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CONTENTS

Contributors vii

Introduction: How Do Integrative Therapies Help Couples and Families? 3
Patricia Pitta, Corinne C. Datchi, and Jerry Gold

I. INTEGRATIVE COUPLE AND FAMILY THERAPY WITH COMPLEX CLINICAL PROBLEMS 23

1. Complicated Loss, Grieving, and Infertility: Assimilative Family Therapy 25
Patricia Pitta

2. Incest and Relational Trauma: The Systemic Narrative Feminist Model 47
Peter Fraenkel

3. Infidelity, Self-Differentiation, and Intimacy: The Mindful Differentiation Model of Couple Therapy 71
Susan Regas

4. Money, Power, and Gender in Intimate Relationships: Cognitive Behavioral Couple Therapy 91
Terence Patterson and Corinne C. Datchi

5. Couples in the Digital Age: A Systemic Psychodynamic Behavioral Model of Couple Therapy 111
Arthur C. Nielsen

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II. INTEGRATIVE COUPLE AND FAMILY THERAPY WITH DIVERSE CLINICAL POPULATIONS **135**

6. Holographic Reprocessing Couple Therapy With Military Couples 137
Lori S. Katz

7. Functional Family Therapy With Couples Behind Bars 157
Corinne C. Datchi

8. The SALUD Model of Family Therapy With Undocumented Latinx Youth 179
Joseph M. Cervantes

9. Resiliency-Focused Couple and Family Therapy With Gay Men 199
David Greenan

10. Stepfamily Therapy With Stepgrandparents and Their Adult Children 219
Scott Browning and Brad van Eeden-Moorefield

11. Integrative Systemic Therapy With African American Couples 237
Gihane Jérémie-Brink and Anthony Chambers

Index 257
About the Editors 273

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CONTRIBUTORS

Scott Browning, PhD, ABPP, Chestnut Hill College, Philadelphia, PA
Joseph M. Cervantes, PhD, ABPP, California State University, Fullerton
Anthony Chambers, PhD, ABPP, The Family Institute at Northwestern University, Evanston, IL
Corinne C. Datchi, PhD, ABPP, Seton Hall University, South Orange, NJ
Peter Fraenkel, PhD, City College of New York, New York, NY
Jerry Gold, PhD, ABPP, Adelphi University, New York, NY
David Greenan, EdD, Teachers College, New York, NY
Gihane Jérémie-Brink, PhD, William Patterson University, Wayne, NJ
Lori S. Katz, PhD, Department of Veterans Affairs, Long Beach, CA
Arthur C. Nielsen, MD, Northwestern University, Evanston, IL
Terence Patterson, EdD, ABPP, University of San Francisco, San Francisco, CA
Patricia Pitta, PhD, ABPP, St John's University, Jamaica, NY
Susan Regas, PhD, California School of Professional Psychology at Alliant International University, Los Angeles, CA
Brad van Eeden-Moorefield, PhD, Montclair State University, Montclair, NJ

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Introduction

How Do Integrative Therapies Help Couples and Families?

Patricia Pitta, Corinne C. Datchi, and Jerry Gold

In times of adversity, couples and families face many stressors and challenges. In clinical practice, therapists work with clients who often describe feelings of loss, confusion, disconnection, pain, fear, shame, guilt, and heightened anxiety in response to stressful events. They talk about their failed attempts at resolving the problems of everyday life and enter treatment stuck in transactional patterns that contribute rather than solve their distress. Their interactions produce high levels of expressed emotion in the family—negativity, criticism, and worrying—that support the development and maintenance of individual psychopathology, including severe mental illness (e.g., bipolar disorder; Hooley, Miklowitz, & Beach, 2006).

How can practitioners help couples and families master the challenges of the lifecycle in hard times? What clinical strategies are most effective to address clients' mental health needs and enhance their functioning? What intervention programs make it possible to successfully treat couples and families in their broader social, political, and cultural contexts? The complexity and variety of problems in clinical practice require a therapeutic approach that allows for responsiveness and flexibility as well as rigor and sophistication.

This edited volume shows how expert clinicians answer these questions using integrative treatment models to help couples and families find solutions to complex challenges: Infidelity, infertility, divorce and remarriage, military deployment, incest, racism, undocumented immigration, gender inequity, new technologies of communication, and incarceration are contextual stressors and

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clinical issues that fall outside established domains of mental health research (e.g., the National Institutes of Health [NIH] framework for investigating mental disorders; NIH, n.d.). However, they affect interpersonal processes that are closely linked to individual functioning, namely family structure, roles, transactions, and cohesiveness (Cliquet, 2003; Minuchin, 1974). The challenges addressed in this book were selected for their contemporary salience, nationally and internationally, as evidenced by drug crime and immigration policies in the United States and abroad, American and European military intervention in the middle East, and the worldwide #MeToo movement that supports community action against sexual violence.

DIVERSITY AND COMPLEXITY OF COUPLE AND FAMILY LIFE

In the past 50 years, there have been significant changes in the structure and living arrangement of families in the United States. Marriage rates have declined, and the number of cohabiting partners and divorce cases has increased. The nuclear family of the 1960s is no longer the prevalent model of family life (Pew Research Center, 2015; Walsh, 2012). In 2014, 46% of children lived with two parents in a first marriage (Pew Research Center, 2015), and in 2017, 20% lived with a single mother (Pew Research Center, 2018a). In 2016, 50% of U.S. adults were married compared with 72% in the 1960s, 18 million adults live in a cohabiting relationship (Pew Research Center, 2018b), and the divorce rate was 2.4% for partners age 25 to 39 and 2.1% for partners age 40 to 59 (Pew Research Center, 2017b).

Divorce, marriage, and cohabitation have contributed to the growing diversity and complexity of family life; they also account for the fluidity of U.S. families, with more adults and children transitioning from a two-parent household in which both parents are in their first marriage to a single-parent, cohabiting, and/or remarried households. Amidst complexity and change, family members may struggle to form new relationships with each other; as a result, they may experience a lack of connection and belonging, and feel lost and anxious. Multigenerational stepfamilies illustrate the relational challenges that come with divorce and remarriage, in particular difficulties with family roles and loyalty (see Chapter 10, this volume).

Other contributing factors to complex clinical issues originate in the social and political context of family life (e.g., changes in norms; technological progress; policies about illicit drugs, undocumented immigration, marriage). On average, today's young adults defer getting married until their late 20s (29.5 years for men and 27.4 years for women; Pew Research Center, 2018a). This represents a change in coupling behaviors: In 2012, 20% of adults age 25 and older remained single compared with 10% in the 1960s (Pew Research Center, 2014). Forming a couple at a later age creates new challenges (e.g., fertility). According to the Centers for Disease Control and Prevention (2017), about 12% of women had difficulties conceiving a child or carrying a pregnancy to term between 2011 and 2015,

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and approximately 17% couples struggled with infertility (Ali, Ebraheem, & Mohamed, 2013). New assisted reproductive technologies offer a solution; however, their success is not guaranteed. Frustration, sadness, and despair are some of the feelings that define couples' experience of infertility and treatment. Some may also describe this experience as a traumatic journey that takes a toll on their relationship satisfaction and mental health (see Chapter 1, this volume).

How individuals connect, form, and maintain relationships is changing as well. The digital world has much to do with this change. Technological innovation provides solutions to medical problems, but also new ways of communicating and bonding with one another. In particular, the Internet and social media have become a pervasive aspect of our lives, with 69% of U.S. adults using at least one social media site in 2018 (Pew Research Center, 2018d). According to the Pew Research Center (2018c, 2018d), up to 74% of individuals age 18 and older are daily users of social media, and millennials (age 18–35), gen-Xers (age 36–53), and baby boomers (age 54–72) are rapidly closing the gap in their adoption of new technologies. Today 57% of baby boomers use social media, 67% own a smart phone, and 52% own a tablet computer (Pew Research Center, 2018c).

Although the Internet and social media help bridge physical and social distance, they also present new challenges for individuals, couples, and families: They have become a place where we escape to cope with individual and relational distress. Rules and rituals for relating to one another in the digital world are still unclear (Tong, Hancock, & Slatcher, 2016). Some people struggle to put down their smartphones and unplug from the Internet and social media, and the boundary between work and family life has become more diffuse (see Chapter 5, this volume). In sum, new technologies have brought people closer to one another while simultaneously creating new forms of disconnection.

Changing gender norms shape individuals' experience in society; they also influence the dynamics and structure of families and the power each family member has in relation to each other (Knudson-Martin, 2012). Despite efforts to promote gender equality, gender disparities and discrimination persist: In the workplace, 20% of women reported experiences of sexual harassment in 2017 and 42% stated they were subjected to gender bias and ill-treatment (Pew Research Center, 2017c). In the family, gender disparities affect relational processes like decision making and the allocation of roles and responsibilities (Knudson-Martin, 2012; Lyonette & Crompton, 2015). Finances are a domain of family life where partners' interactions may reproduce gender inequality (see Chapter 4, this volume). Likewise, family violence, including child sexual abuse, is linked to power differentials in gender relationships that affect family functioning (see Chapter 2). These inequities are a major source of stress, exhaustion, anxiety, and resentment in couple and family relationships; they interfere with partners' and family members' ability to balance individual and relational needs (Pitta, 2014).

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Changing norms also contribute to positives such as the growing visibility and acceptance of same-sex couples, socially and legally. The percentage of same-sex unions has doubled since the 2015 ruling of the U.S. Supreme Court on same-sex couples' constitutional right to marry (Pew Research Center, 2017a). Same-sex marriage now offers gay and lesbian couples a legal pathway for creating a family through adoption or in vitro fertilization. It also legitimizes the attachment bonds of gay and lesbian couples and creates opportunities for healing from the social shame and rejection they experienced during their formative years (see Chapter 9, this volume).

U.S. immigration policies and the criminalization of undocumented immigrants are environmental factors that have had a deleterious effect on individuals and families seeking refuge from war and gang violence in their home country. Immigration is a journey that often involves family disruption and exposure to traumatic events: When individuals leave parents, children, or siblings behind and travel thousands of miles to the United States, they encounter many forms of violence, physical and sexual, from smugglers and/or border patrol agents (Ochoa O'Leary, 2017). At the U.S. border, they may be arrested, detained, deported, and/or placed with relatives who are U.S. citizens. This may be the first time they meet U.S. family members, and the trauma related to immigration and detention complicates the formation of family bonds (see Chapter 8, this volume).

The "tough-on-crime" policies of the war on drugs are yet another contextual factor that has had an important bearing on U.S. families, particularly Black and Latinx communities. The war on drugs officially began during the Nixon administration and expanded dramatically during the 1980s and 1990s with the criminalization of drug use and the incarceration in unprecedented numbers of nonviolent drug offenders (Drug Policy Alliance, n.d.). In 2016, there were over 1.5 million drug arrests, 80% of which were for drug possession; Blacks and Latinx incarcerated for drug offenses represented 80% and 60% of the federal prison population (Drug Policy Alliance, 2018). Harsh drug policies have had collateral consequences for couples and families with loved ones behind bars, including new financial burdens and the separation of children from their parents (Datchi, Barretti, & Thompson, 2016; see also Chapter 7, this volume).

War and childhood sexual abuse are traumatic events that are "extremely upsetting, and at least temporarily overwhelm the individual's internal resources, and produce lasting psychological symptoms" (Briere & Scott, 2015, p. 10). When loved ones are deployed to combat zones in foreign countries, military families experience the stress of separation and the fear of loss (Riggs & Riggs, 2011). Over time, when deployments are prolonged or repeated, they may become estranged from one another and struggle to rebuild family cohesion after the military member returns home. Trauma-related disorders, such as posttraumatic stress disorder (PTSD), exacerbate their difficulties with family reunification (see Chapter 6, this volume). They are associated with impaired relationship functioning, emotional withdrawal, and physical and psychological aggression (Pukay-Martin, Torbit, Landy, Macdonald, & Monson,

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2017). High levels of negative emotions and low levels of support in family relationships contribute to the development and maintenance of trauma-related symptoms and interfere with recovery.

It is estimated that 25% to 35% of women and 10% to 20% of men have experienced childhood sexual abuse in the United States (Briere & Scott, 2015). Child abuse is a traumatic event that produces significant distress for the individual and the family, more so in cases where the perpetrator is a family member. When the abuse is uncovered, the family system is pressured to change to provide for the children's physical and psychological needs. In cases of childhood incest, systemic change is a complex relational process that involves resolving feelings of anger, guilt, and grief and undoing loyalty binds and cross-generational coalitions (see Chapter 2, this volume).

The term *trauma* has also been used to describe the impact of broader societal processes such as racism and other forms of oppression (Holmes, Facemire, & DaFonseca, 2016). The scientific literature has documented the overt (e.g., hate crime) and covert (e.g., microaggressions) expressions of prejudice and discrimination and their traumatic impact on individuals and their relationships (Holmes et al., 2016). When oppression is internalized (i.e., when individuals adopt negative cultural messages about their social identities), individuals are at risk for psychological distress (e.g., low self-esteem, depression, suicidal ideation, substance abuse, disordered eating; Holmes et al., 2016). Internalized oppression may contribute to hostility and violence between family members (Falicov, 2014); it has also been linked to low relationship satisfaction and low rates of marriage among Black couples (Besharov & West, 1998; Kelly & Boyd Franklin, 2009; see also Chapter 11, this volume).

Extramarital sex is a form of betrayal that may produce psychological distress similar to PTSD (Gordon, Baucom, & Snyder, 2008). The injured partner may report high levels of rage, shame, depression, and powerlessness; may experience a sense of abandonment; and may express shock, numbness, and intrusive thoughts about the affair. They may also engage in denial or avoid their significant other in response to what they perceive as a traumatic interpersonal event. Infidelity is a strategy partners may use to deal with unhappiness and disconnection (Perel, 2017) that can be understood as the outcome of poor self-differentiation in couple relationships (see Chapter 3, this volume).

Current knowledge about divorce, trauma, violence, addiction and social inequities shows the complexity of the clinical problems that couples and families present in psychotherapy. It is critical that practitioners be informed about these contemporary issues and their impact on individual and relational functioning and also adopt a treatment approach that makes it possible to conceptualize the multi-faceted challenges of couple and family life. Couple and family therapy integration is a strategy available to clinicians to increase treatment responsiveness through considerations of clients' unique clinical needs, characteristics, and preferences as well as empirical knowledge about what works with whom and under what circumstances.

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OVERVIEW OF PSYCHOTHERAPY AND COUPLE AND FAMILY THERAPY INTEGRATION

Psychotherapy integration involves the combination of separate psychotherapy theories and techniques into unified treatment models that can meet the ever-changing needs of clients. It calls for the reconsideration of practitioners' identification with a single theory and highlights the limitations of individual systems of psychotherapy (Stricker & Gold, 2006). Psychotherapy integration is founded on the following presuppositions: first, that "no single approach to psychotherapy can deal with all of human functioning" (Goldfried, Pachankis, & Bell, 2005, p. 34) and second, that it is possible to combine the strengths of different theories into a broader and more effective approach to treatment.

Specific approaches to psychotherapy integration have been grouped together within a typology of *modes*, a term referring to the ways in which theories and techniques are combined to form new integrative systems. These modes have been named technical eclecticism, the common factors approach, theoretical integration, and assimilative integration. Various systems within the discipline of psychotherapy integration can be identified as an example of one of these modes, although the boundaries between them sometimes may be unclear (Gold & Stricker, 2012).

Technical eclecticism refers to a type or level of integration that focuses almost exclusively on using techniques from various systems of psychotherapy while retaining a single theory as its conceptual basis. An integrative approach is identified as belonging to this mode when that approach promotes the use of clinical strategies and interventions that originate in two or more established therapies. Technically eclectic models tend to rely heavily on comprehensive approaches to the individualized assessment of patients, which in turn lead to very specific treatment plans that allow for the selection of techniques from most or any forms of psychotherapy. The role of theory is downplayed in these models, which usually are based on a single theory or are in fact atheoretical. Once the assessment of the client is completed, interventions are chosen on the basis of the best match of particular techniques to the needs of the client, as guided by the empirical literature and clinical experience.

The second mode of psychotherapy integration is known as the *common factors approach.* Integrative systems that fall under this approach are based on the assumption that it is possible to compile a list of effective ingredients that cut across many, if not most therapies. It is the therapist's clinical task to determine which of the several common factors may meet the patient's clinical needs and produce the desired changes. The next step is to select techniques or interventions that have been demonstrated to activate those change factors within the context of therapy. The recent scientific literature has confirmed the critical role of common factors in the effectiveness of treatment (Messer & Wampold, 2002). Overlapping lists of the most important common factors have been presented as guides to more effective treatment. They include the therapeutic alliance; catharsis; exposure, the corrective emotional experience, learning, and practice of new behavior; hope and positive expectations of change; therapists'

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ability to instill hope and to reinforce positive expectations; and a therapeutic rationale (Grencavage & Norcross, 1990; Weinberger, 1993).

Theoretical integration refers to the mode of integration that is most conceptually driven and theoretically complex and sophisticated. Theoretically integrative approaches are constructed through the process of combining concepts from two or more distinct and often seemingly incompatible theories into a novel, integrative model with an expanded understanding of psychopathology and new mechanisms of change. Frequently, these theoretically integrated theories assume that environmental, motivational, cognitive, and affective variables exist in mutually influential spheres, affecting each other in reciprocal ways. The linear perspective of cause, effect, and change that is typical of most traditional therapies is replaced by nonlinear or circular understanding of the causes of behavior and psychological change. The first and still most influential model of this type of theoretical integration is Wachtel's (1977) cyclical psychodynamic theory.

Assimilative integration, the fourth mode of psychotherapy integration, might best be understood as falling somewhere between technical eclecticism and theoretical integration. Messer (1992), who coined this term, pointed out that all actions are defined and contained by the historical, physical, and interpersonal contexts in which they occur. Therapeutic interventions are highly complex interpersonal actions defined by the larger context of psychotherapy, and as a result the impact and meaning of a therapeutic technique changes when it is used in a context other than the one where it was developed. If a method such as relaxation training is used within the context of psychodynamic therapy, its meaning to and effects on the client are different than when it is used within the context of a standard behavioral treatment.

Psychotherapy integration is a movement that recognizes the importance of evidence-based practice (Boswell, 2017; Goldfried et al., 2005); its aim is to enhance the effectiveness of treatment and to promote data-driven strategies for identifying which activities are most successful with whom, for what type of problems, and under what circumstances. Psychotherapy integration provides an avenue for reducing the gap between science and practice, at the level of the clinician and the patient, through the integration of theoretical and empirical knowledge about therapeutic change mechanisms including common factors and model-specific techniques.

A Brief History of Psychotherapy Integration

The first integrative efforts in psychotherapy can be found in the writings of Freud (1914), who, early in the history of psychoanalysis, recommended an open and experimental approach to clinical practice. Freud's call for innovation had little traction on subsequent generations of clinicians except for French, Kubie, and Rosenzweig. French (1933) and Kubie (1934) studied the then current work in classical conditioning and described the advantages for using Pavlov's theories and methods within a psychoanalytic framework. Rosenzweig (1936) wrote about the common, underlying, and unifying change

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factors that could be found in most, if not all, versions of psychotherapy. Rosenzweig argued that the systematic use of specific change factors, such as exposure or instilling hope, could lead to individually tailored therapies that would be far more effective than a "one size fits all" approach. Rosenzweig's goal of addressing each patient's unique needs and matching those needs with specific techniques and change processes eventually became a central tenet and goal of modern psychotherapy integration.

In the 1940s and 1950s, several proposals for integrative therapies appeared in print, yet were met with little enthusiasm. Shoben (1949) was concerned with integrating psychoanalytic theories and methods with the more sophisticated, cognitively mediated approaches to learning advanced by researchers like Hull (1952) and with models of operant conditioning. During the 1960s, the approach of searching for therapeutic common factors initially introduced by Rosenzweig (1936) was reexamined by Frank. In 1961, Frank published *Persuasion and Healing*, a book that demonstrated how psychotherapy-like interventions exist across cultures and historical periods and how these interventions share certain common change factors. This book created interest in identifying common change factors in existing psychotherapies and became an explicit foundation for further integrative efforts.

As behavior therapy (Goldfried & Davison, 1976) moved out of the lab into real-world practice settings, several psychodynamic therapists seized on these empirically tested methods and incorporated them into their clinical work. Writers like Marmor (1971) and Feather and Rhoads (1972) described the integrative use of techniques like desensitization to reduce unconscious conflict by gradually exposing patients to their warded-off fears and fantasies. Paul (1978) proposed an integrative model on the basis of the synthesis of client-centered therapy and psychoanalysis; and Lazarus (1976), concerned about the lagging effectiveness of his standard behavioral techniques, developed multimodal therapy, a version of cognitive behavior therapy.

Many students of the history of psychotherapy integration consider the publication of the book *Psychoanalysis and Behavior Therapy: Toward an Integration* (Wachtel, 1977) to be the watershed moment in the development and legitimization of the discipline. Wachtel produced the first complete integrative theory and associated integrative psychotherapy, both of which exerted considerable, lasting influence and served as models for future work.

During the 1980s and 1990s, work in psychotherapy integration proliferated at a rapid rate, and this approach entered the mainstream in a powerful way. The Society for the Exploration of Psychotherapy Integration was founded in the early 1980s, and its official publication, the *Journal of Psychotherapy Integration* made its debut in 1991. Currently, psychotherapy integration has been accepted as a central model of psychotherapy, and almost all compendia of psychotherapy approaches include a chapter or more on integration (see Lebow, 2008; Messer & Gurman, 2013).

The impact of the psychotherapy integration movement also is apparent in the numbers of articles that have appeared describing psychotherapy integration as a viable approach in many countries around the world. Norcross (2005)

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surveyed the scientific literature on therapists' theoretical orientations and found that less than 20% of clinicians identified with a single school or orientation. In the United States, approximately 30% defined their approach as integrative, and the rates of practitioners who identified as integrative therapists ranged from a low of 7% among psychologists in Australia, to about 33% in Ireland and New Zealand, to a high of 42% among counselors in Great Britain (Norcross, 2005). Stricker and Gold (2011) found that psychotherapy integration was a well-established approach in countries such as Sweden, Japan, Germany, Switzerland, Argentina, and Chile. In Portugal, 25% or more of therapists reported they adhered to an integrative orientation (Vasco, 2008). In Spain, Coscollá and colleagues (2006) found an increase in the number of clinicians who identified as integrative, from 37% to 46%.

Couple and Family Therapy Integration

Couple and family therapy (CFT) was originally an integrative field of clinical practice influenced in its development by diverse theoretical frameworks such as experiential, humanistic, and behavior therapy; general systems theory; cybernetics; and psychoanalysis (Carr, 2016). However, the history of CFT, like individual psychotherapy, shows it was not immune from fragmentation into competing theories and interventions (Lebow, 2014). The 1970s and 1980s witnessed the growth of separate CFT schools with charismatic leaders like Minuchin and distinct training institutes. In the 1990s, proponents of family therapy integration together with family therapy research began to pave the road for rapprochement: CFT science established the role of common factors in treatment outcomes (Friedlander, Heatherington, & Escudero, 2016), and new CFT programs emerged that integrated concepts and interventions from diverse approaches to CFT, including empirically supported treatment models.

Many evidence-based intervention programs in the field of CFT are integrative approaches: emotionally focused couple therapy (Johnson, 2004, 2008), functional family therapy (FFT; Alexander, Waldron, Robbins, & Neeb, 2013; Sexton, 2011), and integrative behavior couple therapy (IBCT; Jacobson & Christensen, 1996). Emotionally focused couple therapy is a model that integrates attachment and bonding theory (experiential therapy and structural family therapy) to help couples and families learn to attach in a more secure way to promote individual and relational health. FFT is an integrative and empirically validated family therapy model for adolescents age 11 to 18 with externalizing behavior problems. Treatment is a phasic and relational process that activates common as well as model-specific mechanisms of change to increase the family's capacity to solve problems and to buffer against individual and contextual risk factors. IBCT is an empirically supported model that integrates strategies for increasing mutual acceptance into the theoretical framework of traditional behavioral couple therapy (Jacobson & Christensen, 1996). IBCT can be traced back to the early days of behavior therapy research with couples (Weiss, Hops, & Patterson, 1973; Stuart, 1969), to the concepts of mutual reinforcement and reciprocity (Azrin & Nunn, 1973), and to Jacobson and Margolin's (1979) social

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learning model of couple therapy that helped partners build effective communication and conflict resolution skills with the goal of disrupting problematic interactions and promoting healthy patterns of relating.

The first book on integrative CFT edited by Mikesell, Lusterman, and McDaniel (1995) described the various systemic orientations of CFT practitioners and the practice of integrative family therapy across the life cycle with a variety of clinical issues. It was accompanied by a casebook that offered an ecosystemic framework for family therapy integration (McDaniel, Lusterman, & Philpot, 2001). In the ecosystemic approach, the family is seen as a system that has strengths and whose well-being and functioning are influenced by other systems (e.g., workplace, community) and their interactions. The emphasis is on collaboration and the creation of respectful partnerships where power is distributed fairly, thus allowing the goals, needs, and wants of the clients to surpass those of the therapist (McDaniel, Hepworth, & Doherty, 1992). Lastly, the therapist is a coach whose role is to equip the client with new perceptions, tools, and ways to change.

In the 1980s and 1990s, Pinsof (1983, 1995) developed an integrative and problem-centered approach to treatment that offered a systematic method for the selection of interventions from various family and individual psychotherapies. This approach focused on three contexts (family–community, couple, and individual) and six metaframeworks (behavioral, biobehavioral, experiential, family of origin, psychodynamic, and self-psychology) to assess how problems are created and maintained in the client's system. The therapist then identifies constraints that prevent the resolution of presenting problems. Since the 1990s, Pinsof and his colleagues (2017; see also Chapter 11, this volume) have built on the original framework of the problem-centered approach and created a theoretically integrative model that includes the following components: collaboration between the therapist and the client; psychoeducation; empirically supported solution sequences; common sense; therapist's experience, intuition, and feelings with a deep attention given to the client's contexts; and common factors (Sprenkle, Davis, & Lebow, 2009).

In 2014, Lebow described the shared theoretical and empirical base of separate CFT approaches and highlighted the common factors, strategies, and techniques that cut across CFT models and constitute generic domains of CFT practice. He distinguished two categories of common factors: The first category, classic common factors, represents therapeutic processes essential to individual and systemic therapies like the therapeutic alliance, therapist characteristics, collaborative goal setting, hope, motivation for change, and feedback about clients' progress in treatment. The second category comprises common factors unique to CFT. These involve developing and sustaining a relational understanding of the problem and a multisystemic focus; mixing individual, couple, and family sessions; managing session interactions; and promoting positive family communication processes through the use of reframing and solution-oriented, strength-based language.

Lebow (2014) identified four frameworks for CFT integration: the first framework relates to metatheories of CFT practice like integrative systemic

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therapy (IST; for detailed information, see Chapter 11, this volume). The second framework corresponds to specific integrative CFT models that assemble common factors with elements of two to three CFT theories like Gurman's (2008) integrative couple therapy, a treatment approach that focuses on intrapersonal and interpersonal difficulties in couple relationships from a combined behavioral, psychodynamic, and family systems perspective. The third framework is assimilative integration, one of the four modes of psychotherapy integration described earlier. Assimilative family therapy (AFT; Pitta, 2014) is an example of assimilative integration in CFT. This model was developed by Pitta in the 1990s and integrates psychodynamic, cognitive behavior, and communications concepts and interventions into the home theory of Bowen family systems therapy (for detailed information, see Chapter 1, this volume). AFT can also serve as a generic framework for assimilative integration in CFT (see Chapter 8). The fourth framework proposed by Lebow (2014) refers to a group of integrative and idiosyncratic CFT approaches developed by individual practitioners over the course of their career. These individualized approaches typically emerge from the lifelong assemblage of diverse methods and strategies that seasoned clinicians find most effective and suitable for their own practice. Lebow formulated a set of guidelines for the creation of individualized, integrative CFT models. These guidelines call for less emphasis on specific techniques and more attention to the therapeutic relationship and the role of therapists' personal characteristics. They also emphasize common factors, systems theory, clear and coherent principles and procedures for service delivery, and multiple domains of assessment and interventions—intrapersonal, relational, and contextual. Lastly and importantly, Lebow recommended that integrative CFT approaches be evaluated in light of possible negative interactions between theoretically diverse concepts and interventions.

THIS BOOK

Integrative Couple and Family Therapies: Treatment Models for Complex Clinical Issues demonstrates the variety of individualized and well-established integrative approaches to CFT in real-world practice settings. It brings together expert clinicians who use a combination of theories and techniques to resolve complex clinical issues and address the unique concerns of diverse clinical populations. This book is intended for a broad audience of practitioners, including psychologists, social workers, marriage and family therapists, and counselors who work with couples and families and who wish to enhance the effectiveness of their approach through CFT integration.

The book chapters are organized into two sections that represent common foci in psychological research and practice: integrative CFT with complex clinical problems (Chapters 1–5) and integrative CFT with diverse clinical populations (Chapters 6–11). Since the 1980s, the field of CFT has witnessed the development and enhancement of intervention programs as well as therapy models and treatments designed to address specific clinical problems and/or populations.

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The many integrative theories and models presented in this book enables a practitioner to conceptualize and treat the many complex issues throughout the life cycle in our modern society. This organization highlights the relevance of integrative CFT to the treatment of specific clinical problems and populations.

Each chapter begins with a patient vignette that illustrates a set of developmental and clinical challenges followed by a summary of the research about the issues at hand, the description of the integrative approach, and how it is used to develop a case formulation and a treatment plan that are sensitive and responsive to human differences. (To protect clients' anonymity, the authors used pseudonyms and changed identifying information.) Multicultural issues are an integral part of effective therapies regardless of the theoretical orientation; however, discussion of how diversity factors like race and gender shape interpersonal dynamics in integrative CFT is beyond the scope of this book. Likewise, our view is that common factors are essential ingredients of all CFT models; for this reason, each chapter describes the role of common factors in the integrative CFT approach and the mechanisms that activate these factors.

Each chapter explains how theoretically diverse concepts and techniques were combined to create a coherent and systematic model of practice with clear guiding principles, key concepts, and mechanisms of change, using one or more framework for psychotherapy integration. Although some approaches fall nicely into one mode of integration, like AFT and IST, others are best situated at the border between technical eclecticism, assimilative integration, theoretical integration, and/or the common factors approach. Most chapters describe expert clinicians' work with couples. This reflects today's landscape of CFT practice in the United States where practitioners are more likely to treat couples than families for material reasons like difficulty scheduling sessions with multiple family members (Lebow, 2014).

In Chapter 1, Pitta highlights the key principles and interventions of AFT, an integrative model grounded in the home theory of Bowen's (1978) family systems therapy that integrates concepts and interventions from psychodynamic, cognitive behavior, communications, and other systemic theories. Chapter 1 shows how to use AFT to understand a couple's experience of infertility, to help them manage the stress of medical treatment, to resolve difficult emotions about their inability to conceive a child, and to explore alternatives to pregnancy.

In Chapter 2, Fraenkel presents a mode of integration that he defines as multiperspectival and theoretically eclectic, because it brings together, in a systematic fashion, concepts and techniques from different theoretical orientations: structural family therapy, intergenerational family systems, narrative therapy, and feminist family therapy. Treatment consists of using selected concepts and techniques to create conditions necessary for positive outcomes in cases of childhood sexual abuse. These conditions include the creation of a safe environment, a collaborative therapeutic relationship, a focus on cognitive schemas and emotions as well as here-and-now interactions, and a conceptualization of childhood sexual abuse that considers gender and power disparities.

In Chapter 3, Regas describes how to understand and treat infidelity with an assimilative model called mindful differentiation couple therapy that integrates

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concepts and techniques of acceptance and commitment therapy into Bowen's (1978) family systems theory of self-differentiation. The goal of this assimilative model is to foster couples' self-differentiation using mindfulness techniques designed to promote emotional regulation, reduce anxiety, and balance the partners' needs for autonomy and connectedness in their intimate relationship. The assumption is that greater self-differentiation is a necessary condition of intimacy.

In Chapter 4, Patterson and Datchi examine financial conflict in couple relationships in relation to gender and power. They also discuss how to reduce interpersonal distress that stems from concerns about money and sharing, with a well-established, integrative model called cognitive behavior couple therapy (CBCT). This therapy offers a systemic understanding of the reciprocal influence between behaviors, cognitions, and emotions in the context of couple relationships and their broader environment and is supported by abundant research on the outcomes and processes of cognitive and behavioral therapies. In particular, the basic principles of CBCT help conceptualize couple dynamics in relation to gender socialization; they provide a valuable framework for assessing partners' beliefs about money and for understanding their interactions around financial matters. Recent developments of the CBCT model have made space for emotionally focused therapy techniques and dialectical behavior therapy interventions to achieve the goals of treatment.

In Chapter 5, Nielsen highlights the benefits and challenges that new technologies have introduced into couples' everyday life. He shows how to address these challenges through a theoretically integrative approach to couple therapy called couple therapy 4.0, which combines psychodynamic concepts drawn from depth psychology and psychoanalysis, structural family therapy, and Gottman's research on successful marriages with psychoeducation, systemic, and behavioral interventions. Nielsen discusses how couple therapy 4.0 can help to understand and treat a middle-age couple with presenting concerns centering on the use of online pornography and sex-themed chatrooms. He also describes how the therapist uses social media to reduce the partners' social isolation.

In Chapter 6, Katz discusses the unique concerns of military couples postdeployment, and describes the clinical application of an assimilative couple therapy model called holographic reprocessing couple therapy with veterans who have experienced military stress and trauma. This therapy integrates various family therapy techniques (e.g., family genogram, circular questioning) into the framework of holographic reprocessing therapy to help military couples resolve trauma-related symptoms and develop new communication and behavior patterns.

In Chapter 7, Datchi discusses the importance of maintaining couple and family relationships during incarceration and proposes an assimilative model on the basis of FFT to address the unique needs of justice-involved adults and their loved ones or significant others. Specifically, she shows the clinical application of the assimilative FFT model with a married African American couple behind bars. This assimilative model integrates concepts and techniques from Gottman's research, IBCT, and behavioral couple therapy for substance use into

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the home theory and clinical protocol of FFT to assess, conceptualize, and treat the specific relational dynamics that influence the couple's resilience and risk of further contact with law enforcement. The goals of treatment are to support the partners in their efforts to maintain their bond, to strengthen the protective factors in their relationship, and to increase the likelihood that the husband will successfully return home.

In Chapter 8, Cervantes examines the stress and trauma of undocumented immigration from Latin America to the United States, and their impact on the well-being of unaccompanied Latinx youth. He discusses the need for culturally responsive treatment approaches that take into consideration the spiritual values of Latinx communities and describes an integrative model of family therapy called SALUD, which combines concepts and techniques of structural family therapy and narrative therapy with empirical knowledge about Latinx families. A clinical example is provided to illustrate how SALUD helps resolve the effects of trauma associated with the hazards of illegal immigration.

In Chapter 9, Greenan describes resiliency-focused family therapy, an assimilative model based on the home theory of structural family therapy that incorporates mindfulness practice, effective communication skills, and concepts and techniques of accelerated experiential dynamic psychotherapy. This model is designed to address the reenactment of past attachment trauma in couple and family relationships, to improve emotional regulation and communication, and to develop interactional patterns that enhance relationship satisfaction. Greenan illustrates the implementation of resiliency-focused therapy with a gay couple who experience difficulties with intimacy, a product of their gender socialization.

In Chapter 10, Browning and van Eeden-Moorefield present stepfamily therapy, a model that uses strategic family therapy as a home theory and that integrates concepts and techniques of structural family therapy and Bowen family systems therapy. The authors argue that traditional systemic therapies are ill-fitted for clinical practice with stepfamilies because they do not take into consideration the fluidity and diversity of living arrangements that follow divorce and remarriage. This chapter describes how stepfamily therapy responds to the relational needs of a stepfamily struggling to form new bonds across three generations.

In Chapter 11, Jérémie-Brink and Chambers discuss the clinical application of IST with an African American couple. IST was developed from the integration of two approaches: integrative problem-centered therapy designed by Pinsof and metaframeworks created by Breunlin and his colleagues (Lebow, 2016). IST can be defined as a metatheoretical and empirically informed model of family therapy integration. It provides a set of guidelines and a blueprint that allow for the integration of strategies from different treatment models (Russell, Pinsof, Breunlin, & Lebow, 2016). Jérémie-Brink and Chambers demonstrate that IST is particularly well suited for clinical practice with African American couples, given its emphasis on resilience and contextual factors.

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CONCLUSION

The APA Presidential Task Force on Evidence-Based Practice (2006) defined *evidence-based practice in psychology* as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). This book provides examples of what evidence-based practice looks like in real-world clinical settings with the aim of giving readers examples they can use to design their own integrative approach to clinical work with couples and families.

It is our hope that, by illuminating the wide range of integrative practices in CFT, this volume will help professionals begin to identify which practices are the best fit for the complex clinical problems they encounter in the therapy room. We also hope that by pairing summaries of empirical knowledge relevant to the treatment of diverse couples and families alongside our CFT experts' description of how their interventions work, this book will help readers provide the best services they possibly can to improve their clients' individual, relational, and social functioning.

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