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# Integration in Couple and Family Therapy

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Without Abstract

## Introduction

The field of family therapy – indeed, the entire field of psychotherapy – has moved steadily in the direction of integration (Lebow *2014*; Orlinsky and Ronnestad *2005*). Most generally, integration refers to efforts to bridge different models or schools of therapy. There are several types of integration: theoretical integration, in which two models are blended and a higher level of theory unites them; technical eclecticism, in which techniques from a number of different models are gathered together and decision rules are developed to apply these techniques to particular presenting problems; theoretical eclecticism, in which entire theories (not just associated techniques) are selected based on the clinical needs in the therapy at any one time; common factors, in which the unifying principles and practices across models are discerned; and assimilative integration, in which techniques from one or more models are integrated into a base theory/model

## Prominent Associated Figures

Prominent associated figures in the integrative movement include Jay Lebow, Al Gurman, Doug Sprenkle, Sean Davis, Doug Breunlin, Howard Liddle, Virginia Goldner, Michele Scheinkman, Mona Fishbane, Marcia Sheinberg, Barry Duncan, Scott Miller, Arthur Nielsen, and Peter Fraenkel, although there are many others (see Lebow *1987*, for a review of early integrative efforts and Lebow *2014* for a more recent review). This entry draws heavily from the writings of Lebow ( *1987*, *1997*, *2014*) and Sprenkle et al. ( *2009*).

## Description

The rationale for integration is manifold:

***1.***
Theoretical integration provides a more comprehensive explanation of human behavior.
***2.***

Allows for working with a wide variety of clients and problems.

***3.***

Increases the acceptability of therapy by clients.

***4.***

Is aligned with the postmodern position that no one perspective is adequate to explain human behavior or guide intervention.

***5.***

Allows for greater communication among professionals of differing orientations.

***6.***

To date, research has not established one model of family/couple therapy as superior to another.

***7.***

On the other hand, research has supported the efficacy of common factors (described below).

***8.***

All approaches to family therapy have been useful to some clients and with certain presenting problems, suggesting that it makes sense to honor those approaches and integrate them into a more comprehensive approach.

***9.***

Integrative approaches provide a wider set of ideas useful to the process of the therapist adopting a consistent perspective and set of interventions.

***10.***

Likewise, for therapists in training, integrative approaches provide a resolution for the confusion that often results from a survey of different schools of therapy (Fraenkel and Pinsof *2001*).

Most contemporary integrative approaches integrate a wide range of perspectives. They generally adopt a biobehavioral-psychosocial framework. They incorporate core ideas in the field, including systems theory, descriptions of family structure and roles, communication theory, family life cycle, family of origin, and aspects of social location, such as gender, gender identity, race, ethnicity, class, and culture. All understand a person's problems in terms of the immediate and broader context in which they live and view this context as the focus on intervention.

In a seminal paper, Lebow ( *1987*) suggested that all integrative efforts must contend with certain contradictions or "dialectics" in the field, including: that between circular and linear causality; whether to focus on the individual, the family, the extended family, or the total system (including larger systems such as the juvenile justice system, medical institutions, housing resources, social work case management) and, relatedly, whether to include modalities or contexts beyond conjoint family sessions (e.g., couple, individual, group); whether to emphasize insight and meaning making or behavioral change; the time frame of focus, as in emphasis on the present interactions, the link between past (e.g., family of origin) and present patterns, or the future; whether to focus on careful analysis of problems (as with most models) or solely on solutions (as with narrative and solution-focused therapies); degree of directiveness and therapist adoption of an expert stance or a less hierarchical/more collaborative stance; and which "change entry point" to focus on – emotion as in emotion-focused therapy, cognition as in narrative therapy, behavior as in behavioral and cognitive-behavioral therapy, biology/physiology as in

meditation/mindfulness and psychoeducational approaches, and social justice as in feminist family therapy.

Another dimension on which integrated approaches vary is in terms of the structuring/sequencing of interventions – whether the therapist can move flexibly among different interventions as the moment requires (Gurman *1984*; Fraenkel *2009*) or whether the therapist proceeds in an orderly set of stages from one theoretical perspective and set of interventions to the next. An example of a structured staged approach and theoretical integration is Pinsof's ( *1995*) *Integrative Problem-Centered Therapy*, which moves from behavioral and systems-level hypotheses and interventions to biobehavioral interventions (e.g., psychotropic medications), to experiential methods, to family-of-origin methods, and to individual object relations or self-psychology as needed (as one level of intervention "fails"). Scheinkman ( *2008*) proposes another multilevel, staged approach.

Another example of theoretical integration is Liddle's ( *2009*) Multidimensional Family Therapy (MDFT), designed for working with drug-abusing adolescents and their families. MDFT combines structural, cognitive-behavioral, biological-developmental, and ecosystemic approaches into a unified systems-based theory and set of interventions.

The common factors perspective has garnered a fair amount of attention and research support (see Sprenkle et al. *2009* for review). Prominent common factors (not limited to family therapy) include those attributable to clients (motivation, engagement, hopefulness, perseverance and cooperation, expectations), therapist effects (positivity, friendliness, structuring, high level of activity in disrupting problem patterns, lack of defensiveness), as well as client behavioral regulation, emotional experiencing, and cognitive mastery. Common factors pertaining to different therapy approaches include allegiance effects (the degree to which practitioners of a model are enthusiastic about it) and the degree of organization/coherence of the model. Common factors pertaining specifically to systems-based approaches include the degree to which the therapist holds a relational conception of the problem, the therapist's success in disrupting dysfunctional relational patterns, the therapist's ability to expand the direct treatment system (Pinsof *1995*), and the therapist's ability to create a strong therapeutic alliance.

# Relevance to Couple and Family Therapy

The move toward integration in couple and family therapy is significant in that for many years, the field was divided into "camps" defined by pure form approaches such as structural, strategic, Bowenian, MRI, and so forth. There was a great deal of competition for attention and trainees among these different schools. The trend toward integration represents the next stage in the field, where the theories and practices of different schools are blended into coherent syntheses, thus eliminating the competition among models and strengthening the position of systemic approaches, which continue to face challenges in asserting their centrality in a mental health landscape that favors individually oriented treatment.

# Clinical Example

The following clinical example is a briefer version of a detailed vignette presented in Fraenkel ( *2009*). Before presenting the case, a brief description of the integrative approached utilized is in order. Fraenkel's integrative approach is named the Therapeutic Palette, with the idea being that constructing a therapy is like the act of painting, drawing from different perspectives much as an artist utilizes different colors. It represents an example both of theoretical eclecticism and common factors. In this approach, the therapist adopts different theories and their associated techniques depending on the flow of themes, the openings presented by the clients, and the clinical needs of the moment. The TP suggests three common factors (described metaphorically as "primary colors") among extant theories of family therapy: time frame perspective, degree of directiveness, and change entry point. Some approaches focus on analyzing and intervening in the present patterns of interaction or experience, for example, structural, strategic, MRI, emotion focused, experiential, and cognitive behavioral. Others focus heavily on developing insight about the influence of past experiences (especially in family of origin) on the present – for instance, Bowenian and psychoanalytic approaches. Still others focus almost exclusively on the future – for instance, solution-focused and solution-oriented approaches – which focus on setting short- and long-term goals for behavior change. The therapist moves flexibly among these different time perspectives depending on material presented by the couple or family and as one time frame fails to yield progress. For instance, if during training in communication skills one or both partners comment that this way of communicating stands in contrast to how their respective parents argued incessantly, the therapist might shift into exploring, even briefly, each partner's family-of-origin experiences with parental communication. Likewise, as in the case to be described, if the couple completes communication skills training but continues to be in conflict, the therapist might shift to explore family-of-origin experiences or narrative practices to help the couple externalize their conflict.

The second "primary color," degree of directiveness, notes that theories of family therapy differ in the degree to which the therapist takes charge of the session, determining the content and interactive process, and whether or not the therapist teaches skills or introduces new perspectives on interaction or emotional experiencing or, instead, lets families discover these new patterns and experiences through the flow of conversation. For instance, on the extreme end of high directiveness lies structural, strategic, cognitive-behavioral, and emotion-focused therapies; on the pole of low directiveness, with the therapist aspiring to be nonhierarchical, are the constructivist approaches. In the TP, it is suggested that for most families and couples, who enter therapy in a state of crisis – or at least, feeling that their usual ways of handling problems are not working – a higher degree of directiveness is called for early in the therapy, with the therapist backing off as the family starts to develop new skills and useful novel perspectives.

The third "primary color," change entry point, notes that different approaches typically privilege intervening primarily or at least initially on cognitions (Bowenian, psychoanalytic, narrative therapy, constructivist), emotions (experiential and emotion focused), behavior (cognitive behavioral, structural, strategic, MRI), or even physiology (mindfulness/meditation practices, although these practices simultaneously focus on cognitions and emotions). Of course, change in one of these domains of functioning are believed to lead to changes in the others – for instance, in emotion-focused therapy, changes in emotional experiencing are seen as requisite for change in cognitive perspectives on the partner and in interactive behavior, whereas in cognitive-behavioral therapy, changes in behavior patterns are seen to affect cognitions and emotions. In

the TP, the therapist chooses among change entry points (and the theories and associated practices that privilege each change entry point) based in part on the family/couple's theory of change and on the nature of the presenting problem and shifts among cognitions, emotions, or behavior after progress in one of these domains reaches its potential, at least in the moment.

The TP also engages a social justice lens. In particular, the feminist perspective highlights and works with issues of power and privilege, striving for equity between adult partners and addressing patterns of dominance and subjugation as they emerge in the couple's interactions.

Case Description

In this case, I drew upon systemic, cognitive-behavioral, structural, narrative and feminist perspectives and techniques. Rob, 36, a professional musician, and Jill, 32, an assistant director of an arts nonprofit agency, contacted the clinic complaining of communication problems. In the first session, they spoke of how they often fought about money – particularly, Jill's unhappiness with Rob's unsteady employment and his low contribution to their expenses. On occasion, these conflicts escalated to the point at which Rob threw plates and once punched a wall. Although he had never struck Jill, she felt intimated by these displays of aggression and would end up placating Rob; Rob minimized their significance, although he did say that he did not condone male violence. He noted that Jill seemed unwilling to acknowledge the reality of "archetypal male power" (Rob was immersed in the men's movement as described in writings of Robert Bly and Joseph Campbell). After such a fight, the partners would not talk for days, sometimes weeks. In an attempt to explore strengths and alternative, more positive "narratives" of the couple's communication abilities, the therapist inquired as to whether there were times when they communicated in a calmer, more satisfying way about problems. The couple said they did not, and each partner added that they did not have positive role models from their respective parents. In fact, in a brief exploration of their families of origin, both described coming from backgrounds where they witnessed poor communication and aggressive interactions between the parents. Jill also described being verbally abused by her mother, and Rob described numerous instances of beatings from his father, prompting him to leave home at the age of 15.

The therapist presented the outline of his therapeutic approach, noting that it was a combination of changing interaction patterns and developing greater insight into the nature and source of these patterns. He suggested that therapy could start by him teaching the couple communication skills or that they could further explore each of their families of origin and how those experiences shaped their current interactions. Both partners said they did not want to do extensive exploration of their pasts, noting that they each had extensive experience in individual psychodynamically oriented therapy.

The next three sessions drew upon cognitive-behavioral, research-based communication and problem-solving skills. The couple learned the skills and said that although feeling artificial, they could see the benefits.
However, the following session started off with Jill noting that over the weekend, Rob had expressed the desire to end therapy, feeling that now they could practice the skills on their own. On the other hand, Jill expressed the desire to continue therapy, saying that the presence of a third party (the therapist) helped her feel safe expressing feelings that she normally would

suppress. Rob grudgingly agreed to continue. Thinking from a feminist perspective, my hypothesis about why he wanted to terminate was that in learning the communication skills, their communication had become more equitable, which threatened his ability to dominate their interactions. However, I felt that to voice this idea would surely result in Rob becoming defensive and would redouble his intention to quit. Although a next step might have been to explore their families of origin and develop more insight about the source of their problematic communication, they had explicitly told me that they did not want to pursue this approach. I decided to engage narrative therapy, with the hope that it would lead to an externalizing of the problem pattern and, especially, to provide Rob with some tools to work against his aggressive tendencies. The decision to try a narrative approach was also prompted by an observation that, almost in passing, Rob had described at times feeling overcome with his aggressive tendencies, personifying them as "demons." Given his having already given a name to these tendencies, I thought he might be open to the narrative approach, which centrally involves giving a name to troubling patterns and feelings as a first step toward externalizing them.

I explained the basic premise and practices of narrative therapy, and both partners agreed to try it. Rob went first in the process of naming his contribution to their pattern of conflict, importantly noting that he felt shame when acting in an aggressive fashion. He linked this shame to his experiences with his abusive father, who would often degrade him while beating him. Drawing from imagery from the film The Fisher King, he eventually named his shame and tendency toward aggression the "Dark Knight," "who lances me and throws me into the air." For her part, Jill described her tendency to become silenced in the face of aggression (learned from her interactions with her mother) as Rotunda, which she imagined as an exceedingly obese female cartoon-like character, sitting on her and squashing her. The couple was instructed to help each other maintain independence from their respective externalized patterns: When Jill started to feel Rob becoming aggressive, she was to say "I feel the presence of the Dark Knight," and Rob was to adjust his behavior to decrease its intensity. If Rob perceived Jill to be closing down in conversation, he was to ask if Rotunda was present and use his perceptions as a signal to reduce intensity. This approach engaged both partners, and particularly Rob. He noted that the externalizing had allowed him, for the first time, to experience compassion for himself. In the next session, the couple reported much progress – they had an opportunity to try engaging the externalized problems as a discussion began to become conflictual, and the conflict quickly deescalated. The remaining sessions of this relatively brief therapy were spent exploring family of origin themes (which the couple had become more willing to do now that their conflictual patterns had been disrupted) and refining their skills at interrupting escalations. It helped that during this time, Rob started obtaining more regular work.

# Cross-References


- Common Factors in Couple and Family Therapy
- Integrative Problem-Centered Metaframeworks Couple Therapy
- Multidimensional Ecosystemic Comparative Approach
- Multidimensional Family Therapy

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