UNIT 4 PSYCHOTHERAPY INTEGRATION

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4.0 INTRODUCTION

A major emphasis of this unit is on helping you construct your own integrated approach to psychotherapy. Research has indicated that psychotherapy is moving toward an integrated approach to therapy. Throughout the world, when you ask a psychologist or counsellor what his or her theoretical orientation is, the most frequently given response is integrative or eclectic. It is highly likely that upon graduation, you will integrate one or more of the theories presented in this block. This unit explores in detail the integrative approach to therapy. This unit traces the historical development, variables responsible for, the different models and future of integrative approach.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe the concept of integrative psychotherapy;
- Describe the historical perspective of the integrative movement;
- Explain the variables responsible for growth of psychotherapy integration;
- Analyse the different ways to psychotherapy integration;

- Explain evidence based therapy and integrative practice; and
- Analyse the future of psychotherapy schools and therapy integration.

4.2 DEFINITION OF INTEGRATIVE PSYCHOTHERAPY

Integrative psychotherapy is an attempt to combine concepts and counselling interventions from more than one theoretical psychotherapy approach. It is not a particular combination of counselling theories, but rather it consists of a framework for developing an integration of theories that you find most appealing and useful for working with clients. According to Norcross (2005):

Psychotherapy integration is characterised by dissatisfaction with single school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy.

Within this integrative therapy we have Meaning Therapy which is an integrative approach. Meaning therapy (MT), also known as meaning centered counseling and therapy (MCCT), is an integrative, positive existential approach to counseling and psychotherapy. Originated from logo therapy, MT employs personal meaning as its central organising construct and assimilates various schools of psychotherapy to achieve its therapeutic goal. MT focuses on the positive psychology of making life worth living in spite of sufferings and limitations. It advocates a psycho educational approach to equip clients with the tools to navigate the inevitable negatives in human existence and create a preferred future. The paper first introduces the defining characteristics and assumptions of MT. It then briefly describes the conceptual frameworks and the major intervention strategies. In view of MT's open, flexible and integrative approach, it can be adopted either as a comprehensive method in its own right or as an adjunct to any system of psychotherapy.

Integrative psychotherapy offers a safe environment for the exploration of body, mind, emotion and spirit, and their impact on health, personal fulfilment and relationships.

Because everyone is unique, my therapeutic approach is shaped according to your particular needs and wishes. Together we bring your authentic, true self into focus, calling forth your inner strengths and resiliency while you explore your vulnerabilities and concerns. We may use insight, mindfulness, an interactive style of guided imagery, the Work of Byron Katie, solution focused therapy, EMDR, EFT, and cognitive behavioural therapy, to name a few. EMDR refers to EMDR stands for Eye Movement Desensitisation Reprocessing, a highly effective and well-researched therapeutic method developed in 1987 by Dr. Francine Shapiro, for healing many types of psychological distress including past or recent trauma, self esteem issues, creativity blocks, complex unresolved grief, being the victim of a violent crime, combat experiences, and performance anxiety. It is also used to enhance performance, build self-confidence and inner resiliency.

Our brains can process and integrate most of our experiences without leaving a lasting negative effect. But research in the area of trauma tells us that when an

experience is very intense or threatening, the ability to process the experience can get stuck along with negative interpretations or beliefs. EMDR works to unlock the lodged memories and reengage the brain's natural ability to integrate the experience.

EFT refers to Emotional Freedom Technique or EFT for short. It is one of the most remarkable health innovations in the last 100 years. It is based on impressive discoveries regarding the bodies' energy system. It works on just about every emotional and physical issue you can name. In fact it often works where all else has failed and can work where conventional medicine has no answers. EFT has its basis in Chinese acupuncture and psychology but instead of using needles you simply tap on well established meridian points on the upper body. EFT is a painless and relaxing method of healing.

EFT is a powerful technique and a potent technique that helps you take control of your body and your thoughts. This technique was developed by Gary Craig in 1990 and has originated from acupuncture, kinesiology, and psychology. This wonderful technique has shown amazing results in developing attitude and behaviour, resolving personal problems, decreasing stress, and restoring life balance.

Emotional Freedom Technique is an efficient technique offering solutions to stress related problems and helps in balancing the body's energy system. This painless technique effectively deals with any psychological or physiological problem and shows concrete results within a short time.

EFT aims at returning the mind, body, and emotions of an individual to a balanced and harmonious state so that he or she is free from negative emotions.

EFT is a gentle method that works by balancing the body's energy system.

Many a times we are affected by bad relationships, traumas, or losses. Work related stress, depression, interpersonal problems, and anxieties also affect our mental health. These negative emotions block the flow of energy in our system and have a detrimental effect on our health. EFT helps in releasing these negative emotions and resolving the problem.

EFT involves treating physiological or psychological problems by tapping specific acupressure points with fingers. It is you who taps yourself. I have no need to touch you at all. My role is to tell you where to tap and also what to say as you tap. The procedure can be done over the telephone or the Internet. It is easy to do and I have never had a client who found it difficult.

EFT helps in Pain Management, Addictions, Allergies, Weight Loss, Headaches, Asthma, Trauma, Abuse, Depression, Eating Disorders, Blood Pressure, Anorexia, and many more diseases and maladies.

EFT often works where every other treatment fails. In fact EFT helps with virtually every physical and emotional problem that one can think of.

Self Assessment Questions

1) What is integrative psychotherapy?

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2) Describe the characteristics of integrative psychotherapy.

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3) What is EMDR? Explain

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4) Elucidate the EFT technique.

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4.3 HISTORICAL OVERVIEW OF THE INTEGRATIVE MOVEMENT

Integrative therapy draws on some of the oldest techniques of psychotherapy. It was developed during the 1970s by Richard G Erskine PHD and at The Institute for Integrative Psychotherapy.

The Integrative psychotherapy model recognises the use of other therapeutic approaches such as humanistic, cognitive, gestalt and psychodynamic and attempts to fuse them into a approach that is of benefit to the individual. The facilitation of a person's 'wholeness' to improve their quality of life.

The movement toward integration of the various schools of psychotherapy has been in the making for decades. On the whole, however, psychotherapy integration has been traditionally hampered by rivalry and competition among the various schools. Such rivalry can be traced to as far back as Freud and the differences that arose between him and his disciples over what was the appropriate framework for conceptualising clients problems. From Freud's Wednesday evening meetings on psychoanalysis, a number of theories were created, including Adler's individual psychology. As each therapist claimed that he had found the one best treatment approach, heated battles arose between various therapy systems. When behaviourism was introduced to the field, clashes took place between psychoanalysts and behaviourists.

During the 1940s, 1950s, and 1960s, therapists tended to operate within primarily one theoretical school. Dollard and Miller's (1950) book, *Personality and Therapy,* was one of the first attempts to combine learning theory with psychoanalysis. In 1977, Paul Wachtel published Psychoanalysis and Behaviour Therapy: Toward an Integration. In 1979, James Prochaska offered a trans theoretical approach to psychotherapy, which was the first attempt to create a broad theoretical framework.

In 1979, Marvin Goldfried, Paul Wachtel, and Hans Strupp organised an association, the Society for the Exploration of Psychotherapy Integration (SEPI), for clinicians and academicians interested in integration in psychotherapy (Goldfried, Pachankis, & Bell, 2005). Shortly thereafter in 1982, *The International Journal of Eclectic Psychotherapy* was published, and it later changed its name to the *Journal of Integrative and Eclectic Psychotherapy.* By 1991, it began publishing the *Journal of Psychotherapy Integration.* As the field of psychotherapy has developed over the past several decades, there has been a decline in the ideological cold war among the various schools of psychotherapy (Goldfried, Pachankis, & Bell, 2005).

Integrative therapy is different from eclectic therapy. Integration is like choosing raw ingredients to make a balanced and nutritious meal, from a recipe to be used again, whilst eclecticism is like visiting the salad bar to select prepared food for just that meal, equally nutritious, and a different selection can be made next time.

It is this considered, methodical attempt to bring theories and practices together that sets the integrationists apart from the eclectics.

Paul Wachtel, a central figure in the integrative movement since the seventies, says that eclecticism tends to focus on "what works," and relies heavily on empiricism and statistical analysis to discover what seems to work. For Wachtel, it is this lack of theory that distinguishes the eclectics from the more theoretically grounded integrationists, who should be able to say not only what works, but why it works.

Tullio Carere, a committed integrationist, sketches the history of psychotherapy integration in several phases (www.cyberpsych.org/sepidocs.htm). The first, the "latency" phase, began in the early 1930's but was not a well defined area of interest, he says. The 1970's saw the more clear delineation of integration as a concern, with more concerted efforts being made at rapprochement across the boundaries. An interim phase, he says, was marked by the launch of the Society for the Exploration of Psychotherapy Integration (Sepi) in 1983 and the growing concern with a range of themes in integration and common theoretical and clinical languages.

The third phase, he suggests, is beginning with the new century, and, if successful, will see integrative psychotherapy moving from an area of interest to a scientific discipline.

Psychotherapy integration is not a new school, but there are new schools which, while integrative, are discrete new schools which draw on and systematically integrate the most useful ideas they can find from other schools.

A typical integrative brand of therapy is Eye Movement Desensitisation and Reprocessing, (EMDR). But the history of EMDR is illustrative of the emergence of discrete new schools.

The history of EMDR has been dogged by controversy which makes other, more traditional modality wars look tame by comparison. Those opposed to the method have slated the lack of evidence and theoretical grounds for its claimed efficacy (see page 16 of this edition). In response, its proponents have scrambled for more research-based evidence of its value and recruited thousands of practitioners as trainees and advocates of the method.

To be truly integrative then, means to largely abandon one's religious favour about any particular method, including any discrete approaches or philosophies which are themselves integrative of other approaches. Sound like a difficult balancing act? Well, why do you think it has taken integrationism 70 years to get integrated into our psychotherapeutic repertoires?

4.4 VARIABLES RESPONSIBLE FOR GROWTH OF PSYCHOTHERAPY INTEGRATION

Norcross and Newman (1992) have summarized the integrative movement in psychology by identifying eight different variables that promoted the growth of the psychotherapy integration trend in counselling and psychotherapy.

First, they pointed out that there was simply a proliferation of separate counselling theories and approaches. The integrative psychotherapy movement represented a shift away from what was the prevailing atmosphere of factionalism and competition amongst the psychotherapies and a step toward dialogue and cooperation.

Second, they noted that practitioners increasingly recognised the inadequacy of a single theory that is responsive to all clients and their varying problems. No single therapy or group of therapies had demonstrated remarkable superior efficacy in comparison to any other theory.

Third, there was the correlated lack of success of any one theory to explain adequately and predict pathology, personality, or behavioural change.

Fourth, the growth in number and importance of shorter-term, focused psychotherapies was another factor spearheading the integrative psychotherapy movement.

Fifth, both clinicians and academicians began to engage in greater communication with each other that had the net effect of increasing their willingness to conduct collaborative experiments.

Sixth, clinicians had to come to terms with the intrusion into therapy with the realities of limited socioeconomic support by third parties for traditional, long-term psychotherapies. Increasingly, there was a demand for therapist accountability and documentation of the effectiveness of all medical and psychological therapies. Hence, the integration trend in psychotherapy has also been fuelled by external realities, such as insurance reimbursement and the popularity of short-term, prescriptive, and problem-focused therapists.

Seventh, researchers identification of common factors related to successful therapy outcome influenced clinician's tendency toward psychotherapy integration. Increasingly, therapists began to recognise there were common factors that cut across the various therapeutic schools.

Eighth, the development of professional organisations such as SEPI, professional network developments, conferences, and journals dedicated to the discussion and study of psychotherapy integration also contributed to the growth of the movement. The helping profession has definitely moved in the direction of theoretical integration rather than allegiance to a single therapeutic approach. There has been a concerted movement toward integration of the various theories.

Self Assessment Questions

1) Present the historical overview of integrative psychotherapy movement.

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2) Elucidate the variable responsible for the growth of integrated psychotherapy.

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4.5 DIFFERENT WAYS TO PSYCHOTHERAPY INTEGRATION

This section provides an overview of how theorists and practitioners have tried to integrate the various theoretical approaches to therapy. Perhaps in examining how others have integrated their therapy with different concepts and techniques, we might feel more comfortable in thinking about how we might pursue this same avenue. Clinicians have used a number of ways to integrate the various counselling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration.

4.5.1 Eclecticism

Eclecticism may be defined as an approach to thought that does not hold rigidly to any single paradigm or any single set of assumptions, but rather draws upon multiple theories to gain insight into phenomena. Eclectics are sometimes criticized for lack of consistency in their thinking. For instance, many

psychologists accept some features of behaviourism, yet they do not attempt to use the theory to explain all aspects of client behaviour. Eclecticism in psychology has been caused by the belief that many factors influence human behaviour; therefore, it is important to examine a client from a number of theoretical perspectives.

4.5.2 Differences between Eclecticism and Psychotherapy Integration

Typically, eclectic therapists do not need or have a theoretical basis for either understanding or using a specific technique. They chose a counselling technique because of its efficacy, because it works. For instance, an eclectic therapist might experience a positive change in a client after using a specified counselling technique, yet not investigate any further why the positive change occurred. In contrast, an integrative therapist would investigate the *how and why* of client change. Did the client change because she was trying to please the therapist or was she instead becoming more self-directed and empowered?

Integrative and eclectic therapists also differ in the extent to which they adhere to a set of guiding, theoretical principles and view therapy change. Practitioners who call themselves eclectic appear to have little in common, and they do not seem to subscribe to any common set of principles. In contrast, integrationists are concerned not only with what works but why it works. Moreover, clinicians who say they are eclectic tend to be older and more experienced than those who describe themselves as integrationists. This difference is fast disappearing because some graduate schools are beginning to train psychologists to be integrationists.

4.5.3 Theoretical Integration

Theoretical integration is perhaps the most difficult and sophisticated of the three types of psychotherapy integration because it involves bringing together theoretical concepts from disparate theoretical approaches, some of which may present contrasting worldviews. The goal is to integrate not just therapy techniques but also the psychotherapeutic theories involved as Dollard and Miller (1950) did with psychoanalysis and behaviour therapy. Proponents of theoretical integration maintain that it offers new perspectives at the levels of theory and practice because it entails a synthesis of different models of personality functioning, psychopathology, and psychological change.

4.5.4 Assimilative Integration

The assimilative integration approach to psychotherapy involves grounding oneself in one system of psychotherapy but with a view toward selectively incorporating (assimilating) practices and views from other systems. Assimilative integrationists use a single, coherent theoretical system as its core, but they borrow from a broad range of technical interventions from multiple systems. Practitioners who have labelled themselves as assimilative integrationists are: (1) Gold (1996), who proposed assimilative psychodynamic therapy; (2) Castonguay et al. (2004), who have advocated cognitive-behavioural assimilative therapy; and (3) Safran, who has proposed interpersonal and cognitive assimilative therapy (Safran & Segal, 1990).

Assimilative integrationists believe integration should take place at the practice level rather than at the theory level. Most therapists have been trained in a single

theoretical approach, and over time many gradually incorporate techniques and methods of other approaches. Typically, therapists do not totally eliminate the theoretical framework in which they were trained. Instead, they tend to add techniques and different ways of viewing individuals.

4.5.5 The Common Factor Approach

The common factors approach has been influenced by the research and scholarships of such renowned leaders in psychotherapy as Jerome Frank (1973, 1974) and Carl Rogers (1951, 1957). Clearly, Rogers's contributions to common factors research has become so accepted by clinicians throughout the world that his core conditions (or necessary and sufficient conditions to effect change in clients) have become part of the early training of most helping professionals. Researchers and theorists have transformed Rogers's necessary and sufficient conditions into a broader concept that has become known as "therapeutic alliance" (Hubble, Duncan, & Miller, 1999). The therapeutic alliance is important across the various counselling theory schools; it is the glue that keeps the person coming to therapy week after week. Currently, more than 1,000 studies have been reported on the therapeutic alliance (Hubble, Duncan, & Miller, 1999).

The common factors approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on their commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than the unique factors that differentiate among them.

There is no standard list of common factors, but if a list were to be constructed, it surely would include:

- A therapeutic alliance established between the patient and the therapist.
- Exposure of the patient to prior difficulties, either in imagination or in reality.
- A new corrective emotional experience that allows the patient to experience past problems in new and more benign ways.
- Expectations by both the therapist and the patient that positive change will result from the treatment.
- Therapist qualities, such as attention, empathy, and positive regard, that are facilitative of change in treatment.
- The provision by the therapist to the patient of a reason for the problems that are being experienced.

Irrespective of the type of therapy that is practiced, each of these common factors is present. It is difficult to imagine a treatment that does not begin with the *establishment of a constructive and positive therapeutic alliance.* The therapist and the patient agree to work together and they both feel committed to a process of change occurring in the patient. Within every approach to treatment, the second of the common factors, the *exposure of the patient to prior difficulties*, is present. In some instances the exposure is in vivo (occurs in real life), and the patient will be asked directly to confront the source of the difficulties. In many cases, the exposure is verbal and in imagination. However, in every case, the patient must express those difficulties in some manner and, by doing so, re-experiences those difficulties through this exposure.

In successful treatment, the exposure usually is followed by *a new corrective emotional experience*. The corrective emotional experience refers to a situation in which an old difficulty is re-experienced in a new and more positive way. As the patient re-experiences the problem in a new way, that problem can be mastered and the patient can move on to a more successful adjustment.

Having established a therapeutic alliance and being exposed to the problem in a new and more positive context, both the therapist and the patient always *expect positive change* to occur. This *faith and hope* is a common factor that is an integral part of successful therapy. Without this hope and expectation of change, it is unlikely that the therapist can do anything that will be useful, and if the patient does not expect to change, it is unlikely that he or she will experience any positive benefit from the treatment.

The therapist must possess *some essential qualities, such as paying attention to the patient, being empathic with the patient, and making his positive regard* for the patient clear in the relationship. Finally, the patient must be provided with a *credible reason for the problems* that he or she is undergoing. This reason is based in the therapist's theory of personality and change. The same patient going to different therapists may be given different reasons for the same problem. It is interesting to speculate as to whether the reason must be an accurate one or whether it is sufficient that it be credible to the patient and not remarkably at variance with reality. As long as the reason is credible and the patient has a way of understanding what previously had been incomprehensible, that may be sufficient for change to occur.

4.5.6 Multi Theoretical Approaches

Recently, therapists have developed multi theoretical approaches to therapy. Multitheoretical frameworks do not attempt to synthesise two or more theories at the theoretical level. Instead, there is an effort to "bring some order to the chaotic diversity in the field of psychotherapy and "preserve the valuable insights of major systems of psychotherapy" (Prochaska & DiClemente, 2005, p. 148). *The goal of multi theoretical approaches is to provide a framework that one can use for using two or more theories.* Two examples of multi theoretical frameworks are (1) the trans theoretical approach by Prochaska and DiClemente, and (2) multi theoretical therapy by Brooks-Harris.

4.5.7 The Trans Theoretical Model

The most widely recognised model using a multi theoretical framework has been the trans theoretical model developed by Prochaska and DiClemente (1984, 2005). The trans theoretical model is a model of behavioural change, which has been the basis for developing effective interventions to promote healthy behaviour change. Key constructs are integrated from other counselling theories. The model describes how clients modify problem behaviour or how they develop a positive behaviour. The central organising construct of the model is the stages of change. The theorists maintain that change takes place through five basic stages: (1) pre contemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance.

In the pre contemplation stage, people are not intending to take action in the foreseeable future, usually measured as the next 6 months. During the contemplation stage, people are intending to change within the next 6 months. In the preparation stage, clients are intending to take action in the immediate

future, usually measured as the next month. Clients in the action stage have made specific overt modifications in their life styles within the past 6 months. During the maintenance stage, clients work to prevent relapse, a stage which is estimated to last from 6 months to about 5 years. The termination stage of change contains clients who have zero temptation and 100% self-efficacy. They are confident they will not return to their old unhealthy habit as a way of coping.

The trans theoretical model also proposes 10 processes of change, which are the covert and overt activities that people use to progress through the stages. The first 5 processes involve experiential processes of change, while the last 5 are labelled behavioural processes, and these are used primarily for later-stage transitions. For instance, during the experiential processes of change, people experience consciousness rising and social liberation. The 5 behavioural processes of change range from stimulus control to counter-conditioning to self-liberation.

The trans theoretical model does not make assumptions about how ready clients are for change in their lives. The model proposes that different individuals will be in different stages and that appropriate interventions must be developed for clients based on their stages of development.

The trans theoretical model assumes that the different systems of psychotherapy are complementary and that different theories emphasise different stages and levels of change.

4.5.8 Brooks-Harris' Multi Theoretical Model

The most recent multi theoretical model for psychotherapy comes from Brooks-Harris, who provides a framework that describes how different psychotherapy systems come together. Brooks-Harris (2008) begins with the premise that thoughts, actions, and feelings interact with one another and that they are influenced by biological, interpersonal, systemic, and cultural contexts.

Given this overarching premise, he integrates the following theoretical approaches: (1) cognitive, (2) behavioural, (3) experiential, (4) bio psychosocial, (5) psychodynamic, (6) systemic, and (7) multicultural. A brief explanation of each of these areas is provided below (table 6.5.2). His framework emphasises at what point a therapist might consider using elements of psychodynamic theory or multicultural theory. A major umbrella in multicultural psychotherapy consists of the focal dimensions for therapy and key strategies.

MULTI THEORETICAL PSYCHOTHERAPY

Cognitive strategies deal with the focal dimension of clients' functional and dysfunctional thoughts.

Behavioural skills–focal dimension of actions encourage effective client actions to deal with challenges.

Experiential interventions result in adaptive feelings.

Bio psychosocial strategies emphasise biology and adaptive health practices.

Psychodynamic – interpersonal skills are used to explore clients' interpersonal patterns and promote undistorted perceptions.

Systemic – constructivist interventions examine the impact of social systems and support adaptive personal narratives.

Multicultural – feminist strategies explore the cultural contexts of clients' issues.

Brooks-Harris presents five principles for psychotherapy integration, which include

1) Intentional integration,
2) Multidimensional integration,
3) Multi theoretical integration,
4) Strategy-based integration, and
5) Relational integration.

The first principle says that psychotherapy integration should be based on intentional choices. The therapist's intentionality guides his or her focus, conceptualisation, and intervention strategies.

Principle two (multidimensional) proposes that therapists should recognise the rich interaction between multiple dimensions.

The third principle asserts that therapists take into consideration diverse theories to understand their clients and guide their interventions.

The fourth strategy based principle states that therapists combine specific strategies from different theories. Strategy-based integration uses a pragmatic philosophy. Underlying theories do not have to be reconciled.

The fifth or relational principle proposes that the first four principles must be enacted within an effective therapeutic relationship.

Brooks-Harris' (2008) model offers a good plan for therapists seeking to implement an integrative multitheoretical approach. He outlines strategies for each of the seven core areas. For instance, cognitive strategies should encourage functional thoughts that are rational and that promote healthy adaptation to the environment. In addition, he enumerates a catalogue of 15 key cognitive strategies, which include identifying thoughts, clarifying the impact of thoughts, challenging irrational thoughts, providing psychoeducation, and supporting bibliotherapy.

To integrate behavioural therapy into one's practice, he suggests some of the following catalogue of key strategies: assigning homework, constructing a hierarchy, providing training and rehearsal, determining baselines, and schedules of reinforcement.

4.5.9 Helping Skills Approach to Integration

Clara Hill (2004) has provided a helping skills model to therapy integration. Her model describes three stages of the helping process that are based on different therapy schools.

The first stage of helping is labelled *exploration.* Using Rogers' client-centered therapy as the therapy school of choice, Hill (2004) emphasises the counselling skills of attending, listening, and reflection of feelings.

The second stage is termed *insight,* and this stage is based on psychoanalytic theory; therefore, such skills as interpreting and dealing with transference are stressed.

The third stage is termed the *action stage,* and this stage is based largely on cognitive-behavioural techniques. Using the helping skills model, training would focus on teaching graduate students techniques associated with each of these three therapeutic schools.

Self Assessment Questions

1) What are the ways to integrate psychotherapy?

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2) Differentiate between eclectic therapy and integrative therapy.

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3) What is meant by assimilating integrations?

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4) Explain common factor approach in Integrated Psychotherapy.

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5) Discuss multi theoretical approach.

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6) Explain Brooke Harris Multi theoretical approach to integrative psychotherapy.

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4.6 EVIDENCE BASED THERAPY AND INTEGRATIVE PRACTICE

Regardless of whether a therapist uses an integrative approach or one based on a single therapy school, he or she will have to take into consideration whether or not empirical support exists for a chosen treatment approach. Evidence based practice (EBP) is a combination of learning what treatments work based on the best available research and taking into account clients culture and treatment issues.

The American Psychological Association (2006, p. 273) conceptualises evidence based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." Evidence based practice emphasises the results of experimental comparisons to document the efficacy of treatments against untreated control groups, against other treatments, or both.

The arguments in favour of EBP are reasonable.

First, clients have a right to treatments that have been proven to be effective.

Second, managed care requires counsellor accountability in choosing a method of treatment.

Increasingly, counsellors may have to consult with research studies to determine which approach is the most efficacious with what mental health disorder. Helping professionals may be required to answer for using a therapeutic approach with a specific disorder.

How does a therapist implement EBP in practice? The therapist must gather research that informs him or her about what works in psychotherapy. Such information should be obtained *before treatment is begun.*

There are several major resources for evidence-based practice. For instance, the Cochrane Collaboration (http://www.cochrane.org) sets standards for reviews of medical, health, and mental health treatments and provides "systematic reviews" of related research by disorder. Cochrane Reviews are designed to help providers, practitioners, and patients make informed decisions about health care and are the most comprehensive, reliable, and relevant source of evidence on which to base these decisions. Moreover, the United States government also offers treatment guidelines based on EBP principles at the National Guideline Clearinghouse (http://www.guideline.gov/). This site contains very good information on medication.

Other online resources for EBP and treatment guidelines include the American Psychiatric Association (APA), which offers practice guidelines for mental health (http://www.psych.org/psych_pract/treatg/pg.prac_guide.cfm).

4.7 FUTURE OF PSYCHOTHERAPY SCHOOLS AND THERAPY INTEGRATION

What does the future look like for psychotherapy schools? Norcross, Hedges, and Prochaska (2002) used a Delphi poll to predict the future of psychotherapy over the next decade. The experts who served as participants in the poll predicted that the following theoretical schools would increase the most: *cognitive-behaviour therapy, culture-sensitive multicultural counselling, Beck's cognitive therapy, interpersonal therapy, family systems therapy, behaviour therapy, technical eclecticism, solution-focused therapy, and exposure therapies.*

Therapy orientations that were predicted to decrease the most included *classical psychoanalysis, implosive therapy, Jungian therapy, transactional analysis, humanistic therapies, and Adlerian therapy.*

The poll also showed how psychotherapy is changing. The consensus is that psychotherapy will become more directive, psychoeducational, technological, problem-focused, and briefer in the next decade. Concomitantly, relatively unstructured, historically oriented, and long-term approaches are predicted to decrease i.e. Short term is in, and long term on its way out.

4.8 LET US SUM UP

Psychotherapy integration is defined as an approach to psychotherapy that includes a variety of attempts to look beyond the confines of single-school approaches in order to see what can be learned from other perspectives. It is characterised by openness to various ways of integrating diverse theories and techniques.

The movement toward integration of the various schools of psychotherapy has been in the making for decades. On the whole, however, psychotherapy integration has been traditionally hampered by rivalry and competition among the various schools. Such rivalry can be traced to as far back as Freud and the differences that arose between him and his disciples over what was the appropriate framework for conceptualising clients' problems.

Norcross and Newman (1992) have summarized the integrative movement in psychology by identifying eight different variables that promoted the growth of the psychotherapy integration trend in counselling and psychotherapy.

Clinicians have used a number of ways to integrate the various counselling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration.

Regardless of whether a therapist uses an integrative approach or one based on a single therapy school, he or she will have to take into consideration whether or not empirical support exists for a chosen treatment approach. Evidence-based practice (EBP) is a combination of learning what treatments work based on the best available research and taking into account clients' culture and treatment issues.

4.9 UNIT END QUESTIONS

1) Define the term integrative psychotherapy. Trace the historical overview of integrative psychotherapy movement.
2) Explain the common factors approach to psychotherapy integration.
3. Discuss the difference between technical eclecticism and assimilative integration.
4) What are the possible ways of integrating psychotherapy?
5) What are the arguments in favour of evidence based psychotherapy in practice?
6) What does future hold for psychotherapy schools?

4.10 GLOSSARY

Common Factors : This term is used when the techniques are common to all approaches to psychotherapy.

Assimilative Integration : It is an approach in which the therapist has a commitment to one theoretical approach but also is willing to use techniques from other therapeutic approaches.

Technical Eclecticism : In this approach, diversity of techniques is displayed but there is no unifying theoretical understanding that underlies the approach.

Theoretical Integration : This model requires integrating theoretical concepts from different approaches, and these approaches may differ in their fundamental philosophy about human behaviour.

Multitheoretical Approaches : These approaches provide a framework that one can use for using two or more theories.

Evidence-based Practice(EBP): It is a combination of learning what treatments work based on the best available research and taking into account clients' culture and treatment issues.

4.11 SUGGESTED READINGS

Corsini, Raymond J., Wedding, Danny. (2008). *Current Psychotherapies.* USA: Brooks/Cole.

Messer, S. B. "A critical examination of belief structures in interpretive and eclectic psychotherapy." In *Handbook of Psychotherapy Integration,* edited by J. C. Norcross and M. R. Goldfried. New York: Basic Books, 1992: 130-165.

Sommers-Flanagan, John., Sommers-Flanagan, Rita. (2004). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques.* Hoboken, New Jersey: John Wiley & Sons, Inc.

Stricker, G., and J. Gold. (Eds.) *Comprehensive handbook of psychotherapy integration.* New York: Plenum, 1993.