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### **A Principle-Based Approach to Psychotherapy Integration**

**Chapter:** (p. 88) A Principle-Based Approach to Psychotherapy Integration

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A principle-based approach to psychotherapy grew out of a desire to enhance clinicians' abilities to help their clients by integrating ideas from different schools of thought. This approach facilitates such integration by focusing on principles of change shared across orientations. In addition to lowering the barriers between theoretical schools, this approach also facilitates the integration of research and practice by privileging change principles that have empirical support. In doing so, it provides a transtheoretical framework that encourages therapists to enact these evidence-based principles in a flexible, responsive, and hopefully more effective way. Keeping the principles in mind is much more feasible and practical than trying to integrate across hundreds of potential techniques.

#### **The Integrative Approach**



Early in his career, the second author (Goldfried) found that, although his preferred theoretical orientation of behavior therapy seemed to be an effective means of helping many patients, focusing solely on overt behavior and learning models limited his conceptualization of clients' difficulties and his ability to successfully intervene. Along with other behavior therapists,

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he became one of the early advocates of enhancing behavior therapy by integrating cognitive processes. He also began to draw on psychodynamic and experiential ideas that complemented cognitive-behavioral therapy (CBT) (Goldfried, 2015). The rationale behind this rapprochement was that if one set aside the jargon employed by various (p. 89) approaches, it might be possible to identify a set of change principles that were shared by the major theoretical orientations.

In 1980, the second author proposed that a useful way to identify these commonalities would be to focus on an intermediate level of abstraction (Goldfried, 1980). With theoretical frameworks or orientations at the highest level of abstraction and specific techniques at the lowest level of abstraction, at the intermediate level are change principles. By focusing on this intermediate level and describing these principles in clear language that eschews jargon, the goal was to step outside of the contentious competition between orientations and recognize how seemingly disparate techniques actually serve similar clinical functions.

In a 1980 article and in subsequent writings (e.g., Goldfried, 2012), Goldfried delineated five principles that he argued are common across orientations:

1. Fostering the patient's hope, positive expectations, and motivation
2. Facilitating the therapeutic alliance
3. Increasing the patient's awareness and insight
4. Encouraging corrective experiences
5. Emphasizing ongoing reality testing

This set of principles is based on the clinical, theoretical, and research literature of major orientations, especially the cognitive-behavioral, psychodynamic, and experiential/humanistic traditions. For example, compare how the general approach to the reduction of fearful behavior is described from these three orientations.

From a psychoanalytic point of view:

when a person is afraid but experiences a situation in which what was feared occurs without any harm resulting, he will not immediately trust the outcome of his new experience; however, the second time he will have a little less fear, the third time still less. (Fenichel, 1941, p. 83)

Couched in heavy jargon, from a cognitive-behavioral viewpoint:

Extinction of avoidance behavior is achieved by repeated exposure to subjectively threatening stimuli under conditions designed to ensure that neither the avoidance responses nor the anticipated adverse consequences occur. (Bandura, 1969, p. 414)

Referred to as "directive behavior" within an experiential/humanistic approach, the goal is to provide the client with

the opportunity for relevant practice in behaviors he may be avoiding. Through his own discoveries in trying out these behaviors, he will uncover aspects of himself which in their turn will generate further self-discovery. (Polster & Polster, 1973, p. 252)

Each of these instances, stated in a somewhat different language and perhaps implemented technically in different ways, may be seen as reflecting the principle of "encouraging corrective experiences."

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These five common principles of change are not presumed to be exhaustive: additional principles can be identified, particularly as new treatment approaches are developed, as existing approaches evolve, and as the research literature identifies additional predictors of positive treatment outcome. In this chapter, we feature and illustrate only these five principles, recognizing that others would probably expand and revise our list.

## Assessment and Formulation



It is important to recognize that principles of change, by definition, involve general strategic approaches to intervention. They say nothing about the specific techniques that are used to achieve these objectives and also nothing about what aspects of the client's functioning are to be the focus of the intervention. For example, with regards to the strategies just indicated, what should the client become aware of? What is the nature of the experiences that can be corrective? What is the target of the ongoing reality testing? These are the issues that (p. 90) are the focus of clinical assessment and case formulation.

Based on a coding system for the process of change that proves common to more than one therapy approach, the second author developed a transtheoretical approach to clinical assessment and case formulation (Goldfried, 1995). The acronym STAIRCaSE refers to those variables involved in a person's interaction with the environment that can be the focus of intervention. They are: Situation, Thought, Affect, Intention, Consequence, and Self-Evaluation.

- ◆ *Situation*: Refers to something external to the individual, be it an event, circumstance, or interaction with another person.
- ◆ *Thought*: May be of various sorts, such as an interpretation of the external situation, an expectation, or an attribution of the motive behind another person's action.
- ◆ *Affect*: Refers to an emotional reaction that could be conditioned to the situation or one mediated by a thought.
- ◆ *Intention*: Refers to what the person wants and/or needs in this particular situation.
- ◆ *Response*: Represents an action that is observable, which may be something a person does or avoids doing.
- ◆ *Consequence*: Refers to what results from the action or avoidance, be it consequences to the individual or the impact it makes on someone else.
- ◆ *Self-evaluation*: How the individual judges how well he or she responded to the situation.

The following is an example of how STAIRCaSE is used in the assessment and case formulation of unassertive behavior and how this information guides the principles of change.

"Unassertiveness" here is broadly defined as the client having difficulty in verbalizing or acting on what she or he wants, feels, or thinks. This unassertiveness may be the result of fear and/or lack of ability. In essence, this is what we frequently see clinically, where a patient's problematic behavior is more a function of anxiety or inability than what she or he wants and needs.

Because this assessment and case formulation approach is transtheoretical in nature, the specific clinical methods of assessment and intervention, by definition, are not specified. Our principle-based integration directs clinicians to what information to acquire, not how to acquire it. The particular assessment methods (e.g., interview, observation, psychological testing) should be determined by the specific details of the case, clinical judgment, and the existing empirical evidence.

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## ***Gathering Assessment Information Relevant to Current Life Situation.***

In assessing unassertiveness, the therapist looks for difficulty in refusing requests from others, people-pleasing and trying to be “nice,” and reluctance in taking the initiative in requesting what the client wants or needs. These can occur generally or only within specific classes of stations, such as work, school, friends, family, or intimate relationships. Client may be more attuned to “shoulds” than “wants.”

### ***Observing markers in session.***

Passivity, being apologetic, reassurance-seeking; putting oneself down; worrying about what one said or did in the past and/or what one will say or do in the future.

### ***Obtaining client history.***

Past history of criticism, abuse, trauma, neglect, difficulty in forming relationships, strict rules and role constraints (e.g., religion, culture).

### ***Selecting possible targets.***

Anxiety, depression, interpersonal conflict, outbursts of anger following period of passivity, lack of confidence/self-efficacy, excessive concern about impact on others, external locus of control, uncertainty and hesitancy.

## ***Case Formulation***

*Situations:* Request by another person; client needing something from another person.

*Intention:* What client would like to say about what he or she needs or wants, thinks, or feels.

*Thought:* Thought that one can't say what one wants; explicitly or implicitly expects negative reaction from other.

*Affect:* Anxiety at thought of saying what one needs or wants, thinks, or feels, often as the result of feared consequences.

**(p. 91)** *Response:* Behaviorally avoids saying what one needs or wants, thinks, or feels.

*Consequence:* Inconvenienced; doesn't get what one wants; others may view client negatively.

*Self-Evaluation:* Negative thoughts and feelings about self; feelings of inefficacy; regret about not self-asserting.

## ***Providing client with rationale for intervention.***

The goal here is to help clients gain a preliminary understanding of why they are having the problem (concurrently and historically), what needs to be done therapeutically to make changes, and how they can work with the therapist to bring this about.

- 1.** Present formulation to client, together with any relevant history leading to current vulnerability, in-session markers, and therapy targets.
- 2.** Use case formulation described earlier to clarify the STAIRCaSE links that need to be broken: (e.g., “You are afraid [*affect*] to say what you really want to say [*intention*] because you think [*thought*] that it will be taken badly by the other person. The problem is that by remaining silent [*response*], you end up not only failing to get what you want [*consequence*], but the other person may see you in a negative way [*consequence*]. And you also then feel lousy about yourself.” [*self-evaluation*]).
- 3.** Clarify links that need to be made in therapy: S—I—R—C—SE [e.g., “When you are in a *situation* where you want or don't want something, the goal is be able to focus on your *intention* rather than your fearful thoughts and emotions, to notice the *consequences* of

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what you *say or do* for yourself and the impact it makes on others and see if you can *give yourself credit* for what you've done."

Clinical assessment and case formulation naturally lead to goal specification. There are three associated principles of change for clinically pursuing the goal of facilitating assertive behavior.

*Increasing awareness:* The goal here is to help clients become more aware in their day-to-day interactions of the connections between the external situation; their thoughts, feelings, intentions/needs, actions; the consequences of their actions for themselves and others; and how they evaluate the way they dealt with the situation. An ultimate goal is to help them develop a more efficacious view or expectation of their ability to deal with future situations. Although the therapist can point these out, the eventual goal is to have clients make use of their executive functioning to step back and observe these connections themselves in life situations.

*Corrective experience:* The goal here is to create behavior change by speaking up and saying what they want, think, and feel in specific situations. This new behavior will also have an impact on thoughts, feelings, intentions, consequences, and how they evaluate the way they responded in this life situation. There is a certain amount of risk-taking involved (and the client should be informed of this explicitly) where the goal—based on their increased awareness—is for them to behave in a new way that is more effective (e.g., having positive consequences) and satisfying (e.g., positive self-evaluation).

*Ongoing reality testing:* The goal here is to facilitate a synergy between increased awareness and corrective experiences. Once they have a corrective experience by acting in a more self-assertive way, clients become more aware of new links between the external situation, their thinking, feelings, and intentions. Thus, they focus more on what they want to say rather than on being inhibited by excessive concerns about the reactions of others. They also recognize that what they have done differently results in better consequences and makes them feel (p. 92) more positive about what they have done. This increase in awareness resulting from a corrective experience may then be used to encourage more corrective experiences, resulting in an ongoing synergistic process between cognition and behavior.

## Applicability and Structure



This principle-based approach is a framework that addresses the general therapy change process and that therefore can be applied to multiple clinical situations and populations. In fact, we would argue that these principles are relevant for all patients, settings, and modalities and can be applied in either short- or long-term treatments. The five principles provide general guidelines for what needs to be accomplished in therapy. Drawing on these organizing principles, the therapist can then identify subgoals for each principle and select specific methods or techniques that will enable him or her to achieve those subgoals over the course of treatment. Future research may identify certain principles that therapists should emphasize more with specific patient populations or clinical settings. At this point, we see no reason that these principles cannot be utilized with patients undergoing couples or family therapy or who are also receiving psychotropic medication. With patients on medication, clinicians will need to be mindful of how they interpret their corrective experiences: if patients attribute all of their success experiences to medication, they may miss an opportunity to develop a more positive and empowered self-evaluation.

## Processes of Change and Representative Techniques



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In this section, we describe each of the five principles of change in greater detail, together with representative research on and methods using each. As noted earlier, the principle-based approach does not prescribe a specific set of methods and techniques; any technique can be utilized as long as it supports one or more of the principles of change, is within the therapist's skill set, and is responsive to the client's needs and preferences.

## **Fostering Hope, Positive Expectations, and Motivation**

Psychotherapy often proves more effective when patients have hope that their lives can improve, positive expectations that therapy can facilitate this improvement, and motivation to do the work of therapy. The idea that therapists need to take steps to foster this sense of hopefulness and motivation in patients has long been an important principle of many therapeutic approaches. For example, Frank (1961) proposed that patients seek therapy because they are demoralized, and the restoration of their hope and positive expectations is an important part of treatment. Research on patients' expectations about the benefits of therapy shows a small but significant relation with positive outcome in treatment. This research also shows that unmet patient expectations are related to premature dropout from therapy (Constantino, Višlā, Coyne, & Boswell, 2018).

The importance of patient motivation to change is underscored by the transtheoretical model, which conceptualizes change as progressing through the five stages of precontemplation, contemplation, preparation, action, and maintenance. Research on these stages of change has found that patients in the precontemplative stage, who lack awareness of their problems or motivation to change their behavior, are far less likely to make progress in therapy than patients who are more motivated and thinking more actively about making changes (Prochaska & DiClemente, Chapter 8, this volume; Krebs, Norcross, Nicholson, & Prochaska, 2018).

In order to have hopeful, positive expectations about treatment and the motivation to engage in it, it is important that patients know what the treatment entails. *Role induction* is the process of orienting patients to treatment by giving them a general idea of what will happen (p. 93) in therapy and the roles of each participant (Orne & Wender, 1968). Several studies have found that the use of role induction is associated with less dropout and better therapy outcome (Strassle, Borckardt, Handler, & Nash, 2011; Swift & Greenberg, 2015). Useful role induction strategies include helping clients understand the general behaviors of an ideal client and the general behaviors the client can expect from the therapist, providing a credible treatment rationale, and also supplying logistical information about the length and frequency of sessions and how payment is handled.

Therapists seeking to increase client motivation can look to the techniques of *motivational interviewing* (MI; Miller & Rollnick, 2013), a client-centered approach that addresses ambivalence about change. In MI, when a patient resists making changes, the therapist does not directly challenge or confront this resistance, but rather seeks to "roll with resistance" by viewing it as valuable information to understand rather than as an obstacle to progress. Using person-centered techniques, but with some leading as well as following, the therapist helps the patient to recognize the consequences of changing and not changing. Outcome research on MI has demonstrated efficacy and effectiveness across a range of outcomes, particularly alcohol and drug use (Hettinga, Steele, & Miller, 2005; Lundahl & Burke, 2009; Lundahl et al., 2013), and a recent meta-analysis found that therapist skills consistent with MI were correlated with more change talk from clients (Magill et al., 2017).

Finally, in order to help their patients have hope, therapists themselves need to maintain their own hope. Given research that mental health workers report relatively high levels of burnout



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(e.g., Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012; Paris & Hoge, 2010), it is important that therapists practice good self-care (Wise & Barnett, 2016).

## **Facilitating the Therapeutic Alliance**

The alliance is one of the most robust predictors of outcome in therapy (Flückiger, Del Re, Wampold, & Horvath, 2018). Many theorists and researchers draw on Bordin's (1979) conceptualization of the working alliance as agreement between patient and therapist on the goals of therapy, collaboration on the tasks of therapy, and the presence of a positive emotional bond. Although therapeutic approaches may differ regarding the extent to which the alliance is regarded as a mechanism of change (e.g., Safran & Muran, 2000) or as a precondition of change (e.g., Beck, 2011), there is widespread agreement that a "good-enough" alliance is essential for effective therapy. In addition, when problems or ruptures in the alliance arise, if these are not addressed and resolved, patients may quit therapy or fail to achieve good outcomes (e.g., Samstag, Batchelder, Muran, Safran, & Winston, 1998). Conversely, successful resolution of ruptures is moderately related to improved outcome (Eubanks, Muran, & Safran, 2018).

One way to build a strong alliance is to help the patient actually move closer to achieving his or her treatment goals: in other words, effective therapy facilitates a good alliance. In addition, therapists can facilitate agreement and collaboration on goals and tasks by negotiating the goals of treatment with the patient and by giving patients some agency with respect to the tasks. An example of this would be collaborating with the patient to decide on a homework assignment rather than simply telling the patient what the therapist wants the patient to do. Therapists can work to build a strong bond by being empathic and respectful and validating the patient's experience. The empathic style of the client-centered tradition is well-suited to building a strong bond (Elliott, Bohart, Watson, & Murphy, 2018).

Focusing on the alliance is clearly a crucial task early in treatment so that the patient is willing to engage in the work of therapy. Research on alliance ruptures points to the importance of monitoring the alliance throughout treatment and intervening when a rupture emerges (Eubanks et al., 2018). Useful alliance rupture repair strategies include both direct strategies in which the therapist draws attention to the rupture, such as inviting the patient to express his or her thoughts and feelings about (p. 94) an impasse, and indirect strategies, in which the therapist resolves the rupture without explicitly acknowledging it—such as changing a homework task that a patient finds too challenging.

Rupture resolution strategies can be immediate as well, such as providing a rationale for a task that the patient did not understand so that the dyad can quickly resolve the rupture and resume the therapeutic task. Rupture repair strategies can also be more expressive or exploratory and aim to shift the focus of treatment to exploring the rupture and the patient's needs or concerns that underlie it. This form of resolution may entail exploring not only the patient's experience of the rupture, but also disclosure of the therapist's experience and nondefensive acknowledgment of how the therapist has contributed to the rupture.

## **Increasing Patient Awareness and Insight**

Patients often begin psychotherapy in a state of *unconscious incompetence*—unaware of exactly how they are contributing to their difficulties. An important step in therapy is to help the client move to a stage of greater awareness or insight that can be described as *conscious incompetence*.

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As illustrated earlier, a clear case formulation helps therapists identify the thoughts, feelings, intentions, and/or behaviors of which the client needs to become more aware. For example, a client who is unaware of her anger at others may also be unaware of how she inadvertently expresses her anger through indirect slights and pained facial expressions. She then may also be unaware of how her behavior aggravates others and leads them to withdraw from her. A task for the therapist would be to help this client recognize her feelings of anger, how she manifests her anger, and how these manifestations impact those around her. The therapist could draw upon STAIRCaSE to help the client increase her awareness of the links between specific challenging encounters with her employer [*situation*], her belief that she is being treated unfairly but “must not cause a scene” [*thought*], her feelings of anger and frustration [*affect*], and her attempts to “say something nice” while clenching her jaw [*response*]. As the client becomes more aware of these factors and the links between them and how they are interfering with her ability to achieve her career goals [*intention*], she will start to recognize opportunities for positive change.

All of the major therapeutic approaches embrace techniques for enhancing patient awareness. Increasing patient insight has always been a central aim of psychodynamic approaches and, certainly, interpretations, when accurate and well-timed, can facilitate greater awareness in patients of the relational patterns that contribute to their difficulties. Reflections, observations, and feedback have long been employed in insight-oriented therapies for this purpose. The CBT technique of having patients complete thought records can help patients to become more aware of connections among thoughts, feelings, and behaviors. Two-chair exercises, a hallmark of experiential approaches, can help patients to become more aware of implicit feelings and unmet needs (Elliott, Watson, Goldman, & Greenberg, 2004).

## Encouraging Corrective Experiences

In 1946, Alexander and French proposed that a client’s experience of interacting with a therapist in a way that differed from the client’s experiences with significant figures in the client’s early life could, in itself, produce therapeutic change. This concept has been extended to include experiences outside of the therapeutic relationship: a *corrective experience* is any experience in which the patient takes a risk and engages in a new behavior that leads to a shift in cognitions and emotions (Goldfried, 2012).

Corrective experiences can be conceptualized as a form of learning—the patient engages in a new way of behaving that is more effective. For example, exposure in fear reduction is one type of corrective experience. When patients begin to engage in new, more adaptive behaviors, they move into the stage of *conscious competence*: they are choosing to act more effectively and competently through deliberate and conscious efforts.

**(p. 95)** As Alexander and French observed, the therapeutic relationship can also provide a corrective experience. A patient who is accustomed to being criticized or abandoned by significant others can have a corrective experience when a therapist is supportive, empathic, validating, and willing to address and work through alliance ruptures (Eubanks, 2019). A corrective experience is the heart of change—it is the most essential of the change principles.

Therapists can encourage corrective experiences both between and within sessions. Between sessions, therapists and patients can collaborate on identifying possible between-session situations in which clients can attempt to have corrective experiences, such as facing situations that they may have been avoiding. The very process of exploring such experiences in session can also lead clients to consider doing things differently. Questions the therapist raises in the process of exploring a patient’s experience (e.g., “Have you ever told her how that makes you feel?”) may, even without the therapist’s awareness or intent, plant a seed that subtly encourages the patient to try a new behavior. This indirect approach may be particularly well-



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suited to high-reactance patients who do not respond well to being told what to do (Beutler, Edwards, & Someah, 2018).

Corrective experiences within the session can be facilitated through in-session tasks, such as patients reporting more open and expressive reactions about their experiences, or by role-plays in which the patient tries out a new behavior. An empty chair exercise can provide an opportunity for a patient to have the experience of a new interpersonal interaction with a significant other, even someone who has died, as a means of processing unfinished business. Therapists can facilitate corrective experiences by using their case formulation to help them identify what kind of relational experience would be most beneficial for a particular patient (Eubanks, 2019). For example, if a hostile patient is accustomed to encountering hostility from others, the therapist might provide a different experience by being validating and nondefensive. If a hostile patient is accustomed to others fleeing from or cowering before his aggression, a therapist might meet the patient's aggression with active engagement and healthy self-assertion.

Indeed, the therapeutic relationship can provide a corrective experience for the patient even when the therapist is not intentionally trying to do so. For example, once when the first author was giving a client a handout in session, she mentioned that she had come across the handout during the past week and thought the client would find it useful. The client's face lit up and she said, "You were thinking about me!" What the therapist had intended to be a psychoeducational intervention had a relational significance that took the therapist by surprise.

## Emphasizing Ongoing Reality Testing

The ultimate goal of therapy is to help patients move to the stage of *unconscious competence*, in which adaptive behaviors become so well-learned that they no longer require deliberate effort. To reach this stage, patients need to engage in repeated corrective experiences. Patients may also need the therapist's help to process these new experiences: they may fail to detect, accept, or recall their success experiences because these experiences are inconsistent with their long-standing views of themselves. Clients can see how their present functioning differs from their past, less effective functioning and align their expectations of situations, the emotions they anticipate experiencing, the consequences they deem most likely, and their subsequent self-evaluations (Goldfried & Robins, 1982). The client's reality has changed, and the client recalibrates his or her expectations [*thought*] and self-view [*self-evaluation*] to be in line with this new reality. This process of ongoing reality testing represents the consolidation of change.

As patients make positive changes, therapists can help patients process their corrective experiences by using the STAIRCaSE acronym to help patients recognize how each component of their functioning is changing. When altering one's negative self-schema proves difficult, therapists can offer affirmation by celebrating their patients' successes. Therapists can also (p. 96) encourage patients to find or strengthen positive interpersonal relationships that will be a source of support when therapy ends. Finally, therapists can encourage patients to develop healthy habits such as mindfulness, engagement in the arts, or regular exercise. Such healthy behaviors will likely increase their sense of mastery and pleasure and will help them cope with future stressors.

## Therapy Relationship



In our principle-based approach, the therapy relationship can contribute to the change process both indirectly and directly. A good therapy relationship will enable the therapist and client to collaborate on tasks of treatment that are helpful to the client. As noted earlier, facilitation of the alliance, which is an important aspect of the therapy relationship, is a key principle in our approach. A "good-enough" alliance, in which the patient is willing to

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collaborate with the therapist, is a necessary precondition for the work of therapy. The “real relationship” component of the patient–therapist relationship, characterized by a genuine and realistic perception of the other (Gelso, 2014), can also foster a sense of connection and trust that increases patients’ willingness to engage in the tasks of therapy. Within the context of therapy research, the therapy relationship in this instance is said to “moderate” the change process, which may be occurring outside the session.

At the same time, the experience of being in a relationship with a supportive, empathic, and reliable therapist who encourages the patient’s growth can also challenge the patient’s negative beliefs about relationships and provide a new interpersonal experience of what is possible in an adaptive relationship with another person. Patients who are fearful of being vulnerable with others due to a history of being rejected and neglected by their parents may have the experience of opening up to a therapist who is respectful and attentive. Through this relationship, the patient learns that it is possible to be vulnerable with another person and thus gains a new appreciation of his or her own worth. In this second instance, the relationship can be considered a mediator of change.

In our principle-based approach, therapists should strive to be attuned to both possibilities: particularly in early sessions, they should focus on developing a good-enough relationship with the client in order to lay the foundation for collaboration. As treatment progresses, they should be mindful of the patient’s past and current relationships with significant figures, and they should think actively about what kind of relational experience with the therapist would facilitate a corrective emotional experience for the patient. Therapists may find it challenging at times to provide the positive relational experience the client needs as the patient may “pull for” negative responses similar to those the patient has received in past relationships. By closely attending to their own internal experience of the patient—including ways in which they contribute to alliance ruptures by pushing against or pulling away from the client—therapists can identify opportunities to “pause” the therapeutic tasks they are engaging in and turn to actively exploring the therapy relationship. This kind of exploration is necessary if problems in the therapeutic relationship are hindering collaboration between patient and therapist.

## Diversity Considerations



A strength of a principle-based approach to integration is its flexibility with respect to specific techniques when working with patients from diverse cultures, backgrounds, and identities. As we have indicated earlier, in viewing therapy from within the perspective of principles of change, therapists can choose from an array of techniques in support of one of the principles. The therapist’s choice of techniques is informed by the research literature on multicultural competence but should also be tailored to the specific needs and preferences of the individual client because accommodating patient preferences typically enhances treatment outcome and decreases premature termination (Swift, Callahan, Cooper, & Parkin, 2018). There is strong research evidence that therapies adapted for religious clients and for patients of color offer additional benefits (p. 97) compared to nonadapted secular therapies (Captari, Hook, Hoyt, Davis, McElroy-Heltzel, & Worthington, 2018; Soto, Smith, Griner, Domenech Rodríguez, & Bernal, 2018). For example, a therapist can tailor treatment for a religious client by encouraging the client to draw on his or her faith tradition, such as encouraging the client to attend religious services, including the client’s favorite verses of Scripture, or by incorporating prayer.

By closely attending to subtle shifts in the alliance, the therapist can quickly detect therapy ruptures that can arise from differences between patients and therapists with respect to aspects of their identities such as gender, race, religion, sexual orientation, and class (Muran, 2007).

*Microaggressions*, or direct and indirect disrespectful, insulting, dismissive communications about another individual's cultural group, can be understood as a type of alliance rupture (Hook, Davis, Owen, & DeBlaere, 2017), and there may be value in drawing on alliance rupture resolution strategies to address microaggressions (Gaztambide, 2012; Spengler, Miller, & Spengler, 2016).

A principle-based approach to integration proceeds from an assumption that certain principles of change are universal. However, it is certainly possible that this assumption is wrong—certain principles may not be relevant for all patients, or there may be important principles missing from our list. It is important that we approach our work with cultural humility, appreciating how much we do not know about the lived experiences of our clients and how much we may be blinded by our implicit cultural assumptions (Hook et al., 2017). As more principle-based research is conducted with diverse samples of patients and therapists, we expect and indeed hope that additional principles will be identified so that therapists have a rich array of clinical strategies to draw upon when tailoring treatment to a particular patient. (p. 98) (p. 99) (p. 100)

## Case Example

To illustrate our principle-based approach, we present a case example based on clients in our clinical practices. The patient, Greg, was a white, heterosexual male in his mid-40s who worked as an attorney at a prestigious law firm. He presented with anxiety that he linked to work stressors, his distant relationship with his wife, and his frustrations with his teenage daughter who was performing poorly in her academics. Greg met diagnostic criteria for generalized anxiety disorder.

The psychologist was a white, heterosexual female in her early 40s. At the first session, the therapist asked the patient to complete the Outcome Questionnaire (OQ; Lambert, 2015), which indicated that he was experiencing a moderate level of distress.

### **Fostering Hope, Positive Expectations, and Motivation**

In the first session, the therapist inquired about Greg's expectations for treatment. Greg's answer included the unrealistic hope about what the therapist could do— "I am hoping that you have something in your therapist bag of tricks that will put all my demons to rest once and for all. I want a life with no setbacks." He also expressed resignation about his own helplessness— "I think it's something in how I'm wired; I just can't stop thinking this way and feeling this way." The therapist tried to encourage more balanced expectations by orienting Greg to the treatment. She explained that this treatment would be a collaborative effort, with both parties contributing to the work; that it was possible for him to feel better, but it would take some time; and that therapy might not entail exorcising all of his demons but rather helping him develop skills to cope with his demons more effectively. The therapist inquired about Greg's past experience in therapy to gain a better understanding of what he did and did not find helpful. She also observed that Greg brought several strengths to therapy: his awareness that things were not going well in his life, his motivation to seek treatment, and his willingness to share his difficulties fairly readily with the therapist. By drawing attention to these strengths, the therapist not only fostered Greg's positive expectations, but also bolstered her own personal sense of hope.

## Facilitating the Therapeutic Alliance

In the first session, the therapist introduced the concept of the therapeutic alliance to Greg by using Bordin's (1979) tripartite conceptualization of the alliance as (1) agreement between the patient and the therapist on the goals of treatment, (2) collaboration between the patient and the therapist on the tasks of treatment, and (3) the existence of a positive affective bond between the patient and the therapist. She encouraged Greg to let her know if at any point he disagreed with the direction in which they were going. She also shared that she might at times draw his attention to their interaction as a better understanding of how they were relating to each other could help them better understand his interactions with others; in this way, she provided a rationale for any future efforts to attend to and explore alliance ruptures.

Throughout the first few sessions, the therapist paid close attention to the development of her alliance with Greg. As she and Greg spoke about his goals for therapy, she directly noted that she and Greg had different perspectives on the best ways to achieve some of Greg's goals. Greg wanted to include winning more legal cases as a treatment goal because he believed that this would mean that he would make more money and that his difficulties with anxiety would be relieved if he were wealthier. The therapist was concerned that there were many external variables outside Greg's control that contributed to whether he won or lost a case and that making more money would not resolve Greg's difficulties with anxiety. She thought that focusing on the ways in which Greg's own behavior, thoughts, feelings, intentions, and self-evaluation were contributing to his anxiety was a better way to proceed. Greg's tendency to tie his personal worth to his net worth was part of his problem, and she did not want to reinforce this.

Knowing that agreement on treatment goals is a key component of the alliance, the therapist spoke explicitly with Greg about their differing views and engaged in a collaborative discussion about whether they could find a treatment goal with which they were both comfortable. Greg agreed that they could start with focusing on how his thoughts, feelings, intentions, behaviors, and self-evaluation contributed to his anxiety. He said that he still hoped that this would help him be more effective at work and make more money. The therapist agreed to help Greg reflect on his behaviors at work and to identify whether his anxiety was interfering with his ability to do his job effectively, but she also said that increasing his income would not solve his problems. Greg felt that this was fair, and said "OK, we can agree to disagree on that."

In addition to negotiating an agreement on goals, the therapist worked to collaborate with Greg on tasks and to develop a bond. Greg made several references to his former therapist who was "very perceptive and insightful" based on his "years of experience with hundreds of patients." Greg drew contrasts with the current therapist's relative lack of experience: he noted that since she was an academic, her private practice was probably small and that there were things she would know more about "once you've seen more patients." The therapist felt that Greg was challenging her at times by rejecting some of her interpretations and homework suggestions in a slightly confrontational way. She drew Greg's attention to this dynamic, trying to be nondefensive and curious about their interaction: "I feel like you are testing me." Greg laughed and said, "Oh, there you go, talking about our relationship, just like you said you would," in a teasing manner. When the therapist tried to further explore Greg's potential concerns about her ability, he made more jokes and kept the conversation light.

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The therapist believed that while Greg was determining if she passed muster, he was simultaneously eager for her approval. As Greg seemed uncomfortable exploring this aspect of their interaction directly at this point, the therapist decided to back off for the time being.

The therapist reflected to herself on how the therapeutic relationship could provide a corrective experience for Greg. Greg was raised by parents who pressured him to succeed, and he now lived with frequent criticism from his wife, hostile competition from his work colleagues, and numerous demands from his 16-year-old daughter. The therapist hypothesized that experiencing validation, support, and acceptance in the therapy relationship could be a healing experience for Greg. She tried to keep this as a guiding principle in her interactions with Greg.

For example, in one session, Greg was relating an argument he had with his daughter. He acknowledged losing his temper with his daughter and “yelling and doing everything wrong.” The therapist stopped him and asked, “What do you think I think about all of this?” Greg responded, “I hope you are figuring out what parenting techniques I should be using to communicate better with her, set limits better, be more patient—all these things that I keep messing up.” The therapist replied, “I do think there are some things that could be helpful, which I’ll share with you, but that’s not what I was thinking just now. I was thinking, ‘this is really hard.’ ” Greg looked surprised for a moment, then put his face in his hands, and, for the first time in the treatment, he began to cry. The therapist sat with him for several minutes and listened as Greg slowly began to speak about his sadness and pain as a failing parent. This moment felt like a turning point in the therapeutic relationship.

### **Increasing Patient Awareness and Insight**

Based on his prior therapy, Greg could speak fluently about many of his difficulties. However, his insights remained intellectualized—sounding almost like he was talking about someone else when he spoke of his tendency to worry and his history of self-defeating behaviors. The therapist suspected that Greg needed to become more self-aware in an experiential fashion that linked his thoughts with his emotions.

The therapist employed the two-chair technique to facilitate this link. During a session in which Greg was being highly self-critical, the therapist pulled up a chair and facilitated a dialogue between Greg and his critical voice by having Greg go back and forth between the two chairs. This dialogue helped to increase Greg’s awareness of the origins of his inner critic: as he later observed, pointing at the critic chair, “That’s my father.” Greg also shared that highlighting his inner critic increased his sense of self-compassion: “I really felt something—it really activated something emotional for me. I wanted to give myself a hug.” Greg had long known at an intellectual level that he was self-critical; now he seemed to have a deeper, affective understanding of it and an appreciation for how much his self-criticism was hurting him.

Throughout treatment, the therapist periodically reviewed Greg’s progress by readministering the OQ and discussing how Greg felt that he was changing. She also prepared a diagram of her formulation of Greg’s case and shared this with him. Greg agreed with the therapist’s formulation and reported that he found this diagram helpful. The diagram laid out the vicious cycle Greg was stuck in: a sense of inadequacy leading to anxiety that he found difficult to tolerate, leading to efforts to escape the anxious feelings through avoidant thoughts and behaviors, which then contributed to difficulties in his life that fueled his personal sense of inadequacy. Greg reported that he knew many of the pieces of this cycle but had never really connected them. This case formulation increased



his awareness of what was operating and became a useful way to track Greg's progress and to explain the rationale for various interventions by linking them to the stage in the cycle they were meant to address.

### **Encouraging Corrective Experiences**

In addition to facilitating corrective experiences within the alliance, as described earlier, the therapist encouraged Greg to pursue corrective experiences outside of session. The therapist introduced Greg to mindfulness exercises and encouraged Greg to practice these daily to help him be more aware of the present moment and less consumed by his anxious thoughts. Greg found that his mindfulness practice helped him have new kinds of interpersonal interactions. For example, he reported that he was waiting for his wife to get ready for an event they were attending together, and he was getting frustrated that she was taking too long. Usually, this kind of occurrence would be the beginning of an argument that would overshadow the entire evening. However, Greg realized that he could practice mindfulness while he waited for his wife. As he paid attention to his breathing and felt himself grow calmer, he realized that he had skills that he could utilize to manage the anxiety and anger he usually felt when he was helpless to control a situation. He—and his wife—were both surprised at how much they enjoyed their evening together and how much this positive experience subsequently impacted their entire weekend. As Greg relayed this experience to the therapist, she enthusiastically highlighted what an important experience this was and how the accumulation of many of these experiences could help not only Greg's symptoms of anxiety, but also could positively impact his marriage.

### **Emphasizing Ongoing Reality Testing**

Greg began to report more corrective experiences outside session in managing his anxiety, and the therapist processed these experiences with him. At times, Greg needed encouragement to recognize his gains: for example, after he proactively addressed a difficult task at work by appropriately asking for help from a colleague, he tried to minimize what he had done: "I was lucky; he was in a good mood that day." The therapist noted that Greg's proactive and skillful handling of the situation had contributed to the positive outcome and highlighted the contrast between this success experience and his previous, negative interactions with this particular colleague. Drawing on the STAIRCaSE concept, she pointed out how his different *response* was leading to a new *consequence*, and she encouraged Greg to incorporate this feedback into his *self-evaluation*. She also linked this to the case formulation, observing that by tolerating uncomfortable feelings, such as the discomfort of acknowledging his limitations to his colleague and taking proactive steps rather than avoiding the task, he broke his old cycle.

The therapist also drew links between this situation and Greg's behavior in therapy. She noted how Greg's willingness to be open and vulnerable with the therapist had not made him look foolish or weak, but rather had helped her to understand him, had strengthened their bond, and had facilitated their work together. Moreover, it provided him with a corrective experience whereby he could show vulnerability without being criticized.

After approximately 40 individual sessions, Greg's scores on the OQ moved into the normal range. Greg reported that he was feeling anxious less often and felt better equipped to tolerate and manage his anxious feelings when they did arise. He also reported that his relationship with his wife was greatly improved. He felt that he and his wife were working together better as parents, and this was leading to improvements in their relationship with their daughter.



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The therapist introduced the idea of termination. Greg was initially reluctant to terminate, but as the therapist continued to highlight his progress, Greg agreed to a gradual tapering off of therapy sessions. He terminated with definite improvement and with the understanding that he could return for booster sessions should the need arise.

## Outcome Research



In presenting this principle-based approach to integration, the goal was not to create yet another brand of therapy to compete in horse races with other treatments, but rather to provide a conceptual framework for how to think about integrating empirically supported principles into clinical practice. There are no formal or controlled clinical trials on the effectiveness of this integrative approach. Because flexibility—the ability to use a variety of techniques to enact a particular principle—is integral to this approach, it would prove challenging to study principle-based integration via traditional means such as randomized controlled trials.

At the same time, there is some outcome research to support most of the principles. Castonguay and Hill have brought together researchers to collect supporting research on increasing clients' awareness (Castonguay & Hill, 2007) and on corrective experiences (Castonguay & Hill, 2012). A task force sponsored jointly by the Society for Clinical Psychology (Division 12 of the American Psychological Association) and the North American Chapter of the Society for Psychotherapy Research identified research-supported principles for the treatment of four categories of psychological disorders: dysphoric disorders, anxiety disorders, personality disorders, and substance abuse disorders (Castonguay & Beutler, 2006). Principles common across at least two disorders included, for example, providing structure and a clear focus throughout therapy and helping clients to accept, tolerate, and, at times, fully experience their emotions.

Several of the principles in the approach we have described have also been identified (p. 101) by an interdivisional American Psychological Association (APA) Task Force to be elements of the therapy relationship that are probably or demonstrably effective. The most recent compendium featured meta-analyses of the literature to demonstrate the relationship between several of these principles and patient outcomes (Norcross & Lambert, 2019): specifically, client expectations, the alliance, collaboration, facilitating positive expectations, and alliance rupture repair.

## Future Directions



One promising direction is to use principle-based integration as a way of training therapists and to compare the clinical outcomes of therapists trained in this approach to those of therapists trained in other approaches. Beginning trainees can quickly grasp the five principles and use them to organize their thinking so that they are not overwhelmed by the vast array of possible therapeutic interventions. It is far easier to keep in mind a handful of operating principles than to identify which of hundreds of techniques might be relevant in any given case. As they progress through their training, trainees can learn possible techniques nested within each principle and thereby gradually accumulate a larger repertoire of methods for facilitating each principle. Early controlled studies of principle-based training in systematic treatment selection (Consoli & Beutler, Chapter 7, this volume) and transtheoretical therapy (Prochaska & DiClemente, Chapter 8, this volume) have demonstrated its viability and promising results. The context responsive integration model (Constantino, Boswell, Bernecker, & Castonguay, 2013) is an example of a practical and useful way to structure principle-based training with clinical

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markers and related strategies. Thus, if a marker occurs, such as a rupture in the alliance, one should consider using certain rupture repair strategies.

In the future, as the field becomes more aware of the importance of the therapist in treatment (e.g., Castonguay & Hill, 2017), we will address the burden that a principle-based approach to integration places on therapists: it requires that therapists think flexibly and creatively to move outside the box of one orientation, to gain familiarity with a variety of techniques, to look beyond superficial differences between seemingly disparate techniques to recognize common underlying functions, to stay abreast of the research literature, and to tolerate a degree of uncertainty because there is no clear script for the next therapy session other than focusing on principles of change and being responsive to the patient's needs (Stiles, Honos-Webb, & Surko, 1998). It also provides researchers with robust phenomena on which to focus their research efforts—as opposed to clinical trials involving complex interventions designed to treat heterogeneous disorders as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013).

Perhaps most important, this approach requires therapists to be open to recognizing their limits and receptive to continually learning new ways to help their patients. An important future direction is to identify how best to inculcate such openness, flexibility, and skill at integrating research findings into clinical practice in therapist trainees. For example, should trainees develop competence in employing these principles within one orientation first, in order to gain a secure foundation, or would early exposure to how different theoretical orientations implement these principles help maximize trainees' openness and agility? Does the best training approach depend on the trainee and his or her level of anxiety or on other therapist characteristics? Another important future direction for our principle-based approach is to determine whether additional principles should be added to the five discussed in this chapter. A related future direction is the need for more research on applying the principles to work with specific populations, as it may be that certain principles are more critical for specific types of patients or clinical situations. An exciting potential future direction is the possibility that we may one day know enough about the interactions among some patient characteristics, clinical principles, and the effectiveness (p. 102) of particular techniques to develop empirical algorithms to tailor treatment to the patient. One example is the Personalized Advantage Index that DeRubeis and colleagues have developed for determining whether a patient is a better match for cognitive therapy or medication for depression (DeRubeis et al., 2014). Another, broader example is the list of effective treatment adaptations to patients' transdiagnostic characteristics from the intradivisional APA task force on evidence-based relationship and responsiveness (Norcross & Wampold, 2019). Extensive meta-analyses have determined that several patient characteristics serve as markers for doing something particular: *when* the patient presents with this feature, *then* the research indicates this method typically proves most effective. Those six client characteristics are reactance level, stages of change, patient preferences, culture (race/ethnicity), religion/spirituality, and coping style. Not coincidentally, our principle-informed integration already addresses many of them.

As indicated in Chapter 1 of this *Handbook*, there have been four major approaches to psychotherapy integration: common factors, assimilative integration, technical eclecticism, and theoretical integration. A principle-based approach encompasses aspects of all of these approaches. It is clearly aligned with a common factors approach in that it identifies principles/change processes that are common across different therapeutic approaches. As the five principles described earlier are present in all the major orientations, the principle-based approach is also conducive to assimilative integration: therapists can conceptualize a case using the five principles from within their primary orientation and then integrate techniques from other orientations into that primary approach in service of those principles as needed. Similar to

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the technical eclectic approach, a principle-based approach also gives therapists the freedom to select different techniques from different orientations without remaining tied to one school. Consistent with theoretical integration, it does have an integrating, overarching conceptualization of what is necessary for change that guides the selection of various approaches. Thus, a principle-based approach is not only a way to integrate different approaches to therapy, but it also has the potential to facilitate movement toward greater future consensus in the field of psychotherapy integration.

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