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COMPETENCY IN INTEGRATIVE PSYCHOTHERAPY: PERSPECTIVES ON TRAINING AND SUPERVISION

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Increasingly, many psychotherapists identify with an integrative approach to psychotherapy. In recent years, more attention has been directed toward the operationalization and evaluation of competence in professional psychology and health care service delivery. Aspects of integrative psychotherapy competency may differ from competency in other psychotherapy orientations, although convergence is more often the case. Despite the potential differences, there exist very few formal training programs or guidelines to systematically guide clinicians in developing a competent integrative practice. This paper attempts to distill the essential elements of competent integrative psychotherapy practice and focuses on how these might be developed in training and supervision. We address most of these complex issues from a specific integrative perspective: principle-based assimilative integration.

Keywords: psychotherapy training, psychotherapy supervision, psychotherapy integration

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In recent years, there has been an increased emphasis on accountability in health care service delivery, a concern that often goes hand-in-hand with the issue of competence (Kaslow, Dunn, & Smith, 2008; Kaslow et al., 2007; Lichtenberg et al., 2008). Also of note, an integrative approach has become the modal preferred therapeutic orientation of psychotherapists in the United States (Norcross & Goldfried, 2005; Norcross, Karpiak, & Santoro, 2005). Based on these recent and converging trends, we believe it is important to distill elements of competent integrative psychotherapy practice and focus on how these might be developed in training.

This paper is an attempt to address these complex issues from a specific integrative perspective: principle-based assimilative integration. This approach is organized around identifying therapeutic commonalities, principles of change that cut across different orientations, and using these principles to determine when and how to assimilate exogenous techniques into a primary treatment frame (Castonguay, Reid, Halperin, & Goldfried, 2003; Messer, 2001). First, we delineate what we believe are several important components of integrative competency from our perspective. Second, we outline the foundational and functional competency domains that form the basis of these components. Third, we discuss the supervision process from this approach, using a clinical case to illustrate how to foster competent integrative psychotherapists.

Essential Components of Integrative Competency

There are multiple pathways to psychotherapy integration (Castonguay et al., 2003): theoretical integration, technical/prescriptive eclecticism, common factors, and assimilative integration. Our perspective combines these last two pathways. In line with an assimilative perspective, we think that case formulations and treatment plans are optimized when anchored within a specific theoretical approach (e.g., cognitive–behavioral,

psychodynamic, humanistic), while simultaneously incorporating techniques from other orientations that might address the observed limitations of one's preferred approach. The term *assimilation* is used because it signifies an incorporation of new or foreign concepts (exogenous interventions) into existing or predominant schemes (preferred theoretical orientation). Based on a common factors perspective first described by Goldfried (1980; Goldfried & Padawer, 1982), we also believe that the broadening of one's preferred approach (the foundation on which one can incorporate other procedures within a particular theoretical framework) can easily be achieved when based on principles of change that cut across different orientations. We begin by describing the change principles outlined by Goldfried and their role in competent integration, focusing on identifying the skills that are necessary to make use of them.

Goldfried (1980) proposed that focusing on principles of change (also called *core clinical strategies*) can be a fruitful approach to psychotherapy integration because these principles exist at a level of abstraction between specific techniques (in which commonalities across orientations are likely to be trivial) and the theoretical models developed to explain human functioning (in which philosophical discrepancies are likely to prevent any meaningful convergence). Goldfried's principles are select common factors that represent five specific processes of change: promoting an expectation that psychotherapy can be helpful, establishing an optimal therapeutic alliance, facilitating client awareness by providing an external perspective on one's problems and the world (i.e., new perspective of self and others), fostering corrective experiences, and facilitating ongoing reality testing.

These principles can be facilitated in different ways (i.e., different interventions and relationship styles), and empirical evidence can suggest what may be optimal methods for a given psychotherapist and client. For example, there is evidence to support the importance of Rogers's facilitative conditions in developing a strong alliance (one of Goldfried's principles) and promoting positive change[1] (Castonguay & Beutler, 2006). Therefore, these facilitative conditions should be a focus of training, along with empirically based strategies aimed at identifying and repairing alliance ruptures (Castonguay, Constantino, & Grosse Holtforth, 2006; Muran et al., 2009). Empirical research on the use of homework can also provide information on how to promote opportunities for corrective experiences and continued reality testing (Nelson, Castonguay, & Barwick, 2007). As described elsewhere (Castonguay, 2000) research conducted by Beutler (e.g., Beutler & Clarkin, 1990; Beutler et al., 1991) suggests ways (i.e., more or less directive) to foster the acquisition of a new perspective of self based on particular client factors (i.e., more or less resistance).

However, research is unlikely to be sufficient to dictate how to facilitate all of the principles of change in every case. Further clinical guidelines are needed to direct clinicians to more specific relational styles and types of interventions for particular types of clients and problems. It is also clear that the systematic (nonhaphazard) use of principles of change (and the methods used to facilitate them) rests on a cohesive integration of a theoretical model of human functioning and change. As noted by Castonguay (2000):

> Knowing that a therapeutic alliance is an important catalyst of change across different forms of therapy is not particularly illuminating when one is trying to create the most suitable intervention for a client's needs (How helpful would it be for a trainee if his or her supervisor would simply tell him/her: "Well, now go and create a good alliance?!"). For clinicians to know what to do (and what not to do) in order to create a strong alliance at different phases of the treatment, they must rely on an implicit or explicit understanding of the client's problems and how to treat them. Such understanding will be based on case formulation derived from preferred theoretical orientation(s). (p. 265)

If the components of competent psychotherapy practice from this integrative perspective are essentially the facilitation of core change processes, which are themselves dependent on theoretical systems and their respective prescribed interventions, then competent integration is the result of a coherent understanding of the process of change within and between specific theoretical orientations and possession of a diverse clinical repertoire. A competent integrative psychotherapist is aware of the change process he or she is attempt-

[1] We recognize that common factors may operate differently between and within treatments. For example, client perception of empathy is one of Rogers's core facilitative conditions and has received empirical support as an important common factor across a number of treatment approaches. This may be achieved through specific experience-near reflective statements in humanistic therapies or through the use of clarification in psychodynamic therapy.

ing to facilitate, the client characteristics that indicate (or contraindicate) the use of a specific technique (or set of techniques) to facilitate this process, as well as when and how to effectively employ these interventions.

Many techniques of divergent origins can be technical manipulations of the same therapeutic function (e.g., empathic reflection and interpretation can both provide a new perspective of self and others). Competent integrative psychotherapists should be able to adeptly employ a variety of interventions that have been developed within at least two orientations to serve change principles and effectively determine when to reach outside the treatment frame to integrate exogenous techniques. Thus, integration occurs in the service of facilitating a particular change process when (a) one's preferred approach has a specific limitation for which a divergent approach is likely to be effective, and/or (b) one's current approach is not working and a new method may be warranted. Although principle-based assimilative integration assumes that different techniques can serve similar therapeutic functions, whether the principles themselves can guide the appropriate selection of exogenous techniques is an empirical question.

It should be evident that integration is not antithetical to identifying primarily with a specific framework. For example, a predominantly cognitive–behavioral (CBT) psychotherapist's primary goal would be to competently use cognitive techniques to foster a new understanding of self, exposure interventions to facilitate corrective experiences, and relapse prevention procedures to foster continued reality testing. As we will illustrate below, however, he or she could enhance his or her clinical repertoire by incorporating interventions from other theoretical orientations that serve the same therapeutic functions through alternate routes. In our view, the central component of competent integration is theory-informed technical decision making, based on principles of change. That is, being aware of the change process one is attempting to facilitate and the interventions that are most useful to that end for a particular client and blending them into a cohesive theory of psychopathology and change. We will now turn our attention to describing what broad skills and knowledge contribute to the ability to make these decisions.

Foundational and Functional Competencies in Integrative Practice

Although this paper is primarily concerned with principle-based assimilative integration, the broad nature of the foundational and functional competencies highlighted below make them relevant to all forms of integrative efforts. Therefore, in this section we discuss how specific foundational and functional competencies are important both in integrative psychotherapy generally and principle-based assimilation in particular. Although all of the foundational and functional competencies play a role in effective psychotherapy practice, regardless of one's orientation, we highlight those that are especially salient in both integrative psychotherapy more broadly and within a principle-based assimilative integrative model.

Foundational Competencies

Foundational competencies represent the "building blocks of what psychologists do" (Rodolfa et al., 2005, p. 350) and provide a basis on which functional competency is attained. Each of the competency domains delineated by Rodolfa et al. (2005) and the American Psychological Association's (2006) Board of Educational Affairs sponsored Assessment of Competency Benchmarks Work Group is important for all psychotherapists. We believe that several of these foundational competencies are particularly valuable in an integrative model: (a) reflective practice, (b) scientific knowledge-methods, (c) relationships, (d) individual-cultural diversity, and (e) interdisciplinary systems.

Competent integrative psychotherapy requires constant reflection and assessment. Working from an assimilative perspective, for example, one needs to be aware of when a particular intervention or relationship style is ineffective for a client. For instance, a cognitive psychotherapist who is attempting to change a maladaptive self-schema through traditional directive cognitive restructuring techniques (e.g., Socratic dialogue) might observe that the client is not benefiting from this method. In line with research evidence (Beutler et al., 1991), if this client demonstrates a high level of reactance, the psychotherapist might choose to employ a traditionally humanistic technique, such as empathic reflection, to promote schema change and a new perspective of self. The

ability to engage in this process is dependent on the psychotherapist's careful reflection on the psychotherapy process and an assessment of the impact of particular interventions.

Knowing what information to attend to, how to integrate different sources of information, and how to employ interventions tactfully and with timeliness are all based on an adequate foundation of scientific knowledge and methods (Sharpless & Barber, 2009). This foundational domain includes knowledge of major models of psychopathology and psychotherapy, a diverse set of theoretically cohesive clinical methods, and evidence-based practices, which allow the distillation of core principles and clinical strategies (thus, facilitating assimilation). To be an effective integrative practitioner requires an enormous amount of breadth and depth in theoretical, clinical, and empirical research domains. A competent integrative psychotherapist is a flexible yet disciplined thinker who is well-versed in at least two of the major psychotherapy paradigms (including their theories of psychopathology and therapeutic change), and carries a large, empirically informed clinical repertoire. As cogently noted by Norcross and Halgin (2005) "integrative training exponentially increases the student's press to obtain clinical competence in multiple theories, methods, and formats" (p. 439). In an assimilative framework, for example, the psychotherapist must be able to identify important points in therapy and select interventions according to relevant knowledge of process and outcome. Although one cannot competently integrate what one does not know very well, it would be a mistake to assume that an integrative psychotherapist must be a "master of all trades." Just as individuals who spend their careers immersed in a single paradigm never stop learning, psychotherapy integration is necessarily an ongoing undertaking, and as such, is as much a method as an "orientation."

The working alliance is a therapeutic common factor that consistently predicts psychotherapy outcome across all major approaches to psychotherapy. As such, it has been identified as the flagship integrative variable (Castonguay et al., 2006). A competent integrative psychotherapist is aware that developing a positive working relationship is an important principle of change, as it may not only facilitate the implementation of techniques but could also, in and of itself, provide opportunities for transformative and corrective experiences. Competence in this domain includes not only facilitative factors (see Ackerman & Hilsenroth, 2003), but also the continuous assessment of the alliance and the detection of alliance ruptures and interpersonal conflict, as well as knowledge of the diverse methods of repairing such ruptures, which requires the ability to consider the alliance from multiple perspectives (e.g., facilitative conditions and/or collaborative empiricism). Castonguay et al. (2004) developed an assimilative psychotherapy that specifically calls for the use of extraorientation techniques when problems in the working alliance arise, showing that the relationship can be an important integrative touchstone.

Integrative psychotherapists aim to tailor their treatments to the needs of the individual (Beutler, Consoli, & Lane, 2005), with the knowledge that some client characteristics differentially relate to process and outcome, including cultural differences (Zane, Hall, Sue, Young, & Nunez, 2004). Appreciation for and knowledge of individual differences and diversity play a role in decisions with regard to treatment planning, framing of the treatment rationale, and the delivery of interventions (Hill, 2004). More important, some client factors likely interact differentially across types of interventions and treatment approaches. Integrative psychotherapists who base their intervention choice on client characteristics and process variables (as assimilative psychotherapists do) must be aware of the needs, styles, and coping strategies of individual clients to make the most efficient and productive use of her or his relational and technical repertoire.

Competency in interdisciplinary systems has been emphasized by several integrative psychotherapists, and goes beyond the integration of theoretical orientations. Basic research in all areas of psychology provides helpful directions on how to improve clinical practice. Basic research in physiology, emotion, and interpersonal theory, for example, has informed the development of a promising integrative treatment for generalized anxiety disorder (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008).

Functional Competencies

Knowledge and skills in the above foundational domains provide the groundwork for psychologists to subsequently acquire functional competencies (Rodolfa et al., 2005), which in psychotherapy de-

scribe the knowledge, skills, and values necessary to perform effectively. Areas that we believe are particularly salient when practicing from an integrative approach are (a) interventions,[2] (b) research evaluation, and (c) supervision. We focus on the functional competency of supervision in our discussion of competency in the supervisory process in the next section.

Like all psychotherapists, integrative psychotherapists attempt to efficiently gather information from clients in the service of diagnosis, case conceptualization, treatment planning, and outcome assessment. Integrative models often require a multidimensional approach to case conceptualization and intervention selection (e.g., Beutler et al., 2005; Lazarus, 2005; Prochaska & DiClemente, 1992). Competent practice not only takes into account symptom and functional domains, but other variables (participant and relationship) that are crucial for comprehensive case conceptualization and have been empirically linked to treatment process and outcome. Similar to research showing that clients with high levels of resistance to perceived control by others benefit less from directive treatments than from nondirective treatments (Beutler & Clarkin, 1990; Beutler et al., 1991), the distinction between anaclitic/sociotropic and introjective/autonomous personality in the treatment of depressed patients (Beck, 1983; Blatt, 1974) is another example of a participant factor that should be taken into consideration in case conceptualization and treatment planning. Assimilative integrationists may decide to adopt some techniques and strategies from psychodynamic treatments for anaclitic depression into CBT if the client shows some sociotropic features.

A competent integrative psychotherapist must also be a competent seeker and evaluator of research and evidence-based practice guidelines. The evaluation of such information aids integrative practitioners in identifying strengths and weaknesses of a given approach, identifying important process markers, and effectively integrating different types of interventions.

An example of how the foundational competencies of reflective practice, scientific knowledge, and relationships relate to the functional competencies of assessment and interventions can be found in Castonguay, Goldfried, Wiser, Raue, and Hayes's (1996) study of cognitive psychotherapy for depression. Castonguay et al. (1996) found that cognitive psychotherapists tended to increase their adherence to cognitive psychotherapy techniques to deal with alliance ruptures—attempting to convince the client of the rationale—which led to reluctance on the part of the client and increased rigidity on the part of the psychotherapist. In an ideal scenario, an assimilative integrative psychotherapist choosing to work from a cognitive perspective might be aware that strict reliance on cognitive methods may not be the most effective for working through alliance ruptures. Having identified an alliance rupture, the psychotherapist would consider incorporating interventions from divergent approaches that have been linked with alliance facilitation and repair (Muran, Safran, Samstag, & Winston, 2005). Indeed, these factors informed the development of a promising integrative psychotherapy for depression, integrative cognitive psychotherapy (ICT; Castonguay et al., 2004).

Although other important factors exist, we believe that these foundational and functional competency domains provide the basis for effective integrative practice. In the final section, we discuss how our approach to supervision aims to facilitate competent integrative practice.

Psychotherapy Competencies in the Supervisory Process

From an integrative perspective, competent supervision includes both the ability to provide as well as the desire to receive and respond to supervision from multiple perspectives (see Norcross & Halgin, 2005). Given our stance of principle-based assimilative integration, we typically expect supervisees to develop case formulations and treatment plans primarily from a sin-

[2] We also consider clinical assessment more broadly (e.g., initial assessment and tracking outcomes) to fit under the functional domain category of interventions because we believe that the two are closely linked in everyday practice and assessment can be understood as a mode of intervention. For example, we believe that there is enough evidence to conclude that routine outcome assessment is an evidence based practice that cuts across different treatment approaches. We also do not believe that a skillfully implemented assessment can be differentiated from the host of other technical factors present in the context of treatment. In addition, we recognize that previous authors have defined the assessment domain as specifically referring to testing and other types of evaluation, which is different from our current use of the term as it relates to psychotherapy.

gle orientation and to incorporate techniques from different approaches to address the observed limitations of their primary guiding orientation. We would also expect supervision to foster a reflective practice in the supervisee, introduced both explicitly and through modeling by the supervisor. More important, we do not assume that the best treatment for every client requires integration. The decision to integrate techniques from different theoretical orientations is based on the change process one is attempting to facilitate and the strengths and limitations of particular approaches. The specific decision-making process of integration (i.e., when, what, and how) is guided by the best available evidence as well as theory and clinical observation.

As an example specifically related to diagnosis, CBT is an empirically supported treatment for generalized anxiety disorder (GAD). Despite the effectiveness of CBT for this disorder, a portion of clients have been found not to benefit from this treatment. Some research has suggested that some clients with GAD may fail to improve because of emotional processing and interpersonal factors that CBT has not historically addressed as a core focus of treatment and/or dealt with effectively (Newman, Castonguay, Borkovec, & Molnar, 2004). Consequently, the effectiveness of CBT may be enhanced, at least for some clients, by incorporating techniques that facilitate emotional exploration and deepening as well as address interpersonal factors (Newman et al., 2004). With this knowledge, as supervisors, we might advise our supervisees to be mindful of this particular limitation of CBT in the treatment of this disorder and talk with them about how and for whom they might go about effectively integrating specific interventions into the treatment to address these limitations.

Alternatively, unanticipated difficulties may emerge as psychotherapy progresses with a client. In such cases, continued use of theory-specific techniques may fail to facilitate change. In these instances, we find it most helpful to assist supervisees, who frequently focus too heavily on specific techniques, to focus instead on the change process that they are attempting to facilitate. Once the trainee has identified the active principle of change, we encourage her or him to explore what alternative techniques or strategies, either from the present treatment approach or from a different orientation, might serve the same function.

As an illustration, let us hypothetically take a client-centered psychotherapist who has been using empathic reflection to facilitate a new perspective of self and others. Although this technique might have been useful at other points in the treatment, the client and psychotherapist have reached an impasse in this particular area. Consequently, the psychotherapist might decide to incorporate an interpretation, a quintessentially psychodynamic intervention, to help to clarify an internal conflict, thus enabling the client to understand that he or she may hold opposing views of him/herself simultaneously. One task of supervision would be to discuss how such an interpretation, especially if aimed at an emotional insight, could be incorporated into the treatment without disrupting the primarily client-centered frame. Thus, an intervention that originates from a psychodynamic orientation (both in the psychodynamic literature and perhaps from the trainee's own experiences in psychodynamic training) and addresses a particular principle of change can be assimilated into humanistic treatment with minimal interference for the treatment frame.

Case Example

The following case example should help to illustrate our approach to supervision. The trainee in this example was a third-year student in a CBT practicum, who had completed a humanistic psychotherapy practicum the previous year. She was using CBT to treat a client with GAD. In previous sessions, the trainee had successfully used cognitive restructuring to address the client's irrational assumptions about her capabilities and the related underlying belief that she was unable to act as an adult. The client reported experiencing "crying fits" at work when she was chastised for making mistakes. Over time in CBT, the client realized that when she did make mistakes, they were often a consequence of her intense worry about making mistakes. Despite this understanding, the client's irrational beliefs about being an incapable adult continued to be entrenched. The client reported that she could "rationally" see the evidence that she was a capable adult, but this did not resonate emotionally in a way that might facilitate a shift in perspective.

This pattern of using restructuring techniques to no apparent therapeutic effect had gone on for several sessions and was identified through the viewing of videotape and by the psychothera-

pist's report. First and foremost, it was important to ascertain whether inadequate delivery of the intervention (e.g., timing, tact, level of content) might explain its lack of impact. If a specific technique has been implemented competently, then other factors of psychotherapy would have to be considered, such as the nature of the working alliance and the cultural background/context of the client. After validating the trainee's frustration, the supervisor helped her to identify the principle of change she was attempting to facilitate (providing a new perspective of self, reality testing), and suggested an alternative technique originating outside the CBT literature which might provide the client with a different route to achieve the desired effect.

Supervisor: [Pauses the video] It seems like you are doing an excellent job working with your client to identify [the client's] core beliefs and challenging them. Your alliance also seems strong here and you're definitely delivering the techniques like we discussed.

Psychotherapist: Yeah, I feel like I'm doing it pretty well, but she just keeps getting stuck and I don't feel like I'm getting at the core schema. I think we are both working in the same direction, just getting nowhere.

Supervisor**:** Well, I have a thought about that. Though [the client] is capable of engaging in a cognitive discourse with you and seems to be taking to the treatment, it's possible that some of these strategies are not adequately accessing the core belief structure and so there is difficulty producing real change (*modeling reflective practice*). You might need to try a different method to get at some of the underlying affect linked to those core beliefs. It might be helpful to raise the client's emotional arousal and focus on emotions, which has received some empirical support (*integrating scientific methods*; Greenberg, Safran, & Rice, 1989; Greenberg & Webster, 1982; Samoilov & Goldfried, 2000). What are your thoughts about trying a two-chair technique?

Psychotherapist: Well, I've done that before, but I'm not sure how well it fits with the [current] treatment. How does a two-chair make sense in CBT?

Supervisor: Well, think about what you know about "hot" and "cold" cognitions. What you would essentially be doing in a two-chair is facilitating access to "hot" cognitions. We won't be changing the overall approach, just using a different strategy to activate your client's core belief structure to facilitate the restructuring (*integrating the intervention into the broader treatment framework*). Also, the principles of change of interest are for the client to view herself and her assumptions about how others view her differently, and to do some reality testing, correct? With a two chair, we can help her fully engage in and explicate the perceptions that seem to be competing here—the rational and irrational (see Goldfried, 1995).

In our experience, it can be difficult for supervisees to understand how a technique from an outside orientation can be incorporated into ongoing psychotherapy without disruption, in the service of facilitating the change process outlined by the primary treatment approach. When attempting to adhere to a particular approach, psychotherapists in-training tend to think of incorporating exogenous techniques as strange or even bad. It is the role of an integrative supervisor (and especially an assimilative integrationist) to assist the trainee in assimilating techniques into their preferred orientation. Different theoretical orientations emphasize different aspects of functioning (e.g., cognitive, emotional, behavioral) and have developed specific therapeutic interventions based on these theoretical emphases to help facilitate change; in supervision, we highlight that there are also broader principles that cut across different theoretical approaches. In the case example, this was aimed at facilitating a new perspective of self and others and reality testing. In our experience, learning to think about principles and clinical strategies makes integrating diverse techniques to serve similar functions feel less foreign.

Conclusions

At bottom, an integrative psychotherapist should be aware of the limitations of her/his preferred theoretical orientation(s). This requires possessing a firm grasp of theories of human functioning and change, as well as the technical interventions commonly used to facilitate change. We believe that principles of change can provide a useful framework for the utilization of evidence-based practices and competent integration. Graduate students and supervisees should be aware of the change process they are attempting to facilitate (positive working relationship, expectations for positive change, corrective experience, new perspective of self and other, and continued reality testing) and the interventions that are most useful to that end. Competence is achieved when psychotherapists can employ the appropriate evidence-based practices in a responsive and coherent manner.

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