INTEGRATIVE THERAPY IN A NUTSHELL – INTEGRATIVE THERAPIE KOMPAKT Englisch und Deutsch

„Integrative Therapy“: History, Development and Concepts of an Innovative Approach to „Biopsychosocial“. Psychotherapy and Body Oriented Intervention

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***Integrative Therapy* (IT)** was developed in Paris at the end of the 1960s by a group of clinicians and researchers – psychologists and physicians – under the direction of Univ.-Prof. Dr.Dr.Dr. *Hilarion G. Petzold* who was later named as one of the „Leitfiguren der Psychotherapie“ (one of the „leading figures of modern psychotherapy“) by the renowned weekly Magazine „Die Zeit“. *Petzold*, having studied psychology (1963 sqq, PhD 1971) with a clinical orientation, philosophy with *M.Foucault* and *G. Marcel* and Russian orthodox theology, had a broad interest in therapeutic methods and anthropological problems and thus many friends from mainstream therapy schools and approaches. He gathered a group around him whose members were educated in psychoanalysis, behavior therapy, gestalt therapy, body therapy and psychodrama, being dissatisfied with the „*onesidednesses*“ and limitations of their original therapeutic approaches: behaviorists then were only concerend with „overt“ behavior, analysts only focused on unconscious conflicts, and gestaltists on emotions, body therapists focused on physical tensions while neglecting cognitions, psychodramatists focused on acting and creative activities (*Petzold, Orth* 2007). But all these dimensions seemed to be important to treat patients and to help people with difficulties and suffering. This made *Petzold* seek for *common* and *divergent concepts* in **theory** and – inspired by *S. Garfield* a.o. – for *common* und *divergent factors* in **practice**. Trained and experienced in a variety of approaches, he began to experiment with „active techniques“ – like *Ferenczi,* following whose tradition he made his training analysis *V. N. Iljine* -, methods to mobilize regressed and depressed patients. He went to America to work with *Moreno, with Fritz Perls,* and to Oslo for body analysis with the *Reich*-student *Ola Raknes,* becoming a teaching therapist on these approches but at the same time staying to be an academic psychologist, behavioral oriented researcher and clinician in Paris and later in Düsseldorf, where he studied medicine and orthopaedagogics/defectology (1971sqq.). Over the time he developed methods and treatment techniques which brought together the most effective and sound approaches of traditional psychotherapies, and this not as an „eclectic mix“ but on the basis of a schooltranscending „integrative and differential“ theory that he keeps developing since the beginnig of the 1970s when he and some of his colleagues (*Johanna Sieper* PhD, *Hildegund Heinl* MD a.o) founded the „Fritz Perls Institute for **Integrative Therapy**“ (**FPI**). They took the name not because it was an institute centered on Gestalt Therapy but because *Perls* was the first who originally wanted to establish a method-encompassing therapy (a project he unfortunately gave up soon). The FPI-Institute grew rapidly and soon became famous because it introduced Gestalt therapy (e.g. with *Jim Simkin*), Family therapy (with *Virginia Satir*), Bioenercetics (with *Alexander Lowen*), Transactional Analysis (with *Fanita English*) to the German speaking countries. All these protagonists gave their first courses in Europe at the FPI and were running programs there and in the internatinal „one-month intensives“ which were organized every year since 1973 by the FPI on the island Dugi Otok on the Dalmatian Coast. But also famous behavior therapists like *Frederik Kanfer* and psychodramatists like *Zerka Moreno,* and co-founder of Gestalt Therapy, *Lore Perls*, came to teach.
In the same time *Petzold* kept his own approach in permanent development – offering since 1972 a four years program of „**Integrative Therapy**“ **(IT).** At first teaching psychology in Paris, then in Düsseldorf, he was appointed a professor in Amsterdam in 1979, where he ist still teaching, holding a university chair in psychology and in clinical movementtherapy/psychomotorics. In 1981 the „European Academy of Psychosocial Health“ was founded with its spacious premises on beautiful „Lake Bever“ near Düsseldorf, a state recognized training institute for the helping professions (Scientific director Dr. *Petzold*, medical director Dr. *Heinl*, director of traing, Dr. *Sieper*). The Integrative Therapy method was taught and practiced from 1972 onwards not only in Germany but also in the course of training programs and institutes in Austria, Swizzerland, the Scandinavian Countries, later in The Netherlands, Italy, Greece, Spain, New Zeeland. Since 1985 Integrative Therapy was taught in Yugoslavia, these days in the context of training programs, institutes resp. associations in Slovenia and Croatia. Integrative Therapy programs with similar orientations developed also in the USA (*J.Norcross, M. Goldfried* a.o.). The „**SEPI**“, the „**S**ociety for the **E**xploration of **P**sychotherapy **I**ntegration, became the international organization for all clinicians and researchers interested in the „**new integration paradigm**“ in clinical psychology and psychotherapy, editing the „Journal for Psychotherapy Integration“. In 1975 the Journal „Integrative Therapie“, the first one of this name, was founded by *Petzold* and famous *Charlotte Bühler*. These days, this quarterly magazine has celebrated its 25th aniversary. In 2000 the honour of a visiting professor in „psychotraumatology“ was bestowed upon *H.G. Petzold* by the Donau-University in Krems, Austria. Having written and edited more than 60books and authored about 1000 scientific articles (idem 2007h). *Petzold* is nowadays considered one of the most profiled protagonists of European psychotherapy. Psychology Today portrayed him as a “polymath of psychology” (*Geuter* 2008) and “Die Zeit” as one of the “leading protagonists” of modern psychotherapy (*Zundel* 1987, *Sieper* et al 2007).

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Meanwhile, the „**new integration paradigm**" has become a strong international movement in psychotherapy and clinical psychology, with many brilliant clinicians and researchers adhering to it: *Howard* and *Orlinsky*, *Bergin* and *Garfield*, *Wachtel*, *Norcross*, *Grawe, van der Kolk,* to name a few.

The approach – core concepts of theory:

The **Integrative Approach** to therapy has a **biopsychosocial** position and a **life span developmental** as well as a **context oriented** view. Therefore it is following a **multiperspective** complex paradigm, rooted in the longitudinal oriented *„life or bio-sciences*" (biology, medicine with the important subdisciplines neurosciences, psychiatry and immunology), in *„scientific psychology*" (developmental, clinical, social) and in the clinically relevant *„social sciences*" (clinical sociology, organizational science, supervision sciences, history of culture, political science). The background **metatheory** of such a multiperspective approach must be firmly based on modern philosophy, i. e. on epistemological and anthropological views (with *M. Merleau-Ponty, P. Ricoeur* a. o.), on culture critcis with (*M. Foucault, J. Derrida, P. Bourdieu* a. o.), and must provide a clear position of general and professional ethics (*E. Levinas, G. Marcel* a.o.). The background in **clinical theory** has to be based on modern, psychotherapy-relevant neurosciences, where the "Russian School" (*Anokhin, Bernštejn, Lurija, Ukhtomskij* a.o.) was very influential for Integrative Therapy (cf. *Petzold, Michailowa* 2008; *Petzold, Sieper* 2008; *Sieper, Petzold* 2002), but also *A. Damasio, G. Edelman, E. Kandel, J. LeDoux, W. Freeman* are important. Of course we draw on psychotherapy research (e.g. *A. Bergin, K. Grawe, D. Orlinsky,* cf. *Petzold, Märtens* 1999), psychiatry research (e.g. *C. Nemeroff*, *B. van der Kolk*) and on the wealth of contemporary psychology (particularly clinical, developmental, and social psychology).
The basic anthropological assumtion of **IT -** drawing on classical concepts in modern reformulation **–** is a multiperspective view on the *human being* and his situation in the world (micro- and macrocontext) with the others, with his *cosubjects*, fellowmen and women, pointig out five anthropological dimensions and three dimensions of personality.

The Model of Man – anthropological perspective, personality theory

The model of man in Integrative Therapy is grounded in the ontological assumption that „*beeing is essentially cobeing*". It is therefore based on the reality of the „Other and the Self" (*G.H. Mead*), on the „primacy of intersubjectivity" (*G. Marcel*), on the „otherness of the other" (*E. Levinas*).
„*The human being (man or woman) is a* ***body***[1]***-soul***[2]***-mind***[3]***-subject*** *in a* ***social***[4] *and* ***ecological context/continuum***[5]. *By* ***co-respondence with the Other*** *and the interaction with relevant enviroments he has the chance to constitute in a selfreflective and discoursive developmental process over the life span a coherent* ***Self***[I] *a well as a functioning* ***Ego***[II] *and consistent but flexible* ***identity***[III]***,*** *i.e. a* ***complex personality*** *in varying life situations and social networks with different and changing qualities of life in general, and specifcally of health and disease, wellness and illness, happyness and distress, with experiences of despair, hope and of* ***meaning,*** *always rooted profoundly in interpersonal relationships, in intersubjective co-respondence, in polylogues*" (*Petzold* 1970c).

With such a broad model of man, therapy cannot be seen as *psycho*therapy alone, reproducing the old occidental dualistic split of the „body-mind-problem". Therefore we prefere the term „**Humantherapie**" (Germ.) meaning: „*therapy for, with, by and through the human being as a whole*"(ibid.), working with all dimensions of human existence:
1. „**Body**" - is defined as the totality of all biological and physiological processes and the learning achieved by them, stored in the (mostly inaccessible or implicit) „body memory" on an immunological and neuronal level. The bodily reality of the human being is requiring **somato-therapy** (*soma*, gr. body): *body oriented methods* (relaxation, breathing and running therapy, „eustress training", "tension/conflict – solution", „somatization reversal" neoreichian techniques etc.) in order to influence or modify physiological/physical resp. psychophysiological reactions, patterns and (dysfunctional) modalities of body learning (e.g. chronified stress reactions).
2. „**Soul**" – is defined as the totality of all emotional, motivational, and volitional processes and the results of emotional learning, stored in the (mostly implicite) „emotional memory" of the limbic system and in the „scenic or episodic" memory of the hippocampus (which may be also declarative). The psychic reality requires **psycho-therapy** (*psyche,* gr. soul), that is *psychological methods* (e.g. focusing, Gestalt, Psychodrama, active psychoanalysis following the Ferenczi-Tradition, creative methods of expression with colour and clay etc.) in order to influence or modify emotional reactions, patterns and (dysfunctional) modalities of emotional learning.
„3. Mind" – is defined as the totality of all cognitive, reflective and metareflective processes and *their results/products,* i.e. knowledge, science, philosophy, arts, religion stored in the (mostly explicite, declarative) complex memory system (prefrontal cortex, hippocampus) of the individual, also including collective cognitions and memories from the cultural background. The mental reality requires **noo-therapy** (*nous*, gr. mind), *cognitive behavioral* but also *metacognitive methods*, interpretive/hermeneutic procedures, in order to influence or modify cognitive patterns and (dysfunctional) modalities of cognitive learning, e.g. appraisals, attributional styles, control parameters, coping strategies, creative methods to explore und express quests for *meaning* on a symbolic level etc.
„**4**. **Social context/continuum"** constitutes „social reality", seen as the totality of all social influences relevant for the person and its social network (family, friends, colleagues). It requires , if dysfunctional and destructive, as for example in the „scene" of drug addicts or in violent families, **socio-therapy,** i.e. family counseling, social network therapy and other interventions in order to influence or modify communication and interaction styles or patterns and (dysfunctional) modalities of social learning.

„**5. Ecological context/continuum“** constitutes „ecological reality**“,** seen as the totality of all (micro)ecological influences relevant for the person (flat, house, quarter, job environment). It requires, if these influences are detrimental or damaging, microecological interventions such as counseling, environmental modeling, setting reorganisation etc. based on the concepts of ecological psychology (*J.J. Gibson, K.Lewin, U. Bronfenbrenner* a.o.) in order to influence or modify ecological „affordances“ (*Gibson*), reaction patterns e.g. to ecological stress and (dysfunctional) modalities of ecological learning.
Contexts are always intertwined with the c**ontinuum,** considered the totality of influences in, by and through time on all the aforementioned five dimensions: there are influences from the past (*retrospective*), from the presence (*aspective*) and from future anticipations (prospective). The continuum dimension requires a „life span developmental perspective“, a temporalization of the psychotherapeutic situation as a per definitionem *processual* reality, an interpersonal, intersubjective process to work on the results of biographic influences, to support the management of the patient's current problems, and to deal with threats that may be realistically expected (e.g. loss of job, of a partner, of health), with phantasmatic future anxieties, with (negative or dysfunctional) goals, plans, projects etc.

The Model of Personality

I. The **Self** is seen as the core of the person and considered to be the totality of all somatomotoric, perceptual, emotional, volitive and cognitve processes and patterns (schemes) operating in a given *context*. It is a *synergem* which is „more and something else than the sum of its parts“. Ontogenetically, the oldest structural element (body **s**elf) of a *lifelong developing „personality in contexts“* (towards becoming a mature **S**elf) it has the capacity to form an
II. Ego which is seen as a process function of the **S**elf, more precisely a bundle or *synergem* of primary ego functions (sensing, feeling, memorizing, thinking, will, acting) and seondary ego functions (regulating, differenciating, integrating, valueing, creating, coping etc.) that can master internal and external/context-generated tasks and problems and, while interacting with the environment over the time, is able to constitute
III. Identity which is (1) the *synergy* of *social attributions* (identifying: „We know and see him as Peter, a good husband/professional/baseball player etc.!), (2) their *mental evaluation* (cognitive *appraisal* by the prefrontal cortex, emotional *valuation* by the limbic system: „Are they right, is this true? ... husband/professional *yes* ..., baseball player *no*!), and (3) *selfattributions* (identification: „I know myself as Peter and see me as a good husband/professional ... no, I am not a good baseball player, not bad though!“) Identity as the highest ego-function is constituted by five domains (**I**) *body*, (**II**) *social network*, (**III**) *work and achievement*, (**IV**) *material securities* (money, home, property), and (**V**) *values*. Since it is fundamentally rooted in social resp. Interactional processes, therapy must always take the *social situation* („Lebenslage“) – good, precarious or destructive -, the *social network* over the time, i.e. the relevant „*convoy*“, into account, for they sustantially influence on the identity and personality of the patient. Therapy is therefor never working with an individual but with the patient in his „social network“, even if it is only „virtually“ present in the therapy room

The life span model of health and disease in clinical „developmental psychology“

Integrative Therapy is the first psychotherapeutic approach using the new paradigm of *„life span developmental clinical psychology*“ to which it contributed with its own ways of research and theory. It sees health/creativity and illness/destructivity as a range of behaviors in given mircro-, meso- and macrocontexts (the influence of which cannot be underestimated). Therefore in the line of modern health sciences and longitudinal studies one has to take into account the conditions for *pathogenesis* **and** for *salutogenesis, risk factors* **and** *protective factors, deficits* **and** *resources* on an individual (biological, genetic, biographical) and contextual level (economical, social, political situation), because only then there is a chance to properly understand the problems and disorders of the patients . For a healthy development the human being needs *multiple and adequate stimulation* on all levels (perceptive, motoric, emotional, cognitive, communicative). It needs a broad scope of experiences, rich sensory input, possibilities of free selfexpression, room for creative experimentation and for cocreative projects with other people. Pathology may develop through *deficits* (lack of stimulation, neglect), *trauma* (overstimulation, hurts), *disturbances* (unclear stimulation, confusion) and *conflicts* (antagonistic stimulation, fights). If one or more of these constellations have a *long-term* influence on a human being, they will cause stress and strain that eventually may result in disorders or diseases, particularly if there is a genetic vulnerability, only poor resilience, and if protective factors are missing. These *pathogenetic* constellations are not only operating in early childhood but may have impact over the whole life span , just as *salutogenentic* stimulation (reassurance, care, comfort, appreciation, love, encouragement) can become effective at any time up to senescence. Thus health and disease, wounding and healing, psychological erosion and psychological development are lifelong influences coming from beneficial and detrimental environments, supportive or toxic „convoys“, as „social networks“ are called from a longitudinal perspective. Early childhood is important, but with developmental psychopathology and longitudinal research **Integrative Therapy** affirms that it has less impact than assumed by the traditional psychoanalytic paradigm, which has no support from clinical developmental psychology. Consequently therapeutic interventions are promising in any period of life, also in late adulthood or old age, as long as therapists do not block their treatment effects by negative outcome expectations. For the theory of pathology in **IT,** the paradigm of psychophysiological disstress (and also parental neglect or negative family interaction cause negative stress) is of outmost importance in conjunction with the concept of positive stimulation and eustress. *Chains of adverse events* and *chains of positive events „in interaction“*, *constructive life situations* („Lebenslage“), rich in resources and potential, or *precarious life situations*, lacking resources but being confronted with many risks, or even *destructive environments,* filled with violence, negativity and deficits of any kind, are the factors that

have to be assessed in diagnosis and that have to be addressed by therapeutic measures. For this **IT** provides adequate strategies and a sophisticated choice of powerful intervention methods, drawing on the wealth and the experience of „one hundred years of psychotherapy“ in the different „schools“ and traditions that we have systematically explored, screened and „exploited“ for the sake of our patients.
On the gound of its nonreductionist „anthropological views“, the approach may be considered a „**Humantherapie**“ (Germ. „therapy of the human being“), covering the whole domain of the „human condition“. It consequently has to be an **integrative therapy**: **1.** working with the body by help of „*body therapy*“ and psychophysiological methods, **2.** dealing with psychological problems and tasks by help of psychological methods and „*psychotherapy*“ techniques, and **3.** working with mental problems and tasks while using „*nootherapy*“ with cognitive approaches for cognitive problems, on existential questions, however, using „socratic dialogues“ and „narrative practice“. With problems concerning values, political and ethical positions e. g. methods of **co-respondence**, „dicourse and polylogue“, are applied. In spiritual and religious quests for m e a n i n g contemplation, meditation or tools of aesthetic and symbolic expression from creative arts therapies can be offered. **4.** Social problems, e.g. unfavorable childhood, adolescent or adult socialisation, poor job situations, poverty issues etc. and **5.** ecological problems such as depressing living quarters, , violent surroundings, risky environments as pathogenetic influences on one side or as lack of protective factors and ressources, as a deficit of salutogenetic influences on the other , have to be addressed by „*sociotherapy*“, „*microecological interventions*“, and infrastructural programs. **6.** All this has to be viewed in the „*continuum of time*“, consisting of personal biography, presence and future, of collective history, actuality and prospective developments.

On the basis of its „personality theory“, **Integrative Therapy** is centering on **I.** ***S****elf-processes* (selfesteem, selfknowledge, selfsupport, selfassertiveness, sovereignty, sefdefeat, selfdoubts, selfdestruction etc.). **II.** It works with *Ego-processes* (cognitive, emotional and socio-communicative flexibility, coping- and creating-capacities). **III.** It works with situations and processes relevant for *Identity*, e.g. with unfavorable contexts, social networks, rich or poor in resources, with attributional styles, locus of control etc. through methods of *body therapy, psychotherapy, nootherapy*, and *sociotherapy* like familiy and social network interventions.

The methods, techniques and media of IT – core concepts of practice

The complexity of the **IT** approach offers a fascinating and nonreductionist view on the human condition. In order to base the concept of „**Humantherapie**“ in the field of clinical knowledge and experience as it emerged during the development of modern psychotherapy, psychosocial methodologies and practices, we were looking for „models, concepts and pragmatic strategies“, i.e. for „*heuristics*“ in these domains on several levels (macro, meso, micro). Based on comparative studies on all the mainstream „schools“ of psychotherapy, a number of important „*heuristics*“ have been identified and elaborated – among them four **basic orientations** of therapy**:**
1. It has a **clinical orientation,** which is *curative* and *palliative*, trying to restore health and/or to reduce pain and suffering by help of clinical methods and therapeutic interventions.
2. It has a **salutogenetic orientation** fostering health, wellness and fitness, health consciousness and an health-active lifestyle (and this is more than prevention) by couseling and health coaching.
3. It has an orientation on **personality development**, aiming to support and to stimulate the individual to use, to cultivate, and develop his/her resources and potential through selfexploration and systematic selfrealisation.
4. It aims at a **critical contribution to culture,** for psychotherapy is an emancipatoric dicipline.

Concerning **clinical praxeology,** „four ways of healing and fostering“ are differentiated:
1. **Insight centered work to gain personal meaning**
2. **Emotional differentiation and parenting strategies**
3. **Experiential fostering of creativity and personal souvereignty**
4. **Providing experiences of solidarity**

Within this framework several moldalities can be used:

1. Exercise-centered/functional modality. With this style of working, healthy functioning is fostered by training and systematically exercising e.g. awareness excercises, orientation training, relaxation, running or other forms of sports therapy, assertiveness training, role training and other behavioral strategies.
2. Experience-centered/stimulating modality. With this style of working, creative media and forms of creativity enhancing methods (*Petzold, Orth* 2007) are used to develop the potential of patients, to provide „alternative experiences“ and salutogenetic qualities on a cognitive, emotional and behavioral level by means of role playing, imagination, Gestalt methods etc.
3. Conflict-centered/uncovering modality. With this type of process oriented work, unconscious conflicts, psychodynamic problems are uncovered and worked through, using active analysis strategies, Gestalt therapy and Integrative focal therapy.
4. Network-oriented/supportive modality. It is used to find, mobilize and use resources and potentials in the patient‘s social network and/or in agencies of psychosocial help. As **IT** is principally a „therapy in *context/coninnum*“,network and life situations („Lebenslagen“) have to be included into the „therapeutic curriculum“, i.e. the strategy design and the intervention performance of therapy.
5. Medicaton supported modality. With many problems and disorders, intervention by medication is indispensable, e.g. with major depression, for which a combination of modalities 1, 3, 4 an 5 is indicated“.
Advanced process studies of current psychotherapy research have found a range of unspecific and specific „healing factors“. With **IT,** on the basis of the analysis of psychotherapy research studies and the evaluation of

videotapes and transscripts of therapy sessions from various orientations in psychotherapy (psychodynamic, behavioral, client centered, psychodrama, Gestalt, body therapy) „**14 healing factors**“ were isolated and shall be briefly enumerated:

1. Empathetic understanding, 2. Emotional support and acceptance, 3. Help with realistically mastering practical difficulties in life, 4. Fostering emotional expression and volitive decisions, 5. Fostering insight and the experience of meaning, 6. Developing communicative competence and the ability to live relationships, 7. Fostering bodily awareness and the capacity of physical selfregulation e.g. by relaxation, 8. Fostering possibilities of learning and the development of interest, 9. Providing creative experiences and stimulating creative productivity, 10. Opening up positive future perspectives and exspectancies, 11. Supporting the development of a positive value system and consolidating existential quests, 12. Supporting the development of a clear self and identity experience, 13. Fostering the development of supportive social networks, 14. Providing the experience of solidarity and empowerment.

Even if clinically working therapist are mainly concerned with the first **basic orientation**, they will at least implicitly touch the other three, and the „**14 healing factors**“ are operational in all four basic orientations and can be found in the „**Four Ways of Healing and Fostering.**“

The developments in modern global, intercultural and highly flexible societies will demand also from clinically working therapists more than their habitual scope of practice. New demands are arising and new services are developing, new markets are emerging. The psychotherapist of the future will work also as a „health counselor“ and a „personality coach“ for his patiens and clients. The **Integrative Approach** has recognized this challenge for a long time and has developed tools for these tasks, teaching them in the context of clinical education for psychotheapists.

The broad approach of **IT** in the **clinical orientation** to the human being asks for a fresh look at diagnostics, using and complementing the DSM-IV (e.g. with social network and life situation diagnosis, with body oriented views, with family system perspectives) and demands new ways of practice while enlarging and enriching the repertoire of the classical approaches of psychotherapy. Over the decades, a variety of methods and intervention techniques has been developed, others have been *adapted* in a noneclectic, theory grounded manner from the traditional or from innovative approaches in the field of psychotherapy: e.g. cognitive behavioral methods for dealing with anxiety disorders, psychodynamic approaches to deal with depressions, Gestalt methods for assertiveness and selfvalue problems, psychodrama for social conflicts, body therapy for psychosomatic complaints. These influences and elements have been thorougly *integrated* into a „*process oriented style*“ of working „out of interpersonal contact and encounter“, within a „healing therapeutic relationship“, using individual „dyadic“ therapy, therapeutic groups or interventions in natural enviroments such as the home and family situation, e.g. by way of social network conferences. **IT** training programs are therefore designed for educating as well as for treatment in one-to-one relationships and for group settings, offering training to become an individual *and* a group psychotherapist. Basic therapeutic attitudes and skills are necessary for building a productive therapeutic relationship and handling an effecive psychotherapeutic process by using transference and countertransference phenomena, resistance and defence, but also by using coping and creating methods, strategies of enrichment and empowerment such as general interventions, or as „disease specific“ treatment program (e.g. for PTSD-pations or severe personality disorders). Experience activating emotional techniques from Gestalt Therapy are important tools (empty chair, awareness exercises, confrontation etc.). Psychodrama methods are used for resolving social conflicts or to prepare for difficult tasks in life (double ego technique, role reversal, scenic rearrangements etc.). Cognitive behavioral techniques are applied to treat anxieties, build up assertive behavior, to counter depressive cognitions of learned helplessness or to interrupt ruminating thoughts with the obsessive compulsive patient. For somatization and psychosomatic disorders a rich repertoire of methods and techniques has been developed in **IT** to „process“ somatized conflicts, to modify a „stress physiology“, turning it towards a „wellness physiology“. Body charts and body sculptures, self regulation and modern selfrelaxation techniques (IDR= Integrative and Differential Relaxation) are some of the devices to be named. Since **IT** considers creativity and cocreativity a strong healing and development fostering influence (*Petzold, Orth* 2007), a lot of techniques and media from arts therapy, movement therapy, drama therapy have been selected, empirically and clinically evaluated, theoretically elaborated to fit in the conceptual and praxeological framework of the integrative approach for diagnostic (projective and semiprojective) and therapeutich purposes.

Empirical evaluation of Integrative Therapy and the Training Program for Integrative Therapists and Supervisors

IT has brought together methods and treatment modalities by a „*multimodal*“ approach that were themselves empirically evaluated for their effectivity. Metaanalytic studies have documented a wealth of methods and techniques of various therapeutic approaches that are worthwhile to exploit. With Integrative Therapy, compatible approaches and techniques have been adapted and applied in an integrated processoriented way of working „out of the interpersonal relation“. This process as a whole has been evaluated with good results in several studies on several disorders and client groups. Psychotherapy must – whenever possible – be supported by empirical research. Most of the different methods and techniques applied by Integrative Therapy are based on empirical research for their effectivity. If methods are „incorporated“ into the repertoire of **IT,** they are „made compatible“ by framing them into the basic assumption of „co-respondence“, the practice of „intersubjectivity“ and the principle of „selfreflectivity“ and „discourse“. In this way the highly effective treatment methods developed by behavior therapy to treat anxiety disorders have been used together with and on the basis of biographical reflections and interpersonal encounters, i. e. within a framework which is neither reductionistic nor technocratic. In the same line of thinking, psychotherapy research is implemented in cooperation with the patients.

With Integrative Approach, a model of „*Optimal Quality Management*" has been developed, establishing a „*quality cycle*" combining the evaluation of psychotherapy training, psychotherapy research and empirical studies on clinical supervison, the „**EAG-Quality-System**": The training curriculum and the training program have been permanently evaluated since 1974 (n= 1490 participants) in sophistcated studies. In the general evaluation the alumni consider the training to be „very good" and „good" (*Petzold, Steffan* 2000b) on a five points scale. From 1997 to 1999, all the courses offered in the context of the programs of the **EAG** 3995 evaluation forms produced results beween 80 and 95 % on all quality parameters (*Petzold, Steffan, Zdunek* 2000). The same quality was reached in two follow up studies for the years 1999 to 2006 with more than 7000 evaluation forms (*Petzold, Rainals* et al. 2006; *Petzold* 2005s). Of the many studies on the effectivity of Integrative Therapy (overview in *Sponsel* 1995), one is of particular interest. 59 privately practicing therapists, who gaduated from the EAG program as „integrative therapists", participated with 211 patients with various disorders in a study on the effectivity of short term „Integrative Focal Therapy" which a complex set of research instruments (five points of measurement including a 6 months follow up, which showed stable results). The results turned out to be good and very good (*Petzold, Hass, Märtens, Steffan* 2000). Studies with PTSD-patients (*Petzold, Wolf* et al. 2000), with psychosomatic pain patients (*Heinl* 1997) or patients with major depressions (*van der Mei, Petzold, Bosscher* 1997) or addiction problems (*Petzold, Scheiblich, Thomas* 2000) have been sucessfully treated by trainig therapists and graduates of **EAG,** proving on this very concrete level that the education offered by the **EAG** is highly efficient, not only by the judgement of the alumni but according to the results of their practical therapeutic work with patients . A new controlled study by *Leitner* (et al. 2009) at the Donau University, Krems, Austria showed once more very convincing results in the treatmen of a broad scope of disorders treated by integrative psychotherapists, medical doctors in private practice (control group, treatment with medication). Studies on the three years training program for clinical supervisors offered by **EAG** have provided similarly convincing results (*Oeltze, Ebert, Petzold* 2000 n= 68). A study for the Austrian Ministry of Science showed that the training program for clinical supervisors of EAG resulted on the side of the participants in a considerable outcome in interventive competence (Schigl, Petzold 1997).
These supervisors are again bringing their competence to the training program for EAG therapist, and they are instrumental to assure and to develop the quality of the therapists in their clinical work. Internationally, the „EAG Quality System" of evaluating the quality of training, therapy, and supervision (*Petzold* 2003a, 2007a, *Sieper* et al. 2007)of one program is unique in the field of psychotherapy and psychotherapy training on an international level.

To conclude

The field of psychotherapy is in permanent development. New clinical experiences, methodological innovations and research in those sciences as being relevant for psychotherapy as well as outcome and process studies by psychotherapy resarchers themselves have produced many new concepts and praxeologies, differential and integrative approaches that enlarge and often overcome the traditional approaches. Modern approaches of contemporative therapy are aware that their dicipline is in a process of ongoing progress. Integrative therapy is striding here in the first line.
The Program, the Institution, Certification, National and International Recognition

Integrative Therapy (IT)
An Innovative Approach of „Biopsychosocial" Psychotherapy
and Body Oriented Intervention

A Four Years Professional Training for Psychologists, Medical Doctors
and Academic Health Professions in: Individual and Group Psychotherapy,
Body Methods, Family and Social Network Interventions
Offered by:

„European Academy of Psychosocial Health" (EAG)
State recognized Academy of Professional Training, Düsseldorf, Germany

The Training Program:

The Training Program of „Integrative Therapy" has been operated by the EAG since 1972. It offers professional training in modern research based psychotherapy und body oriented (psychophysiological) treatment for psychological and psychosomatic disorders to psychologists, medical doctors and academic health professionals. The curriculum is organized in block seminars (weekends und week residentials) with a „basic level program" (1. and 2. year) and an „advanced level program" (2. and 4. year). The courses and seminars are offered by an international staff of highly experienced clinical training therapists, researchers and clinical supervisors approved by the EAG, by the cooperating clinical university centers, and by the professional organizations in their countries. This way, a high standard of theoretical, methodological and clinical „knowhow transfer" is possible on an European and international level.

Summary
This text offers a concise presentation of „**Integrative Therapy**“ as a *basic approach* of a differentiated and integrative „Therapy of the Human Being“, i.e. psychotherapy, bodytherapy, nootherapy, sociotherapy and ecological intervention with its *methods* of creative therapy (art-, music-, poetrytherapy). Briefly anthropology, developmental and personality theory, theory of health and disease are repesented as well as the structure of education and the professional trainig programme.

Zusammenfassung
Dieser Text bietet in englischer Sprache eine kompakte Darstellung der „**Integrativen Therapie**“ als *Verfahren* differentieller und integrierender „**Humantherapie**“, d.h. der Psychotherapie, Leibtherapie, Nootherapie, Soziotherapie, ökologischer Intervention mit ihren *Methoden* kreativer Therapie z.B. Kunst-, Musik-, Poesietherapie) . Anthropologie; Entwicklungs- und Persönlichkeitstheorie, Gesundheits- und Krankheitslehre und die Struktur der Ausbilung werden kurze dargestellt.

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INTEGRATIVE THERAPIE (IT) KOMPAKT

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1. Die Institution: Das „Fritz Perls Institut für Integrative Therapie, Gestalttherapie und Kreativitätsförderung“ (FPI) wurde 1972 von *Hilarion G. Petzold, Johanna Sieper* gegründet, 1974 mit *Hildegund Heinl* als gemeinnützige GmbH in Düsseldorf, 1981 in der Trägerschaft des FPI die „Europäische Akademie für psychosoziale Gesundheit“ (EAG), staatlich anerkannte Einrichtung der beruflichen Weiterbildung am Beversee, 1985 die Schweizer „Tochter“ (SEAG). Die EAG gilt als das führende Zentrum für Methodenintegration in der Psychotherapie, für kreativitätstherapeutische und leibtherapeutische Verfahren (Integrative Leib- und Bewegungstherapie, Tanztherapie, Musiktherapie, Kunsttherapie, Poesie-/Bibliotherapie). Sie ist europaweit tätig. Fachbereiche: Supervision/OE/Coaching, Psychotherapie, Kinder-/Jugendlichenpsychotherapie, Soziotherapie/Suchttherapie, eigene Forschungsabteilung, Ausbildungen in 8 europäischen Ländern (*Petzold, Sieper* 1996). Universitäre Kooperationen: „Center for IBT“, Free University of Amsterdam, „Zentrum für psychosoziale Medizin“, Donau-Universität Krems.
Hintergrund des Verfahrens: Die IT wurde in den kulturellen Umbrüchen, Innovationen und dem beginnenden europäischen Denken der 60er Jahre in Paris entwickelt.
Einflüsse: *Metatheoretisch* durch Erarbeitung einer „klinischen Philosophie“ (1991a): mit *Marcel*, *Merleau-Ponty, Ricœur, Levinas, Schmitz* für die „therapeutische Hermeneutik“, die Leibsubjekt- und Beziehungstheorie, *Foucault, Deleuze, Bourdieu, Bakhtin* u.a. für kulturkritische Perspektiven, *Darwin, Teilhard de Chardin*, *Florensky, Whitehead* für das Weltbild. *Klinisch-psychologische Einflüsse*: integrationsorientierte Ansätze (*Janet*, *Delaye* u.a.) ergänzt durch neurowissenschaftliche Perspektiven der „russischen Schule“ (*A. Ukhtomsky, N. Bernstein*, *A. Lurija, L. Vygotskij,* vgl. *Petzold, Michailowa* 2008) heute dann auch durch *Damasio, Edelman, Freeman, LeDoux* u.a.), *etwicklungspsychologische*: *Vygotsky, Wallon, Piaget, Baltes* für den „clinical lifespan developmental approach“ der IT (1992a, 1994j), *sozialpsychologische*: *Politzer, Lewin, Moscovici* u.a.. *Praxeologische Einflüsse*: aktionale, erlebnisaktivierende Methoden wie aktive Psychoanalyse (*Ferenczi*), Psychodrama (*Moreno*), Therapeutisches Theater (*Iljine*), Gestalttherapie (*Perls*), Imaginationsübungen (*Janet*), Leibtherapie (*Gindler/Ehrenfried, Reich/Råknes,* Budo-Tradition), behaviorale Methoden (*Bandura, Lazarus, Kanfer, Bernstein,* vgl. *Sieper* 2001). Als „biopsychosoziales Modell“ (2001a) ist IT aus einem *polyzentrischen Netz von Wissen und Praxen, von Konzepten und Methoden* hervorgegangen, einem *polylogischen, interdisziplinären Diskurs* von Humanwissenschaften, in welchem *transdisziplinäre* Erkenntnisse emergieren konnten, ein *eigenständiger methodenübergreifende* Ansatz in Theorie und Praxis geschaffen wurde. Die Integration dieser Komplexität wurde mit dem „*metahermeneutischen* Modell „vielfältiger„Ko-respondenz“ (Polylogik, Diskursivität, *Habermas*, *Bakhtin* u.a.) und durch eine *nicht-lineare systemische* Betrachtung (*Ukhtomsky, Luhmann*, *Haken* u.a.) angegangen. Dabei führen „multiple Konnektivierungen“ von differenten Konzepten und Praxeologien zu zwei Integrationsmodi: „*schwache Integrationen*“ als *Heuristiken* und *Konzepten* oder bei sehr hoher Vernetzungsdichte „*starke Integrationen*“ als Vorhandenes in neuer Weise überschreitende *übergeordnete Modelle* – beide Modi sind wichtig (2002a,b) und müssen ideologiekritisch (*Petzold, Orth* 1999) und empirisch abgesichert werden (*Wirkungs*-/Nebenwirkungsforschung, 2001a, *Märtens*, *Petzold* 2002).
Die IT ist eines der ersten Verfahren im „*neuen Integrationsparadigma*“ moderner Psychotherapie (1992a, *Norcross, Goldfried* 1992) mit eigenen Ansätzen der Kindertherapie, Leib- /Bewegungstherapie, Kreativtherapien (1998a; *Petzold, Orth* 2007), Supervision (*Petzold* 2007a).
Gründer: *Hilarion G. Petzold* (*1944 Kirchen), Weiterentwicklungen mit *J. Sieper, H. Heinl, Ilse Orth* und vielen KollegInnen. *Petzold* studierte in Paris (1963-1971) Philosophie, Psychologie, Theologie (Dr. theol. 1968; Dr. phil. 1971 bei *G. Marcel*), in Düsseldorf und Frankfurt (1971-1979) Medizin, Soziologie, Erziehungswissenschaften (Dr. phil. 1979). 1971 Professur in Paris, seit 1979 an der FU Amsterdam (Professor für Psychologie und Psychomotorik); zahlreiche Gastprofessuren (1980- 1989 Bern, Abt. klinische Psychol. *K. Grawe*), seit 2000 Psychotraumatologie und Supervision, Donau-Universität, Krems. Arbeitsschwerpunkte: Vergleichende Psychotherapie, Entwicklungspsychologie der Lebensspanne, Psychotraumatologie, Supervision. – mehr als1000 Veröffentlichungen (*Petzold* 2007h). Begründer von „Integrative Therapie. Zeitschrift für vergleichende Psychotherapie und Methodenintegration“ 1975ff. *Petzold* wurde von „Die Zeit“ als „Leitfigur der Psychotherapie“

und von „Psychologie Heute" als „Universalgelehrter der Psychologie" portraitiert (vgl. *Geuter* 2008; *Zundel* 1987; *Sieper* et al. 2007).

Verbreitung, Zahlen, Chartamitgliedschaft: In Deutschland, Österreich, der Schweiz wird IT ab 1972 und seitdem in zahlreichen europäischen Ländern und in Übersee gelehrt. Integrative Psychotherapieformen haben große internationale Verbreitung.

AbsolventInnen/Mitglieder: In Schweizer Fachvereinigungen (SPV, FSP, SIBT u.a.) ca. 300; international: ca. 3500; in Ausbildlung ca. 30; international: ca. 180. Gründungsmitglied der Schweizer Therapie Charta.

2. Menschenbild: Therapeutisches Handeln erfordert eine – Genderperspektiven berücksichtigende - Entwicklungs- und Persönlichkeitstheorie, Gesundheits-/Krankheitslehre im Rahmen einer Therapietheorie vor dem Hintergrund eines anthropologischen Metakonzeptes, das zu fassen sucht*, was zur* „Hominität", *zu Wesen und Natur des Menschen gehört, über die immer wieder zu jeder Zeit und an jedem Ort von den Wesen, die sich Menschen nennen, nachgesonnen, nachgedacht werden muß,* damit sich dieses Wesen beständig entwickelt und „Humanität" geschaffen wird. 1965 wurde eine *anthropologische Grundformel* erarbeitet (mit den Elementen 0, 1, 2, 3, A, B, C):

- *„Der Mensch als Mann oder Frrau ist zugleich exzentrisches Leibsubjekt und als Leib zentriert in der Lebenswelt. Er ist ein Körper[1]-Seele[2]-Geist[3]-Wesen in einem sozialen[A] und biophysikalischen[B] Umfeld, d. h. er steht in Kontext und Kontinuum[C] in der lebenslangen Entwicklung einer souveränen und schöpferischen Persönlichkeit und ihrer Hominität[0]".*
- Er hat in der Ko-respondenz mit dem Anderen (*Levinas*) und in der Interaktion mit relevanten Umwelten (*Vygotsky, Lewin*) die Chance, in selbstreflexiven und diskursiven Entwicklungsprozesen in der Lebensspanne[C] und in zu gestaltenden sozialen Netzwerken und Lebenslagen[D] seine Hominität[0] und eine komplexe Persönlichkeit zu entwickeln: d.h. ein kohärentes und zugleich pluriformes Selbst[I] mit einem leistungsfähigen, transversal operierenden Ich[II] und einer konsistenten, aber flexiblen Identität[III].
- Integrative Identitätstheorie und -therapie differenziert 5 „Säulen der Identität": 1. Leiblichkeit, 2. Soziales Netzwerk, 3. Arbeit/Leistung/Freizeit, 4 materielle Sicherheiten, 5. Werte. Die zentralen Begriffe (Fettdruck und Siglen) wurden mit *Anschluß* an sozialwissenschaftliche Theorien spezifisch definiert (2002b).

Ein differentielles und integratives Therapieverständnis folgt aus dieser komplexen Sicht.

3. Gesundheits/Krankheitsverständnis: Die IT kennt eine „anthropologische Gesundheits/Krankheitslehre", die die gesellschaftliche Dimension fokussiert und auf die Kernkonzepte „*multiple Entfremdung*" für kollektive und individuelle *Pathogenese* und „*multiple Zugehörigkeit*" für die *Salutogenese* zentriert. Daneben gibt es eine „allgemeine" und „spezielle" klinische Krankheits/Gesundheitslehre, die *einen* verwobenen Prozess von „Salutogenese/Pathogenese über die Lebensspanne" annimmt. Sie gründet im Kernkonzept „*multipler Stimulierung*" des Menschen durch vielfältig interagierende Einflüssen aus der Umwelt, in die er eingebettet (*embedded*) ist, und die verleiblicht (*embodied*) werden: mit *salutogener Stimulierung* (protektive Faktoren, z.B.Anregung, Herausforderung, Support, Konsolidierung) und mit *pathogener Stimulierung* (Risiko- und Belastungsfaktoren). In Auswertung der *empirischen entwicklungspsychologischen Longitudinalforschung* (*Petzold* et al. 1993) wurden herausgearbeitet:

- Pathogenesefaktoren: 1. Genetische/somatische Einflüsse und Dispositionen, 2. Entwicklungsschädigungen (frühe und in der Lebensspanne), 3. adversive psychosoziale Einflüsse (Milieufaktoren), 4. Negativkarriere im Lebenslauf, 5. internale Negativkonzepte, 6. Auslösende aktuale Belastungsfaktoren, 7. diverse Negativeinflüsse als ungeklärte Faktoren. Salutogenesefaktoren: 8. Entwicklungsförderung (frühe und in der Lebensspanne), 9. konstruktive psychosoziale Einflüsse, 10. Positivkarriere im Lebensverlauf, 11. internale Positivkonzepte, 12. aktuale Unterstützungsfaktoren (2001a).
- In der „speziellen Krankheitslehre" wurden *störungsspezifische* Modelle (z. B. Genese von depressiven, posttraumatischen Störungen usw.) entwickelt (*Petzold* et al. 2002).
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4. Therapieverständnis: Therapie hat 1. eine klinisch-kurative, 2. gesundheitsfördernde, 3. persönlichkeitsentwickelnde, 4. eine kulturkritische Aufgabe. Sie geht differentiell vor und zielt: a) *somatotherapeuisch* auf die körperliche Realität des Menschen, b) *psychotherapeutisch* auf die seelische, c) *nootherapeutisch* auf die geistige, d) *soziotherapeutisch* auf die sozioökologische Realität. Ein überaus reiches Repertoire an psycho-, körper- und kreativtherapeutischen Methoden und „kreativen Medien" (*Petzold, Orth* 2007) wurde deshalb in der IT für ihre Arbeit in *intersubjektiven therapeutischen Beziehungen* und in den *Polylogen* netzwerkorientierter Behandlung entwickelt. „Vier Wege der Heilung und Förderung" bieten eine differentielle Praxeologie:

I. *Weg*: kognitives Verstehen/Bewußtseinsarbeit → Einsicht in biographische Determinierungen, neue Sinnfindung durch Evidenzerlebnisse

II. *Weg*: Emotionale Differenzierungsarbeit, parenting, Durcharbeiten →, Nachsozialisation, Bekräftigung von Grundvertrauen

III. *Weg*: Erlebnisaktivierung, Trainig → Förderung assertiven und kreativen Verhaltens, Persönlichkeitsentfaltung

IV. *Weg*: Solidaritätserfahrung, empowerment → Förderung persönlicher Souveränität (2002a)

Forschungsgestützt wurden 14 Heilfaktoren herausgearbeitet. Sie werden indikationsspezifisch eingesetzt. Das Verfahren und seine besonderen, störungsspezifischen Vorgehensweisen wurden mit guten Ergebnissen empirisch evaluiert und als nebenwirkungsfrei/-arm befunden (2001a; *Märtens, Petzold* 2002). In der Verbindung der Ergebnisse moderner Psychotherapieforschung mit denen neurowissenschaftlicher und psychologischer Forschung (*Petzold*, *Sieper* 2008) und mit fundierten philosophischen Positionen, politisch engagiertem Handeln und einer kreativen Praxeologie (*Petzold, Orth* 2007) liegt die besondere Charakteristik des Integrativen Therapieverständnisses.

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