doi:10.1002/jclp.20135
- Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of change. *Journal of Clinical Psychology*, 67, 143–154. doi:10.1002/jclp.20758
- Orlinsky, D. E., Strauss, B., Hill, C. E., Carlsson, J., & Castonguay, L. G. (2012, June). *Research on training and development of psychotherapists*. Workshop presented at the Annual Meeting of the Society for Psychotherapy Research, Virginia Beach, VA.
- Overskeid, G. (2007). Looking for Skinner and finding Freud. *American Psychologist*, 62, 590–595. doi:10.1037/0003-066X.62.6.590
- Paul, G. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting Psychology*, 31, 109–118. doi:10.1037/h0024436
- Perry, J. C., Hoglend, P., Shear, K., Vaillant, G. E., Horowitz, M., Kardos, M. E. ... Kagan, D. (1998). Field trial of a diagnostic axis for defense mechanisms for DSM-IV. *Journal of Personality Disorders*, 12, 56–68. doi:10.1521/pedi.1998.12.1.56
- Prochaska, J. O. (1979). *Systems of psychotherapy: A transtheoretical analysis*. Oxford: Dorsey.
- Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin.
- Prochaska, J. O., & DiClemente, C. C. (2005). The transtheoretical approach. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 147–171). New York, NY: Oxford University Press.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103. doi:10.1037/h0045357
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6, 412–415. doi:10.1037/1053-0479.12.1.5

- Ryle, A., Leighton, T., & Pollock, P. (1997). *Cognitive analytic therapy and borderline personality disorder: The model and the method*. Hoboken, NJ: John Wiley & Sons.
- Safran, J. D. (1990a). Towards a refinement of cognitive therapy in light of interpersonal theory: I. Theory. *Clinical Psychology Review, 10*, 87–105. doi:10.1016/0272-7358(90)90108-M
- Safran, J. D. (1990b). Towards a refinement of cognitive therapy in light of interpersonal theory: II. Practice. *Clinical Psychology Review, 10*, 107–121. doi:10.1016/0272-7358(90)90109-N
- Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology, 64*, 447–458. doi:10.1037/0022-006X.64.3.447
- Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.
- Safran, J. D., Muran, J. C., DeMaria, A., Boutwell, C., Eubanks-Carter, C., & Winston, A. (2014). Investigating the impact of alliance-focused training on interpersonal process and therapists' capacity for experiential reflection. *Psychotherapy Research, 24*, 269–285. doi:10.1080/10503307.2013.874054
- Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. Lanham, MD: Jason Aronson.
- Schatzberg, A. F., Rush, A. J., Arnow, B. A., Banks, P. L., Blalock, J. A., Borian, F. E., ... Keller, M. B. (2005). Chronic depression: Medication (nefazodone) or psychotherapy (CBASP is effective when the other is not. *Archives of General Psychiatry, 62*, 513–520. doi:10.1001/archpsyc.62.5.513
- Schottenbauer, M. A., Glass, C. R., & Arnkoff, D. B. (2005). Outcome research on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 459–493). New York: Oxford University Press.
- Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21*, 367–384. doi:10.1080/10503307.2011.582186
- Stricker, G., & Gold, J. (2003). Integrative approaches to psychotherapy. In A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies: Theory and practice* (2nd ed., pp. 317–349). New York, NY: Guilford Press.
- Swift, J. K., & Greenberg, R. P. (2015). *Premature termination in psychotherapy: Strategies for engaging clients and improving outcomes*. Washington, DC: American Psychological Association.
- Truax, C. B. (1966). Reinforcement and nonreinforcement in Rogerian psychotherapy. *Journal of Abnormal Psychology, 71*, 1–9. doi:10.1037/h0022912
- Wachtel, P. L. (1977). *Psychoanalysis and behavior therapy: Toward an integration*. New York, NY: Basic Books.
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York, NY: Routledge.
- Webb, C. A., DeRubeis, R. J., & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*, 200–211. doi:10.1037/a0018912
- Weinberger, J., & Rasco, C. (2007). Empirically supported common factors. In S. G. Hofmann & J. Weinberger (Eds.), *The art and science of psychotherapy* (pp. 103–129). New York: Routledge.
- Wolfe, B. E. (2005). *Understanding and treating anxiety disorders: An integrative approach to healing the wounded self*. Washington, DC: American Psychological Association.
- Wolfe, B. E., & Goldfried, M. R. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology, 56*, 448–451. doi:10.1037/0022-006X.56.3.448
- Yin, K., Huang, X., & Fu, Y. (2009). The present situation of the research on psychotherapy and counseling methods in China: Through a content analysis of articles in Chinese psychological journals. *Psychological Science (China), 32*, 783–787.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York, NY: Guilford Press.
- Zack, S. E., Castonguay, L. G., Boswell, J. F., McAleavey, A. A., Adelman, R., Kraus, D., & Pate, G. A. (in press). Attachment history as a moderator of the alliance outcome relationship in adolescents. *Psychotherapy*.
- Zarin, D. A., Pincus, H. A., West, J. C., & McIntyre, J. S. (1997). Practice-based research in psychiatry. *American Journal of Psychiatry, 154*, 1199–1208. doi:10.1176/ajp.154.9.1199